
Psychotherapist-Patient Privilege, Recordkeeping, and Maintaining Psychotherapy Case Notes in Professional Practice: The Need for Ethical and Policy Reform Confidentialité des communications psychothérapeute-patient, tenue des dossiers et des notes de cas de psychothérapie dans le cadre de l'exercice professionnel : nécessité d'une réforme déontologique et politique

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ABSTRACT

A growing trend in Canadian mental healthcare professes that the best standard of practice is to keep complete notes and correspondence of all patient transactions in the mental health practitioner's file, including a record of intimate personal details revealed in therapy. This file, however, is subject to intrusive inspection by third parties who may ask to view its contents. This creates a conundrum and a potential risk for the field of mental health. Professionals of all kinds are asked to keep in confidence whatever is disclosed in sessions, but the law prohibits privileged communication. This article challenges the distinction between privilege and confidentiality, and discusses the recording and filing of psychotherapy case notes, as well as the greater ethical questions these issues generate. I advocate a corrective: an alternative method of recordkeeping that maintains files for process notes separate from the official clinical record. This procedure insulates the patient and therapist from potential risk of ethical and legal exploitation inherent in our current presumption that all clinical notes and records are subject to disclosure and inclusion in the client's file. The future of professional policy is at stake for all mental health professionals in Canada unless this issue is addressed.

RÉSUMÉ

Selon une tendance de plus en plus marquée dans le domaine des soins de santé mentale au Canada, la meilleure norme de pratique exemplaire consisterait à tenir des notes et correspondances complètes sur tous les échanges avec les patients dans le dossier sur le patient maintenu par le praticien de santé mentale, y compris en consignand les détails personnels révélés en cours de thérapie. Toutefois, un tel dossier est exposé à une inspection intrusive de la part de tierces parties qui peuvent demander à l'examiner et scruter son contenu. Cela constitue donc une problématique et un risque potentiel dans le domaine de la santé mentale. On demande à tous les professionnels de préserver la confidentialité concernant tout ce qui est divulgué durant les séances, mais la loi interdit la communication privilégiée. Dans cet article, on remet en question la distinction entre le caractère privilégié et le caractère confidentiel, l'enregistrement et l'archivage des notes de cas de psychothérapie, ainsi que les grandes questions de déontologie que ces enjeux soulèvent. À titre de mesure corrective, l'auteur milite en faveur d'une autre méthode de tenue des

dossiers qui consisterait à tenir des dossiers distincts pour les notes sur la démarche et les notes inscrites au dossier clinique officiel. Cette procédure met le patient et le thérapeute à l'abri d'une exploitation potentielle éthique et juridique eu égard à la présomption actuelle selon laquelle toutes les notes et tous les enregistrements cliniques sont susceptibles de divulgation et d'inclusion dans le dossier du client. L'avenir de la politique professionnelle est en jeu pour tous les professionnels canadiens de la santé mentale, à moins que l'on ne trouve une solution à cette problématique.

[EDITOR'S NOTE: The views expressed in this article are solely those of the author, who is providing a critique of current note taking practices. Many if not most bodies that regulate professional counselling and psychology would not recommend the keeping of two sets of notes for clients.]

In a recent article advocating for best standards of recordkeeping practices for psychologists in Canada, Taryn Bemister and Keith Dobson (2011) provided a broad overview of the ethical and legal parameters of recordkeeping facing contemporary psychologists and offered many viable recommendations. They promoted and advanced a professional space for important dialogue and debate, and their contributions may have tangible impacts on policy issues governing best standards of practice. They advised all practicing psychologists to thoroughly record every major transaction that occurs between the patient and clinician and include this in the patient's file. This recommendation includes everything from phone calls to e-mail correspondence, text messages, and, when appropriate, the intimate (and potentially graphic) details of disclosures and confessions made in the sanctity of the consulting room at the discretion of the clinician, especially if they find such material relevant. All of this, they professed, should be put in the official file.

They also advocated that clients should be allowed (and even encouraged) to examine the psychologist's case notes, including current process notes in the session (see Bemister & Dobson, 2011, 2012), which they argue are a patient's legal and ethical right. I have challenged these recommendations because they place the client's privacy and confidentiality at risk, do not protect the patient from third-party exploitation, and unnecessarily compromise the therapeutic relationship (Mills, 2012). Instead, I urge the profession to adopt a different perspective with regards to recordkeeping that places the patient's best interests and the therapeutic framework above legal paranoia. Given that Bemister and Dobson's (2011, 2012) recommendations have real consequences for mental health professionals in private or independent practice, the fate of professional policy is at stake.

Throughout this article, I will point out various ethical and legal conundrums I have experienced in private practice with regards to recordkeeping and offer a set of suggested guidelines for mental health practitioners united in a common goal of optimally helping their clients. Although therapists of all kinds and from different backgrounds may find this project of value, many of the orienting principles I address may apply to psychotherapists, counsellors, social workers, and psychologists who have a diverse breadth and scope of practice and thus offer multiple clinical

services to the public. Therefore, many of the issues discussed here are aimed at the general mental health practitioner.

CONFIDENTIALITY AND THE DISCLOSURE OF RECORDS

The concern over patient confidentiality, protecting the integrity of the therapeutic encounter, and professional autonomy in recordkeeping within ethical and legal contexts has been intensely discussed within psychoanalysis for more than a decade. We largely owe this debt of gratitude to two Canadians, psychologist and psychoanalyst Allannah Furlong and psychoanalyst Charles Levin, who have advocated for preserving the inviolability of confidential therapeutic relationships (Koggel, Furlong, & Levin, 2003; Levin, Furlong, & O'Neil, 2003), thereby stimulating noteworthy discussions on ethical and legal reform for therapeutic practitioners and patient rights (Des Rosiers, 2003). Various clinicians have been concerned with the invasion of patient and therapist privacy for some time, especially with regards to the betrayal of confidentiality (Bollas & Sundelson, 1995; Cordess, 2000; Garvey & Layton, 2004; Levin, 2003), and thus see an urgent need to institute an ethical practice model (Fisher, 2008).

It is now commonplace in legal proceedings and insurance claim practices for therapists and mental health practitioners to receive requests for all clinical notes and records for civil suits involving the automobile insurance sector; child custody disputes; workplace disability claims; suspicion of fraud; substance abuse allegations; workplace harassment; wrongful dismissal; accusations of child neglect, physical, and/or sexual abuse; competency hearings; and complaints of professional incompetence. Third-party payers in particular believe they have a right to all clinical documents because they often foot the bill for the client's treatment. Each of these contexts presuppose that the mental health practitioner has adopted various professional roles in relation to their clientele that may involve assessment services, consultation, supervision, file reviews, critiques of other's clinical work and opinions, expert testimony, and/or direct therapeutic intervention. It is important to emphasize that context and contingency determine the parameters of third-party requests, entitlement to disclosure, the permeability of sharing information, and the limits of privacy rights and confidentiality. These issues become more complicated when the practitioner performs multiple roles in the course of practice and does not merely conduct psychotherapy.

Christopher Bollas (2003) may be credited with sparking the debate over the betrayal of patient confidentiality by alerting us to the systemic forces that pressure psychotherapists to become informants, and to how various professional societies within the mental health field have failed to combat these encroachments through their complicity and lack of resistance (Bollas & Sundelson, 1995). The conflict is further compounded when the rights of individuals are suspended or subordinated to the rights of others (for the so-called good of collective society), especially when legal counsel is involved. Levin and Ury (2003) viewed this more

as a product of the political need for transparency reflective of a “therapeutic culture” that demands access to confidential information under the guise of “freedom of information” commonly reported in mass media and entertainment, which subverts individual privacy for social liberty rights.

Ethical dilemmas over therapists’ disclosure of psychotherapy dossiers have led to highly publicized court cases in Canada (*R. v. O’Connor*, 1995; *R. v. Carosella*, 1997) and the United States (*Jaffee v. Redmond*, 1996) focusing on the rights of defendants to prepare a defense versus the rights of individuals in treatment to prohibit the dissemination of their confidential disclosures to third parties. This dispute largely centres on the question of relevance over privacy rights (Furlong & Lefebvre, 1998), where psychotherapists have no class privilege in court proceedings or protection under the law in Canada. This has been historically problematic when psychotherapists have produced treatment session notes that were used against patients in court proceedings (Campbell, 2003). Not only does this undermine trust in a helping relationship, it dissuades oppressed and disenfranchised groups from seeking therapy (Koggel, 2003) due to fear that they will be interrogated, blamed, shamed, judged, and made to suffer induced guilt. This is particularly unsavory when patients, largely women who were allegedly sexually violated (Busby, 2003), are revictimized during cross-examination that uses the clinician’s case notes to negate particulars of the record, which are displaced from the original seeking of therapeutic intervention and the larger context of the helping relationship (Denike, 2003). As Bollas (1999) insisted:

No psychoanalyst should ever hand over clinical notes to a court of law, or disclose information gained in a session. To do so may well be in compliance with the law of the land, but it is unethical. It betrays the analysand, it destroys psychoanalysis, and finally it fails the long struggle in many countries to provide a place of psychotherapeutic sanctuary for all persons whose mental life causes suffering to self and to others. This space is to the common good of all societies that have worked to create it. (para. 16)

From a clinical point of view, there are many reasons why breaches of confidentiality are detrimental. Hinshelwood (2003) argued that the patient is inhibited if confidentiality is not honoured in the clinical encounter, hence undermining the ethic of honesty in therapy (Thompson, 2004). Furlong (2005) in particular has been concerned with the integrity of the analytic relationship and in safeguarding the capacity for honesty and freedom within the therapeutic dyad, especially if sharing confidential information does not further a therapeutic purpose or end (Furlong, 2003b). Within the psychoanalytic community, staunch protests have been made over interference from third parties because this disrupts the unique ways in which analysts conduct their therapeutic method, especially when such interference compromises listening practices, the facilitating environment, the neutrality of the therapist, transitional space needed to associate freely and form meaning constructions, and the transference-countertransference dynamic.

Being coerced or ordered to hand over records is not only an invasion of patients' privacy, it is an assault on the therapeutic framework itself. Because the therapeutic dyad is an intersubjective system, the psychologist is part of that dialectical unit, which complicates the nature of the right to privacy and disclosure. As long as the therapist is seen as an essential ingredient in the treatment frame, separating out one person's participation from the other person's is logically incoherent and contradictory. In philosophy this is referred to as a "mereological fallacy," an attribution error where one ascribes the acts, characteristics, or properties of a whole to its parts. In other words, the limits to client confidentiality and the clinician's decision to disclose or not disclose records only demarcates one side of the dialectic, while failing to consider the supraordinate system that properly defines and bestows valuation to the therapeutic frame. The integrity of the frame is jeopardized if we stay focused only on individual rights. Following these lines, Bollas (2003) perspicaciously argued that confidentiality is ultimately held in the name and practice of the profession itself.

PRIVILEGE VERSUS CONFIDENTIALITY IN RECORDKEEPING

An unresolved issue facing the current dilemma with regards to professional practice is the ethical quandary surrounding legal privilege or strict confidence in private-professional interpersonal communications (i.e., client disclosures) and the role of the psychologist (Mosher, 2003; Slovenko, 1998). Furlong (2003a) argued that privilege should apply to the therapeutic encounter and that the confidentiality of the professional relationship itself "reinforces the integrity of treatment" (p. 27). According to the law, a murderer can confess his crimes to a lawyer and, in some countries, his sins to a priest and have perfect immunity. But if he makes such disclosures to a psychotherapist in Canada, especially a regulated health professional, nothing is regarded as an absolute secret.

Bemister and Dobson (2012) highlighted the distinction between privilege and confidentiality in the psychologist-patient professional relationship—the former being a legal category the psychologist does not enjoy, and the latter being an ethical principle the psychologist should uphold but may contravene under certain circumstances. I wish to revisit this ongoing debate regarding this particular aspect of recordkeeping in clinical practice and hope to further this discussion on the best standards of practice in the field.

Amplifying Truscott and Crook's (2004) position, Bemister and Dobson (2012) revealed that psychologists do not enjoy protection under the law following a strict criterion of practitioner-patient privilege. They argued that case notes are not considered privileged and are not legally protected from disclosure (see Bemister & Dobson, 2012, p. 143). Confidentiality, they maintained, is a separate category that is not legally protected in the same manner as privileged communications. Bemister and Dobson alerted us to an important conundrum that our best ethical intentions and practices may not withstand: *there is no such*

thing as pure confidentiality as long as the law is designed to deny mental health professionals the right to privileged communications and disclosures. What this means is that there is no guarantee of confidentiality in the professional relationship unless it is privileged, and our professions are impotent in such matters under the law. Unlike in the United States, where the Supreme Court allows for psychotherapist-patient privilege under Rule 501 introduced by the precedent-setting *Jaffee v. Redmond* (1996) case, there is no equivalent to psychotherapist-patient privilege in Canada.

As Bemister and Dobson (2012) reminded us, “Case notes are not inoculated from the risk of disclosure” (p. 143). The context is paramount here, however, and we should not commit a hasty generalization and assume that this applies in all circumstances just because a lawyer says so. I wish to advance this debate by emphasizing that the context determines what is considered privileged and confidential, and that we should not automatically assume that all case records or clinical process notes are subject to inclusion in the client’s file; the therapist or counsellor maintains certain privilege under the law when it comes to the recording of private thoughts.

Psychology and psychotherapy registration boards and colleges in every province and territory in Canada, as well as the national psychology and counselling organizations, including the Canadian Psychological Association (CPA), the Canadian Register of Health Service Providers in Psychology (CRHSPP), and the Canadian Counselling and Psychotherapy Association (CCPA), should lobby for changes in the law. This should be initiated to support psychologist/psychotherapist-patient privilege so that patients have the freedom to disclose information in strict confidence without fear that such communication will become subject to exposure or exploitation by third parties. One therapeutic reason for this is that, without the protection of privilege, a patient could potentially never feel secure and safe enough to disclose information that is part and parcel of their psychological difficulties or the pathology they are seeking help for. As long as there is no legal privilege of protection against disclosure to third parties, there is no confidentiality; without confidentiality, there can be no genuine sense of trust or comfort in seeking professional intervention because any communication could be made part of a record that might have to be disclosed to a third party. Here the therapeutic milieu is rendered fundamentally devoid of privacy, which is anathema to treatment efficacy as well as the autonomy and security of our profession. Whether we like it or not, if we make a pledge to privacy, we must uphold it under certain conditions, even if we find the content distasteful. However, the context determines everything; thus the clinician should retain the right to determine whether sharing client information is relevant or not.

Certain conditions are not protected, however, especially when it concerns the law. The duty to act or inform (e.g., in cases of child protection, intent to commit homicide or suicide) is not the same as the imposition to record everything in a file that can be made public at any lawyer’s whim or insurer’s demand under the guise of the law. We should not confound the issue of breach of confidentiality

with the issue of the psychologist's discretion over sharing or refusing to share information regarding privacy matters.

Our friends south of the border have already established ground-breaking legal precedent in securing psychologist-patient privilege based on the *Jaffee v. Redmond* (1996) victory. This has led to reform in U.S. healthcare legislation that protects both patients and psychologists, especially under the Health Insurance Portability and Accountability Act (HIPAA), which further led the American Psychological Association (APA) to revise its Record Keeping Guidelines in 2007 (Sturm, 2012). Not only do psychologists enjoy privilege under U.S. federal law, their psychotherapy process notes are further protected from third-party exploitation under HIPAA.

Although psychologists in Canada have historically made a legal distinction between privilege and confidentiality, this is a false distinction that hinges on a category mistake. If something is truly confidential, it is not subject to review by anyone else without the patient's or psychologist's permission. That is, the mental health professional's private thoughts about patients are confidential too, which constitutes a form of privilege and should not be part of the clinical record or patient file unless it is willingly included. We should not confuse legal terminology with clinical praxis and the orienting principles that guide ethical theory. Many psychologists want to (blindly) preserve a traditional system of differentiating privilege from confidentiality, and they accept the legal imposition *in toto*, but we as a profession should not support it. We should not be merely content with interpreting the law, but instead should be motivated to change it under the initiative of best standards of ethical practice. Our professions should be educating the public, lawyers, judges, and lobbyists in political positions of power who have influence over legislative reform. Bemister and Dobson (2012) accepted the argument of legality via an appeal to authority. However, the very legitimacy of such appeal to authority ought to be questioned, and I urge our mutual health professions to consider pressing legal reform into service. Moreover, mental health disciplines should redefine their ethical codes and standards to be grounded in moral reasoning that guides best practice, and provide advice to their members based on an ethical fulcrum rather than deference to legal arguments alone. In fact, it is unethical not to do so because to do otherwise merely perpetuates a mindless herd mentality based in a lack of critical thinking, unreflective tendencies in clinical practice, fear of confrontation with established authority, and political lassitude that fails to challenge the status quo.

It is potentially damaging to clients and our respective fields not to have legal privilege for confidential communications, because this means that a certain portion of the population seeking or requiring psychological treatment could be hurt or exploited for making disclosures while seeking help, especially if records are legally extracted against their or their practitioner's will. These conditions, I suggest, should be challenged and militated against in political circles in order to change legislative policy because they jeopardize our value as a profession and endanger patients' personal lives. We must remind ourselves that patients who seek

help are those who suffer (*pathos*), and therefore, we should provide them help rather than punish them (under the directive of law) as a general respect for their humanity. If someone cannot access healthcare due to fear that their confidential disclosures will be breached, then we are failing in our pledge to therapeutically serve the public.

DISCLOSURE, INTELLECTUAL PROPERTY RIGHTS, AND RECORDS

The United States has established the integrity of psychotherapist-patient privilege, and Canada should follow its example. It will likely take education; collaboration with multiple mental health, psychotherapy, and counselling associations and/or accrediting bodies in Canada; political pressure; and lobbying efforts to introduce legal reform. Until privilege is secured, mental health professionals will continue to navigate ethical and legal challenges that are presented by barriers to confidentiality, including what to include and exclude in the clinical record, disclosure of case notes, and professional policy when it comes to standards of practice. Under HIPAA, all psychotherapy and counselling notes must be separated from the rest of the patient's medical record, and they are not subject to disclosure by the psychotherapist. These notes, which are often called "process notes," "field notes," "clinical notes," and "case notes," are the recorded contents (in any medium) of a private therapy or counselling session, whether for individual, couples, family, or group interventions (Dunlap, 2013). Unlike in Canada, under the HIPAA privacy rule, health insurers and third-party payers of clinical services are not entitled to obtain these notes, nor can they cut off patients' benefits for noncompliance or for withholding consent.

Although therapy notes are to be kept in a separate record and do not have to be disclosed to third parties or to patients, there is variability in state laws, with some opposing federal regulations by giving patients more rights to access privacy information. Although the question of patients' right to view their health record is not in dispute, their entitlement to view the therapist's process notes remains unresolved in some states and districts. Therefore, the question of patient entitlement to *all* records is moot. Like in the United States, Canadian legislation germane to the practice of psychotherapy varies across provincial and territorial boundaries. As it currently stands, most jurisdictions in Canada except Quebec are under the legal directive to disclose the complete clinical record. With credit to its perspicacity, Quebec is more sensitive to the conundrums surrounding patient confidentiality, disclosure of records, psychologist-patient privilege, and recordkeeping practices. According to the Ordre des psychologues du Québec, psychologists are required to keep a record (the official file) on patients, but they are discouraged from keeping the detailed contents of psychotherapy session notes in that file.¹ The tacit assumption is that the psychologist should not keep personal notebooks on patients in addition to maintaining the file, but this is inconclusive. Although the psychologist is not allowed to keep parallel files, they are permitted to keep personal process notes as long as they contain no identifying information

about the patient. Because patients have the right to access their files, it is prudent to say very little save what is necessary to uphold professional competence. It may also be interpreted that the dossier containing the clinician's psychotherapy notes belongs to the patient rather than the psychologist, but this is debatable.² I am not in agreement in principle that the dossier belongs to the patient, because that limits professional activity and scientific freedom, and I am not in agreement that no case notes should be kept, because this may hinder the quality of therapeutic efforts, training, or supervisory work and the academic liberty of the practitioner.

Short of changes in the legislation, we can also use existing legislation to justify the position that clinical process notes are privileged and confidential because they are the intellectual property of the practitioner (Mills, 2012). We can use a similar legal justification to argue that our private intellectual property (i.e., private thoughts and reflections) about the patient is not subject to report in the record or disclosure to other parties (unless forfeited at the discretion of the professional). By way of analogy, this right of protection is comparable to trade secrets, copyright shield, trademarks, or details of patents one is not obligated to reveal under the law. According to the Canadian Intellectual Property Office (2012), intellectual property is defined as "legal rights that result from intellectual activity in the industrial, scientific, literary, and artistic fields." Process notes on a client could be considered both a scientific and a literary activity.

We are not required by legislation to tell a patient how we really think about them if we clinically determine that it would be poor judgement to do so, especially if it is professionally deleterious or countertherapeutic. Handing over a psychotherapy dossier that reveals the therapist's inner thoughts and feelings about a patient in their uncensored form would alter the patient's perception of the helping professional and would vitiate the integrity of the therapeutic relationship.

The psychotherapist's personal notebooks on patients, I argue, do not belong to the client, even if they reflect about the client and the therapeutic encounter, because they are writings that were created and intended for the therapist's use only (e.g., to track the transference and countertransference, defenses and enactments, unconscious themes and patterns, repetitions that emerge over time, emotional resonance states that arise in the therapist, as well as worries, fears, predictions, speculations, and so forth). This makes any subjective reflections in field notes a personal matter, not a public one open to inspection by others, let alone the patient. If that were the case, there would be no reason to keep detailed psychotherapy case notes at all. If practitioners are not granted rights against forced disclosure of personal notes on patients, the healthcare provider would be prompted to either abandon the note-taking process, or censor and omit important information that may be useful to a clinician conscientious about conducting optimal therapeutic work. This particularly applies to psychoanalytic practitioners who are trained in a tradition of keeping detailed process notes that track the course of treatment as part of performing a competent analysis. It also applies to receiving sound supervision and consultation practices, where a detailed review of sessions is a necessary part of perfecting one's craft. Not keeping good process notes could

interfere with best standards of practice within certain specialty areas in psychology that require detailed notes, especially for training purposes, and could mute proper attempts at scientific inquiry and research (especially phenomenological or qualitative psychotherapy research) because proper data collection would be curtailed by concerns over third-party disclosure. This is why we need to appeal to personal and professional distinctions in what is included in the patient's file. The personal-professional bifurcation as a class distinction is my preferred way of conceptualizing the partition between the practitioner's private intellectual property and the professional property belonging to the official file.

Do therapists and counsellors not have legal rights to privacy, and must they give consent for disclosure to other parties? If we do not give consent, then the same rationale should apply under the rubric of the acts that currently govern our jurisdictions, such as the *Personal Information Protection and Electronic Documents Act* (PIPEDA) and the *Privacy Act* in Canada. The psychotherapist's right to privacy particularly applies to private practice, which is not part of a health organization where privacy legislation allows for disclosure of client records held by public institutions. What is included in a client file in the public sector may be entirely different than what is included in independent practice. Regardless of whether therapists or mental health workers are employed in the public or private sector, they should have sanctions against the mandatory inclusion of their case notes in the client file.

Just as intellectual property has proprietary value, basic respect for confidentiality as privileged communication carries therapeutic currency. An argument can also be made for the need to protect psychotherapists' disclosures to patients because therapy is a two-way interactional dynamic. This protection is especially important when working with severely disturbed patients and those with character disorders, because verbal communications may be easily distorted from their original context, twisted to suit peculiar perceptions or interpretations, and altered from their original intent and meaning, which potentially leads to destructive enactments when working in the transference, or when confronting pathological behaviours gets interpersonally delicate and unpleasant. As a specialist working with character pathology for over two decades (Mills, 2005), I have found that it becomes a prudent practice to record patient disclosures and track the therapeutic process (including the patient's affects, defenses, and one's inner experiences in relation to such unfolding phenomena) in order to (objectively) better observe the organic and developmental trajectory of therapy, as well as safeguard against charges of boundary violations or false allegations that may later spring up. But I would never include this as part of a tangible record the patient has the so-called right to review. It would only invite trouble, and predictably ruin the treatment. We do not need a study or experiment to tell us the obvious. Anyone who makes their living as a practicing clinician knows these empirical facts all too well. But if I had to produce my private record as evidence of the treatment process in order to vindicate myself in a disciplinary hearing or court of law, it is available for me to share or disclose at my discretion. I protect the patient and myself by not

documenting the treatment session by session in the file. This is also in keeping with the best standards of practice suggested by the American Psychoanalytic Association's (2009) guidelines for not charting the details of treatment sessions (probably designed as a potential deterrent from impingements by managed care in the United States).

My personal thoughts are not subject to documentation in the client's record, I argue, because they are private and privileged. This makes any personal emotional reactions or speculative reflection by the clinician—such as subjective affects, intuition, quasitheorizing, unsubstantiated hypotheses, or countertransference feelings—a separate privacy issue, and—it bears repeating—this should not be part of the clinical file. Does the law have the right to demand that you give over your personal diary or journal, or the passwords to your social media networks, when there is no indication that you have broken the law?

PROPOSAL FOR A TWO-SYSTEM METHOD OF RECORDKEEPING

In most jurisdictions and under the ethical guidelines adopted by many mental health associations, the information that one is officially obliged to record in a dossier is relatively minimal in terms of deontological directives. Bemister and Dobson (2011) requested that we include much more than what is currently officially necessary. What I propose as a temporary palliative to legislative reform is a two-tier method or system of recordkeeping that fulfills (in principle) the minimum qualifications of every accreditation board and/or the ethical standards of the mental health association in every province and territory while still preserving the privacy of the practitioner's clinical notes.

Records should be divided into two categories: (a) information deemed necessary for inclusion in the patient file; and (b) information considered the private intellectual property of the clinician, including any psychotherapy process notes or material pertaining to case formulation and the professional's therapeutic role. Recall that this practice is already legally protected in the United States and is endorsed by the APA's standard on recordkeeping (Sturm, 2012). Contrary to Bemister and Dobson's (2011) advocacy for complete thoroughness and inclusivity in records to be included in the client's file, which is subject to review by the patient and third parties, I argue for a minimal record that includes basic biographical information necessary to identify and contact the person(s) or organization, and denotes the date, time, and type of service, fees, and the general content and/or themes of the session (e.g., self-esteem issues); that is all that should be recorded in the file if the professional service was for therapy, counselling, consultation, or psychological intervention. If a progress or discharge note is required or requested from a third-party payer, such as an insurer, and after consultation with and consent from the patient about the content to be included in the report, this should also become part of the official file.

If the nature of the clinical service was an assessment, this should naturally include a final report; however, the details of the clinical notes should remain

private and confidential, just as raw test data are protected under the auspices of copyright laws and test security. In other words, the final report is what constitutes the official file. In the case of a psychologist, social worker, or psychiatrist, there are many other professional functions one may engage in, such as performing file reviews for insurers, case management, critiquing previous assessments conducted by other professionals, supervisory and consultation work, and so on, each introducing unique contingencies that necessitate an individualized tailored approach to recordkeeping. For most practitioners, however, the above guidelines may apply.

This two-system method of recordkeeping maintains professional integrity and insulates the client and the health professional from patient defensiveness, mistrust, therapeutic acting out, legal manipulations, and third-party exploitation. This also protects both the liberty rights and property rights of all parties. Yet this issue can quickly become complicated.

Although this two-tier system of recordkeeping is designed to protect the client and therapist from undue invasion of privacy from third parties, the practitioner may encounter a number of uncertainties in and challenges to the rule. For example, if an insurer requests the client's file or clinical record, and the patient has given consent under the threat that their insurance benefits would be cut off if they did not comply, that would not mean the therapist has to disclose their personal notebooks or private journal—that is not deemed part of the official clinical file. The therapist would merely be obligated to give the bare clinical file as I have described it (which, I reiterate, is in compliance with all major codes of ethics across Canadian mental health disciplines), and the insurer or legal representative would likely be appeased. Because the notes are minimal, they do not compromise the integrity of the client's or therapist's privacy. But another circumstance would occur if the clinician were subpoenaed to court and asked to bring in the entire clinical record. This is less likely to happen in most psychotherapists' careers as the third party would likely already be in possession of the file in some form, and only the most aggressive legal counsel would suspect or accuse the professional of withholding vital information. Here a number of scenarios can unfold.

Unfortunately, unlike in the United States and until Canadian mental health professionals receive psychotherapist-patient privilege under the law, private notes held outside of the file are technically not considered privileged information and can be subpoenaed for court (McEvoy, 2013). Subpoenas usually require therapists to deliver all relevant records in their possession, but this does not necessarily mean one has to hand over private personal notes maintained outside of the clinical file. When this has happened to me, I would bring the file but not my personal notebooks, as those recordings are more about me and the therapeutic process, including my countertransference reflections. Clinicians have much liberty in determining what constitutes relevance, but if asked under oath about other documents about the patient not contained in the records presented before the court, they potentially run the risk of perjury if they deny the existence of other material not contained in the official file. On the other hand, private journals or diaries that are used for self-care purposes or therapeutic expressive/ameliorative

methods designed to aid therapists in their own healing process usually do not have enough information about clients to warrant the material being relevant for court purposes, and are usually not required by a judge. Here I would advise therapists to exercise their right to interpret the meaning of relevancy. If I was asked about any personal notebooks, I would tell the truth and present my case to the judge, explaining that they are not germane as they are personal narrative reflections and subject to privacy and intellectual property protection.

Here the legal process may take one of a number of possible directions: (a) one may be asked to supply the notes, which is subject to the counsellor's rebuttal or appeal to the court's discretion; (b) legal counsel may request that the notes be turned over; or (c) the judge would decide if they are relevant by examining them. Recall that in Quebec, the therapist does not have to turn over private notebooks under the law, and this legal precedent (despite being unique to Quebec) may be presented during court appearances as a rationale for why private records are not automatically subject to inspection by third parties. If I were in this situation, I would respectfully ask that the Honourable Justice inspect my personal notebooks in his or her chambers, rather than in a public legal forum, to determine relevancy before making a decision to have them included or excluded from the court record. Regardless, those documents would be produced at a later time and subject to interpretation. There are a number of other permutations, such as having the ability to blacken out various personal and private revelations before they are disclosed, or even destroying personal confessions if the therapist is worried about sensitive admissions being exposed—this, once again, is open to the clinician's interpretation.

It bears repeating that several other important reasons for maintaining separate notes are for (a) supervision, such as when presenting case material to training faculty or supervisors is mandatory, or when one is in psychoanalytic training and maintaining lengthy process notes is part of one's education and an exercise in self-introspection; (b) research and case study, such as when preparing case material for publication or presenting qualitative research; and (c) one's own self-care. Because the presenting scenarios are not uniform and are open to multiple instantiations, I argue that advocating for this two-tier approach is reasonable until the law changes to give our professions therapist-client privilege.

Bemister and Dobson (2012) claimed that extensive notes and records protect psychologists from legal repercussions and complaints of negligence, and "hold psychologists more accountable for their actions" (p. 144). But this should not be our central aim or reason for keeping records. If psychologists primarily worry about professional negligence or accountability, and keep records to prove otherwise, this suggests to me that they have been unduly frightened by legal paranoia, have been improperly trained, or are potentially ill-equipped to competently serve the public. Bemister and Dobson further stated that the patients' legal right to see extensive detailed records "reduce[s] harm to clients," but such records could be potentially viewed or seized under the law. This could create more harm than good, especially if it sullies the therapeutic alliance and imperils treatment pro-

gress, or is used by third parties to negate particular clinical findings, such as in legal disputes (e.g., custody and access evaluations), or to deny extended health benefits (e.g., by insurers, workplace disability, or human resources departments).

THE NEED FOR A POSITION STATEMENT

I realize that this proposal may only apply to certain practitioners who are engaged in certain types of clinical work that would necessitate such procedures, and that the context of a professional's practice will determine if the proposal is indeed pertinent. By offering these guidelines—which are by no means inclusive, generalizable, or injunctive—I hope to reach multiple practitioners with different clinical activities that may be representative of Canadian mental health specialists in general with diversified professional practices. I am also aware of the multiple strands of complexity that stem from particular dilemmas facing the practitioner regarding the questions, breadth, and limits to confidentiality, which cannot be addressed as a single category or factor. Although the confines and contextuality of confidentiality in professional relationships need to be further researched and expatiated in professional space, I hope the issues raised here orient our respective fields to continue constructive dialogue.

Bemister and Dobson (2012) advocated that extensive and inclusive record-keeping practices “elevate the stature of our field” (p. 144), which I fear may lead to exponentially greater ethical and professional practice dilemmas. One major concern is that it may turn the therapeutic process into a micromanaged technocratic enterprise where professional psychologists, counsellors, and psychotherapists devolve into transcriptionists worried about bureaucratic bean counters and legal departments that could be hovering over them at any time. If psychologists (or any mental health professionals) are forced to adopt such stringent criteria of recordkeeping (where practically everything is recorded and placed in the file at the client's peril), it could potentially create a decline in the way we serve the public. For the time being, until mental health professionals achieve professional-client legal privilege, keeping a minimally competent record that is designated as the official file is prudent. Psychotherapists who wish to maintain their own private psychotherapy process notes are encouraged to do so if it aids in their practice, supervision, training, and/or qualitative research, but I would suggest this be maintained as a separate record not privy to others.

Certain organizations within the field of psychoanalysis have been a step ahead of psychological and counselling associations in Canada when it comes to categorically separating ethics from the law (Furlong, 2005; Koggel et al., 2003; Levin et al., 2003). The position of the American Psychoanalytic Association (APsA, 2005) on patient confidentiality offers a clause so that the analyst may object to certain breaches of confidentiality for ethical or clinical reasons even if the patient gives consent:

The psychoanalyst should resist disclosing confidential information to the full extent permitted by law. Furthermore, *it is ethical*, though not required, for a

psychoanalyst to refuse legal, civil or administrative demands for such confidential information even in the face of the patient's informed consent and accept instead the legal consequences of such a refusal. (IV, Sec.1, emphasis added)

What is most noteworthy and virtuous about this position is that it prioritizes the freedom, rights, and agency of the analyst. By sanctioning the professional autonomous judgement of the clinician with regards to disclosing records or confidential information, it places ethics above the law by exalting its determinative value. The International Psychoanalytical Association (IPA; 2000) has a much terser clause: "*Confidentiality*. Psychoanalysts shall respect the confidentiality of their patients' information and documents." The Canadian Psychoanalytic Society (CPS, 2002) repeated practically the same idea with an additional proviso:

(C) Protection of Confidentiality.

A psychoanalyst shall respect the confidentiality of his patient's information and documents.

When a psychoanalyst uses case material in exchanges with colleagues for scientific, educational or consultative purposes, he should make every reasonable effort to ensure that the identity of the analysand is protected.

Notice there is no reference to legal qualifiers or the law in either the IPA or the CPS code of ethics. This demonstrates that these progressive organizations are not being counselled or pressured by lawyers as are their American counterparts. But the APsaA still places ethics over legal mandates, which shows how lawyers have a limited role in defining a profession's code of conduct. These pithy phrases about confidentiality by the IPA and the CPS also allow for greater freedom of interpretation to act with regards to disclosure of records by being deliberately silent about qualifications that other professional organizations feel the need to directly address in their ethics standards. Conversely, the Canadian Psychological Association's (2000) *Code of Ethics for Psychologists* has the stipulations "except as required or justified by law" under two of its three sections on confidentiality (see I. 43 & I. 45), and the Canadian Counselling and Psychotherapy Association's (2007) *Code of Ethics* defers confidentiality, recordkeeping, and access to files to legal requirements (see B2(ii), B6, & B7). Here axiology for the sake of its autonomous importance (whether categorically or philosophically) seems to take a backseat to legal caveats.

The need to balance ethical and legal requirements becomes a daunting task for a mental health practitioner with a diverse scope of clinical activities, especially when multiple professional roles with different purposes co-exist on parallel plains, overlap, or are antagonistic toward each other in aim and intensity. The question of right of access to records is more convoluted in private practice than in public institutions, especially when a practitioner is a service provider receiving funds from external parties, agencies, or companies independent of the patient. This complicates matters of recordkeeping, privacy, confidentiality, consent, and entitlement to disclosure. Before we can resolve these *aporiai*, with their subtle

inflections of complexity, we need to start with an honest professional dialogue and appeal to our respective professions to take a stand on these matters.

Every organized mental health, psychotherapy, and counselling institution in Canada—from every provincial licensing or accrediting body or college, to membership organizations and societies that adopt a code of professional conduct for practitioners—should issue a position statement on these conundrums. I would specifically ask that the position statements address the ethical nature of the issue at hand, and not merely reiterate what the law or in-house legal departments say pertaining to my request. It is only possible to address this broader policy issue directly, with regards to professional practice standards, by hearing from the representatives that govern and act as spokespersons for the professional bodies that regulate our practice. We need guidance from our professional bodies and support from our peers when ethical and legal categories coalesce or collide. The need to have ethical principles that stand separately from the law is paramount when there is an inherent clash of values. It is my hope that the questions of therapist-patient privilege, case notes, and recordkeeping within the broader parameters of confidentiality and disclosure receive the proper attention they deserve.

Notes

- 1 See *Regulation respecting the keeping of records and consulting-rooms by psychologists; Professional Code* (chapter C-26, s. 91); Division I: Keeping of Records, Sec. 5: “a psychologist shall avoid adding to a file any unprocessed data or any unverified information that could harm the client.” O.C.448-92,s.5. http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=%2F%2FC_26%2FC26R221_A.htm
- 2 Nathalie Girouard, Ph.D., Conseillère à la qualité et au développement de la pratique, Ordre des psychologues du Québec, personal communication, January 21, 2013.

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