

THEORY AND PRACTICE

Client or patient? Contrasts between medical and counselling models of confidentiality

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ABSTRACT *Conflicts can arise within counselling in primary care settings over issues of client confidentiality as perceived from a therapeutic as opposed to medical perspective. 'Ideal types' of counselling confidentiality and medical confidentiality are compared, according to a proposed structural model of confidentiality. In contrast with a therapeutic concept of confidentiality as an interpersonal contract between client and counsellor, a structural model of confidentiality appropriate to medical and primary care settings would include reference to crucial aspects such as risk assessment, and the sharing of client information within a multi-disciplinary team. The client-centred counselling model of confidentiality is then explored with reference to the Derbyshire Inquiry Report on the mental health care provided for a client with psychiatric problems. The limitations of adopting an exclusive client-centred counselling approach towards confidentiality in primary care settings are noted, given the requirements of the Care Programme Approach for effective risk assessment and inter-professional liaison in the care of clients and patients with psychiatric problems. The potential resultant issues of counsellor and general practitioner liability are identified in relation to complaints systems and the key legal concept of vicarious liability.*

Introduction

The rapid growth of counselling within primary care presents an opportunity for the wider provision of therapeutic services in a multi-disciplinary setting, and for greater public recognition of its real value to the community. It also raises, in an acute form, key professional dilemmas, where the promotion of client care may conflict with the ethical value of maintaining confidentiality. Such difficulties can arise where professional groups, such as medical practitioners and counsellors, operate according to different value-bases regarding client/patient autonomy, risk management, and the process of sharing sensitive personal information. These issues are highlighted by the

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Inquiry Report into the care of a psychiatric patient, Anthony Smith, which exemplifies the increasing pressures upon client confidentiality entailed by operating the Care Programme Approach for vulnerable patients in the community. These concerns also raise the issues of counsellor accountability and liability, further illustrating the complexity of this problematic interface between medicine, counselling and the law.

This article explores the dimensions of medical and counselling perspectives on confidentiality, and the ways in which these differences are exemplified in the Inquiry Report into the care of Anthony Smith (SDHA/DCC, 1996). The form of counselling provision described in the Report is located within a specific counselling model of confidentiality, and considered in the light of developing policies for the care of psychiatric patients in the community. Issues of counsellor liability and accountability are identified, and set in context within the complex, overlapping systems available for client redress.

As a starting point, the Inquiry Report makes some key points about the role of counsellors in primary care. It presents an opportunity for eliciting some of the major implications for counselling practice in this setting. The Report's discussion falls in the context of a developing literature, both on breakdowns in psychiatric after-care, as documented by organisations like the Zito Trust (Sheppard, 1996), and from the sobering tradition established by child abuse enquiries dating from the mid-1970s (Reder, 1993). The real significance of the Inquiry report lies the prominence afforded to *counselling* as a specific professional activity within the overall framework of patient care. Material from the Report illustrates in practice the clash between the medical and counselling approaches to patient confidentiality. It also indicates how this underlying conflict may have influenced some of the counsellor's responses, in attempting to work to a specific therapeutic model which can be problematic within this multi-disciplinary setting.

There is a long history in the literature of noting problems concerning differing perspectives on confidentiality between counsellors and the rest of the primary health care team. One such survey refers to 'problems of interprofessional referral, information exchange and patient confidentiality' (Sibbald *et al.*, 1996, p. 17). These problems, and how to resolve them, were 'central to the development of counselling services within general practice' (p. 17). The concept of confidentiality can clearly mean different things to different professionals, and often means different things to different counsellors. This is apparent from the above research, which indicates that the term 'counsellor in primary care' can really include two different sub-groups of counsellor—namely community psychiatric nurses (CPN) and psychologists as one sub-group, and 'practice counsellors' as a second sub-group. There seem to be significant differences between, say CPNs or psychologists on the one hand, and 'practice counsellors' on the other, in terms of how they saw and responded to issues of confidentiality. Confidentiality can sometimes be waved as a kind of banner, signalling loyalty to a cluster of professional values or concerns, the detail and content of which are not necessarily made explicit to others. This can become problematic where professional groupings, such as practice counsellors, are working in multi-disciplinary settings, and where a differing concept of

confidentiality may be held by co-working professional groups such as CPNs or medical practitioners.

The concept of confidentiality is often understood by counselling practitioners primarily as a form of *interpersonal contract* between client and therapist. While there are strong grounds for establishing confidentiality as the basis for the proposed therapeutic alliance, there is a danger that an over-emphasis on the therapeutic role of confidentiality neglects other crucial aspects of the relationship, and understates the wider responsibilities of the therapist. Operating confidentiality also possesses, inevitably, a *social and legal* dimension. Confidentiality can be a legitimate expectation arising from the special trusting nature of the relationship between counsellor and client, whether explicitly protected by the terms of a contract or not. Maintaining confidentiality of client material may be directly required by statute, as in the case of the Official Secrets Act 1989. Alternatively, it may be limited by legislation, such as the Children Act 1989, or the Mental Health Act 1983. Case law further indicates that confidentiality may be broken in the public interest, in order to prevent 'serious crime'. Given that neither medical practitioners nor therapists possess full evidential privilege, unlike some of their counterparts in the US, confidentiality may additionally be over-ridden via the process of discovery in legal proceedings.

These factors undermine any lingering illusions concerning the special status of client confidentiality in therapy as primarily the expression of an interpersonal contract, which is somehow set apart from an external world of constraints or wider social obligations. Instead, the concept of confidentiality needs to be firmly placed within an understanding of relevant legal structures, such as contract, statute and case law (Harbour, 1998). Confidential relationships are also bounded by a complex web of social factors, such as employment relationships, service delivery requirements, and of patterns of liability and organisational accountability. This is particularly true of the concept of confidentiality as operated within the complex organisational structures of the National Health Service. Growing public concerns over the perceived failures of community care for vulnerable groups of clients, such as people discharged from psychiatric care, produce additional pressures on professionals to share sensitive client information. The need for effective inter-disciplinary cooperation, and for accurate assessment of the risk posed by certain client groups, both to themselves, and to the public, need also to be included in this complex mix of factors impinging upon therapist-client confidentiality (Reed, 1997).

An understanding of confidentiality based on awareness of these structural and legal constraints needs to include reference to wider factors such as responsibility for decision-making and service provision; inter-disciplinary collaboration; the discretionary handling of sensitive client information; risk management; and issues concerning records and access to information.

This is not proposed as a comprehensive or exhaustive list, but where the term confidentiality is used in the context of primary care, it will necessarily impinge upon one or more of these related topics. This *structural* perspective on confidentiality departs from the classic client-centred definitions, which tend to centre more on the

actual or desired personal and professional relationship between counsellor and client. This approach takes a broader view, in attempting to reconstruct the therapeutic relationship in the context of other social and professional activities. The suggestion here that there is a kind of 'scaffolding' of other relationships and obligations, which provides the necessary frame for the relationship between the GP and patient, and the counsellor and client. This 'scaffolding', or external frame, is crucial to the process of delineating the differences between medical and counselling models of confidentiality.

There are a number of difficulties which can arise in exploring the differences between medical and counselling models of confidentiality. There is clearly a danger of generalising about professional approaches, or about primary care, when the latter is so diverse that it defies simplistic categorisation. There is also a risk of over-simplifying, or even of stereotyping, distinctive models in order to make a particular point. Medical and counselling models may, however, usefully be considered as Weberian 'ideal types', as poles on a continuum or spectrum, while possessing a significant degree of movement, fluidity and dynamic interaction (Gerth & Mills, 1946). An ideal model of medical confidentiality would need to include factors such as its value base, forms of accountability, conception of boundaries, legal foundation and its relationship to its social context. These factors are outlined in more detail below, and then contrasted with key features of a corresponding ideal-type counselling model of confidentiality for clarification of points of divergence.

The medical value-base is proposed here as one which necessarily starts from an external view of the 'best-interests' of the patient. The medical perspective clearly requires obtaining the patient's cooperation for treatment, but is based, first and foremost, on the doctor's *expertise* in assessment and diagnosis. While this has to be tempered by the need to obtain the patient's informed consent, the starting point is necessarily based on an *external* frame of reference, or an informed view of what the patient needs, and of what is in their best interests. This is evident from the stated values of the medical profession, such as the Declaration of Geneva and the proposed revised version of the Hippocratic Oath (Hurwitz & Richardson, 1997). The tensions thus generated in extreme situations can be observed at work in the recent debate over the use of enforced Caesareans, which focussed on the conflict between what was perceived to be in the patient's interests, and the patient's own expressed wishes.

The framework of accountability for medical decision-making is complex. This is particularly so in primary care, where there are overlapping systems of contract, employment relationships, legal liability, professional and clinical responsibility. The options for patient complaint or redress, it follows, are also complicated and many-faceted, despite the recent changes brought in following the Wilson Report, *Being Heard* (DoH, 1994).

Medical confidentiality is based on a team approach, or what can be termed an 'inclusive model' of confidentiality (see Bond, 1992). That is, the contract of confidentiality 'includes' those members of the health care team who 'need to know' the relevant information. Underlying this is the notion of the patient implicitly giving

their consent to this necessary process of sharing of information (McHale, 1993, p. 76).

Crucially, the medical model of confidentiality is based on an established framework of statute and case law (Darley *et al.*, 1994). Interestingly, the medical approach to confidentiality stresses the *limitations* to containing sensitive patient information: the BMA's own proposed document on confidentiality suggests this by its actual title: '*Disclosure in the Public Interest*'. The title perhaps signifies a revealing contrast in professional cultures between the medical and counselling professions regarding perspectives on confidentiality. It is hard to imagine a counselling document on client confidentiality whose title revealed so forcefully its initial premise.

Finally, the medical model of confidentiality is crucially bounded by organisational factors. General practice and the primary health care team do not exist in a vacuum, but are part of a wider complex system of health care. This is increasingly subject to external scrutiny, and to medical audit, with its own implications for potential inroads on patient confidentiality (Godber, 1996). Aspects of this can be seen in the recent heated debate about computerisation of NHS patient records, for instance, and in the potential breaches of patient confidentiality posed by audit requirements.

Counselling model of confidentiality

To restate the point, this presentation of an 'ideal model' of counselling confidentiality, is not in the sense of being 'preferred', but in clustering together some of the most striking characteristics of this approach that may mark it as being distinct from that of other professions. Using the same set of structural factors, the main aspects of the counselling model of confidentiality demonstrate a number of key differences from the medical model.

In terms of its stated value base, there is wide agreement on the key importance of counselling seeking to promote the client's autonomy (BAC, 1998). Confidentiality is necessary, first of all, to establish the degree of trust required for counselling to take place. Secondly, it provides the space for the client's self-determination to develop (Bond, 1993, 1995, p. 1). Counselling's value base accordingly stresses the value of exploring the client's world-view, with the counsellor working as much as possible to communicate within the client's frame of reference.

Counsellors clearly are accountable for their practice, but understanding about exactly how and to whom varies, given the complexity of the working arrangements to be found in primary care. This setting can include counsellors who are self-employed, salaried, students on placement, and to which can be added the role of mentors and external supervisors. Counsellors' accountability is far from being unknown or unknowable, but clarity about its precise configuration here is sometimes lacking. Rain (1996) provides a valuable exception to this trend, in clearly setting out the lines of their professional accountability when working in primary care.

For some schools of counselling, the therapeutic relationship between counsel-

lor and client is *primary*, acting as the channel for clients to explore issues and feelings, and to make their own choices. Confidentiality between counsellor and client protects the space, or holds a 'frame' for this important work to carry on (Casement, 1997, p. 158). One approach to confidentiality here would be to establish an 'exclusive' or excluding form of confidentiality, limiting the release of information outside this kind of therapeutic 'bubble' to the absolute minimum. This approach may produce conflict if transferred to a general practice setting, as this is a form of medicine which can also place great stress on the distinctive nature of the doctor–patient relationship (Balint, 1995).

Bond has written about the lack of case law concerning counsellors in the courts in England and Wales, as presenting difficulties in setting out the established basis of counsellor–client confidentiality with absolute certainty. However, the probable contours of such case law can be divined, based on a knowledge of confidentiality in other professions, such as medicine (Jenkins, 1997). Where the legal basis of confidentiality is not spelled out, this can leave counsellors in many working situations, including primary care, primarily referring to their professional codes of ethics and practice, together with supervision, to guide them in their decision-making (BAC, 1998; East, 1995, pp. 66–70).

Professional codes of ethics such as BAC's are important documents, but, as the latter explicitly recognises, they cannot give definitive guidance in resolving some important issues, but rather seek to indicate best practice (BAC, 1998). It is also significant that they have, as yet, no statutory basis in law, given their existing status as a professional or advisory code. This is in contrast with codes produced under legislation such as the *Code of Practice for the Mental Health Act 1983*. Failure to comply with a statutory code of practice, such as the latter, may be referred to in evidence in legal proceedings (Para 1.1, DoH/WHO, 1993). Counsellors need to be clear that following a professional code of practice, such as that of the BAC, may not carry the same weight in a court of law, such as in a Coroner's Court investigating a former client's suicide.

Some of the key points made in the BAC Code relevant to confidentiality include reference to the need for counsellors needing to know and work within the law; to agree with the client any prior contractual limits to confidentiality that may apply; to clarify and communicate to involved parties their own personal and professional attitudes towards issues of client self-harm or suicide; and to make appropriate arrangements for supervision and professional consultation. Under specific provisions of the Code, counsellors *may* break client confidentiality where they believe the client will cause serious harm to themselves or to others, after consulting with the client and supervisor. Furthermore, confidentiality may be broken *without* client agreement 'where there are also good grounds for also believing the client is no longer willing or able to take responsibility for his/her actions' (BAC, 1998).

Finally, the origins of counselling have been strongly influenced by the model of private practice, where the therapeutic contract is set between the client, the counsellor and, implicitly, the counsellor's supervisor. There are other alternative organisational models, based on the experience developed by counselling practice in

schools and marriage guidance settings, but the private practice model still remains a powerful underlying influence (Casement, 1997; Langs, 1979). In some instances, this may make for problems in counsellors adapting to the organisational context where they are required, or choose, to practice. Organisational factors arising from the nature of multi-disciplinary teamwork can then seem like an unwelcome intrusion into the counselling relationship, rather than providing the necessary contractual foundation for the counselling work to take place.

To summarise, some of the points of contrast or difference between medical and counselling approaches to confidentiality, seen here as 'ideal types', are summarised in Table I. The danger here of over-stating differences is recognised. The contrasts between two different approaches to confidentiality are presented in this schematic way, in order to better understand the points of emphasis or of potential conflict between them. Much work has already gone on to resolve these differences, and create a viable, integrated model of counselling in primary care, such as that done by Dr Graham Curtis-Jenkins, and the Counselling in Primary Health Care Trust. The contrasts also may help to clarify some of the processes involved in the care provided for Anthony Smith, and the rationale which underpinned the provision of his care.

Inquiry report on care of Anthony Smith

In relation to the Report into the care of Anthony Smith, a committee was set up in 1996 as an independent inquiry by Southern Derbyshire Health Authority and Derbyshire County Council, the bodies jointly responsible for his care. It took as its terms of reference a review of the effectiveness of overall arrangements for his care, including primary care, counselling, hospital admission and after-care in the community. Issues of client confidentiality were central to the care of Anthony Smith, a psychiatric patient with a history of schizophrenia. He received counselling from a practice-based counsellor, on a weekly basis, for just over a year. During this period, his mental health deteriorated, and he was admitted to a psychiatric hospital. On his discharge, family relationships continued to worsen. He killed his mother and half-brother 4 weeks after his discharge.

A number of key issues emerge from the Report (SDHA/DCC, 1996). These

TABLE I. Comparison of ideal types of confidentiality

	Medical model	Counselling model
Values	'Best interests' of patient	Autonomy of client
Accountability	Clinical	Professional
Boundaries	'Inclusive' or team-based	'Exclusive' or client-based
Foundation	Statute and case law	Professional codes of ethics
Context	Complex, organisational	Private, contractual

concern the position and role of counsellors working within a system of delegated care, the accurate assessment and management of risk, indicators for breaking client confidentiality, and the role of counselling supervision.

The counselling provided by the practice was, presumably, intended to encourage the client's autonomy. Certainly, the report suggests that Anthony Smith found the counselling useful, although the precise objectives or goals of the counselling were not specified to the Inquiry. Information on the client was apparently not passed back to the GP, for review or re-assessment purposes. The arrangements for information exchange between counsellor and GP seemed, therefore, to be implicit rather than explicit. The counsellor referred to his professional code of practice to explain his choice not to refer back to the GP information about the client other than 'the most serious matters'.

After a year, psychotic symptoms (auditory hallucinations and paranoid features) were detected by the GP, who then referred her patient for psychiatric assessment by a consultant psychiatrist. The Report raises questions about the degree of awareness amongst counsellors generally concerning their knowledge of these symptoms and of their possible significance. Professional supervision of the counsellor within the practice did not appear to clarify or address the above concerns noted retrospectively by the Inquiry.

Each of the aspects noted above can be located within the 'ideal type' of counselling confidentiality described earlier. One factor concerns the process of counsellors working within a system of delegated care. While there is much talk of the primary health care *team*, clinical responsibility for the patient is still held by the GP concerned (GMC, 1995, p. 9). Rain pinpoints this key aspect with precision in her guide to counselling in general practice: '... while, in counselling the relationship between the counsellor and client is primary, in a general practice it is the *relationship between GP and patient which is primary*, i.e. it's the GP's patient before it's the practice counsellor's client, the *counsellor being the agent of the GP*' (1995, p. 70, emphasis added).

In addition, the idea of an external 'assessment' may in itself be problematic for some counsellors, as it may conflict with the notion of being exclusively person- or client-centred. Evidence suggests that GPs refer patients on a differential basis to CPNs and to practice counsellors, according to the nature and severity of their perceived mental health problems (Ward and Loewenthal, 1997). Counsellors in primary care nevertheless need to be familiar with the basic symptoms of mental illness, and to be able to carry out an informed assessment of the degree of risk posed by a client to themselves or to others (Daines *et al.*, 1996, p. 85). Sibbald's work suggests that a high proportion of counsellors appears to have no specific training in mental health assessment (1996, p. 16). The Inquiry Report regarding Christopher Clunis recommended 'training in the assessment of dangerousness' for all those working with mentally ill people where there was a risk of violence (Ritchie *et al.*, 1994, p. 119). This needed to include an awareness of 'signs and symptoms in the patient which may indicate that the patient is likely to relapse', including non-compliance with medication (p. 119). Weapon carrying also may be considered an additional risk factor (Perry *et al.*, 1998). Developing enhanced skills in risk

assessment, although recommended by successive Inquiry Reports, may conflict for some counsellors with allegiance to a more narrowly client-focussed counselling value base.

In relation to the issue of breaking client confidentiality, the BAC *Code of Ethics* offers the possibility of the counsellor retaining client information, or, in exceptional circumstances, of *breaking* client confidentiality. There are clear precedents in medical case law for using a public interest argument to pass on information concerning a client liable to harm others (*R. v. Crozier* [1990]; *W. v Egdell* [1990]). If the counsellor is working in primary care, it is likely that they will be required under their contract of employment to inform the GP or team of suspected self-harm or threatened harm to a third party, in the same way that they would be required to follow child protection guidelines in reporting suspected child abuse (HO/DoH, 1991).

In this Report, there is no indication of how the concerns about the purpose of the counselling, or of concerns about the client's behaviour were raised or responded to within professional supervision. While there has been increasing emphasis on the role of supervision and professional consultation within the counselling community, this would need to take full account of the differences between counselling and medical models of confidentiality to provide an effective monitoring of the service on offer to the patient.

To summarise, the model of counselling provided for Anthony Smith appears, from the published Report, to have followed closely the ideal counselling model of confidentiality presented earlier, in its apparent stress on client autonomy, its reference to professional codes of ethics for its legitimation, adherence to a client-focussed approach to information sharing and in its provision of therapeutic or contractual version of confidentiality. However, this is not to imply that the adoption of this model was necessarily a contributory factor in the tragic outcome of the case. Nor would adherence to an alternative medical model of confidentiality necessarily have entailed a different and more positive result. Yet the counselling practice and principles described in the report are clearly at odds with developing policy perspectives on improved care for psychiatric patients in the community.

The Inquiry Report is unusual in its close and sympathetic attention to the role of counselling within primary care. The Report is also scrupulously careful in avoiding the implication of criticism regarding counselling practice in this case. There were many diverse factors relating to Anthony Smith's care, which each had a bearing on the eventual tragic outcome. However, in the context of the wider public debate about community care for vulnerable individuals, and the more specific requirements of the Care Programme Approach for discharge psychiatric patients into the community, there are a number of key points of concern.

Recent prominent media publicity has highlighted situations where members of the public or professional carers have been injured or killed by psychiatric patients discharged into the community. Inquiry Reports have called for more investment of resources, increased coordination between service providers and improved decision-making processes (Sheppard, 1996). Under the Care Programme Approach intro-

duced by the Department of Health in 1991, discharged psychiatric patients are subject to risk assessment and receive a negotiated package of care monitored by a key worker, with the overall care plan being subject to regular review. Under legislation, the Mental Health (Patients in the Community) Act 1995, certain former psychiatric patients may also be supervised closely, to minimise the risk of harm, both to themselves or to others. However, despite continued critical media attention, the actual risk of harm to members of the public can easily be over-stated. Initial findings by the National Inquiry into suicide and homicide by people with mental illness indicate that such patients are at greater risk of committing suicide than homicide. Where homicide occurs, furthermore, one third of the victims were acquaintances, rather than strangers. A further third of known cases of homicide committed by persons with a mental illness concerned a family member, as occurred in the case of Anthony Smith (Appleby, 1997, p. 13). The risks are, in descending order, therefore, to patients themselves, to acquaintances and family members, rather than to the general public.

Discussion about improved after-care services for psychiatric patients in the community consistently returns to the related themes of improved training in risk assessment, and on the need for the more effective sharing of patient information between professionals involved in patient care (Reed, 1997). Both these proposals have implications for counsellors working in primary care, by requiring greater knowledge and skills in recognising risk factors amongst clients with mental health problems, and a corresponding ability to work within an inclusive, inter-disciplinary model of confidentiality. These recommendations would require conscious adaptation to a medical model of confidentiality by some practice counsellors.

Systems of accountability and redress

Discussing confidentiality from the perspective of a structural model necessarily involves consideration of the related issues of accountability and redress by clients. This will become an issue of increasing importance, in view of the operation of the policy of the Care Programme Approach as a focus of broad public concern and media attention. Policy changes regarding mental health care for discharged patients may improve the overall standard of services, but they also raise public expectations, and set new benchmarks for future complaints or even for potential litigation (Harrison, 1997). Establishing the principles of counsellor accountability within primary care tends to reflect the overall complexity of the system as a whole. Crucially, the general practice holds *vicarious liability* for the work of its employees (Scott, 1994, pp. 64–65). The employing GP, or the practice as a legal partnership, is therefore liable in law for any negligence on the part of its partners or employees (Hughes, 1994, p. 15). In the past, rates of litigation against GPs have tended to be low. Brazier suggests that this is so for two reasons. Firstly, this is because of the often close, personal nature of the relationship between patient and doctor. Secondly, proving negligence may be hard to establish, given the nature of tort law, which places a heavy burden on the plaintiff of proving causation (1992, p. 354). Concerns have been expressed that medical negligence

claims against GPs are set to rise with the introduction of conditional fee arrangements. The likelihood is that the high cost of legal insurance associated with medical negligence cases will still act as a significant deterrent for many potential litigants.

An alternative to legal action is in making a complaint under the revised NHS systems, following the *Wilson Report* (DoH, 1994). Complaints against GPs increased to 30,000 in 1997, two thirds of which were resolved locally within 4 weeks (*Pulse*, 31/1/1998). The Medical Defence Union, one of the major medical protection societies, has produced its own analysis of complaints made in general practice. None of the complaints appear to be related to counsellors, although some referred to other categories of staff, such as receptionists, nurses and practice managers (MDU, 1996, p. 5). The earlier most widespread cause of complaint against GPs was 'failure to visit' but this has now been overtaken by failure, delay or wrong diagnosis, so there seems to be a shift in the public's expectations of the service provided by general practice (1996, p. 6). It seems that a GP's liability to third parties, rather than directly to patients, is limited: a recent case found that a GP was *not* liable to a child's parents for misdiagnosis (Dyer, 1997).

It follows that counsellors' accountability within primary care is a product of a complex mix of employment and professional relationships, where the primary responsibility for patient welfare is held by the GP. The counsellor working in primary care is nevertheless liable for their own decision making within the counselling process, despite overall *clinical* responsibility being held by the GP. This process could take a number of forms, such as the counsellor being the subject of complaint to professional association such as the British Association for Counselling, if a member; or via complaint made by the in-house general practice scheme; or through being the subject of direct legal action for breach of contract or negligence, if the counsellor is self-employed.

The counsellor is therefore covered by the concept of vicarious liability if employed, or, arguably, when working *as if employed*, by the practice. The case would probably be brought against the counsellor *and* the practice together. As illustration, in the well-known *Ramona* case (1994) of alleged false memory in the US, the legal case was brought against the counsellor, Marche Isabella, Dr Richard Rose, *and* the Western Medical Centre where they both worked. Based on the concept of vicarious liability, action for negligence would involve the practice as employer, rather than simply the counsellor as sole defendant.

The legal liability of *supervisors* for their supervisee's practice has been the subject of some speculation. However, in the absence of established case law, this liability, in reality, would seem to be very limited. The employer, in this case the practice, holds vicarious liability for the actions of its employees. Supervision in counselling is really a form of professional consultation about practice. This is unlikely to open up the possibility of the supervisor being liable for the mistakes or errors of the counsellor (CMS, 1995, p. 6). This is distinct from the situation in the US, where supervisors hold liability for the practice of counsellors and social workers, but only as part of arrangements for state registration, not as a matter of course.

Conclusion

In a situation similar to that occurring with Anthony Smith, a counsellor could be subject to complaint to a professional association, or to the practice as such, via the in-house complaints system. If self-employed, the counsellor could also be the subject of litigation for breach of contract or for professional negligence, though liability to third parties such as a patient's family is usually limited. The practice, as a partnership, holds legal responsibility for the counsellor's work if the counsellor is employed or, arguably, when working as if employed. A model of client confidentiality which restricts critical information to the counsellor is in potential conflict with the GP's position of overall *clinical responsibility*, and of ultimate *legal liability* under the concept of vicarious liability. In view of emerging policy on patient care under the Care Programme Approach, it may also not be the best protection for the client's interests, where issues of self-harm or harm to third parties can be discerned.

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