I find it fascinating how even recent history can become distorted and feel the desire to put the record straight.

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Reply

DEAR SIRS

I should have mentioned the wards and day unit at St Giles Hospital, but could not have done so without bringing in details important to my own impressions of this corner of history.

I was appointed to the joint Kings-Maudsley chair with an assignment to integrate academic efforts in psychiatry in the two places. With the exception of the few people I mentioned, neither party really wanted integration. There were three pressure groups. First, the psychological medicine department at King's wished to retain the status quo with what they regarded – not wholly without justification – as a sufficient and happy department. They were prepared to contemplate academic expansion in competition but not collaboration with the Maudsley. Second, the rest of Kings College Hospital and Medical School consultants and administrators alike saw no point in Kings continuing to have its own psychiatric department, especially as considerable expansion would be necessary to meet the requirements of a full district service. The Maudsley was across the road and, it was suggested, could do it all. Third, the Maudsley wanted no financial or other responsibility for Kings, but wished to gain access to the general teaching hospital with its clinical and research opportunities for liaison psychiatry in adult and child psychiatry.

So when I set foot in the Kings department I was given certain admonitions to which I referred only briefly in my interview with Hugh Freeman. The St Giles unit, I was told, was running well and needed no contribution from me: I was offered no facilities to start a clinical unit on the lines I thought necessary for the circumstances. My proposals for organising the registrar rotation to meet the stringent (and appropriate) requirements of the Royal College of Psychiatrists approval exercise were rejected out of hand until a departing consultant was replaced by Dr Gaius Davies who took on a massive amount of work as the first clinical tutor. Even so, very big problems kept coming to light.

I am sure the wards at St Giles did good work during Dr Roberts' early years in psychiatry; indeed I recall some medical students' generous praise for John Hutchinson's clinical teaching. But the unit was in all sense isolated from the teaching hospital, and had some inbuilt weaknesses which became progressively more damaging. As a result, in later years there were some extremely bad practices, many complaints, and some very distasteful disciplinary problems and grievance procedures. Matters became even worse when the unit was moved to another run-down hospital, St Francis. Despite all that my colleagues and I were able to do, it was, and remained, a disgrace to King's and probably one of the most objectionable mental hospital units in the country. It is well that the Maudsley was eventually forced to take over the service.

Dr Roberts feels the desire to put the record straight; and of course he and I observed events from very different vantage points. I would have preferred to leave the veil undisturbed, but I am grateful for this opportunity to support Oscar Wilde's view that the truth is rarely pure and never simple.

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Maudsley monographs

DEAR SIRS

In my conversation with Hugh Freeman, reported in the *Psychiatric Bulletin* (May 1993, **17**, 260–273), I mentioned that Vera Norris wrote the first *Maudsley Monograph*. I am ashamed of myself. By one utterly regrettable stroke I have given cause for offence to the authors of the first five *Monographs*. Everybody knows that Peter Sainsbury wrote the first: he was followed by Hans Eysenck and colleagues, Michael Shepherd, the late Erwin Stengel and Philip Connell. Had Vera Norris herself survived she would have sent me to an alienist.

I apologise to all concerned, and regret having misled those of your readers who were not in a position to know the facts.

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Guidelines – managing sexual abuse disclosure

DEAR SIRS

It was with some disquiet that I read the article by I. E. Babiker 'Managing sexual abuse disclosure by adult psychiatric patients – some suggestions' (*Psychiatric Bulletin*, May 1993, **17**, 286–288). In speaking of adult patients who have revealed former sexual abuse Dr Babiker states that "... immediate reporting ... of their abuse [is] required by the [Children] Act 1989". Dr Babiker's thesis is that because the child's welfare is paramount under the

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Act, medical confidentiality and the health and safety of some adult patients must be subjugated to that principle. This is a misinterpretation of a primary principle of the Children Act and a misunderstanding of the nature of medical confidentiality.

> Section 1(1) of the Act, the welfare principle, states that: "When a court determines any question with respect to: (a) the upbringing of a child ... the child's welfare shall be the court's paramount consideration."

The need to give the child's welfare paramount consideration is a principle of law applied by the courts, in the course of litigation. It is not a principle, somehow applicable to society at large and the doctor/patient relationship in particular, and certainly not one which requires mandatory reporting of former abuse in adult patients.

At the heart of all codes of medical ethics is the obligation to maintain patient confidentiality. The major exception in English law is contained in section 18 of the Prevention of Terrorism Act 1989 which makes it an offence for any person having information which he believes may be of material assistance in preventing terrorism or apprehending terrorists to fail, without reasonable excuse, to give that information to the police.

This is in contrast to Dr Babiker's suggestion that a duty be thrust on general practitioners to "take steps to report [the sexual abuse of a patient] before referring the patient for psychiatric treatment" and to report patients who have a condition which could pose a risk to children, before referral to a specialist. Dr Babiker is seeking to throw the burden of disclosure onto the general practitioner yet compliance with this guidance may breach the legal duty to the patient. The GP will certainly have breached the ethical standards of the General Medical Council.

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Reply

DEAR SIRS

Mrs Bridge is quite right in stating that the Children Act 1989 specifically instructs the courts to give the child's welfare paramount consideration. I am not qualified to argue the finer points of law, but it seems to me that the question is whether this principle is confined to court proceedings or has wider application. In *Working Together*, jointly published in 1991 by four government departments including the Department of Health, the principle of paramountcy is interpreted as applying to all situations where professionals become aware of risk to children. All health professionals are therefore under obligation to cooperate fully with local authorities who have statutory responsibility for the protection of children who are abused or at risk of abuse. They are also bound by local agreements health authorities and social services departments, as well as policies and procedures drawn up by local child protection committees requiring health professionals to report risk of child abuse to social services departments.

The preface to *Working Together* makes it clear that the document "does not have the full force of statute, but should be complied with unless local circumstances indicate exceptional reasons which justify a variation". Our guidelines represent compliance with clear departmental directives which we believe are based on a sound interpretation of the Act.

As far as breaching the ethical standards of the General Medical Council is concerned, *Working Together* includes an extract from the Council's 1987 Annual Report which concludes "... if a doctor has reason for believing that a child is being physically or sexually abused, not only is it permissible for the doctor to disclose information to a third party but it is a duty of the doctor to do so."

Although doctors may be on safe legal and ethical grounds when reporting risk of sexual abuse, the decision is often difficult in practice because of the fear of breaching medical confidentiality. Our guidelines attempt to reconcile ethical and legal duties through exploring the dilemmas facing both doctor and patient following disclosure of sexual abuse and providing guidance on how to safeguard the interests of both patient and society.

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Psychiatry and philosophy

DEAR SIRS

Mark Morris (Reply: *Psychiatric Bulletin*, 1992, **16**, 727–728) is missing the essential point when he refers to my "clarification of 'materialism' as a type of philosophical realism". My thesis is that commonsense realism is fully compatible with both metaphysical idealism and realism. I cannot see how Dr Morris can claim to be "fundamentally in agreement" about the person/organism conceptual polarity when there was no indication in his article that he was aware of such a distinction.

What he says about "phenomenology' applies only to Karl Jaspers' extremely limited notion of "descriptive phenomenology". He should refer to