

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 common-sense 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

the phenomenological literature if he seeks illumination on the (apparent) objections he has raised – consulting in particular the works of Kurt Goldstein, Aron Gurwitsch, Maurice Merleau-Ponty and R. D. Laing. Suffice it now to say that his notion of “a phenomenological metaphysic” is fundamentally incoherent. It has been the perpetual endeavour of phenomenology to avoid (Husserl) or to dissolve (Heidegger) questions regarded in the philosophical tradition as “metaphysical”. The ambition of both the founding fathers (Husserl and Heidegger) has been to recover, in their own striking but divergent ways, and in an absolutely original manner, the primordial experience of man’s contact with the world.

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### Further reading

- SPIEGELBERG, H. (1972) *Phenomenology in Psychology and Psychiatry: A historical introduction*. Evanston: Northwestern University Press.
- (1982) *The Phenomenological Movement: A historical introduction*. The Hague: Martinus Nijhoff.
- STRAUS, E. W., NATANSON, M. & EY, H. (1969) *Psychiatry and Philosophy*. Berlin and Heidelberg: Springer-Verlag.

### Fear of flying

DEAR SIRs

I am writing to enquire whether there are practitioners working in the field of the treatment of fear of flying who would like to take part in an international study I am coordinating. The study was developed following presentation of my research results at several international conferences. The research examined the nature of fear of flying and the process of cognitive change during treatment which consisted of a standardised two session treatment programme, the second session being a return flight to Europe.

Contact has been made with doctors and psychologists working in various centres, and a standardised questionnaire developed which will enable international comparisons to be made on the different types of treatment, and their effectiveness, and add to the understanding of the process of cognitive change.

Clinicians are invited to participate in this study. Referrals are also being accepted for the study.

Please contact Elaine Iljon Foreman, Chartered Clinical Psychologist, at EIF Consulting Rooms, 21A Dean Road, London NW2 5AB (telephone/fax 081 459 3428, for further details).

I look forward to your reply.

ELAINE ILJON FOREMAN

## Psychiatric vignettes

The editors welcome vignettes of not more than 300 words. ‘Tea with Alzheimer’ by Henry R. Rollin

(*Psychiatric Bulletin*, September 1993, 17, 566) can be used as a model.

## Errata

‘Preparing for Mental Health Review Tribunals: reports and dilemmas’ by B. Brockman (*Psychiatric Bulletin*, September 1993, 17, 544–547): the second reference should have read Langley, G.E.

‘Counselling in Primary Care? Expectations, values and effectiveness’ (Conference briefing, *Psychiatric Bulletin*, March 1993, 17, 169): the correct spelling of the author’s name is Margreet Peutz.