Correspondence

Guidelines to Staff on Confidentiality

DEAR SIR,

Dr Baldwin, Dr Leff and Professor Wing, of the Social and Community Psychiatry Section of the Royal College of Psychiatrists, have stated (*British Journal of Psychiatry* (1976) **128,** 417–27) that the risk of leaks of confidentiality were perhaps greater from information kept *inside* the hospital than from information sent to *outside* computers. Our hospital's Records and Confidentiality Sub-Committee has already tried to improve the security of information outside our hospitals (*Bulletin*, March 1979, p 47); it is now trying to improve the security of information *within* them.

While realizing that each consultant must make up his own mind on any action concerning the imparting of confidential information, we have felt that the various clerical workers in the hospital are often unsure whether or not it is proper to give information on request and that we should give them some guidelines. After much discussion and consultation, we have drafted such guidelines for clerical staff, and later will offer them to our nursing colleagues as a basis for any guidelines they may wish to produce for nurses.

Since it took much effort to produce these guidelines, we feel that psychiatrists in other hospitals who may also be trying to tighten up their local security of confidential information might be glad to see them and possibly use them as a basis for their own. We are not sure we have got them right and would welcome criticism and suggestions. We feel that this subject, though tedious and dull, is an important one which should be discussed and we therefore append a summary of our guidelines.

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Summary of Guidelines for Clerical Staff*

Members of staff in possession of medical records must safeguard them in order to maintain confidentiality of information about patients.

A. *Release of Information about Patients*

1. Authority for release of information

Authority to release medical information must always come from either the consultant in charge of the patient, a member of his medical team, the Data Custodian or his deputy. Since admission implies a psychiatric diagnosis, a telephone reply should in the first instance give no indication that the alleged patient is actually a patient in the hospital or ward, and if the identity of a caller is in doubt, the recipient should ask for the caller's number and ring back after checking. Whenever possible information should be requested in writing. Information should not be given even to the police, the court or solicitors without the consultant's permission, except in certain situations (see Para 2).

Telephone requests from general practitioners should be referred directly to the consultant or his team.

2. Situations in which information can be given without the permission of the consultant

(i) Enquiries concerning National Insurance and Supplementary Benefit from the DHSS (and occasionally, with the patient's consent, his employer) arising from a medical certificate for sickness benefit signed by the patient and sent by him to the DHSS, sometimes via his employer. (The patient's permission may be assumed to be implicit in his signature on the form, and the maintenance of confidentiality by his employer or the DHSS must be assumed.)

(ii) Information concerning a patient's property requested by the Court of Protection or a person appointed as Receiver.

(iii) Information requested by a Coroner or his deputy (but not by the Coroner's Officer, who is a police officer) should be given at once (though legal compulsion to give it occurs strictly only *at* the Inquest).

(iv) Where there has been a serious assault by a patient while on hospital property, or serious theft, or serious damage to hospital property, information about a patient may have to be released to the District Administrator or to the police, but only with the authority of the *Sector or Hospital Administrator* who will, wherever possible, discuss any proposed disclosures with the consultant concerned, and will, where appropriate, obtain the patient's consent to any disclosure.

(v) In addition, statutory regulations demanding automatic release of specific information about patients by doctors apply in cases of notification of infectious diseases, drug abuse forms for the DHSS, certification of cause of death and registration of death.

B. *Safe-Keeping of Case-Notes*

3. Access to case-notes

Members of the specific multidisciplinary team dealing with a patient in the ward or day hospital, or involved clinically with an out-patient, may need to

* These guidelines are not intended for the telephonist who passes an enquiry on to the relevant ward or department, nor for nurses who deal with most enquiries from relatives about patients actually in the ward or day hospital.

consult the case-notes. Other professional or non-professional workers should not read case-notes in the ward or day hospital or borrow them from the Medical Records Office without the permission of the consultant concerned.

Patients, their relatives or their representatives should not be permitted to handle or read case-notes.

Professional *hospital* workers involved with the clinical care of out-patients may also have access to the notes. Consultants should give a list to the Medical Records staff of the particular workers who may have access to their patients' notes. If the records clerk is uncertain that a certain worker has that general permission, she may ask for proof by a referring letter or written permission from the consultant.

Only doctors or psychologists involved with the clinical care of out-patients in their homes or at outlying clinics may take the notes away with them. They should be returned to the hospital as soon as possible. Apart from these occasions case-notes must not be removed from the hospital or out-patient department.

4. Borrowers of case-notes

Borrowers of case-notes are responsible for their safe-keeping; they should keep them in a tidy and orderly manner and prevent any unauthorized person having access to them.

If the case-notes are removed from the Records Library, the borrower should sign a register showing the date of borrowing and the date of return.

5. Transfer of case-notes

Medical documents transferred within the hospital itself must be in a sealed envelope. Case-notes should *never* be sent out of the hospital: a photostat copy of the relevant parts of the notes, authorized by the doctor concerned, may be sent to another hospital. Requests for case-notes from another hospital should be made through the Medical Records Office, and that office should be informed in the case of private enquiries. Case-notes borrowed from another hospital should be returned through the Medical Records Office.

6. Research or training projects by students or staff

Research must first have the approval of the relevant Ethical Committee and the consultants concerned. A signed consent form should be obtained from the Data Custodian, indicating approval for that specific project and stating that the borrower undertakes not to pass the information on to a third party.

Students or staff wishing to obtain out-patient notes for training purposes must produce a signed consent form from the relevant senior professional worker in the hospital (the senior psychologist, senior nursing officer, senior hospital social worker or the senior occupational therapist) who must obtain the approval of the consultants of the patients involved, and who takes responsibility for ensuring confidentiality.

The case-notes may only be borrowed through the Medical Records staff and should *never* be removed from the hospital.

[A copy of the full Guidelines is available from the author on request.]

Prevention and Treatment of Depression (The UK PTD Committee)

DEAR SIR,

The International Committee for the Prevention and Treatment of Depression was established in 1975 at the International Congress on Psychosomatic Medicine in Rome. The purpose of this Committee is to spread knowledge pertaining to the diagnosis and treatment of depressive illness in general practice around the world. Since then the International PTD Committee has expanded and now has members from Austria, Britain, Denmark, France, Germany, Holland, Italy, Japan, Spain, Sweden, Switzerland and the United States. Each country has a National Committee whose aim, besides that of the parent body, is to improve co-operation between psychiatrists and non-psychiatrists. In no country are there sufficient psychiatrists to cope with all the patients suffering from depression and it is hoped that by the Committee's educational efforts the treatment of depressed patients in general practice will become more effective.

The UK Committee is composed of an even division of psychiatrists and general practitioners. The psychiatric members are Drs Hugh Freeman, John Pollitt and Nita Mitchell-Heggs, and Professor Robin Priest. General practitioner members are George Beaumont, who has made a considerable contribution to postgraduate education in the field of depression; David Wheatley, a founder member of the British Association for Psychopharmacology; and Arthur Watts, author of *Depression: Understanding a Common Problem* (1966) and *Defeating Depression: a guide for depressed people and their families* (1980).

Our first symposium was held in London in conjunction with the Swedish National PTD Committee in December, 1979. Experts from Scandanavia discussed lithium treatment and kidney damage; the use of ECT in Sweden; and tricyclic antidepressants; there were also papers on life events and depression and cycloid psychoses, as well as contributions from Depressives Associated and Depressives Anonymous, two of the self-help groups in this field.

Our first bulletin, entitled 'The Treatment of Depression in Everyday Practice' was distributed with the January 1980 issue of *The Practitioner*. It is printed by Geigy Pharmaceuticals and will appear quarterly.

The International Committee, on which I am the British representative, meets two or three times a year to exchange papers, slide-tape educational programmes and up-to-date ideas on the treatment of depression in the different