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 officé 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

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countries. The proceedings of the last symposium 'The General Practitioner and his Depressed Patient' will be published in 1980 by Huber in English and German.

DESMOND KELLY,
Chairman,
UK National PTD Committee

Priory Hospital,
Priory Lane,
London SW15 5JJ.

Research in Decline

DEAR SIR,

We were most interested in Dr Cranmer's article (*Bulletin*, November 1979, p. 174) and the lively comments on the matter (February 1980, pp. 28–30). We agree with Dr Crammer's views and would like to share our own way of overcoming such difficulties at a local level.

Recently the Clinical Psychology Department initiated the setting up of a Multidisciplinary Research Group. Membership includes psychiatrists at all levels, psychologists, nurses, and other interested health workers in the Area. The following objectives were agreed in our first meeting:

i To hear about research and evaluation now being planned or carried out in the Area.

ii To assist each other with advice about designing, planning carrying out, analysing and writing up projects anyone might wish to undertake.

iii To build up references in specialist areas and keep each other informed about matters relevant to research.

iv To co-ordinate (possibly through nominating someone for the task) a link-up between members who might have the time and interest to participate in research or evaluation and members who need assistance with such a project.

Though newly formed we hope to be a lively and useful group. We would be most interested to liaise with similar local groups and with the Royal College Research Committee.

MOHAMED EL-BAKLEY,
Senior Registrar
PATRICIA E. KINGERLEE,
Principal Clinical Psychologist

St Crispin Hospital,
Duston,
Northampton NN5 6UN.

The College

Life Insurance: Applicants with a History of Psychiatric Illness

Report from a working party of the Public Policy Committee.

Following a complaint from a former psychiatric patient who was unable to secure a life policy after a mental breakdown, the Public Policy Committee suggested that the problems associated with life insurance for people with a history of psychiatric illness should be investigated. After preliminary enquiries, the Committee was put in touch with Mr E. K. Goldwin (then Life Manager of Crusader Insurance). Mr Goldwin gave useful information about methods of assessment and rating for life insurance; the Committee then invited members of the College known to have a particular interest in psychiatric morbidity to meet with Mr Goldwin. Dr John Reed served as Convener and at Mr Goldwin's suggestion invited Mr Colin Trew (Manager, and an author of the M&G Reinsurance Company's rating Manual) to join the meeting which was held on 27 November 1978. Dr S. I. Cohen and Professor Andrew Sims also participated in the discussion. (A number of references in the literature were circulated before the meeting and are listed below.)

From a study of the rating schedules used by life managers, it is obvious that insurance companies seriously set out to establish the type of mental illness suffered by applicants and base their decision on the individual history and prognosis.

Only a small number of proposals are turned down or are required to pay a weighted premium. There is no evidence to suggest that companies are more discriminating against psychiatric illness than physical illness. Figures quoted by Mr Trew and Mr Goldwin show that for all life insurance companies approximately 4.5 per cent of applications are rated because of a medical impairment and less than half of 1 per cent are declined.

The companies' medical advisers and underwriters base their assessments on knowledge of the causes of mental illness, its treatment and prognosis, but inevitably because of the lack of reliable statistics and the need to substantiate the success of different treatments and new developments, they

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