Brit. J. Psychiat. (1970), 116, 345–352

Correspondence

HOSPITAL ADMISSION AND DISCHARGE RECORDS

DEAR SIR,

As from 1 January 1970, I understand that the Department of Health and Social Security is asking that all psychiatric hospitals complete a common form to record their admissions and discharges. I understand also that this form is to be filled in quadruplicate, three copies for internal hospital use and one for the Department.

In this, there is nothing very new. What I find disquieting, however, is the tendency for official bodies to seek for ever more detailed and more confidential information about our patients. This form, for example, enquires specifically whether one's patient is suffering from epilepsy, drug addiction or alcoholism, and in addition asks for the code-number for the patient's complaint, be this depression, phobia or fetishism.

It seems to me not unreasonable that the Department should know something about the type of patients we are treating—though far more information seems to go into that vast organization at the Elephant and Castle than ever comes out. However, it does seem to me quite unreasonable that, in normal circumstances, the Ministry should have our patient's *names*. To give just one example of the potential danger here. At this present time, more and more people are being vetted for 'credit-worthiness'. Large firms have sprung up to carry out this very job. It does not seem far-fetched to imagine some unfortunate Ministry clerk being somehow manoeuvred into giving away a great deal of highly confidential information to a Credit Agency dishonest enough to use such methods.

Even if one believes that nowadays confidentiality counts for very little, the wideness and occasional vagueness of diagnostic categories can lead to the lumping together of very different sorts of people. The main-line Methedrine junkie presents a very different credit risk from the middle-aged man uncomfortably habituated to nocturnal barbiturates. The deteriorated senile epileptic has a very different prognosis from the young man with petit-mal. Such semantic blurring matters little in the cellars where the hospital stores its records. But it could mean great hardship to a man where this half-information fell into the wrong hands—and it would be very difficult for such a subject to find redress.

Our patients are all the time growing better informed, and I think there may be much indignation when it is found out that the confidentiality of medical records means so little. One effect here may be to dissuade patients from seeking in-patient care at an early stage of their illness. In general, this would be a great pity; with a drug addict, it might be absolutely disastrous.

In recent years, I have found the agents of public bodies taking it more and more as their right that they should know about our patients in detail. This is a trend that should be arrested and reversed. Meanwhile, the Department might be content to accept the hospital record number of our patients rather than their actual names.

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DEAR SIR,

Records of admissions and discharges of named psychiatric patients have been collected, with knowledge of the medical profession, in the Mental Health Enquiry since 1949. In the earlier years of the Enquiry these records were returned to the General Register Office, but latterly to the Ministry of Health, now Department of Health and Social Security. The combined admission and discharge form which Dr. Neville-Smith refers to is a revised version of the separate admission and discharge forms which have hitherto been used in the Enquiry. Recent publications arising from the Enquiry are given below.

The advantage of recording the name of the patient on the form, with some other identification particulars such as date of birth, is to enable records of hospital spells occurring to the same person to be linked for statistical study; for example, for cohort studies which follow the hospital history of groups of patients admitted to hospital in a particular period. Hospital unit numbers, which Dr. Neville-Smith suggests might be used rather than actual names, would give no indication to staff carrying out these studies whether a patient admitted on different occasions to different hospitals was one and the same person. Indeed, there is no guarantee that the same hospital number will always be preserved over the years for a patient who is admitted several times to hospital.

It must be emphasized that it is irrelevant to

statistical study who a patient may be; what is relevant is the information of medical significance recorded on the forms and whether forms relate to the same or different persons. The named forms are processed statistically under conditions of strict confidentiality by staff of the Department who have all signed the Official Secrets Act. Contravention of the Act can incur serious penalties. On occasion, dates of admission, dates of discharge and hospital unit numbers of patients named to the Department by members of the medical profession engaged in or supervising research have been given to these members of the profession for their research.

Recent publications arising from Mental Health Enquiry:

General Register Office. Studies on Medical and Population subjects No. 18. A Cohort study of patients first admitted to mental hospitals in 1954 and 1955. H.M.S.O. 1963.
Ministry of Health. Reports on Public Health and medical subjects No. 116. A census of patients in Psychiatric beds 1963. H.M.S.O. 1967.
Ministry of Health. Statistical Report Series No. 4. Psychiatric Hospitals and Units in England and Wales. Inpatient statistics from the Mental Health Enquiry for the years 1964, 1965 and 1966. H.M.S.O. 1969.
Department of Health and Social Security Statistical Report Series No. 5. Psychiatric Hospitals and Units in England and Wales. Inpatient statistics from the Mental Health Enquiry for the year 1967. H.M.S.O. 1969.

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SOME PSYCHIATRIC SEQUELAE OF CHILDHOOD BEREAVEMENT

DEAR SIR,

I was interested to read Munro and Griffith's paper (*Journal*, March 1969, p. 305) on the complex problem of bereavement and mental illness, but would like to make the following comments.

The review of the literature is confusing, for they do not make it clear which studies are concerned with early bereavement in the sense of parental death and which are concerned with a variety of early deprivation experiences including bereavement. As Hill (1969) has stressed, absence of parent due to divorce, separation, abandonment, etc., may denote a higher index of psychiatric disturbance in this group of parents and thus indicate a genetic aetiology. Absence of parent due to death is more likely to indicate an environmental aetiology. Thus it is essential to differentiate clearly between the two types of absence. Studies to date suggest that the importance of each type varies with the clinical group studied. Referring to the special case of depression, they say that Forrest *et al.* (1965) and Hill and Price (1967) show an excess of 'parent loss' in depressives, and (in the next sentence) that Gay and Tonge (1967) find that the excess of 'parent loss' is more frequent in psychogenic than in endogenous depression. In the first case 'parent loss' means parent death; in the second a variety of separation experiences. Similarly 'A number of workers have failed to find a significant association between parental bereavement and depressive illness' is followed by a reference to the study by Oltman *et al.* (1951) on 'parental deprivation' which again included a variety of separation experiences.

Apart from Gay and Tonge's study there is no justification for the assertion that parental deprivation is less important in the aetiology of 'manic-depressive' or 'endogenous' depression. Brown (1964) claims to have shown the opposite, though he has never published his findings. As the 'endogenous' group of depressions is usually considered to be more severe than the neurotic group, it would be difficult at the same time, as Munro and Griffiths do, to sustain the argument that deprivation may contribute more to the severity of depressive illness. Certainly the criteria Munro (1966) has used to differentiate between severe and moderate depression, e.g. 'if it is recurrent in the absence of adequate provoking factors or if there was a previous history of manic illness,' are more likely to differentiate between the 'endogenous-manic-depressive' and neurotic forms of depression. In my own investigation (1970a) the criteria for distinguishing severe from moderate depression included such psychotic phenomena as thoughts distorted by depressed mood, and depressive delusions. Although the incidence of early parent death was similar in depressed and non-depressed patients, it was significantly higher in severe as opposed to moderate depressives. As the incidence of early parent death in the moderate depressives was shown to be no greater than that in the general population, and as it was further shown that is is significantly higher in psychiatric patients as a whole (1970b), it is likely that early parent death contributes only to severe forms of mental illness. Thus differences in findings between Brown (1961) and Munro (1966) regarding depressives versus the general population, or Hill and Price (1967) and myself regarding depressives versus non-depressives, may be accounted for by the severity of the cases studied.

The suggestion that high incidences of 'deprivation' in depressive illness may be due to contamination of the depressives by personality disorder, delinquency