treated episode is often the third or fourth actual episode. Again research is needed.

Lastly, how do we know that a proactive chronic disease model is better than the present "laissez-faire" model. We, like the Seattle group,[20] have adopted a proactive approach to management of current illness. When people do not take their drugs, implement their pleasant event activities, use problem solving, or attend for appointments we ask why. Whether such proactive care works in the longer term is simply unknown, and research is needed. However, we think anything is better than leaving patients to languish at home, too dysphoric and anergic to seek help.

Depression and diabetes are alike in burden, and both have chronic courses marked by periods without symptoms and by occasional emergencies. The UK prospective diabetes study showed the effectiveness of intensive follow up in preventing long term complications in diabetic patients.[27] There has been no equivalent study in depression, and, given the promise of the work by the Seattle group, the time is ripe for such a long term prospective study. We must encourage research into efficient strategies for long term treatment and prevention of relapse in depression. After all, it is the largest single cause of disability in the world.

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**Correction**

*Results of genetic testing: when confidentiality conflicts with a duty to warn relatives*

An error in the electronic production process caused the reference list in this article by Leung (9 December, pp 1464-5) to be missing. It will be found on the *BMJ* website (www.bmj.com/cgi/content/full/321/7274/1464).

## The importance of patient confidentiality

As a third year medical student just starting out in clinical medicine, the importance of patient confidentiality has often been emphasised to me. Unfortunately, until now, it is something that I have not considered in detail. I am probably guilty of the odd Friday night pub conversation: "You won't believe what I saw today." I am sure many of my fellow colleagues would be guilty of the same.

But while I was completing my special study module on domestic violence my eyes were opened. My tutor asked me to contact several victims of violent domestic abuse who had been treated in the accident and emergency department. I obtained telephone numbers from patient records. Some individuals, however, had omitted to leave their number. I contacted directory inquiries only to discover that they were not listed. This suggested that these people had no wish to be contacted.

At my tutor's request, I contacted the practices where the victims were patients. The receptionists at all six practices freely gave out the numbers I required without asking for any proof of identity. I was shocked at how easily I could obtain information that was obviously not meant for public knowledge. It was more worrying as the cases involved domestic violence.

Some of the victims may have been withholding telephone numbers to try to create a barrier between themselves and their violent ex-partners. Would they be happy to know that they were so easily accessible? The receptionists concerned had no proof that they were speaking to a medical student with no harmful intentions. Perhaps we should all give a little more thought to patient confidentiality.

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We welcome articles of up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to.