Recording family and social history

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SUMMARY. A diagrammatic method of recording family and social history using a family tree is described. Its advantages are identified and details of the way it has been introduced into the records in one general practice are given.

Introduction

THE general practitioner has been described as "a doctor who provides personal, primary, and continuing medical care to individuals and *families* . . . His diagnosis will be composed in physical, psychological, and social terms" (RCGP, 1972). Attention has been drawn to the fact that a patient's demand for primary medical care is a function of human behaviour rather than a pathological process, and Williams (1967) has observed that "when we try to justify general practice as a separate branch of medicine we claim that its very generality enables us to see the whole picture, to identify disease against its natural background of minor illness and social upheaval, and to understand it longitudinally in family life over several generations."

All these statements clearly imply that to do his work satisfactorily the general practitioner needs to be aware of the many factors that are likely to influence the lives and behaviour of his patients. Yet when we look critically at the extent of the general practitioner's knowledge of family and social history there is increasing evidence that it may be less substantial than many would care to admit.

In studying the records of 187 general practitioners Cormack (1970) found that in no instance was the family history recorded in a formal organized way, and what family history there was, was scattered throughout the day-to-day records. Similarly, Dawes (1972) found no indication of marital status for 99 per cent of male patients, and no details of occupation for 66 per cent.

This apparent lack of adequate recording is sometimes excused by doctors on the grounds that their personal knowledge of their patients makes formal history-taking unnecessary. However, it should be noted that the information about family history will be especially difficult for general practitioners to retain, since it often concerns people with whom they have little or no contact. In a study in which not only the contents of the records but also the doctors' personal knowledge of their patients was tested, it was found that the doctors were ignorant of much information considered important for the provision of clinical care, and this deficiency was particularly marked for the family and social history (Zander, 1977). There was uncertainty about the existence of 46 per cent of close family members (spouse, parents, children), and ignorance of 81 per cent of the serious illness or cause of death of members of the family. The employment status was known for only just over half the single patients and less than a quarter of the married ones. In 15 per cent of cases the doctors did not know if the patient was married, and were unaware of 19 per cent of the family members living within the same household.

Walford (1955) wrote the thought-provoking statement, "it is strange that the family history was so much better recorded in hospital records than in general practice."

In recording family and social history, attention needs to be given to the following critical questions:

1. How and when should the information be collected?

In hospital, medical care is concerned with an episode of ill health. There is a clearly identifiable beginning to the clinical process, and the time at which a full history is obtained is clear-cut.

This contrasts with general practice where care is continuous. The method of recording social as well as clinical information must therefore be dynamic, allowing for the continual addition of information as it arises.

Some general practitioners take a full history at the initial consultation, but time and other constraints may make this difficult. Sheldon (1974) has, for this reason, introduced a self-administered questionnaire to be given

to the patients at the time of registration. Walford (1955) advocates the collection of information as it occurs during consultations over the years, rather than taking a formal history at one point in time.

One natural consequence of there being no obvious moment for recording this information is that it is not undertaken, and therefore much is to be gained by establishing a routine procedure for obtaining some of this basic information.

2. *How should the information be displayed?*

The way information is recorded is of considerable importance. Several attempts have been made to introduce some systematic form of recording for family history. Scott (1950), Williams (1967), and Jameson (1968) have all described their use of family or household record cards. Kuenssberg (1964) introduced the F Book as a means of recording morbidity within households, the Research Unit of the Royal College of General Practitioners developed F Cards for the same purpose, and Backett and Maybin (1956) have described their use of a folder holding the records of all members of a family living in the same household. Cormack (1971) has summarized some of the problems associated with many of these methods.

It is generally recognized that certain types of information can be absorbed more rapidly from a diagram than from written notes, and Kuenssberg (1964) and Cormack (1975) have suggested the use of a family tree for recording family and social history.

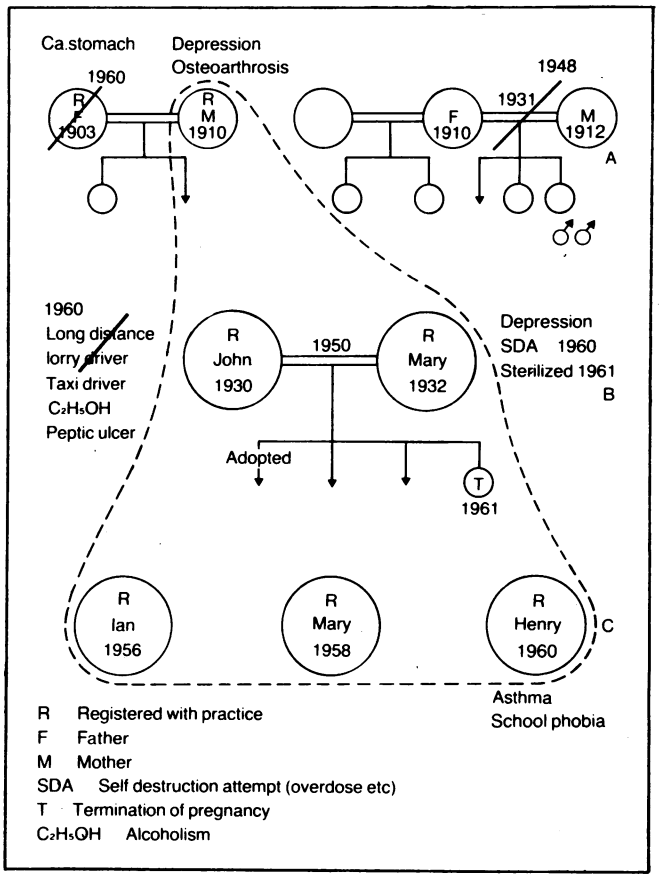

Figure 1. *Family chart.*

Method

In our group practice a study has been undertaken to develop a basic record format, suitable for use in any group practice, with the usual resources of ancillary staff. The record used has been of A4 size, but this is not essential to the basic idea underlying the method described here for recording social information.

Establishing a method of recording family and social history

For adequate recording of family and social history, the following five main criteria were identified:

1. The record should be maximally useful for ordinary day-to-day general practice.
2. The information must be clearly displayed to allow rapid comprehension of the relevant details.
3. The information should be immediately apparent to the doctor at the time of the consultation. Its retrieval should not depend on any action by the doctor if and when he feels the information might be relevant.
4. The format must allow for easy updating.
5. Completion and maintenance of the record should not demand excessive time from secretarial or other staff.

The use of a family tree was adopted as the most satisfactory way of fulfilling these criteria, and the format used is shown in Figure 1.

Data included on the family chart

1. The names of all members of the family (in the sections B and C).
2. The year of birth of all members of the family.
3. The date and cause of death of all members of the family.
4. An indication of which members of the family are registered with the practice.
5. Details of all members of the family living within the same household.
6. Details of dates of marriages and divorces.
7. Details of terminations of pregnancy, stillbirths, and adoptions.
8. Details of relevant medical and social information.

In a separate part of our study of records in general practice, a classification of 'significant' problems of patients had been made. These were defined as "those problems which it was important for the doctor to be aware of in his continuing care of that patient", and these then made up the summary problem list of the patient (Zander *et al.*, 1977).

We therefore agreed that all problems on the summary problem list (usually varying from two to five)

should be included on the family chart of all other family members registered with the practice.

The FP 7/8 cards are suitable for recording a family tree, but the amount of information to be included clearly needs to be adapted to the space available.

Design of the family chart

The family tree consists of three spaces or parts A, B and C which represent different generations (Figure 1).

In representing a couple, the male is conventionally in the lefthand circle. Christian names only are written within the circle, unless the surnames are different. The names of siblings in spaces A and B are not included unless either the sibling is registered with the practice, or lives within the household. When writing the date, only the year is used.

Social and medical information about family members is written on the chart. Any basic social history that is not to be entered on the family chart can be entered on the reverse side of the sheet. A perspex stencil has been produced to make the construction of the chart as rapid as possible. The time taken to complete a family tree varies from four to ten minutes.

Completing the family chart

The information is obtained from a questionnaire, completed by patients, and the chart is constructed by a record clerk.

As new information arises it is extracted by the clerk (the last entry on the consultation sheet is routinely surveyed by the clerk before refiling the records) and entered on that patient's chart and the charts of all other family members registered with the practice (Figure 2).

Confidentiality

As the information on the chart is easily visualized some abbreviations have been introduced for particularly confidential items, for instance: Alcoholism, C_2H_5OH; Homosexual, ♂♂-♀♀; Self-Destruction Attempt, SDA; Termination, T.

Discussion

The use of the family chart as a means of recording family and social history has several advantages over the traditional methods of recording. The information is easily and rapidly absorbed. The chart is the same for all members of the family. Once constructed it can be photocopied and inserted into all the relevant notes.

Information can be added without difficulty to the charts of all members of the family, which is of particular significance in ensuring that our records are suited to our function as family doctors. An added advantage is that this procedure can be undertaken by a clerk and requires minimal participation by the doctor.

Family charts are now being introduced into the records of all newly registering patients. In view of the work involved, it is difficult to envisage how it would be possible to achieve this for most of the patients already registered. As the charts are clearly of greatest benefit when several members of a family are registered, questionnaires are being given to young mothers at the time of their attendance at the well-baby clinics. They are also being given to any specially selected families for whom the doctors feel a chart would be particularly useful. We have not met any big problems so far and have already completed over 150 family charts.

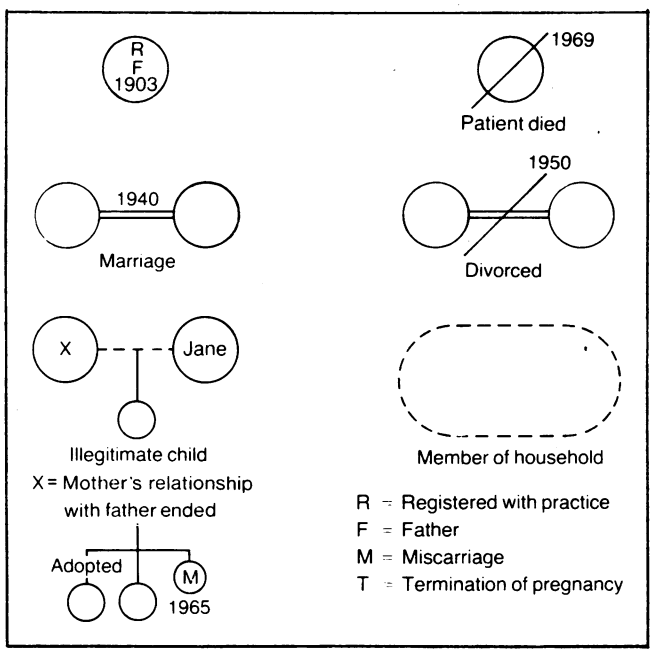

Figure 2. *Key to completion of family chart.*

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