LETTERS TO THE EDITOR

RECORDING FAMILY AND SOCIAL HISTORY

Sir,

We were interested to read the findings of Dr Zander (September *Journal,* pp. 518-520) in which he describes the lack of adequate recording of family and social history in general practice.

We have recently attempted to compare a practitioner's personal knowledge of his patients with his documented notes.

In this single-handed practice of 1,800 patients, the notes of 50 patients seen consecutively by the trainee general practitioner were examined for content of medical, family and social history, and for occupation.

We found that 36 patients (72 per cent) had notes of medical history which were considered relevant; no patients' notes contained family history; seven patients' notes (14 per cent) contained relevant social history; 17 patients (34 per cent) were known to be in employment (53 per cent of the practice population is of working age) and in 12 of these (70 per cent) occupation was documented.

The trainer was then consulted in order to discover the extent of his personal knowledge of these patients. He found little to add to the medical history. Family medical history was added in only six cases (12 per cent). Social history was added to in 15 cases (30 per cent). The occupations of three of the five cases outstanding was known.

From these findings we would certainly agree with the view that family and social history recording should be formalized. However, we would like to raise several points: first, the extent of the practitioner's ignorance in a relatively stable, self-contained rural community was rather less than might be expected in city practice. Secondly, remembering that the major purpose of formal records is to improve care for patients, we doubted whether detailed family cards as described by Dr Zander were necessary for all families. In an area such as this, where many branches of one family are in the same practice and intermarriage between them occurs, the production of formal family records would be a formidable task indeed and one which might not pay dividends in terms of care for the patient.

Finally, we are aware that not all the personal knowledge of general practitioners comes directly from their patients and there are doubtless occasions where doctors have information which patients would normally withhold. Despite the secrecy of medical records, there might arise a situation where a locum or an incoming partner accidentally confronts the patient with a family secret, which would surely damage the doctor-patient relationship.

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PHYSICIANS AND FAMILY DOCTORS

Sir,

I welcomed Dr Horder's article (July *Journal,* p. 391), when he spoke of general practitioners and consultants facing a "bottomless pit of human need", and especially the patient's need for personal care. "Bottomless pit" describes exactly how lost we feel when faced by a patient feeling equally lost and unable to mobilize his own resources. He may get *some* help from us but we know that often his need is not within our power to fulfil and we may be left feeling useless, though at least we can share his dilemma.

Hospital doctors are able to offer their patients physical resources, whereas family doctors are better placed to make the most of their inner resources. We need not give too many antibiotics, nor deliver all babies in hospital, nor allow other professionals to take over too much from families in a crisis. In other words, we are well placed through our knowledge of the patient to assess problems and apportion responsibility.

Dr Horder writes that the hospital consultant has "two patients, the usual patient and the general practitioner". However, the triangular situation is as real for the general practitioner. The consultant sees his role as helping the general practitioner as well as the patient by finding out why the general practitioner wants to be relieved of his patient. But how often does a family doctor refer a patient for something specific only to find the consultant taking some action with which he does not agree without consultation, leaving the family doctor also feeling he has "two patients"? He may even have to advise his patient on how to use the consultant resources.

This is especially marked in obstetrics where, in general-practitioner units, we and hospital doctors are learning a new kind of collaboration. There has been a revolution in obstetric care in the last two years, led by the public demanding more freedom for their relationship with midwives, husbands, and babies. This collaboration is not easy and requires that the general practitioner and hospital specialist meet on an equal basis, while representing different obstetric roles. It is a highly threatening situation to both sides, but also a rewarding one in strengthening family ties. To learn to cope with shared responsibility requires family doctors, midwives, and hospital doctors to meet regularly, both to discuss cases and review the contract between them. In the same way in group practices we need to counter the "pre-Harveian error" that meeting regularly is not as essential as, say, diagnostic facilities.

In psychiatry, too, great changes are in the air with the reduction of space in mental hospitals and the need to develop local resources. On the one hand there is a possibility of patients being abandoned through the confusion and despair of those giving them care, and on the other, the possibility that we should learn to consult with our consultant colleagues, sharing and apportioning the responsibility.

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AGE-SEX REGISTERS

Sir,

Thank you for your acknowledgement (September *Journal,* p. 515) about our job creation programme, directed towards the provision of age-sex registers. I thought you might like to know that we are providing registers to cover 292,000 patients on the lists of 112 doctors for whom Sheffield is the major user.

The programme was originally timed to run from April to October 1977, but as the time-speed rating we set has not been achieved, the Committee has re-