Inclusion of social problem categories in disease registers

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SUMMARY. The reliability of a disease register as a record of the number and type of social problems was investigated in one practice of approximately 12,000 patients. A comparison with a randomly selected sample of the practice population, matched for age and sex, indicated that some social problems were not included. The types of problem concerned, and the reasons why they were not included, are discussed.

Introduction

IT is an accepted tenet of good general practice that illness should always be considered in the context of the whole patient—namely, that all relevant physical psychological and social factors should be taken into consideration.[1] Surveys have shown that patients are willing to reveal social problems to their general practitioners.[2-5] However, general practitioners vary in their ability to recognize that a social problem may underlie the illness presented by the patient,[6] yet this recognition is a necessary prerequisite to its assessment and management.

The inclusion of social problem categories in disease registers would give a fuller impression of general practice work. The association of social problems with disease, whether organic or psychological, is well known.[7-12] Descriptive categories for social problems, analogous to diagnoses of diseases, have been incorporated in both the US *National Ambulatory Medical Care Survey: Classification of Symptoms*[13] and the second *International Classification of Health Problems in Primary Care (ICHPPC-2).*[14]

Disease registers have several functions besides the recording of episode and consultation rates for all illnesses. National morbidity statistics have been produced by recording a diagnostic label for every patient contact in selected practices.[15] For teaching purposes, cases may be identified for undergraduates and postgraduates. The disease register is particularly useful for research purposes: groups of patients with the same illness can be identified. The inclusion of social problem categories would be a further facility for research in general practice.

A category of social problems is difficult to validate objectively, although the same may be said of the diagnosis of certain diseases. Since social problems are frequently multiple and may vary in relation to one another in the same patient, it may be desirable to have a system that permits multiple recording along with indication of the main problem.[16]

A study was mounted to investigate the supposition that the addition of a 'Social problems' section to a practice disease register would be a useful tool for reminding a general practitioner to consider that a social problem might exist.

Aims

The aims of the study were:

1. To see how well the general practitioners contributed to the 'Social problems' section of a disease register;
2. To determine the types of social problem that should be included in the register;
3. To examine the possibility that the presence of concurrent disease would influence the recording of a social problem in the register.

Method

The study was carried out in the general practice operated by the Department of General Practice at the University of Manchester. Eight principal general practitioners and four trainees were involved. This practice is situated south of the city centre, near to the university and two teaching hospitals. It includes about 12,000 patients, many of whom are students or nurses. There is a large immigrant population, mainly from the Indian subcontinent and the West Indies.

A selective disease register has been established in the practice for some years. The register includes the rubric 'Social problems', but the definition of a social problem, in the context of the register, has never been defined.

The medical records of two groups of patients were examined in relation to events over a period of 12 months: an 'indexed group' comprising patients who were listed in the disease register as having a social problem; and a 'recorded group' comprising patients whose medical records mentioned social problems which had not been included in the disease register.

The recorded group were identified using the practice age-sex register. This register contains a card, filed by year of birth, for every patient in the practice. There are separate files for males and females. Within each year of birth, cards are filed at random. Thus it would only be by chance that the cards of members of the same family would appear consecutively. Patients were matched in age and sex with the indexed group by extracting the card before and after that of each member of the indexed group. If the medical record was found

Family problems (include stable unions)
Marital—including stable unions, both heterosexual and homosexual
Parent/child and child/parent
Adult/adult's parents (and in-laws) and vice versa
Aged parents (and in-laws)
Medical care problems (care of sick person)
Physical split-up of family (affecting child and/or others)
Other family

Other interpersonal problems
Girlfriend/boyfriend—of whatever age
At work or school
Friend, neighbour
Social relationships in general
Social isolation
Other interpersonal

Individual problems
Cultural/political/religious
Pregnancy out of wedlock, unmarried parent, single-parent family
Occupational problem (including unemployment)
Legal problems (including imprisonment)
Other individual

Environmental problems
Economic problems
Housing problems
Need for supervised accommodation
Other environmental

Figure 1. *Classification of social problems.*

to be missing (for example, if a patient had died or had recently left the practice), the next card in order was substituted.

The diseases (except for minor illness) and social problems recorded in the notes of each group of patients during the 12 months up to 30 September 1980 were identified.

The classification of social problems used in the study is shown in Figure 1. It was divided into four sections—Family problems, Other interpersonal problems, Individual problems and Environmental problems. The reference to the rubric 'Adult/adult's parents' under Family problems related to patients who, though now adult, had mentioned being upset by dispute with parents. Some were still living in the parental home, others, especially married women, had established a separate residence but remained greatly affected by parental values and criticism.

Each social problem in the clinical notes was listed. Where more than one social problem was recorded in the clinical notes, the problem that featured most prominently was identified. In order to consider the influence of concurrent illness on the recording of a social problem in the disease register, patients with social problems were subdivided as follows:

a) No serious illness

b) Organic illness (other than minor) or serious mental illness. (Serious mental illness included organic psychosis, schizophrenia, affective psychosis, other psychoses and mental retardation)

c) Psychological illness. (Including neurosis, behavioural disorder, personality disorder, abuse of alcohol or drugs, sexual problems, and transient situational disturbances)

d) Organic and psychological illness.

Any indication that a social worker had been involved with a patient was noted.

Table 1. Social problems in indexed and recorded groups of patients. (Number of patients and in parentheses percentage of patients in each group who have this problem.)

	Indexed group ($n=126$ patients)		Recorded group ($n=40$ patients)	
Type of social problem	All problems	Main problem	All problems	Main problem
Marital	46 *(36.5)*	40 *(31.7)*	10 *(25.0)*	9 *(22.5)*
Family split-up	21 *(16.7)*	14 *(11.1)*	4 *(10.0)*	4 *(10.0)*
Parent/child and child/parent	19 *(15.1)*	11 *(8.7)*	2 *(5.0)*	1 *(2.5)*
Housing	19 *(51.1)*	5 *(4.0)*	5 *(12.5)*	3 *(7.5)*
Occupational	18 *(14.3)*	6 *(4.8)*	4 *(10.0)*	3 *(7.5)*
Adult/adult's parents	15 *(11.9)*	6 *(4.8)*	3 *(7.5)*	3 *(7.5)*
Economic	15 *(11.9)*	3 *(2.4)*	0	0
Social isolation	12 *(9.5)*	9 *(7.1)*	0	0
Pregnancy out of wedlock/ single-parent family	10 *(7.9)*	7 *(5.6)*	3 *(7.5)*	3 *(7.5)*
Supervised accommodation needed	10 *(7.9)*	7 *(5.6)*	0	0
Girlfriend/ boyfriend	8 *(6.3)*	4 *(3.2)*	3 *(7.5)*	2 *(5.0)*
Medical care in family	7 *(5.6)*	4 *(3.2)*	6 *(15.0)*	4 *(10.0)*
Legal	7 *(5.6)*	2 *(1.6)*	2 *(5.0)*	1 *(2.5)*
Social relationships in general	6 *(4.8)*	4 *(3.2)*	0	0
Other family	5 *(4.0)*	2 *(1.6)*	4 *(10.0)*	4 *(10.0)*
Friend/ neighbour	4 *(3.2)*	1 *(0.8)*	1 *(2.5)*	1 *(2.5)*
Cultural/ religious/ political	3 *(2.4)*	1 *(0.8)*	4 *(10.0)*	2 *(5.0)*
Other individual	2 *(1.6)*	0	0	0
Other problems of social adjustment	2 *(1.6)*	0	0	0
Other	0	0	1 *(2.5)*	0
Total	229	126 *(100)*	52	40 *(100)*

Results

One hundred and sixty patients with social problems were recorded in the disease register, a frequency of 14 per 1,000 patients registered. Thirty-four (20 per cent) of these patients had left the practice, the same rate of turnover as for the practice as a whole. (They had been registered with the practice for the same length of time as the indexed patients remaining and as all the other patients in the practice. The reasons for removal given by the Family Practitioner Committee were much the same as for other removals.) This left 126 patients for the indexed group.

The records of a further 252 patients who had not been entered in the disease register were examined; 40

patients (16 per cent) were found to have social problems (the recorded group). The recorded group had the same age-sex distribution as the indexed group.

The commonest social problem in the indexed group related to the family circle (Table 1). The mean number of social problems per patient was 1.8 for the indexed group and 1.3 for the recorded group. Social workers were implicated with 60 patients (48 per cent) in the former group and with seven patients (17 per cent) in the latter group. Marital problems were the commonest single category in both groups. Social isolation, a need for supervised accommodation, problems with social relationships in general, and economic problems appeared only in the indexed group (Table 1).

The health categories of both groups of patients are shown in Table 2. Fewer patients in the indexed group had suffered significant illness ($0.02<P<0.05$); fewer had organic (excluding minor) or serious mental illness ($0.01<P<0.02$), though serious mental illness was distributed equally: nine patients (7 per cent) in the indexed group; three patients (7.5 per cent) in the recorded group. There was no significant difference in the number of patients who had psychological illness ($0.10<P<0.5$).

The number of patients suffering from the same disease in the two groups was too small for statistical examination, but it was noted that there were five cases of duodenal ulcer and four of migraine in the indexed group and none in the recorded group.

Discussion

Certain inferences may explain the differences between the two groups of patients with social problems.

The general practitioners had indexed, under the rubric 'Social problems', 14 per 1,000 of the patients registered with them. In comparison with Gray[17] (157 per 1,000 patients) this represents a considerable shortfall. However, the disclosure that 40 (16 per cent) out of 252 patients matched for age and sex had a social problem recorded in the clinical notes but not in the disease register suggests that many more patients ought to have been 'indexed'. Indeed, if it were assumed that the 252 patients were representative of the practice as a whole, a recording rate of 159 per 1,000 may be deduced, a figure remarkably similar to that of Gray.[17] Although much of the shortfall may have been due merely to doctors' forgetting to include patients in the disease register, it was found that, on average, the indexed group had more problems per patient and that more of them had had contact with a social worker. This implies that their problems had more effect on the patient or on the doctor or on both, influencing the doctor to include them in the disease register. On the other hand, as perusal of the records of the recorded group has shown, many problems that could have been included in the disease register were omitted from it. This may have been because these particular problems were perceived differently by the doctors concerned.

It appeared that some social problems that were always indexed did not occur in the recorded group (Table 1); thus they may have been considered more important by doctors. Fewer patients in the indexed group had a concurrent illness that might have distracted attention from a social problem. Examination of the recording of concurrent illness suggests that organic illness was the main type. Cooper[18] has shown that psychological illness, as it is diagnosed in general practice, represents an inextricable mixture of psychological symptoms and social needs and difficulties, which is why psychological illness and social problems are often considered together.

Table 2. Health category of 'indexed' and 'recorded' groups of patients.

Health category	Indexed group Number	%	Recorded group Number	%
No illness	31	*25*	4	*10*
Organic (other than minor), serious mental illness	44	*35*	24	*60*
Psychological illness	26	*21*	5	*13*
Organic and psychological illness	25	*19*	7	*18*
Total	126	*100*	40	*100*

$\chi^2=8.88$, df = 3, $0.02<P<0.05$.

Conclusion

After considering a number of the factors involved, it seems that the inclusion of patients with a social problem in a disease register would not reflect the true incidence of such problems in a general practice. The presence of a rubric for 'Social problems' does not describe the type of problem and it would be an advantage to subdivide this rubric to include, at least, the four main headings used for this study.

Finally, an audit of the type represented by this study could be mounted in any practice to determine the accuracy of disease indexing. Such an exercise might improve the validity of records and increase the motivation of doctors to record accurately. The disease register can be a means to an end, not just an end in itself.

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Acknowledgements

I thank Professor D. H. H. Metcalfe, Dr H. W. K. Acheson and Dr E. I. Williams for their help, and Mrs Anne Donnan.

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Predicting suicide

It has been predicted that the closer attempted suicide is to completed suicide, the greater the risk of suicide later. Using two risk scales, weighted according to their value in discriminating between suicides and attempted suicides, and a rating of intent to die during the index suicide attempt, the authors followed up 1,236 attempted suicides for two years. Ten of the twelve suicidal deaths in the first year occurred in patients scoring in the top quartile; and among high-risk scorers there was an excess 'of those defined as 'failed suicides' at the index attempt. The potential value of these findings is discussed.

Source: Pallis DJ, Gibbons JS, Pierce DW. Estimating suicide risk among attempted suicides. II. Efficacy of predictive scales after the attempt. *Br J Psychiatry* 1984; **144:** 139-148.