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The family history and the family doctor

THE nuclear family may well be in decline, but the family is still important to an individual's health because it provides the genetic and environmental background to illness. Patients' fears may be related to the (real or imagined) cause of their own parents' death which may indeed be relevant to their future morbidity. Genetic factors need to be taken into account in making many diagnoses. The early death of, or separation from a parent, is seldom without adverse consequences for a child. Equally, the death or serious illness of a child or a stillbirth or miscarriage is often inadequately mourned by parents and may therefore have a continuing and unrecognized effect on their health. Illness in an individual, particularly if it is chronic, creates stress and even ill health in other family members. These examples will perhaps serve to emphasize the value of knowing the family history. But how can this knowledge best be acquired in clinical practice?

General practice records in the United Kingdom used to contain little information about families[1] and scrutiny of almost any batch of patients' notes will reveal a lack of even the most basic data about the family. We may think that we know about the families of our own patients but projects that I have organized in several practices show that our memory is patchy and incomplete. Moreover, what is remembered but not recorded is, of course, unavailable to partners or other members of the primary health care team.

As medical students we are taught that caring for a patient requires a full history.[2] Yet a truly comprehensive history should include not only the present and past illnesses, but also family, social and geographical histories and an account of the patient's present physical, psychological and social state. During vocational training, experience soon shows that this is impractical owing to lack of time and because it is inefficient for problem solving. The hypothetico-deductive method is usually more appropriate and more effective as a method of problem solving.[3]

It seems probable that many doctors have a limited range of family and psychosocial hypotheses. They will therefore fail to make some diagnoses, partly because they have inadequate knowledge of family structure and dynamics in general and of a family in particular. Could it be that in bypassing the traditional family history we are bypassing the family itself? Perhaps there is still a place for more formal history taking, preferably early in a patient's relationship with the doctor, so that the doctor would then be equipped with a firmer basis for making diagnostic hypotheses involving the family and planning appropriate therapeutic interventions?

The five, seven or 10 minute consultation puts severe constraints on the family doctor, who may be reluctant to spend much of this time acquiring the family history. But there are ways of lessening this burden. A major part of any family history is fixed (though the memory of it may change) and only needs to be taken once. Patients can be given questionnaires to complete on registration with a practice, or at some other convenient time and, on the whole, patients provide reasonably accurate information.[4] Acquiring this information does not excuse the doctor from acknowledging and discussing salient points with the patient. In fact the government's new contract for general practitioners provides for such arrangements by requiring the family doctor to see all new patients and thus giving us an opportunity to take an adequate family history. Many doctors will now probably offer a double

appointment when new patients register, if they do not already do so. Some practices in the United States of America see the whole family on registration and thus establish a family orientation from the beginning of their relationship.[5]

An alternative way of learning about a family is to create a genogram.[6,7] This is a family tree which is made with the cooperation of the patient or family and includes the causes of death and physical, psychological and social characteristics of family members. Rogers and Durkin[8] have demonstrated that using a genogram to record the family history of newly registered patients enabled four times as much medical information to be obtained as did the normal informal interview and that it took no longer. The majority (96%) of patients thought that using the genogram improved doctor–patient communication.

Whatever method is used to obtain it, the family history should encompass the dates of births and deaths, major illnesses, abortions, terminations of pregnancy, alcohol and psychological problems of the parents, siblings and children. Ideally, this information would be stored in each patient's records and then be available to partners and other members of the health care team. In a fully computerized system the history could be entered initially and then updated in all the family's records whenever new information was acquired. To attempt this manually is a task doomed to failure because of its time consuming nature. Filing family notes together does not help either as it is quite impractical to look through the records of each family member at every consultation.

Creating a family record card,[9] which is filed separately but produced with the individual's record whenever a patient is seen, provides a feasible alternative. The cards have two parts: a family tree and an ongoing section for all family members registered with the practice, so that a brief entry (just the problem and the date) can be made at every consultation. The cards can be initiated by a secretary from the patient questionnaires and completed by the doctor with the help of a family member. The information on this card must remain confidential, however, and not be thoughtlessly shared with other members of the family.

Any general practitioner who is not fully persuaded of the value of knowing the family history should try checking the notes to see if there is an adequate family history on their next 10 consecutive patients. If not, he or she should ask about the family history and, either way, note the effect of considering the family history on the consultation itself and on the management of the problem.

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Editorial freedom

FOR the past eight years I have had the privilege of being editor of this *Journal* and during that time I have enjoyed complete editorial freedom. From now on, I shall be experiencing a new kind of freedom, released from concerns about the content of forthcoming issues of the *Journal.*

Since 1982, over 3000 papers have been submitted to the *Journal* and the annual number submitted has increased by 60% since my first year as editor. The steady and increasing flow of research papers is encouraging both for the *Journal* and for our discipline. My main impression over my time as editor has been the goodwill shown by authors and readers and the support of assessors and colleagues.

Peer review in medical publishing is far from being an exact science. Often the final decision about acceptance or rejection hinges on the subjective view of the editor alone. Through the efforts of our growing international panel of assessors, we attempt to maintain the highest possible standards of objective refereeing. The enthusiasm with which assessors take on their unseen task is evidence of the commitment of the medical and scientific community to the development of general practice. The number of assessors that we use regularly is so large that the task of thanking them all individually would be enormous. I am sure that they will forgive me if I take this opportunity of thanking them here. The *Journal* is particularly grateful to the team of statistical assessors recruited by Dr Ian Russell, none of whom are general practitioners but all of whom give generously of their time; I feel that the College and the discipline owes them an enormous debt.

The editorial staff of the *Journal,* the editorial board and, not least, my practice partners have given me unwavering practical help throughout the years and I am grateful for this. I have also benefitted from the constructive criticism which can sometimes only be provided by those with whom we are in close contact.

What about our readers? Are they unfailingly supportive, unhesitating in their praise? Of course not, and this is not to be desired. The purpose of a scientific journal of record is to challenge and confront existing conventions. If I have any regrets as editor, it is that we have not sufficiently challenged existing orthodoxy. Is general practice the best way of providing primary health care in all parts of the United Kingdom? Is continuity of care always best? Is it desirable for general practitioners to spend the majority of their career in one locality? Carrying out and writing up a research project is an extremely difficult task. Writing a paper which exposes the lack of scientific evidence for present clinical practice demands equally high standards of