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

imagination and logic.

The *Journal* has been attacked for being dull. While the editorial team strive to make it as interesting as possible, the *Journal's* main function is to be a scientific journal of record and most of our time is taken up with editing poorly presented work to the standard required in other disciplines. Careful descriptions of research will never make for light and easy reading. Other, more readable publications for general practitioners feed off the original work published in this *Journal* and in other serious publications. It is entirely appropriate that this should be the case. From time to time, other publications attack the *Journal*, but the only magazine which I have criticized is *Punch for Doctors*. I continue to think it is wrong for general practitioners to be entertained courtesy of the pharmaceutical industry by receiving *Punch for Doctors* free of charge.

In my new freedom I am looking forward to returning to a proactive rather than reactive role in the research world of general practice. Research in general practice is not easy. I have tried to be sympathetic to researchers, for whom the incessant demands of clinical practice leave little time or energy for the painstaking process of research. Contributors have universally been gracious in their acceptance of editorial decisions, three out of four of which result in letters of rejection. I can only hope that the new editor of the *Journal*, Dr Alastair Wright, will be impartial but kind in the way in which he uses his own editorial freedom.

E GRAHAM BUCKLEY
Editor of the Journal

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