A SYSTEM OF RECORDING THE FAMILY HISTORY IN GENERAL PRACTICE

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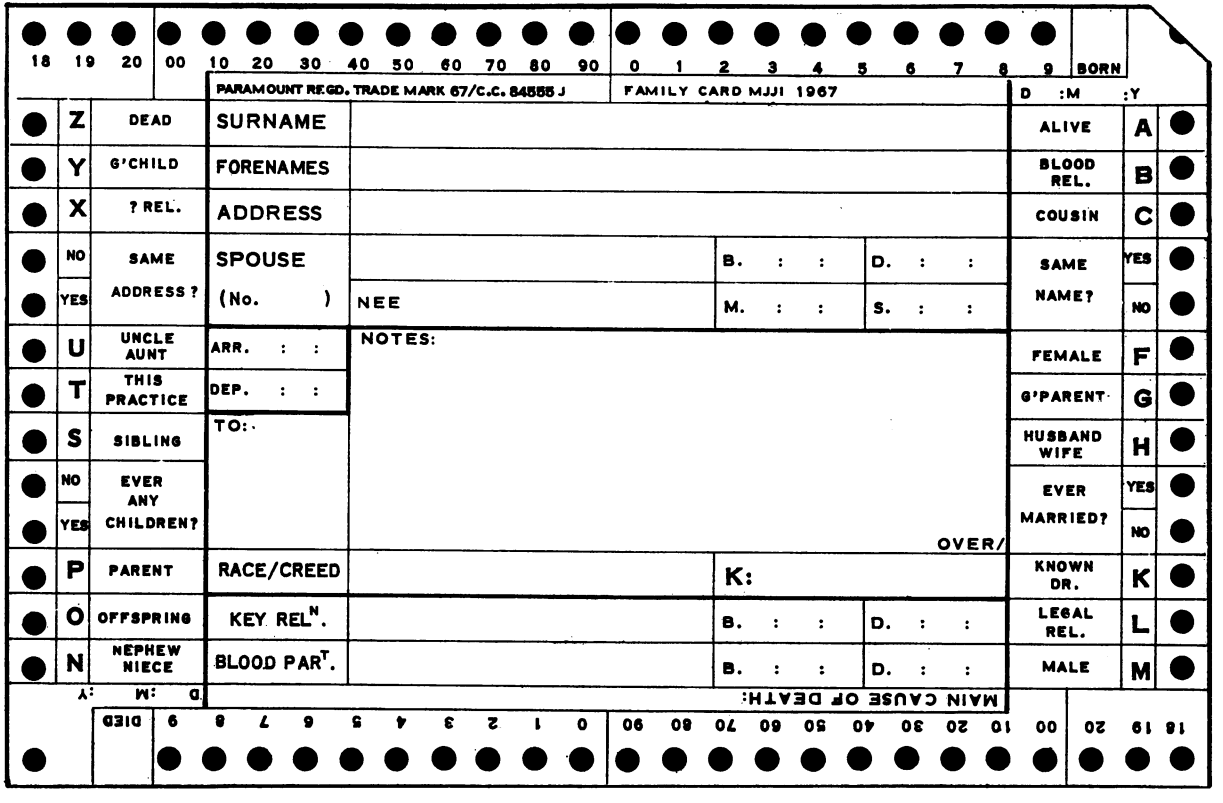
A CARD index[1] was developed and used from 1963 to 1965. It was then transplanted to the branch surgery of the new practice when a move became necessary by chance, and it was again used for a year's trial with less than 1,500 cards before introducing it into the main surgery. As a result the family card in use has been slightly modified (figure 1).

This use of Copeland-Chatterson punched cards is not intended for feeding to computers in the first instance. The value of the holes is simply that they can record more information in an accessible form than either the 'F' book[2] or any other ledger. And it is also possible to shuffle and stack them and renew them as necessary without effort, because they are rigid rectangles. Rounded corners would help, but are not available yet.

The system is a safe-deposit for family data, which by their very emotive nature cannot be 'taken' from the patient when they might be of particular interest medically. It provides a rational way for the doctor to get to know his patients. It is especially useful when patients move around a lot, and when many do not speak his language well.

Although mainly designed to record the basic soundings made in the stream of the patient's family life, it can also be used to record diseases or symptoms relevant to the family or social history; but the Fry design[3] of a morbidity index is better for this and can be introduced first, (or after it has been running smoothly for a little while) but if so staff is needed.

The basic data of a patient's identity are the surname, forenames and address, and the date of birth. It is necessary to have a card for each patient on the list. If the doctor keeps the system in order himself, especially if there are only one or two partners in the practice, each patient can be recognized and remembered from his card at once, even if he has not been seen often in the flesh. When a new partner takes the card over in running order, it provides con-


18 19 20 00 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9 BORN
PARAMOUNT REGD. TRADE MARK 67/C.C. 84555 J
FAMILY CARD MJJI 1967
D :M :Y
Z DEAD
Y G'CHILD
X ? REL.
NO SAME
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NEE
B. : :
D. : :
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S. : :
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TO:
NOTES:
OVER/
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K:
KEY REL^N.
BLOOD PART.
MAIN CAUSE OF DEATH:
ALIVE A
BLOOD REL. B
COUSIN C
SAME NAME? YES NO
FEMALE F
G'PARENT G
HUSBAND WIFE H
EVER MARRIED? YES NO
KNOWN DR. K
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MALE M
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18 19 20 00 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9

tinuity of care, and in a partnership this is its main job all the time; it is an age/sex register of all the patients for whom the practice is medically responsible. The cards of patients who have left or died are kept in another box and can be used for continuing education and research.

If a particular family is of interest, similar cards may be made out for non-patients of the practice who are relatives, but such a collection should be kept separately, and the family given duplicate cards to those in the main register, so as not to disturb it.

In order to trace a particular card in the index, the patient's birthday is first found from the normal practice records, whether private or the property of the Minister of Health. Once the system has been introduced, it is merely a matter of habit to record this early for each new patient, whether they come in person or are signed for by proxy.

The family card

1. *Orientation and style*

This is rectangular and stiff, with the width greater than the height. Printed on one side only, it is one of the Copeland-Chatterson Paramount series, and is 6.4 in. x 4.0 in. Of the possible 84 holes, the following are punched ready for clipping: (numbering clockwise from the top lefthand corner as you look at it) 1–23, 26, 28–40, 42–65, 68, 70–83. There is usually one item of information per hole, and if it is unclipped it means 'No' or not relevant, and if clipped, 'Yes'. The style of type and choice of capitals or lower-case can be varied to suit the style of the practice stationery, but the present use of bold type and differences in type size is recommended for legibility. In the lay-out, priority tends to be from large to small and from the top down, but the edge data are alphabetical, in order to reduce errors and omissions and to side-step such issues as male superiority and whether blood is thicker than water.

2. *The key patient*

For each household there is someone who sees the doctor more often, and whom he can get to know more quickly; whether it is the mother, wife, sister or one of the other members does not matter, provided that one such person is chosen as the keystone of the family for the purposes of the system. Her name is put in the space marked 'key patient' on the card of each member of her household in the register. When her children leave home, and even when they marry, this need not be altered. But when they start to have children of their own, a new one must be chosen for their own household.*

*If the key relation is the mother, a standard family unit may be defined as "U, P, S, key relation, H, O", and a list can be made in that order of all blood

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The key patient's card is the place to collect all the data about the family together, and this usually means building up a list of the basic data of her relatives on the blank reverse side of her card. The purpose of the diagonal cut through hole No. 26 is to make it possible to spot cards which have been left back to front in the box by mistake, after looking at this list. The order of the list is unimportant at first, as a clean card can be made out any time as necessary. If there is too much to get onto one card, a second can be made out, but it should be kept next to the first and painted yellow with ink along the upper border in front. Provided the clipped information is the same as the first, there is no harm in keeping it in the main register.

The key patient's family record needs to be brought up to date only once a year, at a time convenient to the practice, because the system is only an *aide mémoire* for what the doctor already knows in part, and a framework on which to get to know the rest, from day to day, as details come to hand.

3. *The blood parent*

The key patient is therefore related in some way to every member of the household or family so recorded on her card, whether by blood or in law; or as a '?relation', which covers all the other less definite or unrelated members for the system.

In order to record the direct link in her relationship to each member of her family, where necessary, her nearest forebear is chosen as the 'blood parent'—the nearest that is, who is also related to the member concerned (by blood or otherwise).

This then distinguishes the key patient's cousins from one another at a glance, as it does her aunts, or nephews or any others. Even though such a person may not be a blood relation, and in some cases is not a parent of either person concerned, the term 'blood parent' covers the majority literally, and it would be cumbersome to describe each relationship by other names.

4. *The marital details*

Each card in the register carries details of the current marriage,

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relations of the key patient, whether alive or dead; complete units may be compared either between different families or between different generations of the same families. The in-laws' details are on each family card anyway, and need not be listed in the standard unit.

The family cards of each standard unit are stored in that order also; different generations of the same family may be stored in the same box in adjacent batches, distinguished by the surname of the key relation, but the box should be marked with the surname of the male line if possible; boxes for each family under review can then be stored alphabetically.

as necessary. If the patient's marital status changes from married to widowed or separated, these details are added in the boxed space provided; but if the patient re-marries, a new card must be made out, and the previous one stored separately from the main register. As this will not happen very often, these can be kept with the cards of patients who have left, but in alphabetical order rather than by age. Patients who have died, and this applies to special family registers of non-patients as well, must have their year of death (and if possible date) entered and clipped as soon as known, but they too should be kept together alphabetically, because their name will be used for finding their card long after their dates are forgotten. The 'dead' grooves are needed for special surveys, and assist in rapid sorting when these are being done.

Divorce may be recorded in the notes beneath, but the date is not so important as separation, from a medical point of view, and either date is usually only learnt in retrospect on questioning.

In the case of a married woman patient, her maiden name (and not her previous married names, if any) should be added to her basic data, after her forenames. In the case of a man, his wife's maiden name has a space for it in the marital data. The number of the patient's marriage should be filled in under 'spouse' only when it is known for certain, but in any case the dates sort themselves out in retrospective studies.

Mohammedans and others may need two current cards, or more, but as this is not different from a special family study, it can be treated in the same way if a note is made on the card in the register.

5. *The data at the edge*

1. The date of birth: After filling in the full date of birth in the top righthand corner under 'born', the three places are clipped on the top edge for the century, the decade, and the year. It is the grooves made by these clips on successive cards which make it so easy to spot any out of place, and to insert or remove cards as necessary. The length of the grooves also gives an instant idea of the number of patients in any or all of the groups, without the need to count them, and aim off for erasures, as in a ledger. If the cards are pressed neatly from the front back, a pretty accurate count can also be taken with calipers (and an improvised scale to suit the pressure being used), but for accurate analysis they must be counted singly as with all registers. 'D. M. Y.' must be printed for day month year, because it is usual in North America to put 'M. D. Y.'; apart from the distance between registers, any confusion would be spotted by a central computer programmer, from the practice identity code.

2. The date of death: The year of death is usually known, but the

day may not be learned for some months unless advantage is taken of a relative's grief, and the same may apply to the main cause of death, but there is space for it when it is known; a family history is a patchwork quilt at the best of times.

3. The alphabetical data: The four questions, placed at D, E and I, J on the righthand side of the card and at Q, R and V, W round on the left, are chosen arbitrarily as the most useful in describing the relationship between the patient and his key patient. But they can alter from Yes to No and back again more quickly than other data, and so they have two holes, not for clipping at first but rather as markers for ringing the answer until it is definite enough to be clipped; this applies especially to 'Same address?' and 'Ever any children?'. These questions can be altered to suit special cards for special purposes, but the identity markings of the practice must note this. The lefthand Yes/No's are 'upsidedown' because they are still Yes/No going clockwise, and this is easier for checking left and right sides quickly. The only other data needed to define how the patient and key patient are related are as follows, and refer to *the patient:*

A: Alive, i.e. known to be alive within the last year.

B: Blood relation, i.e. a blood relative of the key patient, and the notes and the space for blood parent will give details.

C: Cousin, i.e. first cousin, second, or 'removed' etc., but always give details if possible.

F: Female; the title Mrs or Miss is inferred from other data.

G: Grandparent, i.e. by blood or marriage ('step' etc.) but give details.

H: Husband/wife; give details in marital data spaces, and do not forget to put the name of the spouse as key patient too.

K: Known doctor, i.e. the card is not to be in the main register because the patient is not on the list. Put the name of the patient's doctor in the space next to this hole.

L: Legal relation, i.e. spouse, in-law, step-relative, adopted child or parent, etc.

M: Male; while the male is put first in such labels as husband/wife, and while British surnames are those of the male line, other races and creeds differ, and must be checked.

N: nephew/niece, i.e. nephew, greatnephew or their spouse etc.; here the blood parent will be the key patient's sibling, etc.

O: Offspring, i.e. own child, step-child, adopted or foster child of the key patient. (Not grandchild, etc., which is 'Y', gamma).

P: Parent; *see* Offspring above.

S: Sibling; *see* Offspring above.

T: This practice; useful for spotting stray non-patients in the register by looking down this groove, on lifting out each handful of the cards in succession, from the 'University' flip-top boxes.

U: Uncle/aunt; in this case the blood parent will be the patient's sibling, etc.

X: ? Relation, i.e. relationship vague or a non-relative who lives at the same

address; or a very distant relation.

Y: Grandchild, i.e. the Greek gamma. *See* Offspring above.

Z: Dead, i.e. known to be dead and data have been completed.

When the cards are being filled in and clipped, as soon as new patients become the medical responsibility of the practice, it is possible to recognize types of family and differences in marital data at once, because the new patient's information can be compared mentally with previous experience of other cards; a visual memory for the clip-patterns develops and the initial letters become secondary.

The system in action

How it was restarted: The notes at the branch surgery were orientated for each patient[4] and any birthdays that could not be discovered from the contents or from the executive council, were asked for from the patient direct, or from a member of his family. This took about a year to do during, and for a short time regularly after surgeries, bit by bit. At first one of the old family cards[1] was made out for each of the men, in order to get into the habit of making out one for each new patient at the right time. During this period the lay-out of the middle of the card was altered until it was suitable, and then this new form was printed, but the system is still confined only to the branch because it is not yet used fluently enough to cope with the large number of highly mobile immigrants, from Ireland, Europe, and the many Commonwealth countries.

The women's cards were then sifted through and a key patient chosen for each household. At this introductory stage a separate one was chosen for households consisting of young married-couples without children, even though it was already known in some cases that their parents lived nearby and were patients with folders at the branch; also, in the few cases when such patients transferred to the main surgery, their family card was removed from the main (branch) register and filed in a 'main surgery' box ready for expanding the system.

The practice records of patients who were known to have left the branch or to have died were filed separately to the rest of the branch records; no family cards were made out for them because of expense. Also, no record of the numbers in each category were kept at this stage because they would not be significant for statistical comparison later. At this stage, too, only the date of birth and basic data were filled in and clipped; it not being certain that the best choice of key patient had been made. (See footnote, page 137). At the time of writing, the alphabetical data are being completed and clipped.

This is the main reason for introducing it into part of the practice at first; if there is no branch in a practice wishing to introduce it, the cards can be made out for patients on the list of one partner

only, and when he has proved its uses then the others may follow. It is ideal for use in single-handed practices with an efficient rota for off-duty.

Using the data: Already it had been found with the old cards that the daily chore of taking note of names, addresses and dates was becoming interesting, and that they were being recorded more accurately. And it was surprising to find that, in the National Health Service at least, there was already so much work of this sort being done automatically by doctors themselves when they were seeing their patients, but on the M.R.E. there was nowhere that the family data or even the basic marital data could be described. Immediately it became obvious that certain trends were noticeable among different groups of patient, such as among couples without children, or wives with husbands much younger than they, or bachelor and spinster siblings living in the same house for years; but it is far too soon to draw any conclusions. It is difficult to unlearn the fallacies that attach themselves to such groups and to watch their progress with an open mind. Another suprise was to find that there appeared to be little difference between classes or social groups, as far as the broad pattern of behaviour of these types of family were concerned, if the barnacles accreted from their different environments could be ignored. Whether this has anything to do with phenotypes and genotypes has yet to be proved.[5]

The fact remained that no filing system is ever a real substitute for getting to know the people concerned, but it does seem that there is a place for scientific and professional efficiency in that task, instead of the well-meaning amateurism of a bygone age, which had fewer patients but worse communications.

Recommendations

1. A card index system of recording the family history should be developed for daily use in general practice, whether in medicine or in other fields of work with similar needs and responsibilities.

2. Standardization of method, nomenclature and the like are needed, and a defined policy should be adopted by anyone in the field, but especially by combined research.

3. The means of exchanging basic data about a patient are out of date in the National Health Service. Business efficiency methods should be used by a general practitioner to help himself get to know the basic data of his patients and those of his partners as quickly as possible when needed.

4. Confidentiality of information about a patient's relatives is the same as confidentiality about other medical matters, even though the data may be available from other sources, and non-medical ones at that; but a system should be devised, whereby data from one source

in a family are available for reference by the doctor when another member of the family presents with a problem that may be relevant to them.

5. The patient's own medical record should be used only to record data heard from him direct, unless he knows that the doctor knows his family well.

6. The problems of handing on such information from one doctor to another, especially in the case of death vacancies in a highly mobile society, should be worked out in more detail.

Summary

A system is described, which has been designed to help the doctor to observe the effect on the family of someone who seems to be a primary source of stress.

A parallel morbidity index is needed to record details of disease occurring in the family at the same time.[3]

The system is not confined to medicine and may be used by any professional person with similar responsibilities.

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REFERENCES

1. Jameson, M. J. (1964). *J. Coll. gen. Practit.* **8**, 246.
2. Kuenssberg, E. V. (1964). *J. Coll. gen. Practit.* **7**, 410.
3. Fry, J. (1966). *Profiles of disease.* Edinburgh and London. E. and S. Livingstone Ltd.
4. Jameson, M. J. (1966). *J. Coll. gen. Practit.* **11**, 336.
5. Parnell, R. W. *Behaviour and physique.* London. Edward Arnold.

Visiting—falling work-load in general practice. G. N. MARSH, M.B., B.S., D.C.H. D.Obst.R.C.O.G. *Brit. med. J.* 1968. **1**, 633.

"Rigid adherence to the time consuming exercise of visiting patients in their homes" is a major factor in the increasing work-load of general practitioners. Dr Marsh, despite some increase in his list size, has reduced his average daily visits from 18 per day in 1961 to 9 per day in 1967. The main factor in this reduction has been a sharp cutting down on revisiting after an initial home call. New visits were also reduced although to a lesser extent. Modernization of the waiting room and the introduction of an appointments system were of help here. Further suggestions for reducing visiting include the provision of transport to the surgery, the use of a visiting practice-nurse and geographical rationalization of practices.