Family portraits—a method of recording family history

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SUMMARY. Family doctors are particularly concerned with family relationships. Family relationships are generally poorly recorded in general practice in the traditional records. Conversion to A4 folders in the practice provided an opportunity to develop a diagramatic representation of family structure and thus create for each patient a family ' portrait.'

Introduction

Despite all assaults and stresses upon it, the family remains the basic biological and social unit in society. On the basis of this fact alone, if for no other reason, the general practitioner must still remain a family doctor. His fundamental objectives of providing personal, primary and continuing care for the individual can be effectively realised in many, if not the majority of instances, only in the context of knowledge of that individual's biological and social environment, the most immediate part of which is his family. The picture of the old-style family doctor with his contact with and intimate knowledge of complete families may have had to give way to the reality of the modern general practitioner who, because of population mobility and patterns of urban living no longer necessarily knows the families of his individual patients, but must nonetheless know of them.

There are two obvious clinical reasons for seeking knowledge about a patient's family. Firstly, instances of familially related or genetically determined diseases can provide vital diagnostic pointers. Secondly, more subtly, knowledge that the patient has had intimate contact within his family with some disease processes (such as malignant disease, coronary artery disease, or psychiatric morbidity) can heighten that patient's awareness of and anxiety about similar symptomatology, although his own pathological processes (if any) may be different.

Awareness of the existence of such experience can materially assist the doctor's assessment of his patient's symptoms; ignorance of the existence of such experience may be the indirect cause of the promotion of increased anxiety and further suffering.

There is, however, more to the possession of knowledge of a patient's family than simply the recording of family experience of morbidity. John Donne encapsulated the truth of humanity's interdependence in his statement that " no man is an island, entire of itself; every man is a piece of the continent, a part of the main." By this token no man can be known as a person, as opposed to simply a vehicle for some pathology, without his being set in his immediate context, the most important part of which is his own family. The structure of a patient's family provides us with indications of his responsibilities and of his sources of support and sometimes also of his anxieties and his attainments.

The doctor-patient relationship, the rock on which all general practice is built, is immensely strengthened by the doctor's overt interest in the patient's family. Perhaps this is nowhere more clearly seen than in the diagnosis and treatment of psychiatric disorders, where an enquiry about an aged parent in a far off town, or a child battling with adolescent difficulties, or a sibling handicapped by chronic disease, can precipitate the quiver of the lip or the clenching of the fist, which can be such an eloquent diagnostic pointer and source of therapeutic catharsis.

Knowledge of the names of small siblings can immediately indicate to a mother a sense of interest and involvement on the part of the doctor when he sees a child patient and enquires about a brother or sister by name, or ' remembers ' the correct name of the toddler who accompanies his sibling into the consulting room. The examples could be multiplied many-fold by any

practitioner, but so too could examples where such data is not remembered and usually not remembered because not recorded.

Walford (1955a) stated that " it is rather astonishing that the family history to which so much time is devoted in hospital record keeping, should be virtually ignored in the records of the general practitioner to whom the family is all-important." He also remarks elsewhere (1955b) that family history is even more difficult to carry in one's head than personal history, because it so often relates to people in whom one has no personal interest, and that it is therefore all the more important to write it down where it will be seen, because surprisingly often it provides the missing clue.

Weed (1968) in promoting the concept of problem orientated medical records is convinced that the quality of medical care (and of medical education) can only be improved by having for each patient an easily identifiable data-base that is as complete as possible—and the completeness of any data-base must presuppose an adequate family history.

I have shown in an earlier study (Cormack, 1970) that data about the family are in general poorly recorded (and indeed are in most cases absent) in the records currently kept by general practitioners in the National Health Service.

Some practices and practitioners keep their patients' records in family folders (Backett and Maybin, 1956; Bristol Local Health Authority, 1967), which goes some way towards meeting the objective of having data available about members of a patient's family at the time of consultation, but in general this is limited by the absence of records of family members not registered with the practice.

The family portrait

The opportunity to summarise patients' records during conversion to A4 folders provided the occasion for an attempt to devise a new system for recording family structure and history. The aim was to construct a simple, easily understood, statement of the essential points about a patient's family, readily identifiable as a separate, but integral, part of that patient's own medical record.

This method consists of making up ' family portraits ' by the use of three simple rubber stamps. The basic symbols comprise a 2cm square to indicate a male, a circle of 2cm diameter for a female and a square and a circle joined by two parallel lines for a married couple (figure 1).

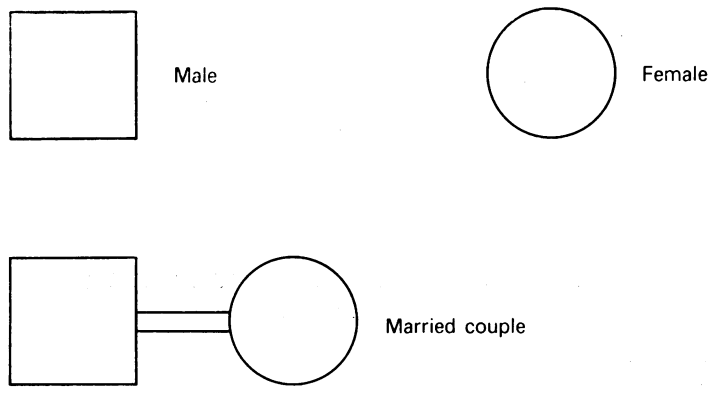


Figure 1
Basic symbols

Additional information is inserted using some conventions for individuals (figure 2), for children (figure 3) and for marital incidents (figure 4).

The portrait is constructed by using the symbols in rows to designate in descending order parents (row 1), siblings—where possible in birth order (row 2), the patient (and spouse) (row 3), and children (row 4). The ' portrait ' is thus three generations, illustrating first degree relationships only; the patient's own generation is represented in two rows—the patient himself (with his spouse) in one, the patient's siblings in the row above. Where there are no siblings or no children these facts are indicated in writing—a blank in the appropriate row would indicate that the data on this point were incomplete (figure 5).

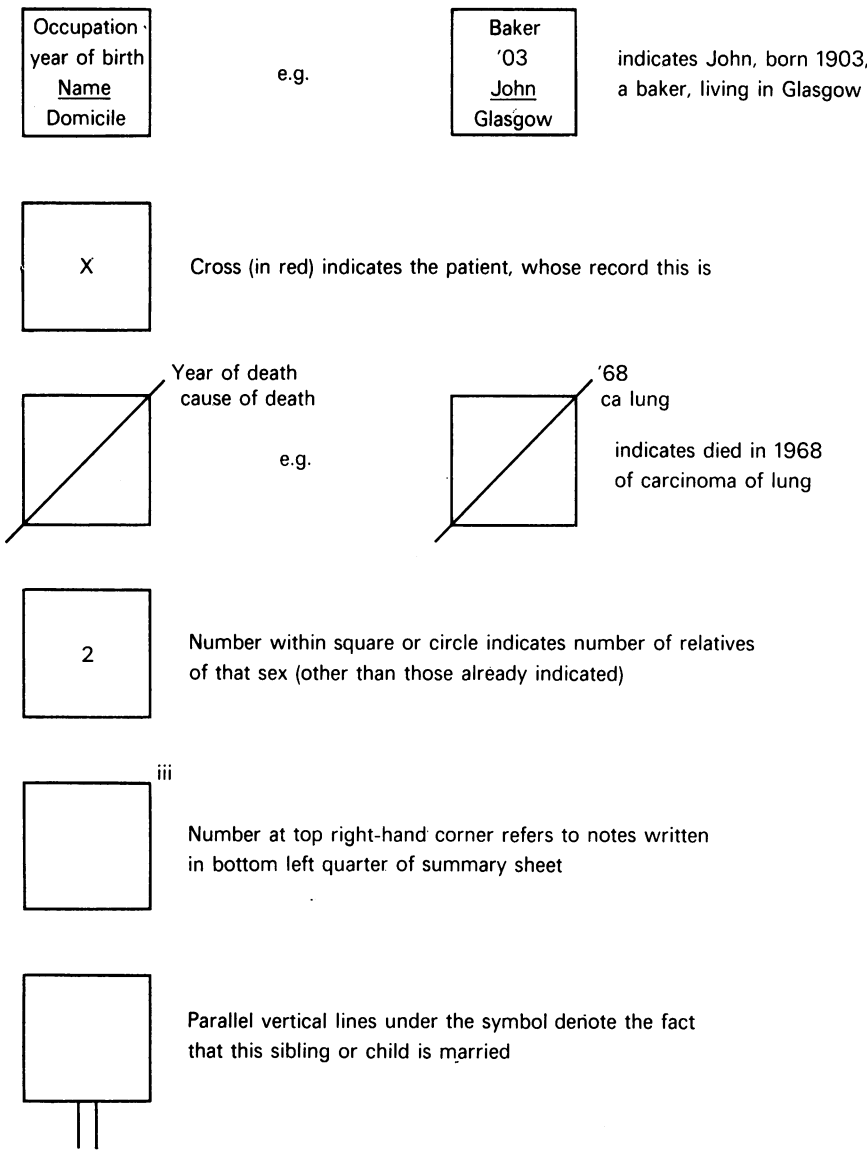


Figure 2
Additional information.

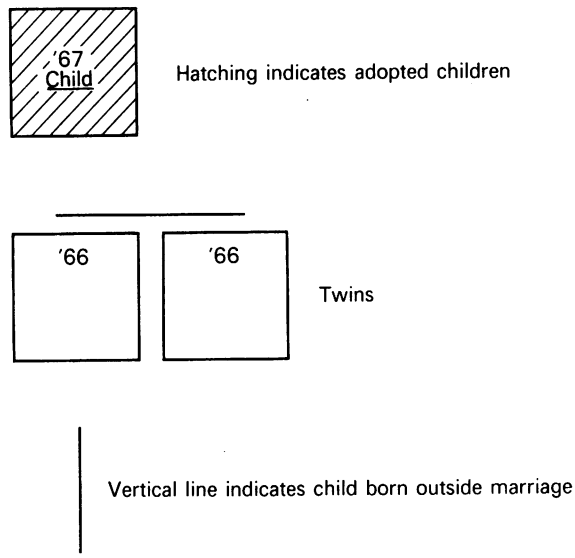


Figure 3
Additional information for children.

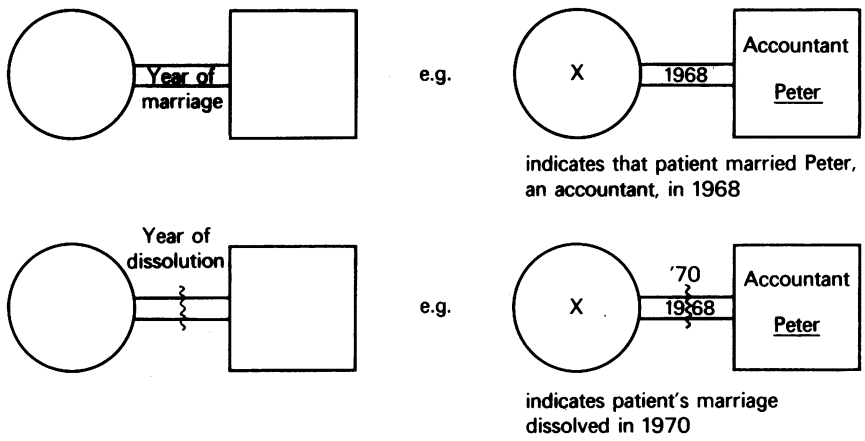


Figure 4
Marital information.

A fictitious family portrait is illustrated in figure 6, with its interpretation in table 1. In order to incorporate all the symbols and conventions used, it should be noted that this fictitious portrait is considerably more complex than that of the average, more normal family.

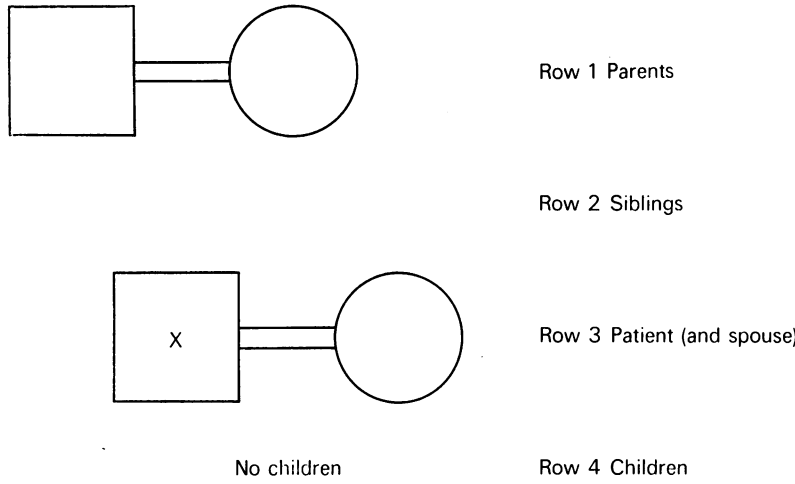
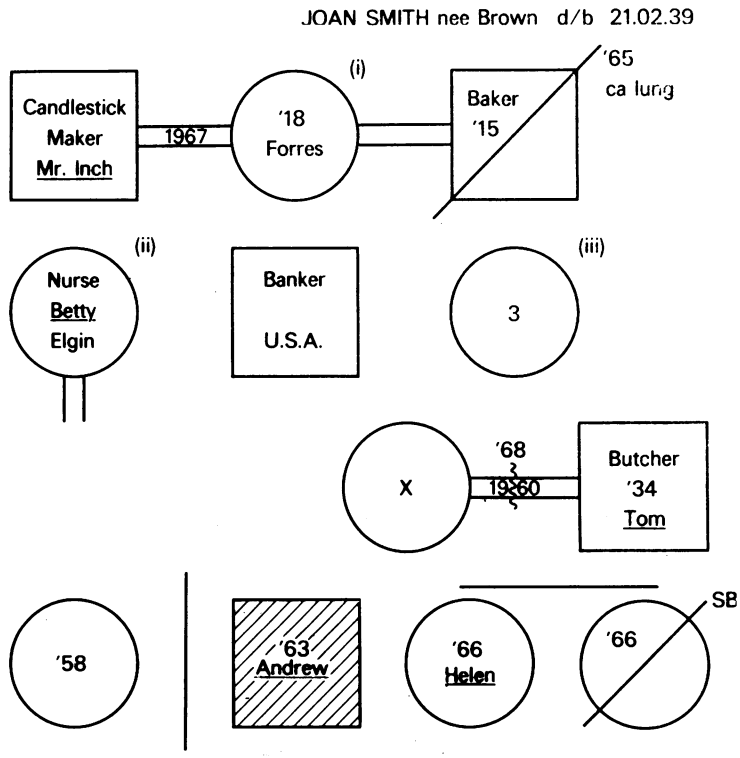


Figure 5
Family where the patient has no children, and where there is no information as to whether or not he has siblings.



(i) Had M.I. in 1971.
(ii) Diabetic.
(iii) One younger sister (*Susan*), unmarried, lives with patient.
Two other younger sisters married, both in England.

Figure 6 A fictitious family portrait.

TABLE 1

INFORMATION DERIVED FROM THE FAMILY PORTRAIT IN FIGURE 6

1939	Joan Brown was born, the third child of a baker aged 24 and his wife aged 21
1958	Joan had an illegitimate baby daughter
1960	Joan married Tom Smith, a butcher, aged 26
1963	Joan and Tom adopted a baby boy, Andrew
1965	Joan's father died at the age of 50 of carcinoma of the lung
1966	Joan and Tom had twin daughters, but one was stillborn, the other (Helen) surviving
1967	Joan's mother re-married—Mr Inch, a candlestickmaker
1968	Joan and Tom's marriage was dissolved
1971	Joan's mother had a myocardial infarct

We also know that Joan's mother and her stepfather now live in Forres.

Her eldest sister, Betty, who is a nurse, is diabetic and lives near their mother in Elgin. We also know that she (Betty) is married.

Their only brother is a banker in the United States.

Joan has three younger sisters, one of whom (Susan) is not married and lives with Joan. Her two other younger sisters are married and are both in England.

Discussion

This scheme for illustrating family structure and history has been in use for about a year on a limited number of patients' records—those which have been converted to A4 folders and summarised by me. The collection of the relevant data has not usually been difficult; a family history can be taken quite rapidly and without too much trouble at most consultations (the actual construction of the portrait is done later from notes) and some details are already obtainable from existing records.

Problems may arise when the patient expects the doctor already to have some or all of this information (especially perhaps with elderly patients who have " grown up " with this practice where the author is himself a third-generation family doctor). Information is not always necessarily complete—it may for instance be inappropriate to ask for the names or occupations of adult siblings or about their marital status. Families are dynamic units and changes take place so it is necessary from time to time to update the information; too many alterations (for instance in recorded occupations or places of residence) may necessitate a reconstruction of the portrait on a fresh summary sheet—this has not yet arisen, but should be relatively simple.

The family portrait is only part of the information recorded on a summary sheet; the patient's significant medical history, occupation, blood group, hypersensitivities and recreational pursuits help to complete the summarised data base. The family portrait idea could doubtless be adapted to any form of record keeping, but it is one of the major advantages of the change from medical record envelopes to A4 folders that space is provided which allows for, and indeed encourages, experiment and innovation of this sort.

It is notoriously difficult to measure quality of care and enhancement of the doctor-patient relationship, and impressions must in this instance suffice; it can only be stated that this family portrait scheme is simple to construct and helpful to use in providing a pictorial representation of data which can often be vital to satisfactory primary patient care. The scheme is reported simply as an individual *aide-memoire* which might be adapted to the needs of other colleagues and as a small contribution to the continuing search for new and improved methods of medical recording.

Acknowledgements

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THE FAMILY MEDICINE PROGRAMME

'Family medicine programme' is the name given by the Royal Australian College of General Practitioners to the plan to train more family doctors, which has been supported by the Australian Government by a large grant.

The vocational training period extends from the end of the intern years (first year after graduation) to the end of the fifth graduate year. During the second and third graduate years the trainee undertakes rotating hospital appointments including a minimum of three months in an accredited family practice.

During this basic training period he undertakes a course in sciences basic to medicine and surgery which will be provided in all States and regions. Towards the end of the period he takes Part 1 of the RACGP examination.

After this the trainee enters the advanced training period in accredited family practices. During this period which occupies the fourth and fifth graduate years, the trainee attends the advanced vocational training course, designed and conducted by the Royal Australian College of General Practitioners. This will be available in all States and Regions, and consists of 80 three-hour sessions, spread over two years, in which the group discussion format will be used as an educational method.

On completing this advanced training the trainee will take Part 2 of the RACGP examination for Fellowship. On passing this test the trainee receives the Diploma of the Royal Australian College of General Practitioners and is admitted to the Fellowship of the College.

About 60 per cent of the Australian Government grant will be used to provide the necessary personnel and facilities to prepare educational material, to direct the programme to select training posts and place trainees in them. Forty per cent of the grant will be spent subsidising the salaries of the trainees during their time in family-practice posts.

The *Australian Family Physician* comments that this family medicine programme is the most striking event in the history of general practice in Australia.

The Family Medicine Programme (1973). *Australian Family Physician*, **2**, 568.

AWARENESS AND EXPERIENCE OF GENERAL PRACTITIONERS OF DRUG INTERACTIONS

The awareness of general practitioners of selected adverse drug interactions has been assessed. The drugs studied included adrenergic neurone blockers, warfarin, antidiabetic agents, and monoamine oxidase inhibitors. The findings must be interpreted with caution, but they suggest that there is a clear need to improve the effectiveness of communication of information about adverse drug interactions if unnecessary iatrogenic disease is to be avoided.

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