The Family-Oriented Medical Record

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The usual form of the Problem-Oriented Medical Record is primarily focused on the individual, and thus has serious deficiencies for the family-oriented physician. This paper presents a practical, office-tested medical charting system that incorporates features of the Problem-Oriented Medical Record and allows the recording of aspects of the family situation that are of particular importance to the family physician. The essential features of the chart are described and the special features, advantages, and disadvantages are discussed. This record has been developed to avoid the gaps that appear when attempts are made to use individually-oriented record systems in a family-oriented practice.

In recent years there has been widespread interest in the Problem-Oriented Medical Record, a long overdue application of efficient data organization to traditional medical records. While most of the concepts involved in the problem-oriented record are useful to the family physician, to a large extent they are *individually* focused and thus ignore a basic tenet of family medicine – namely, that the *family** is the unit of health-care delivery. Recognizing the advantages of incorporating the concept of the family into the medical record system, we have devised a *practical* medical record that has been useful in clinical practice for a small group of family physicians. This system has evolved over a period of years and undoubtedly will be revised further as time goes on. The basic features of the record and the advantages to the family physician will be discussed.

The Family Folder

The chart is organized as a family folder in which each individual family member has a component part. The family folder is a standard manila jacket with the family name printed in large type on the index tab and the individual family members' names printed in smaller type underneath. The major features of the family folder are the following:

1. *Problem list for all the family members,* listed together on a single page. (See Figure 1.) This problem list contains enough room for concise identification of the ongoing problems of each family member. There is room for only four children on the initial page, but this is adequate for most families. The Family Problem List is located on the inner facing page of the family folder, available instantly for inspection as soon as the chart is opened.

2. *Problem list for the family as a whole.* (Figure 1, lower third) This problem list focuses on those aspects of family life which are particularly important in troubled families, where a problem involving the whole family will by its very nature affect each individual member. These problems may occur at normal family developmental nodal points where a family frequently experiences distress (eg, the birth of the first child, teenage individuation stresses); they may be related to wider dislocations that can disrupt family life (eg, husband laid off job, multiple moves of family, poverty); or they may signal unique and severe kinds of interpersonal adaptational conflicts.

3. *The family tree data.* Information on the family of both the mother and father is included as part of the family folder. This is located on the Family Information sheet which is attached to the inner back cover of the family jacket (Figure 2). The family tree contains places for identification of kin in the extended family and identifies them by name, current residence, and significant health problems. This gives the physician information on the location of the family network of which his patient family is a part, and allows clearer understanding of family problems that would not otherwise be readily apparent. For example, if all the extended family is located at a great distance, a family's feelings of isolation and defensiveness could be more easily understood. This possibility is quickly suggested to the physician by simple inspection of the family tree section of the family folder. This form is designed to be filled out by the family members, either at home or in the waiting room.

4. *The family financial data.* This data is also included on the Family Information sheet (Figure 2) and contains basic information regarding the financial resources of the family, as well as employment information, home telephone number and other important sociological data which become a part of the family data base.

The Individual Component

Each individual member of the family has a portion of the chart which consists of a heavy manila file-back with most of the individual's significant medical data incorporated on one sheet of paper (Figure 3). This file-back becomes the backbone of the individual's record in the family jacket. Grouping the individual's most significant medical events on one sheet of paper allows the physician to refresh his memory quickly concerning past significant medical events which it may be useful to have in mind at each encounter with the patient. The basic summary page is especially useful because the patient's hospitalizations, consultations, and ongoing medications can be seen in a matter of seconds, allowing more time for dealing with the patient and his family rather than going through the chart

*The term "family" is used here metaphorically as well as literally to include that group of intimates with a history and a future who make a special kind of difference in each other's lives.

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FAMILY PROBLEM LIST

NAME _____ ADDRESS _____ PHONE _____

Problem No.	Date	PROBLEM DESCRIPTION	Problem No.	Date	PROBLEM DESCRIPTION
		DOB			DOB
1			1		
2			2		
3			3		
4			4		
5			5		
6			6		
7			7		
8			8		
9			9		
10			10		
11			11		
12			12		
		DOB			DOB
1			1		
2			2		
3			3		
4			4		
5			5		
6			6		
		DOB			DOB
1			1		
2			2		
3			3		
4			4		
5			5		
6			6		

PROBLEMS OF FAMILY AS A WHOLE

Figure 1. Family Problem List

FAMILY INFORMATION

HUSBAND _____ (Name)

Occupation _____

Address _____

Employer _____

Home Phone _____

Bus. Phone _____

Birthdate _____

Social Security No. _____

WIFE _____ (Name)

Employer _____

Address _____

Business Phone _____

Birthdate _____

Social Security No. _____

CHILDREN (or others living in home)

Name	Birthdate	Mo.	Day	Year

HUSBAND'S FAMILY

HUSBAND'S FATHER

Name _____
Occupation _____
Current
Residence _____
Age _____/or Age at death _____
Health _____

HUSBAND'S MOTHER

Name _____
Occupation _____
Current
Residence _____
Age _____/or Age at death _____
Health _____

HUSBAND'S BROTHERS & SISTERS

Name _____
Occupation _____
Current
Residence _____
Age _____
Health _____

Name _____
Occupation _____
Current
Residence _____
Age _____
Health _____

Name _____
Occupation _____
Current
Residence _____
Age _____
Health _____

Name _____
Occupation _____
Current
Residence _____
Age _____
Health _____

Number of additional brothers: _____ Number of additional sisters: _____

WIFE'S FAMILY

WIFE'S FATHER

Name _____
Occupation _____
Current
Residence _____
Age _____/or Age at death _____
Health _____

WIFE'S MOTHER

Name _____
Occupation _____
Current
Residence _____
Age _____/or Age at death _____
Health _____

WIFE'S BROTHERS & SISTERS

Name _____
Occupation _____
Current
Residence _____
Age _____
Health _____

Name _____
Occupation _____
Current
Residence _____
Age _____
Health _____

Name _____
Occupation _____
Current
Residence _____
Age _____
Health _____

Name _____
Occupation _____
Current
Residence _____
Age _____
Health _____

Number of additional brothers: _____ Number of additional sisters: _____

Medical Insurance Co. _____

Bank Reference _____, _____ Branch

Other Credit References _____

Home Own ☐. Rent ☐. Mortgage Holder/Landlord _____

Previous Doctor _____ Name, _____ Address.

Church _____

Previous Dentist _____ Name, _____ Address.

No. & Kind of Pets _____

Figure 2. Family Information

IMMUNIZATIONS	DATES				
SMALLPOX					
POLIO					
DTP					
DT					
TET TOX					
RUBELLA					
MEASLES					
MUMPS					
FLU					
TINE					
MMR					

CONTINUING MEDICATIONS

MEDICATION	START	STOP

DATES	HOSPITALIZATION DESCRIPTION

DATE	CONSULTATIONS

SPECIAL NOTES

ALLERGIES _____

name _____

Figure 3. Significant Medical Data of Individual

PHYSIOLOGICAL DATA SHEET I

BLOOD PRESS LAS								
BLOOD PRESS RAS								
WEIGHT								
VISUAL ACVITY-L								
+R								
COLOR VISION								
OCULAR TENSION L								
OCULAR TENSION R								
HEARING - 1000								
(DB. LOSS) 2000								
L/R 4000								
VITAL CAP - L.								
% OF PREDICTED								
FEV_1								
MEFR								
CHEST X-RAY								
EKG								
PAP SMEAR								
HEMOGLOBIN								
HEMATOCRIT								
W BC								
DIFF. PMN/LYMPH								
PLATELETS								
SED. RATE								
CALCIUM								
CREATININE								
URIC ACID								
CHOLESTEROL								
TRIGLYCERIDES								
FASTING SUGAR								
POST 100 GRAM GLUCOSE ½ HR								
1 HR								
2 HR								
3 HR								
5 HR								

name _____

Figure 4. Physiological Data Sheet I

PHYSIOLOGICAL DATA SHEET II

DATE								
THYROID - T3								
T4								
THYROID INDEX								
URINE SP. G.								
SUGAR								
ALBUMIN								
MICRO-WBC/RBC								
CASTS								
U.G.I.								
GB SERIES								
IVP								
BA ENEMA								
MISCELLANEOUS X-RAYS								
SIGMOIDOSCOPY								
STOOL GUAIAC								
VDRL								
TB TINE TEST								
URINE CULT.								
THROAT CULTURE								
BLOOD TYPE		RUBELLA TITER						

name _____

Figure 5. Physiological Data Sheet II

seeking information. At the top of each file-back are two punched holes allowing the attachment of a two-tab metal fastener which holds in place the other pages of the individual's file. These include the physiological data sheets on which an ongoing record is kept of the common physiological measurements made in a physician's office. In addition, other laboratory and x-ray results can be entered on the data sheets. As can be seen from looking at these data sheets (Figures 4 and 5), one can quickly compare findings over a period of many years and easily detect changes in significant parameters.

The top sheet of an individual file-back can be a flow sheet which allows visit-to-visit assessment of significant parameters that are being evaluated on frequent visits. Flow sheets of this sort, eg, the Rocom Flow Sheets, are very easily adapted to this situation and greatly minimize the amount of writing necessary for continuing assessment of long-term problems.

Each individual component contains a brief typewritten record of each patient's visits. These sheets of paper are attached with the metal fasteners to the individual file-back. We find that brevity of description should be emphasized in the recording of information about each visit. For instance, instead of repeating "Problem #3 – Hypertension," one simply lists "3" and goes on directly to the S-O-A-P process. We find it helpful, in order to minimize the amount of space used for recording, to use a running commentary for each problem, rather than trying to break it into its component parts. We feel the most important aspect of the S-O-A-P process is that it be habitual in the physician's approach to the patient rather than that it be written down formally in the chart for each problem on each visit. At each visit, the necessary information on each problem is dictated, then later transcribed on pre-gummed paper which is glued into the chart.

In addition, the individual medical record contains periodic assessments which are done at varying intervals depending on the patient's age and problems. At the periodic assessments, which tend to be on a yearly basis in older patients and at three to five-year intervals in younger patients, each of the patient's problems is assessed and the data base is entirely renewed. We find that although we may check on each of the major problems that a patient has on every visit, we tend to focus on the more active ones. We then shift to others at other visits, reserving the periodic assessment for the complete review of all problems whether active or inactive.

Advantages

The major advantage to the family physician of this method of family charting, is that it makes available the entire array of problems which face a family. By placing all of the individual problem lists on a single page along with the problems of the family as a whole, the physician has a sense of the entire family's health problems when seeing any one family member. Two orders of data are available simultaneously: information about both the individual and the family system. This method of charting also reminds the physician of problems that other members of the family are having who are not being immediately seen. For instance, a six-year-old girl is brought to the office with a severe laceration. The mother helps to calm and reassure the child while the laceration is being sutured. By glancing at the single-page *Family Problem List,* the physician can spot the fact that the child's sister has had recurrent urinary tract infections in the past. If this has not been checked for some time, a reminder can be given to the mother to bring the child in for follow-up. The fact that the father's hypertension has not been checked for some time can also be brought to his wife's attention and arrangements made for follow-up. Simple knowledge that the physician has been asking other family members about a problem is often enough to bring the person with the problem into the office for follow-up. The thought that, "If it's enough to worry the doctor, then maybe I better check it out," is often an impetus to bring the patient back to the office.

The medical chart becomes considerably simpler and more compact when arranged in the way described above. One of the major efforts we have made is to limit the amount of data brought from outside sources and inserted in the chart. Almost all laboratory data is copied onto the physiological data sheets by secretarial personnel in the office. It has been particularly useful to bring almost no data from the hospital to the office to be included in the chart. Instead of bringing duplicates and other reports of the laboratory work, admission, history, physicals and x-rays that are done in the hospital, we use the discharge summary from the hospital which includes all pertinent data, and we insert this single sheet into the chart. We find it useful never to duplicate in the chart information that is stored elsewhere, particularly in hospital charts. Duplicated information is a great contributor to bulk and eliminating it frequently reduces the size of the chart by one-half, a big help if one is cramped for space.

A great advantage of this charting method is that it allows the other physicians in the group who do not customarily care for the family, to step in and very rapidly get a grasp of the entire family situation. Particularly useful has been the description of the problems of the family as a whole. Often medical information about an individual assumes an entirely different dimension when it is known that the family has a chronic disorganizing problem. For example, a 12-year-old boy is brought to the office with a problem of abdominal pain on a day when the family's primary physician is not present. The doctor on call (another family physician in the group) sees the child and whoever accompanies him to the office – probably the mother. Now, this problem will require a careful history, physical, and perhaps laboratory evaluation. But if the on-call physician is able to look at the Family Problem List and finds that the family as a whole is in distress (eg, the family is in the midst of a trial separation), it may significantly alter his interpretation of the information he receives from the patient. He may find that the child's abdominal pain is directly related to the family distress, and instead of proceeding with a total laboratory evaluation to "rule out" an organic source, the physician may use the opportunity to communicate with the child and mother about the interrelation between family and individual distress. This kind of information is frequently an important factor in motivating parents to work out a solution to family conflicts.

Disadvantages

There are some disadvantages to charting in this fashion. For one thing, the small physical area of the problem list does limit the amount of information that can be placed there. Certainly there is no room for acute, self-limiting, or temporary problems. Although there is little room on the individual problem list for coding of problems according to the E-Book or other methods, this could easily be done by substituting a code number for the problem number now being employed. We are currently studying the adaptation of the *Pri-Care* system to our family-oriented problem list.

One of the problems with listing laboratory data on flow sheets is that mistakes can be made in transcribing. We find, however, that these have been minimal. We have been impressed by the fact that most laboratory data loses almost all of its value once the information becomes known to the physician. If it is significant information, it generally is acted upon immediately, and if a mistake in the laboratory data is discovered at a later date, it is usually found to be unimportant. One way to minimize the importance of transcription errors is for all laboratory data to be initialed by the attending physician before it is included in the chart. If the physician discovers an abnormal value (eg, an elevated SGOT suggesting hepatitis), he will generally initiate action immediately, and even if the laboratory value is entered in the chart as 180 rather than 1,800, the appropriate action has already been taken.

Unusual and very irregularly done tests are inserted in the chart in the traditional fashion. All tissue pathology slips are similarly included in the chart in the traditional manner. However, much laboratory data that is initially useful in treating patients can be discarded when the treatment is completed, such as urinalysis reports with typical cases of acute cystitis.

Concluding Remarks

We have presented a revision of the problem-oriented medical record which allows important aspects of the family to be included within this modern, efficient method of organizing medical records. This record is particularly adapted to the special needs of the family physician who sees the family as the unit of special focus. It has been developed to avoid the gaps that appear when attempts are made to use individually-oriented record systems in a family-oriented practice. Truly, family-oriented medicine needs a family-oriented record.