Family Records in the Health Department*

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THE health officer realizes that in the course of his work many services rendered on behalf of an individual may affect other members of the household, and sometimes deals with the family as a group when he encounters a specific problem in a home. But much of his thinking is in terms of cases reported and individuals served, and the word “family” seldom appears in health department annual and special reports; or for that matter in textbooks on public health organization. Development of methods for using the family as an administrative unit by nursing and social agencies, and growing interest in studies such as those presented here, make it desirable to explore the situation as to family records now existing in health departments. One may then speculate as to what extent keeping account of services on a family basis might contribute to more efficient administration and provide material for research.

Family information is commonly found in three types of health department records, namely, clinical history sheets, nursing folders, and communicable disease investigation forms. The medical term “family history” was obviously borrowed from hospital and dispensary practice many years ago and the purpose was to assist the clinician. A space on record forms was sometimes labelled “family history” without amplification, and sometimes the father, mother, and other relatives were mentioned.

Among forms of this type were cards or sheets used in tuberculosis clinics. Here it was the clinician who wanted family data to aid in diagnosis, and the records were not primarily designed for use in contact investigations and other control measures. Some health departments soon found it necessary to keep a roster of members of tuberculous families, but among a group of large cities from which record forms were collected as recently as 1929, there were still two without provision for a household roster on tuberculosis forms. Moreover the term “family history” was repeated on several blanks in all cities.

Public health nurses in official agencies are under the impression that they began to list members of households when home visiting became a part of tuberculosis control. Visiting nurse organizations kept family records much earlier, and were influenced by closely related social and welfare groups. When organized in the 70’s, “family societies” apparently copied many of their record keeping systems from charitable organizations in England. By twenty or twenty-five years ago, “so-

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cial data" or "history" sheets were common to social work, and to official and voluntary nursing records. These for the most part, however, were for administering current situations, rather than for keeping permanent, continuous records of what happened to families. An interesting proposal for voluntary continuous registration of important events in family life was made by Taylor in 1912.

Although a fairly diligent effort has been made to do so, it has been impossible to determine by whom the nursing family folder was originally devised or by what nursing service it was first used. Writing in 1920, Olmsted described a family folder for the rural nurse working alone or in a small unit. Discussing the advantages of such a system, she declared that it saves clerical labor, since information regarding the family is not repeated on various forms. She also said that it helps to impress upon the nurse the effect of wages and environment, and aids in cooperation with other agencies; it assists in communicable disease control, and in collecting statistics.

The necessity for having as complete a picture of the family as possible, and for assembling all facts in one place, developed in larger communities with the change from specialized to generalized nursing. Family folders became a part of the record system of many official and voluntary nursing agencies by the middle of the 1920's, and their use has been continued and extended since. Thus, in the nursing field, the family is an established administrative unit, but even here the records may not be suitable for analysis to evaluate activities and services.

According to Frost (1938), Chapin deserves the credit for being the first in this country to list routinely members of households in which communicable disease occurred, and numbers of exposed persons became ill. Dr. Chapin's own statements quoted by Frost indicate that he thought of using the information he collected for study as distinguished from administrative purposes. He speaks of family records for acute communicable diseases in relation to "scientific investigation" and of "collecting facts which perhaps are not of much value in themselves but may be when the number of cases can be increased." The results of his enumerations of exposed persons and cases among them must have been in his mind when he wrote on fumigation and other subjects, but they are rarely mentioned. And one of his close associates is of the opinion that he regarded his acute communicable disease data as of particular value for special studies.

His example of using local facilities for collecting information has not been followed in many health departments, either with respect to acute diseases or to tuberculosis and other chronic diseases more difficult to handle administratively and statistically. Some years ago it was planned to study mortality in upstate New York from streptococcus infections not diagnosed as scarlet fever but occurring in scarlet fever families. This was to be done by collecting case cards from all over the area and by comparing names of persons on such cards with registered deaths. The enterprise failed because the family roster on most cards was incomplete. Names written down were ordinarily those of children affected by quarantine and school exclusion regulations. Acute disease records such as this collection from a hundred or more local jurisdictions in the 1930's could not have been used for obtaining secondary attack rates, easily calculated from Dr. Chapin's observations long before the turn of the century.

It is apparent from the foregoing that family records have been developed independently by divisions, bureaus, or other units for a variety of reasons, and
that they are incomplete and scattered through health department services. The system devised in Westchester County to consolidate records and to bring the sum of family needs and services into prominence has been previously described in detail (Bellows and Ramsey, 1939).

This system provides for a steady flow of information between the central office and the field. There is a single folder for each family in which all medical and nursing records are bound together. The same folder contains child hygiene, tuberculosis, syphilis and orthopedic clinic records, as well as records of nurses’ home visits. After each clinic the folder goes to the central office, where pertinent data are entered on case registers and in the department’s master index. At the same time information revealed by the index which came directly to the central office is placed in the folder for the benefit of the field workers. The folder contains a summary sheet on which all services rendered to the family appear except those for minor communicable diseases such as measles and chicken pox. Each new family is cleared through the County Council of Social Agencies, and welfare and other agencies which have been in contact with the family are listed on the summary sheet.

A 4 years’ trial has proved the advantages of the new record system. Clinicians find it helpful to have all the medical records of the family at hand when they are examining or advising their patients. Information obtained by physicians in clinics and nurses in the field is pooled, and the folder itself tends to encourage consultation between members of different divisions of the health department in deciding the best interests of the patient. The statistical division, using the same original records as the physician and nurse for its clinic and other reports, adds pertinent facts to them, such as information from case and laboratory reports and birth and death certificates. The statistical division may find data in the folder of value to itself, such as facts that help in improving the accuracy of death certification, or tuberculosis and syphilis contact registers. Since the coordinated record system was introduced, the proportion of families carried on two or more clinic services has nearly doubled, the increase being from 356 to 708 families.

By using the folders and master index it is possible to obtain many facts of administrative interest. For example, it was found with little effort that among the 6,437 families enrolled on clinic services, 186 are households in which there are or have been cases of both syphilis and tuberculosis. Cancer has been reportable in New York State for only 18 months, but there are known to be 68 health department clinic families with cancer and tuberculosis cases, 24 in which there were both syphilis and cancer, and 8 families with cases of all three chronic diseases.

Additions are being made constantly to the pooled family records, and they should prove a body of information valuable for a wide variety of special studies. A year ago a study was undertaken of tuberculosis among familial associates of tuberculosis cases as compared with the same disease among familial associates of cases of syphilis. The tuberculosis rate among associates of that disease (1 per 100 person-years) was similar to that in other studies, and there was no evidence that tuberculosis was more prevalent among associates of syphilis cases than in the general population.

These findings appear to afford a more or less satisfactory test of the adequacy of the original records. Actually, it was necessary to correct and add to them before analysis could be undertaken. The most common fault was incompleteness of the family roster.
Members of the household who had left or died were often omitted, and sometimes an over zealous nurse listed transient visitors as members of the family. This experience led to a course of instruction for nurses on the content of a family roster, the reasons for filling out a roster completely in relation to their own work, and so that the record might serve research purposes.

The majority of family studies in recent years have been conducted under unusual circumstances with record forms quite different from those in routine use, and often with personnel outside of the regular health department staff. There is no question as to the value to the health officer of keeping his clinic and field records on a family basis. It also seems entirely feasible to maintain health department records of such a character and quality that they will be suitable for studies in which life table methods and other statistical procedures are employed. And it should be possible to assemble data routinely with much less effort and expense than by special surveys. In other words, it appears that health officers themselves may well take cognizance of newer methods of statistical investigation and, even though unfamiliar with the pitfalls and technics of family studies, should give thought to the consolidation of record systems.

REFERENCES


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**Nutrition Foundation Announces Policy for Grants**

The Nutrition Foundation, New York, N. Y., has announced that grants will be made to established institutions in the United States and Canada, the first series becoming effective July 1, 1942.

Problems of critical importance in the war emergency will be given primary consideration. Grants will also be made in the support of projects that have a direct bearing upon public health.

Special concerns of the Foundation include dental caries, and nutritional requirements of infants, growing children, and the old age group. The Foundation's long-time program will place emphasis upon fundamental research to advance the frontiers of science.