

HEALTH ADVOCACY

What Happened to the Social History?

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ABSTRACT

Background: How well do physicians document and transmit relevant patient information? Growing evidence suggests that socioeconomic status, social support networks and spirituality impact morbidity and mortality are important determinants of health. We reviewed physician-dictated admission and discharge notes to identify how well social determinants of health are documented and communicated.

Methods: The admission and discharge summaries of 101 adult inpatients of a general medical ward at a community hospital were randomly selected and reviewed for completeness of social history. Three components were assessed: employment or education as markers of socioeconomic status (SES), marital status or social supports as markers of social support network (SSN), and religious affiliation as a marker of spirituality (SPR). The components were categorized as either absent, inadequate or adequate based on pre-defined criteria.

Results: Documentation of SES was absent in 47 cases, inadequate in 31 cases, and adequate in 23. Documentation of SSN was absent in 65 cases, inadequate in 12 cases, and adequate in 24. SPR was absent in all 101 cases. Overall, all three components of social history were absent in 62 cases. By multivariate analysis, only the patient's age was a significant predictor of documentation of SES and of SSN.

Conclusions: Documentation of important social health determinants in a community hospital admission and discharge notes is generally poor. The social history is an integral part of a medical assessment and physicians should improve on its documentation.

INTRODUCTION

A physician must have an appreciation of both the medical and non-medical determinants of health.¹ Some determinants of health are well studied and receive widespread attention by physicians. Smoking, dyslipidemia and attempted suicide are examples of typical risk factors that physicians may inquire about and document in a complete medical history.

Other parts of the medical history such as "social history" may not be explored in detail but are, nevertheless, important determinants of health and an essential component of the patient-physician dialogue. Current literature suggests the social history is not well documented and ranges between 34% to 73% in some studies.^{2,3} Important parts of a social history include the socioeconomic status, social support networks and spirituality. Though these factors may be considered "soft" determinants of health, a

growing body of literature suggests they influence morbidity and possibly mortality. As with other parts of a medical history, synthesis and documentation of this information are vital to patient care.

Few studies have assessed the quality and completeness of medical records, probably because it is difficult to study.⁴ In this paper, we use documentation of the components of social history as a marker of physicians' appreciation of their patients' social determinants of health.

METHODS

Data Collection

Permission to review hospital charts was obtained from the Medical Advisory Committee/Ethics Committee at one rural hospital in Southwestern Ontario serving a population of about 35,000 people. Only charts of adult inpatients (18 years and older) of the general medical ward were eligi-

ble for inclusion in this observational study. Randomization was achieved through a number generator. From the year 2001, eighteen dates were randomly generated and all adult patients discharged on those dates (N=101) had their admission histories and discharge summaries reviewed. No patient was reviewed twice.

Staff at the medical records department documented demographic data. The dictated admission and discharge notes were carefully reviewed for documentation of social history by one author (KJK). Three specific components of the social history were assessed: employment or education as markers of socioeconomic status (SES), marital status or social supports as markers of social support network (SSN), and religious affiliation or regular worship as a marker of spirituality (SPR). Documentation of a social history was categorized as either absent, inadequate, or adequate. "Absent" was scored if nothing was mentioned about the SES, SSN or SPR. "Inadequate" was scored if the factors were indirectly mentioned, outside the specific context of a social history, and based on a model from previous studies.⁵ "Adequate" was scored if a direct reference to the factors was documented in the context of a social history. Some interpretations were made in the evaluation of the physician notes. In the absence of specific details, the SES was scored "inadequate" if the age of the patient was stated as 65 or older because it is inferred the patient was retired from employment. Both the SES and SSN were scored "inadequate" if the patient lived in a nursing or retirement home, since acceptable living conditions and social activities are inferred. Reference to religious affiliation anywhere else in the medical record was not counted.

Data Analysis

Using SPSS statistical software (version 17.0), multiple logistic regression was employed to identify if factors including age, gender, length of hospital stay or type of physician providing care were significant predictors of the components of social history. Socioeconomic status and social support networks data were independently analyzed in the multivariate analysis for 100 of the 101 charts; one randomly selected chart had incomplete demographic information.

RESULTS

There were 44 males and 57 females. The average age of the patients was 69 years (SD = 17 years). The average length of stay was seven days (SD = 7 days). The admitting physicians were specialists in seven cases only. All remaining patients were under the care of their family physicians.

Socioeconomic status was absent in 47 cases, inadequate in 31 cases, and adequate 23 cases. Mention of any social support network was absent in 65 cases, inadequate in 12 cases, and adequate in 24 cases. Mention of spirituality was

absent in all 101 cases (Figure 1). Overall, all three components of social history were absent in 62 cases and only 15 cases had adequate SSN and SES recorded. In the multivariate analysis, age was the only demographic variable that was significantly associated with documentation of SES (odds ratio [OR] = 1.09, 95% confidence interval [CI] 1.05-1.12) and SSN (OR = 1.08, 95% CI 1.04-1.13).

DISCUSSION

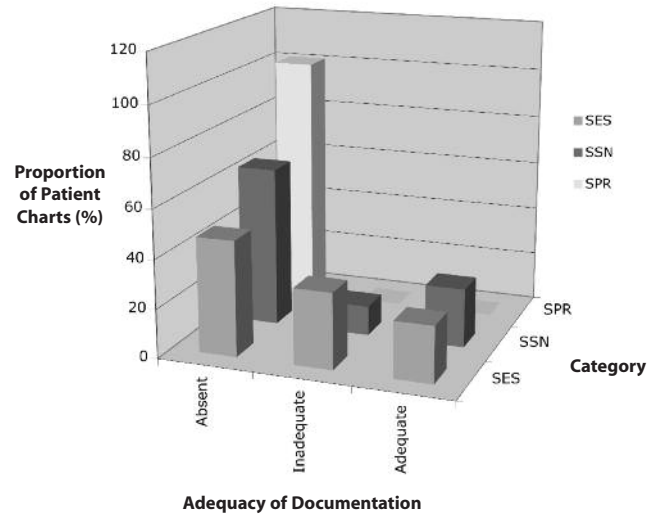


Figure 1. Documentation of social status in admission and discharge notes (N=101).

Abbreviations: SES = socioeconomic status; SSN = social support network; SPR = spirituality

The global paradigm of medicine is changing from disease-centred to patient-centred in the past decade,⁶ and studies confirm that patients have a strong preference for the patient-centered physician.⁷ The history from a patient can be more valuable for an accurate diagnosis than physical examination or subsequent investigations.⁸ But the patient-centred encounter must also lead to a patient-centred medical record.⁹ Thorough documentation of the social history is vital to understanding how context affects disease in the patient-centered model and should be considered as important as documenting other parts of a medical history. The failure to communicate the knowledge of social factors in a patient's chart may suggest indifference by physicians towards important social determinants of health. We discuss three social determinants of health (SES, SSN, SPR) from the literature that physicians should be conscious of when providing patient-centered care.

Socioeconomic Status

Financial difficulty is a risk factor for many common diseases. The reasons underlying the increased morbidity and mortality are debated, but the association cannot be

ignored.^{10,11} The Socioeconomic Status and Acute Myocardial Infarction (SESAMI) group studied the relationship between SES and outcomes in Canada after myocardial infarction. Patients with lower incomes were twice as likely than higher income patients to die before follow-up at 30 days, one year, and two years ($p < 0.001$ for each).¹²⁻¹⁴ In addition to individual income, area SES affects mortality and birth outcomes and may be an independent determinant of health.¹⁵⁻¹⁷

Social Support Networks

Illness affects individuals in myriad ways. For example, depression is common in persons with heart disease with a prevalence of up to 35%¹⁸ and leads to a increased post-myocardial infarction mortality risk (OR = 3.4, $p = 0.006$).¹⁹ In a similar cohort of patients, living alone independently predicted mortality and was mitigated as one or more persons lived with the patient.²⁰ The value of companionship is also observed by the high mortality in the first year of widowhood.²¹

Spirituality

Recognition of a patient's spiritual concerns is an essential aspect of high quality patient-centred care.²² Up to 77% of patients want spiritual issues discussed in their medical care but only 10 to 20% of physicians do.²³ Whether spirituality influences morbidity or mortality is debated,²⁴ but it is shown to affect surrogate markers of morbidity like smoking in pregnancy.²⁵ The lack of comfort from religion in elderly patients was independently related to the risk of death six months post-cardiac surgery.²⁶ Other studies support the idea that positive methods of religious coping are associated with improvements in health.²⁷

Limitations

This study has a number of limitations. Ideally, a prospective study capturing relevant discussions as they take place is the best means of studying physicians' practice. Our sample size is relatively small and the study is based in a single non-teaching hospital with a single reviewer. We use documentation as a measure of physicians' encounters with patients which may not be accurate. It is possible that physicians are relying on allied health teams like social workers and chaplains to address some of the social factors evaluated in the study. When reviewing charts, only access to the admission and discharge summary was permitted based on the ethics application, so allied health care notes were not reviewed.

The setting was a small community hospital approximately serving a population of 35,000 people with 50 acute care beds and 30 chronic care beds. The patients are cared for mostly by local family physicians, though seven patients in this sample did have specialist care. It may be that family

physicians know their patients well and documenting social history and related information in a medical note was considered redundant.

CONCLUSIONS

In our study the extent to which physicians are reviewing a social history with their patients appears similar to other studies: generally not well documented. One can conclude from our data that older patients are more likely to have socioeconomic status and social support networks documented. The reasons for this are unclear, but it may be that older patients are more vulnerable to multiple medical problems where concern over their basic necessities requires an understanding of their social circumstances. This level of concern should be equal for patients of all ages. Efforts in the United Kingdom are being made to form minimum standards for patient records.^{28,29} With minimum standards and regular audits of medical records, the future of the social history is promising. Should Canada adopt a similar approach? Our study certainly raises the question. †

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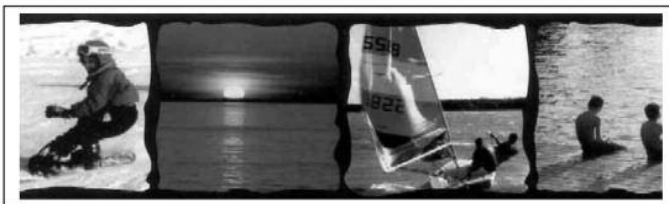
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