

The birth of the International Classification of Primary Care (ICPC)

Serendipity at the border of Lac Léman

Henk Lamberts and Maurice Wood^a

Lamberts H and Wood M. The birth of the International Classification of Primary Care (ICPC). Serendipity at the border of Lac Léman. *Family Practice* 2002; **19**: 433–435.

Twenty years ago, in early spring, we were sitting in the Japanese garden of the WHO Headquarters in Geneva. It was the last day of a week of hard work, together with Sue Meads from the US National Centre for Health Statistics (NCHS), on the Reason for Encounter Classification. Since 1978, WHO had—with fiscal support from the NCHS—invited us several times to come over and prepare a classification representing patients' ('subjective') demand for care. This seemed important for health care planning, as an addition to data collected with ICD reflecting 'objective' patients' need from a medical perspective. Internationally, the focus of ICD was shifting from mortality towards morbidity, and thus the reasons to visit a doctor became of more interest. The three of us seemed to be rather well equipped for this exercise: two family physicians (FPs) with experience in family practice morbidity statistics, and a taxonomer who, as a country doctor's daughter, felt equally sceptical about many diagnoses and the utility of the resulting interventions.

Sitting there, we discussed our present situation. We had just finished the field trial version of the Reason for Encounter Classification, together with a manual for its use.¹ Support from WHO, NCHS and WONCA would soon facilitate field trials in Australia (Charles Bridges Webb), Barbados (Mike Hoyos), Brazil (Maria Lucia Lebrão), Hungary (Marianne Szatmari), Malaysia (Raja Rajakumar), The Netherlands (Cees de Geus and Henk Lamberts), Norway (Bent Bentsen) and the USA (Maurice Wood and Sue Meads). The atmosphere in WHO headquarters was optimistic. The Report *Health for all in the year 2000* was on its way, as was ICD-10 as

the centre of a 'family of classifications'. It was quietly accepted that FPs would not use ICD-10 (~10 000 classes) as a diagnostic classification, but that the ICD-9-related primary care classification ICHPPC-2 (370 classes) would be succeeded by an ICD-10-related version.²

The trial version of the Reason for Encounter Classification contained ~700 classes.¹ Included were 200 symptoms, complaints, concerns, fears and psychosocial problems not available in ICD-9 and ICHPPC-2, because of the observation that patients often formulate health problems as symptoms and complaints. In addition, they sometimes formulate their problem as a diagnosis (I'm here for my hypertension), so most diagnostic classes of ICHPPC-2 were also included in the new classification. An essential and really new element was the inclusion of reason for encounter rubrics for patients' requests such as: I would like a prescription, a referral, a blood test; would you please measure my blood pressure, or listen to my lungs.

Serendipity struck when we, on that sunny afternoon on the border of the lake, realized the strange situation into which we had manoeuvred ourselves. How on earth could FPs effectively communicate with patients if an artificial barrier existed between the language spoken by patients and their own? Why would the structure of the reason for encounter classification not meet the needs of both patients *and* FPs? We realized that we needed a comprehensive International Classification of Primary Care (ICPC); such a classification would not diminish the availability of the usual diagnostic classes in ICHPPC-2 but would, on the contrary, add over 200 symptoms, complaints, fears and psychosocial problems for use as diagnostic labels. A patient's problem then could, especially at the start of an episode of care, receive a symptom diagnosis. In addition, interventions also needed a communication tool. This ICPC would need to provide three ordering principles within one single nomenclature: a classification of (i) patients' reason for encounter; (ii) the FPs' diagnostic labels; and (iii) primary care interventions.

At that time, in medical schools and post-graduate training courses, the 'mind-body dichotomy' was pre-eminent. Teaching was that doctors should not always

Received 22 April 2002; Accepted 13 May 2002.

Department of Family Practice, Academic Medical Centre/University of Amsterdam, Amsterdam, The Netherlands and ^aEmeritus, Department of Family Practice, Virginia Commonwealth University, Richmond VA, USA. Correspondence to Professor Dr H Lamberts, Division of Public Health, Department of Family Practice, Academic Medical Centre/University of Amsterdam, Meibergdreef 15, 1105 AZ Amsterdam, The Netherlands; E-mail h.lamberts@amc.uva.nl

accept patients' statements at face value, but should, if they saw fit, try to help them to understand better their 'real, underlying' problem, and guide them through the sometimes painful process of dealing with the 'question behind the question', and not too easily provide 'symptomatic' treatment. From our perspective, both for epidemiological and 'ethical' reasons, patients' statements of their reasons for encounter should, in principle, be taken at face value, and the availability of a wide range of explicit physical and psychological symptoms and complaints would allow patients to express 'documentably' what bothered them in a straightforward manner. And why should GPs be blocked from the use of these terms to express and document their professional considerations?

Dark clouds were coming in over the lake of Geneva, and followed us as we returned to the WHO building. The first objections came from within the international coding arena, but also in our own family practice milieu the reactions to our 'heresy' were sometimes quite fierce. This is illustrated by the comment of a colleague: "I find it personally objectionable to ask the patient why he has come to see me, and then diagnose his problem in the form of a symptom diagnosis. I have not spent most of my adult life in medicine to be diminished in this way. I can diagnose any symptom or complaint of my patients with a proper disease label."

After the successful completion of the field trials (132 participants in nine test sites collected and coded >90 000 reasons for encounter³), the ethos at WHO also changed, and any possibility that the new concept of ICPC could have impact on the development of ICD-10 was effectively blocked. We, for our part, had never considered ICPC to be in competition with ICD-10. In the public health arena, however, the increasing criticism of the lack of conceptual progress made in ICD revisions raised the fear that ICPC could become 'a problem'. The project ended in 1984 after much debate, during which WHO finally agreed to the title of International Classification of Primary Care.

It was published in 1987 by Oxford University Press.⁴ It had no foreword from WHO, but a 'Historical Preface' by Kerr White (Deputy Director of the Rockefeller Foundation), a staunch protagonist of the concepts incorporated in ICPC, who would also provide ongoing support in the years to come. In The Netherlands, the Transition Project was on its way, testing two essential assumptions: (i) do reasons for encounter explain variation in interventions within diagnostic classes that cannot otherwise be explained; and (ii) can patients' symptoms and complaints be used for reliable estimations of prior probabilities for common diseases in family practice?⁵⁻⁷ A third crucial element to be addressed was the validity of the concept of the reason for encounter: to what extent does a coded reason for encounter coincide with the patient's perspective? It was fortuitous that Inge Okkes, an experienced linguist,

accepted the responsibility for this study, undertaken first in The Netherlands and later in nine European Union countries. Overall, a high concordance between FPs and patients was found concerning reasons for encounter.⁸ The European study proved at the same time that comprehensive coding of episodes of care does effectively characterize the content of family practice in different settings.⁵

The only question still unresolved by then had to do with relations with ICD. An earlier attempt to map ICPC to ICD-9 (and the ICD-9-related Royal College Code, RCC) was not successful. ICD-9 simply did not cater for the needs of family practice. However, we were more optimistic about the possibilities of mapping ICPC and ICD-10. A joint residency from the Rockefeller Foundation allowed us to finalize the work started earlier by Hans Meijer (University of Amsterdam). A reliable mapping in both directions between ICPC and ICD-10 was produced, providing a much more detailed diagnostic nomenclature for ICPC.⁹ Double coding with both systems became a realistic option. From that moment on, the argument that a choice for ICD-10 or ICPC would exclude the other system as a diagnostic classification was no longer valid. Our British colleagues, including those engaged in the organization of the morbidity surveys (then based on ICD-9), were, however, less enthusiastic. In the USA, ICPC was formally applauded by several organizations, but the US health care system prohibited family doctors from characterizing their daily work using ICPC. In the English-speaking world, only Australia warmly welcomed ICPC. In the non-Anglo-Saxon world, translations of ICPC in 18 languages were decisive for its success. National Colleges and family practice departments in several countries realized that ICPC could advance the development of the domain of family practice in the framework of national needs, and, gradually, ICPC has gained a wider acceptance.^{10,11}

Several publications of ICPC by Oxford University Press have helped substantially to show convincingly that it can characterize the content of international family practice better than any other system. In this issue of *Family Practice*, a new revision of ICPC-2-Electronic (as a follow up of the 2000 revision¹²) is presented on page 543, accompanied by an extension to the highest level of specificity of ICD-10, to be used in electronic patient records in family practice.

The increasing availability of empirical data from day to day practice in many countries has softened early criticisms. Now, the relationship between the WONCA International Classification Committee (WICC) and WHO is restored, and a WONCA/WHO committee has started work to explore the potential family relationships between the classifications. Even if this does not result in more formalized ties in the next few years, we are quite confident that our child has grown up into a well-balanced young adult, able to assist family practice in the emergence of a new generation of electronic patient

records. ICPC-2 and ICD-10 need each other, and after 25 years it is only fair to acknowledge their child-(step)-mother relationship.

References

- ¹ Meads S. The WHO Reason-for-Encounter Classification. *WHO Chronicle* 1983; **37**: 159–162.
- ² Classification Committee of WONCA. *ICHPPC-2-Defined*, 3rd edn. Oxford: Oxford University Press, 1983.
- ³ Lamberts H, Meads S, Wood M. Results of the international field trial with the Reason for Encounter Classification. *Soz-Präventivmed* 1985; **30**: 80–87.
- ⁴ Lamberts H, Wood M (eds). *ICPC. International Classification of Primary Care*. Oxford: Oxford University Press, 1987.
- ⁵ Lamberts H, Wood M, Hofmans-Okkes IM (eds). *The International Classification of Primary Care in the European Community*. With a multi-language layer. Oxford: Oxford University Press, 1993.
- ⁶ Okkes IM, Oskam SK, Lamberts H. The probability of specific diagnoses for patients presenting with common symptoms to Dutch family physicians. *J Fam Pract* 2002; **51**: 31–36.
- ⁷ Hofmans-Okkes IM, Lamberts H. The International Classification of Primary Care (ICPC): new applications in research and computer-based patient records in family practice. *Fam Pract* 1996; **13**: 294–302.
- ⁸ Hofmans-Okkes IM. An international study into the concept and the validity of the reason for encounter. In Lamberts H, Wood M, Hofmans-Okkes IM (eds). *The International Classification of Primary Care in the European Community*. With a multi-language layer. Oxford: Oxford University Press, 1993: 34–42.
- ⁹ Wood M, Lamberts H, Meijer JS, Hofmans-Okkes IM. The conversion between ICPC and ICD-10. Requirements for a family of classifications systems in the next decade. *Fam Pract* 1992; **9**: 340–348.
- ¹⁰ Okkes IM, Polderman GO, Fryer GE *et al*. The role of family practice in different health care systems. A comparison of reasons for encounter, diagnoses, and interventions in primary care populations in the Netherlands, Japan, Poland, and the United States. *J Fam Pract* 2002; **51**: 72.
- ¹¹ Donaldson MS, Yordy KD, Lohr KN, Vanselow NA (eds). *Primary Care. America's Health in a New Era. Committee on the Future of Primary Care*. Washington (DC): Institute of Medicine, National Academy Press, 1996.
- ¹² Okkes IM, Jamouille M, Lamberts H, Bentzen N. ICPC-2-E: the electronic version of ICPC-2. Differences from the printed version and the consequences. *Fam Pract* 2000; **17**: 101–106.