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
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 ‘ques-
tion 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 ‘document-
ably’ 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 encounter), 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 Classi-
fication of Primary Care.

It was published in 1987 by Oxford University Press. 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? A third crucial element to be ad-
dressed 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.
The European study proved at the same time that com-
prehensive coding of episodes of care does effectively
characterize the content of family practice in different
settings.

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
omenclature for ICPC. 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 depart-
ments in several countries realized that ICPC could
advance the development of the domain of family prac-
tice in the framework of national needs, and, gradually,
ICPC has gained a wider acceptance.

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 revision) 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 relation-
ships 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