CONTROVERSY

Where does the College stand in the field of classification?

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Dr Patterson has been a member of the WONCA classification committee. He here argues that the College ought not to diverge from the system developed by WONCA.

IN the early 1970s, the World Organization of National Colleges, Academies and Academic Associations of General Practice/Family Medicine (WONCA) decided to develop an International Classification of Health Problems in Primary Care *(ICHPPC)*. The purpose was to produce a classification of diseases appropriate to general practice use in many countries, with some chance of reasonable comparability of analysis in the setting of practice in different countries.

The code was developed basically from the original RCGP classification, based on compatibility with the International Classification of Diseases *(ICD-9)*. The RCGP representative on the WONCA classification committee took part in the formulation of the original *ICHPPC,* accepting that of necessity this was a consensus of opinions from different countries with differing health care systems. It was realized that there was room for considerable improvement in the original version and its second format was developed in the late 1970s to be published as *ICHPPC-2,* and finally in its form with definitions of many of its rubrics in 1983 as *ICHPPC-2 Defined.*

During the development of *ICHPPC-2* there was no impact from the successive official RCGP representatives even in the form of comments or criticisms, this work being carried out by an RCGP member who had been adopted on to the WONCA classification committee from its direct foundation membership and who was subsequently appointed as the official RCGP representative. His position, however, became intenable in view of the contrary opinion of the RCGP Research Executive regarding classification of diseases in UK general practice.

National morbidity study

There have been two national morbidity studies to date, based on sentinel practices scattered through the country, although not randomly selected, and coordinated by the Birmingham Research Unit. The third NMS is now in the late stages of planning, although many await publication of details of the previous two studies, and a *New College Classification* has been formulated, as reported in the March *Journal.*

The classification for *NMS-1* and *NMS-2,* although numbered differently, and with a few more rubrics than *ICHPPC-1* and *2* were compatible with the latter codes. The planned *NMS-3* classification, on the other hand, has become much more numerous in its rubrics, with 631 as compared with *ICHPPC-2's* total of 350 and has also become very much less compatible with the WONCA code, contrary to the opinions of the *Journal* report.

It will therefore be much more difficult to correlate *NMS-3* with any comparable study elsewhere in the world other than by indirect referral via *ICD-9.* In addition, many other UK practitioners are already using *ICHPPC-2,* including those using the classification software in the 'Micros for GPs scheme—a potential 150 practices.

ICHPPC-2 Defined

This is a classification which has been developed for use in general practice and which in its limited form the Birmingham Research Unit, on behalf of the Research Division of the RCGP described in June 1977 as follows—'The International Classification of Health Problems in Primary Care was adopted by the World Organization of National Academies and Colleges of General Practice in 1974. It will gradually replace the College classification, enabling international comparisons to be made with greater accuracy'.

ICHPPC-2 allows for optional hierarchy in whole or in part by adding to its essentially 3-digit numerical system. The College could therefore have increased its specificity by increasing the use of extra digits rather than by developing an incompatible code. Indeed, there is a difference of opinion amongst the Research Committee members regarding the degree of incompatibility of *NMS-3* and *ICHPPC-2.*

For the first time in general practice a classification has been provided with definitions of a large percentage of the rubrics, this being *ICHPPC-2 Defined,* the aim being to make more accurate the comparisons of disease incidence and prevalence between practices in the same and different countries.

RCGP and WONCA

What, then is the relationship between the Royal College of General Practitioners and the World Organization of Colleges and Academies? The classification of diseases is one mechanism whereby activities of research and comparison of diseases may be extended beyond parish and national boundaries. The Research Committee of the RCGP has however decided, albeit in good faith, that in its opinion the *NMS-3,* or *New College Classification,* is more appropriate. This means a loss of comparability between codes.

It is accepted that no code can be perfect for all uses and that there will always be items which any individual doctor would prefer classified differently, but the official RCGP representatives had every opportunity to take part in the communications and debates during the development of *ICHPPC-2.* Their failure to give any opinions inevitably resulted in any such possible adjustments never being voiced, far less instituted.

This controversy is all the more difficult to understand when increasing numbers of UK practitioners are using *ICHPPC-2.* It is all the more unfortunate in that it has strained the erstwhile good relationships between the different international groups of general practitioners at a time when the number of UK doctors attending the triennial meetings of WONCA is multiplying at a rapid rate. These doctors realize that the fertilization of ideas between coun-

tries is both fascinating and educative whilst at the same time seeing life in a variety of locations very different from their own.

Conclusion

The College must, therefore, decide where it stands on this question, bearing in mind that only six years ago the Research Division itself considered that *ICHPPC* would become the accepted code for general practice. This opinion has been confirmed in 1983 by the World Health Organization's acceptance of *ICHPPC-2 Defined* as its official primary care classification. The College must also decide whether good relationships with WONCA and primary care medicine in other countries is important. The writer, having been so closely involved with doctors from these other countries on the classification committee, has experienced the value of such international discussion and friendship and has no doubt as to the benefits from and advisability of enhancing such relationships.

These considerations apart, the use of an expansive code such as the *New College Classification* is in the writer's opinion difficult, particularly for the ordinary working general practitioner as opposed to those in highly academic settings, whether with or without the help of computers. The simpler *ICHPPC-2* with its fewer rubrics, but optional hierarchy of increased specificity would seem more appropriate for most uses in practice, and perhaps those doctors who have been involved in *NMS-1* and *NMS-2* will agree once they have seen the greatly expanded classification described in the March edition of the *Journal*.

The areas of prime concern must therefore be that the College is separating itself from WONCA in this expanding field of activity and at the same time, one section of taxonomers of UK general practice is now being diverted along an incompatible track compared to the other, depending upon which classification system is being selected.

Perhaps this widening gulf might be narrowed, if not indeed closed, by union in the projected production of a *Reasons for Encounter Classification* between the Research Executive of the RCGP and the WONCA classification committee.

Dr Clifford Kay, chairman of the College Information Technology Working Party, replies:

Dr Patterson makes several errors of fact, but it would be tedious for the reader if I were to correct them all.

I will confine my remarks to a statement of the principles which guided Council when it adopted the new Classification. These points were well summarized in the conclusions to the College recommendation (March *Journal,* p.125) but they evidently need to be repeated.

1. The opportunity arose to produce a classification which could be used for automatic coding of clinical information by computer. Computer coding demands a much larger list of terms than might be acceptable for a manual system. Contrary to Dr Patterson's view, longer lists and more specific terms are much easier to use than short lists, since they dramatically reduce the need for clinical judgement when coding.
2. A classification for use in the British NHS must give high priority to direct translation to the International Classification of Diseases because of the value to the NHS (which uses the ICD) of morbidity and mortality data derived from primary care. The classification itself is only part of a package of recommendations which will permit uniformity of recording and analysis of data which will unlock the vast store of clinical information previously inaccessible in our records.
3. Dr Patterson need have no fears about the compatibility of the College Classification with ICHPPC-2. There is never any difficulty in accommodating long lists into shorter lists. Translating in the opposite direction is much more difficult, and may be impossible.

I believe that the new Classification, whether used on the computer or in manual form, will allow doctors to monitor their patients' problems and their own performance in a comprehensive and flexible manner which has not previously been available. It is one more important mechanism for achieving a substantial improvement of the quality of care which we extend to our patients.

WORKING WITH OTHER PROFESSIONS

Thumbnail Osteopathy

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During the past 20 or so years there has been growing interest by the general public in osteopathy. There have been endless articles in the media and increasing demand for treatment. More and more patients are asking their general practitioners whether they should see an osteopath and yet the general practitioner often has no reliable information or experience. Certainly there is no formal instruction or advice given in the medical schools. The general practitioner may know or have heard by repute of one or two osteopaths but may find himself in the position of having to form an opinion based on very limited information.

OSTEOPATHY is the science of human mechanics. It is the system of diagnosis and treatment which lays emphasis on the structural and mechanical problems of the body. The osteopath, then, is most concerned with the mechanics of the musculo-skeletal system and how well it is functioning.

Much of the osteopath's work is to do with malfunction and mechanical derangements that have occurred in the musculo-skeletal system. These can come from traumatic or non-traumatic causes. Traumata such as sports injuries, road traffic accidents and birth injury can cause all kinds of mechanical problems such as joint strains and of course the only too common back strains which affect 80 per cent of the population at some time or other. Traumatic musculo-