The feasibility of a national general_practice morbidity and intervention survey in the netherlands

Report of a symposium

December 2nd 1982

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This publication consists of two lectures, the first (by Donald Crombie) about 'practice and principles of the 3rd National Morbidity Survey in England and Wales', the second (by Jouke van der Zee) about the usefulness of a Dutch National Morbidity Survey for health services research in the Netherlands. After the two lectures a discussion took place: a synopsis of the main topics can be found in this report.
The conference was attended by a number of persons, professionally interested in the possibility of a Dutch national morbidity and intervention survey in general medicine.
The conference was held on December 2nd, 1982 and organized by the Netherlands Institute of General Practitioners, Mariahoek 4, Utrecht, Holland.

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CONTENTS

PRACTICE AND PRINCIPLES OF THE 3RD NATIONAL MORBIDITY SURVEY IN ENGLAND AND WALES

D.L. Crombie

What I have been asked to explain is why we embarked on a National Morbidity Survey when there are so many criticisms which can be made of such surveys. That is why I called what I am going to say "The Problems of National Morbidity Surveys". I shall use transparencies. They are convenient because they have headings covering the problems while I am talking. I think we should start with the question "Why do morbidity surveys at all".

Why carry out morbidity surveys: - The main reason for running a morbidity survey at all is to establish the patterns of morbidity in the area in which the health care system (your work) is being delivered. This assumes, and of course this is a big assumption, that the variations of incidence and prevalence of morbidity are directly determined by medical need and consequently all the other things such as workload, services used, and indirectly how the general practitioner responds to them. That is a big supposition. The biggest mistake that we made in our approach to measuring what is going on in the health care system was to assume that the characteristics of our patients and the environment that they live in are the main determinants of the variability that we see in the way they report illness. One of the most important things I would like to show you today is evidence that points (whatever the cause may be) to the fact that the largest amount of variability lies not, or does not correlate with, the characteristics of the patients nor with their environment, but with the general practitioners who deliver the care![1] This may sound very odd but I hope that when we go through the material it should be self-evident. We ought to have learned this lesson in the First National Morbidity Survey![2] The data concerning general practitioner variability is all there. The fact is that we never analysed it in any detail because we did not think that it was important.

With these reservations about the base line of morbidity, we still have to know what is going on in measurable, reproducable terms as the basis for any systematic approach. For example, teaching is impossible without

base lines which can be reproduced and mean the same thing to those teaching and those taught. Such information is absolutely essential even if it is poor, even if it is partial. There cannot be any sensible teaching, research or planning without information of this kind as a base line. The more important forms of research into the study of natural history of disease, the more important research into the outcome of various forms of treatment, whether they are retrospective or prospective, but particularly if they are retrospective, cannot be done without having built-up indexing systems[3] that allow you immediately to identify representative cohorts of patients. So, indirectly that is another reason for having this sort of system in being and on-going. That is just one area of research. The main reasons for conducting morbidity surveys are given in Table 1.

Table 1.

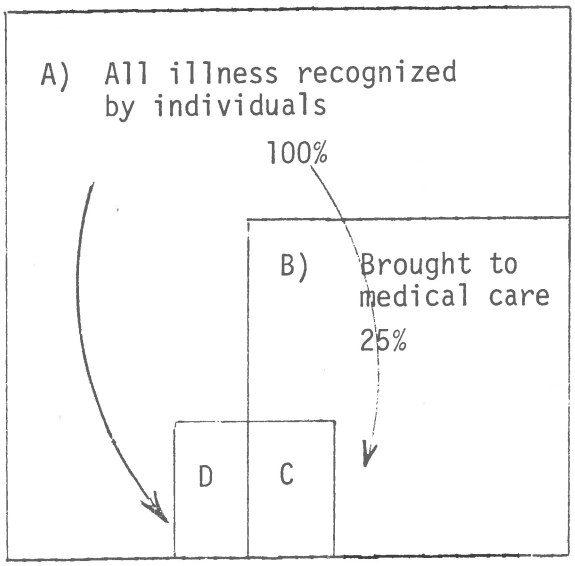
WHY DO MORBIDITY SURVEYS ?
Base line estimate of reported morbidity
Variations in base line by : age, sex, season, social status, region
Research and Teaching
Information and planning of services
Retrospective cohort studies in prospective mode (original Oral Contraceptive Study)
Relationships between one disease and another (Standardised Morbidity Ratios)
Practice and practitioner variability
Comparison of causes of death with reported morbidity
International comparisons
Construct models of demand and utilisation
Comparison with previous surveys

The establishment of a body of systematic data of this kind leads to the construction of models of the health care system. The models require you to think about other ways that the system might work, and of course is tied up with how you are going to plan for the future of your own particular services. You can also compare the present survey with previous surveys or other surveys. You cannot construct models and test them without good information or without the best information you can get even if it is inadequate. Knowing where it is inadequate is important but without it you are just the blind leading the blind.

The purpose of health services: Can I remind you about what we are in business for. This figure (Fig.1.) produced by the Horders in 1954 is one of my favourites. The situation has not changed much since that time![4]

Figure 1*

MEDICAL CARE AND RECOGNIZED ILLNESS



Normal Illness Expectancy In Life

Number of Episodes

A	400	C	Referred for Hospital Care	1.5% ±
B	100	D	Hospital attendances without previous referral	0.2%
C	5 ±			

C & D refer to Great Britain.

*Abstracted from Horder & Horder (1954)

The square represents the aberrations from health that the patients recognise in themselves. In 1954 it worked out at 400 episodes of illness in a lifetime, it is now 500 episodes. People do not actually suffer more illnesses but people have a different perception of being ill. Figure 1 shows that a quarter of the population goes to the general practitioner (this proportion has gone up a little since 1954). More of them now go to hospital. The ratio is perhaps 10% instead of 5%. The point being made here is that only a quarter of the patients in Great Britain and to a large extent in Holland, having recognised that they are not well, feel that they should do something about it. In Great Britain patients go into the hospital system via their general practitioner. In theory they must gain access to the hospital system via the general practitioner though a few do get in through the back door of casualty departments.

Problems in morbidity surveys: These are outlined in Table 2.

Table 2

PROBLEMS:
Exclusion of morbidity not reported to general practitioners
Morbidity not workload
Representativeness of sample (patients and doctors)
Size of sample
Denominator problem if no registered population
Classification problems
Socio-economic data difficult to obtain(particularly for non-attenders)
Costs in money and other resources

The main criticisms of morbidity surveys based on general practice are as follows: they concern reported morbidity only and do not measure illness not reported to general practitioners; there are no agreed criteria and definitions for many of the morbid conditions; patients bring problems to their doctors and morbidity is only one component of their problems; the studies do not cover the whole of the general practitioner's workload

as distinct from the morbidity he encounters.

Workload and morbidity: We are here to help patients to solve their problems, their clinical problems and morbidity (whether it be organic morbidity, psycho-emotional morbidity, socio-economic morbidity or a mixture of all these, they still come with problems). If you use morbidity as the base line then it is morbidity you are measuring and workload only indirectly. Workload is equally important from the point of view of health services studies that relate to the patterns of delivering care.

Representativeness: Perhaps the most important criterion of the information collected in your system is that it must be representative of the whole of the community that you are looking at. That means representativeness not only of patients but also of doctors. One of the problems that we have had in the past is that, while populations are certainly represented as far as patients are concerned (by age and sex, social class and regional distribution), we have problems with the doctors. This is related to the size of the samples. You do not need a bigger sample than is necessary to obtain the minimal information for solving the problems you are setting yourself. You do not have to go and look at every health transaction in your community forever to answer some of the questions. You only need enough information to do so.

Defining populations at risk: In Great Britain we are lucky to have age/sex registers based on a registered population.[5] The lack of such registered populations has I believe been overdone as a problem. The more we know about what is going on, the less important is the so-called denominator problem. The arguments for ignoring the denominator problem and using 'patients consulting' as a statistical base line are summarised in Table 3. You have to know something about the structure of the population other than the simple things like age and sex. We are lucky again in Great Britain with the Second National Morbidity Survey[6-8] in that we were able to link directly census data to the morbidity data for each patient. We attempted this linkage for the whole of the 300.000 patients in the population and achieved it for 80%. There were problems here partly technical but mainly to do with confidentiality.[9]

Table 3

THE DENOMINATOR PROBLEM

Why not ignore patients " not consulting "

1. Numbers not available for most countries

2. Not necessary when comparing practices rather than whole populations at risk

3. Data refers only to reported and not total morbidity

4. Direct questioning of a representative sample of the population will be adequate for most purposes(G.H.S.) = General Household Surveys

5. Doctor variables in performance outweigh patient variables:

   classification of morbidity ;
   referrals to hospital and ;
   use of anciliary services

6. Non-attending patients not representative of all patients

   patients who never complain ;
   no time to attend ;
   always away from home ;
   consults colleagues privately (medical) ;
   health cranks ;
   consults non-medical advice ;
   consults hospital services direct (casualty or internal referral) ;
   relatives and friends of doctors.

7. Need to measure indirect as well as direct consultations

   repeat prescribing can equal 50% of all consultations ;
   telephone consultations ;
   advice by nurses, health visitors and non-medical receptionists

8. Among many variable parameters, patients consulting per 1000 at risk shows least inter-practice variability

9. A large part of the non-consulting group are people who have moved from the practice area.

Survey method: There are two basic methods. Because we are a College of General Practitioners and a Research Unit catering for the needs of working general practitioners, our survey was based on collecting information about the direct contacts of general practitioners with their patients in

consultation. Another method is to take a representative sample of the population and ask them questions directly about their health and use of health services (The General Household Survey in Great Britain,[10] The National Sickness Survey in the United States and your equivalent studies in Holland). Other points are outlined in Table 4.

Table 4

HOW SHOULD WE DO THEM ?

Surveys based on doctor-patient consultation

Disease Index: (NMS II) Basis for direct cross reference to clinical records but patient morbidity experience requires special cross linking.

Patient Record Card: (NMS I) Patient morbidity experience already linked.

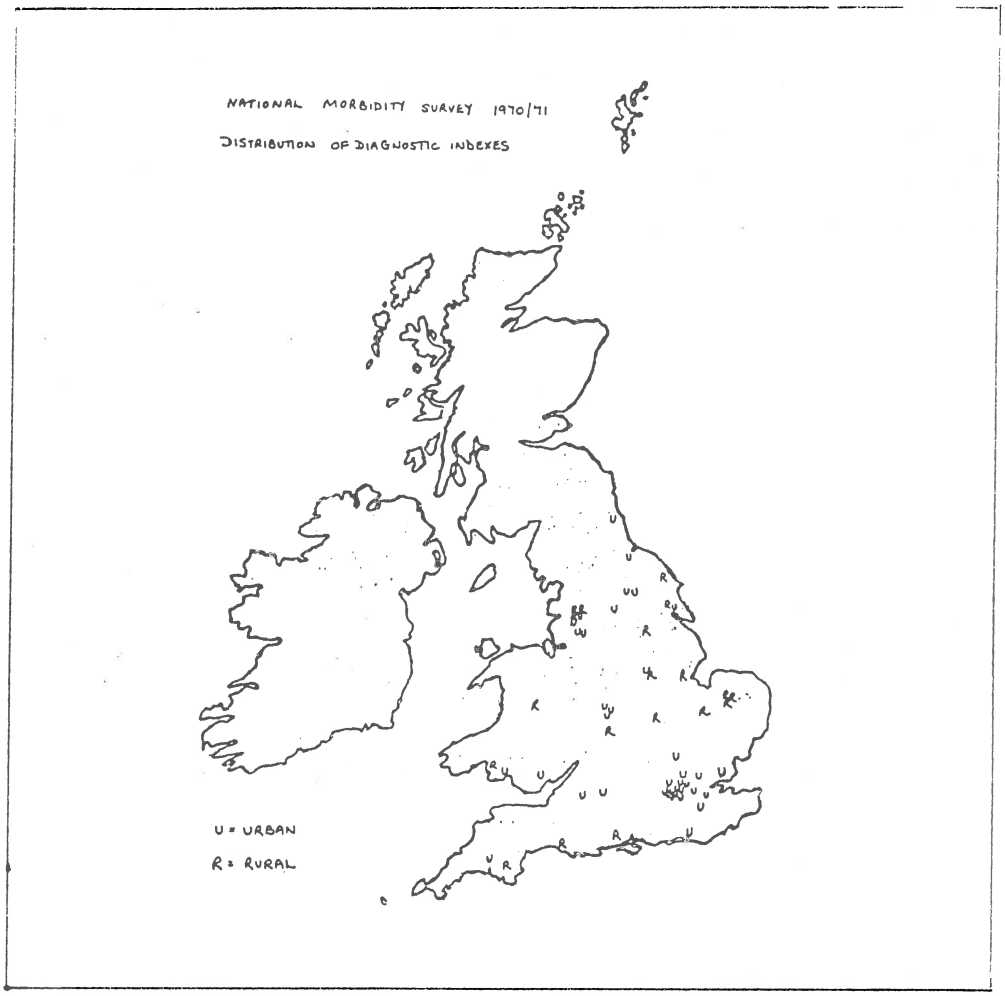
Consultation Record: Suitable for sampling procedures.

Surveys based on patient reporting :

General Household Survey - Great Britain

National Sickness Survey - United States of America

The system in Great Britain chose itself. We needed about 100 doctors in 60 practices looking after about a quarter of a million population. It happened that these were just about the number of doctors already keeping standard disease indexes. Some because they fed into our Weekly Returns System of communicable diseases(11) based on recording in disease indexes and some because they maintain disease indexes for teaching in research purposes, personal reasons in other words. The purpose of the index in these circumstances is as a cross referencing system to the clinical record. We started with the disease index simply because they were there. We might have used the patient's record card as we did in the First National Morbidity Survey.



The recording practices: This is a crude map of England and Wales to show a rough distribution of the practices by urban and rural. The important point here is that there is a good national representative sample by urban/rural by single/group practice, by practices at the seaside compared with inland etc., and even a reasonable regional distribution of the population. However it is not possible to use it for disaggregation for regional purposes. This is one of the anomalies and will be explained later. On paper it is a magnificent distribution but the facts of life are such that there are great restrictions on how we can use the data.
I mentioned that there were 60 practices, 31 singlehanded, 29 group practices, 115 doctors in total looking after just under 300.000 patient years of recording in each full year. We chose the year 1970-71 because that year was also a census year and we wanted to link census data to the morbidity data. We had approximately 2.500 patients per doctor which is a little higher than the national average.

Recording system: This was based on disease indexes in which are recorded episodes of illness as they are brought to the doctor. An additional entry is made at each subsequent consultation (Appendix 1). The importance of distinguishing incidence from prevalence is outlined in Table 6. The definitions for episode typing are given in Table 7. Episode typing looks after the kind of episodes we are dealing with so that we can separate out one of the most important epidemiological necessities: incidence from prevalence and with the total number of consultations for workload purposes. Table 6 and Table 7 follow.

Table 6

NMS III - 1981-82

INCIDENCE AND PREVALENCE

1. The incidence of disease is the number of new episodes in a given period of time.

2. The new incidence concerns people experiencing a condition for the first time

3. The prevalence is concerned with the number of people suffering from that condition and is indicated by the number of people consulting

4. Incidence, new incidence and prevalence are distinguished by using a code to define episode type

5. The total number of consultations provides an indication of the impact of a condition on a primary care service

Table 7

NMS III - 1981-82

EPISODE TYPE

Against each problem or diagnosis identified a code representing the episode type is attached

Code 1	An episode for which the patient was already under a doctor's care at the time the study started.
Code 2	A new episode which began since the study commenced
Code 3	A new episode which began during the period of the study for a recurrent condition which has been previously diagnosed either during the study or prior to consultation
Code 4	An episode initiated outside the practice (e.g. casualty department). Takes precedence over 2 and 3
Code 5	An episode with more than 4 consultations
Code 6	An amended diagnosis

Fig.3 : Side 1 (RCGP-E9)

DATE			E T	SURNAME				INITIALS		DATE OF BIRTH			CONSULTATIONS				I.C.D. No.					
													1	2	3	4						
12 – 13	14 – 15	16 – 17	18	19	20	21		22		23 – 24	25 – 26	27 – 28	29	30	31	32	33	34	35	36	37	38	39	40	41

Drs. Code No. 1 2 3 4 5 6 7 | Sex (Male) 1 8 | Diag. Code Number 9 10 11

The actual episode sheets used in the disease index are shown in Fig. 3. The detailed instructions for use of the system are available as an Appendix 1 for reference.

Fig.3 : Side 2

Drs. Code No. 1 2 3 4 5 6 7 | Sex (Female) 2 8 | Diag. Code Number 9 10 11

DATE			E T	SURNAME				INITIALS		DATE OF BIRTH			CONSULTATIONS 1	2	3	4					I.C.D. No.				
12–13	14–15	16–17	18	19	20	21		22		23–24	25–26	27–28	29	30	31	32	33	34	35	36	37	38	39	40	41

Age/Sex register : An accurate register is essential. All patients who are registered with the practice are included however short the period of registration. Temporary residents and patients in long-stay institutions are not included. Procedures for reporting deaths, withdrawals and name changes must be observed. The age/sex register is the basis for establishing the population at risk and for estimating all the basic rates by which morbidity in this morbidity survey is measured.[5] The other socio-economic information comes out of the census link (Table 8).

Table 8

List of 1971 Census variables linked to morbidity

1. Marital status
2. Occupation
3. Employment

4. Social class (derived)
5. Occupation of married women
6. Persons per room
7. Tenure
8. Birthplace (11 countries or continents)
9. Number of children (to married women under 60)
10. Amenities
11. Urban/rural (local government definition) -(derived)
12. Occupation change (yes/no answer)
13. Year of entry of immigrants
14. Birthplace of mother
15. Birthplace of father
16. Movement in past 12 months (yes/no answer)
17. Family relationship (derived)
18. Household size
19. Region

The study organisation : This study was a co-operative exercise between the College, the OPCS* and the DHSS*. The College could not have done this on its own. The Office of Population Censuses and Surveys supplied all the data processing, all the systems analysts and programmers, the census computer for handling the data afterwards and the production of all the tabulations. We have no idea of the total cost of this survey. The OPCS did not work out detailed costs for their contribution because they do not keep their accounts in a way that would have made this possible. The OPCS exists, the census computer exists and has spare time available. In the same way there are always marginal times available to systems teams, design teams and programming teams. Provided that we were prepared to put up with the long waiting times, the study could be conducted at marginal costing. In fact it took 5 years to publish the first main findings simply because it had to be fitted in to these OPCS schedules. I think it is an important point to make. What was the role of the Department of Health? It certainly provided the money to fund the general practitioner contribution and 'grease the wheels' all over the place to make it possible for

*OPCS= Office of Population Censuses and Surveys. DHSS=Department of Health and Social Security

general practitioners to have access to other parts of the health services who perhaps did not understand what we were doing and if left to themselves might not have been so helpful. With the Department of Health (perhaps as big brother, I dont know) able to make it clear that it was considered worth doing the way for the whole of the field work.

Practice finance: There were costs for organising meetings but they were small costs. We had several regional meetings in the build-up to the study. The recruitment was not expensive. The first regional meetings were not expensive even though they included paying some of the expenses for the attendance of the doctor and secretary of the practice who was going to be most involved. The main cost of actually running the study was the £ 400 for recording doctor (this is actually the cost for the Third National Morbidity Survey in 1981-82). In the Second National Morbidity Survey, it was £ 100, that is £400-£500 of today's money, plus of course the fact that the practice could always get a further 70% reimbursement for any recording secretary's time in addition. They had to pay the first 30% themselves and that 30% came out of the £400. This sum was not a payment to the doctors themselves but it covered the out-of-pocket expences for taking part. It was meant only to meet the costs that they would genuinely have been involved in and came to a total of about £50.000 altogether for the year. The Central Research Unit costs were fairly negligible because we get a grant and it simply meant that we had to spend more of our time in that year and in subsequent years on the National Morbidity Survey and could not do other things. We were not paid any more money.

The Results : In table 9 are given examples of the rates on which the whole survey was based.

Table 9

MORBIDITY SURVEY RATES

Primary Utilisation Rates	Secondary Utilisation Rates
Patients consulting /1000 population	Referral rates Inpatient Outpatient Diagnostic services Para-medical services Local Authority services
Episodes/1000 population	
Consultations/1000 population	Prescribing rates

You can construct other rates from these: consultations per episode for example. You also have utilisation rates; the referral rates to hospital and for diagnostic services, the use of other services that are not medical and outside the practice altogether what we then called local authority services, and all the other services that general practitioners have to manipulate and use. Finally, we do have some information about prescribing though not enough. That is the basic output.

Population Sample : In table 10 is a sample of the kind of information that we had about the structure of our studied population. It is a reasonable match for the population of England and Wales. The regional distribution for what it is worth as far as the population was concerned was also a reasonable match.

Table 10

NMS II 1970-71 PATIENT REPRESENTATIVENESS

Sex/age percentage distribution of study population compared with that of England and Wales (mid 1971)

Age Group	Sex	ENGLAND AND WALES Study	Mid-1971
0-	M	7.9	8.4
	F	6.9	7.6
5-	M	17.7	16.5
	F	15.3	14.9
15-	M	15.0	15.1
	F	14.4	13.8
25-	M	26.0	25.1
	F	25.3	23.3
45-	M	23.6	24.1
	F	23.3	24.4
65-	M	6.6	7.4
	F	8.6	9.7
75+	M	3.1	3.1
	F	6.2	6.3
All Ages	M	48.0	48.6
	F	52.0	51.4
	Persons	100.0	100.0

The practices: We also collected information about the practices themselves.

Table 11

NMS III - 1981-82

PRACTICE PROFILES

A Practice Profile is required. This involves a a description of the practice under the following headings:

1. Doctors' names, ages and graduation dates.
2. Information about trainees/trainers etc.
3. Information about anciliary staff ; members hours etc.
4. Attachments : nurses, health visitors etc.
5. Accomodation

A great deal of detail about what the doctors were like, how old they were, where they trained, about the staff employed, the buildings they worked in were included. It was called the practice profile.

Table 12

NMS III - 1981-82

VALIDATION

A. As far as possible every item of information to be processed must be capable of verification in the records or other source document.

B. Spot checks of records chosen by random methods are an integral part of the study and some of these will involve research workers from O.P.C.S. and the Research Unit.

Validation : Obviously the quality of the data is determined by the care with which it is created in the first place so validation really starts before the study. We held meetings before the study so that the agreed criteria for definitions could be consolidated in the manual of procedures (Appendix 1). Also everybody would then know them clearly, secretaries understand them, and know when and where they could look things up. We had standard classifications of illness : various lists (a short list for the desk, a long list for the inclusion and exclusion terms for reference, and a list of 5000 commonly used terms); cross referencing to the numbering system we were using and to the ICD-8 which was the current ICD at that time, and eventually also to the ICHPPC-2 classification when it arrived. We ran a pre-pilot where the doctors filled in their records in the way they would in the main study and we went round every one of the practices abstracting up to 100 entries and cross-checking the records with the doctor's clinical records, looking for errors at all levels in the recording system. There were many systematic errors, each practice had its own particular group of systematic errors so we hoped we had most of those out of the system before we actually started. We then ran another validation visit where we did exactly the same thing going through the records, cross checking with what would come into the system immediately after the start and then ran additional visits depending on the quality of the recording in that first earlier visit. Some practices had three visits. We then had other meetings more ad hoc through the year and finally a post-study validation exercise where we cross-checked the quality of the data we now had. We could not do anything about it at that stage but this allowed us to make estimates of what the error rates would be or what we might expect them to be. We had to accept these, that is a necessary part of checking what you have got.

The lessons of the Second National Morbidity Survey have been incorporated in the Third National Morbidity Survey of which we have just completed the field work. We do not yet know what the data is like and have just carried out the post validation exercise. It does seem that the material probably is better in terms of quality than the Second National Morbidity Survey data. The classification systems are very similar.

Table 13

NMS III - 1981-82

DISEASE CLASSIFICATION

A. NMS III uses a disease classification based on the I.C.D. for its main structure but simplified for use in general practice. It is also compatible withICHPPC-2.

B. The classification includes social problems

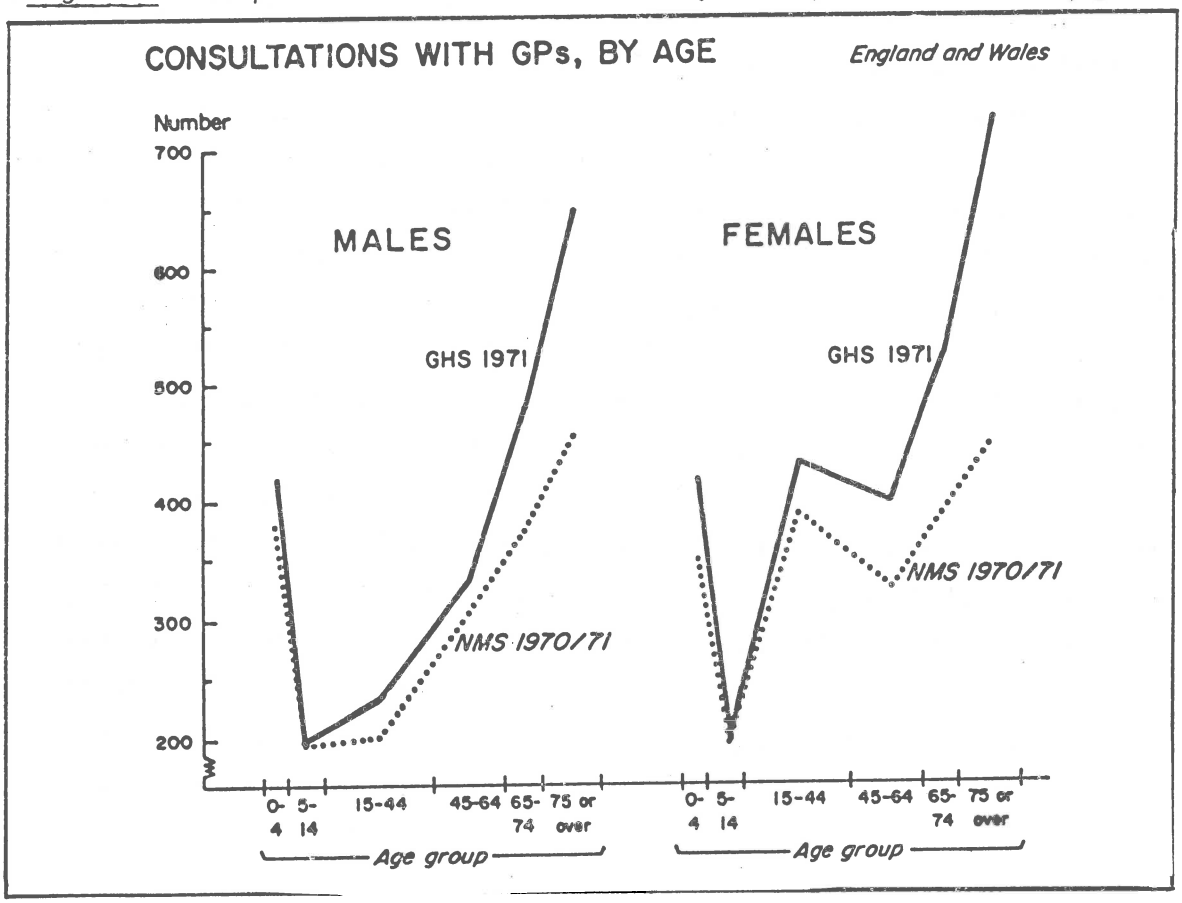
C. Amplification of some codes is required. For this the full ICD number will be used.

Disease Classification : We had a problem here because we had a classification system which still leaves the general practitioner the ultimate decision in choosing what he is going to call the clinical problem that is sitting there in front of him. We do not provide him with a set of definitions or criteria for the diagnostic situation itself. There are several reasons for this. Clinically we are not in a position to be so definite anyway. Where it is easy it is not necessary. For serious organic diseases there are standard text book descriptions that are generally acceptable and they cause no trouble. The problems arise from the ill-defined non-lethal biologically trivial conditions or those where you have overlapping organic labels with psycho-emotional states. These are the diffuse areas and to a large extent the definitions or rather the weakness in definitions reflect our own clinical ignorance in these areas. In other words these are the areas where from the clinical point of view an enormous amount of research work ought to be going on. Part of the spin-off from a study of this kind is to identify areas of this kind and be much more systematic about it. For instance from the Second National Morbidity Survey, we looked at malignant hypertension, gout, depression and particularly depression in relation to subsequent mortality rates and Parkinsons Disease. We carried out various studies to sharpen up the clinical understanding of the conditions themselves. One other problem

with rigid definitions and criteria concerns the labelling of conditions with one criterion unfulfilled. For example, if the definition of whooping cough requires a positive culture as one of the diagnostic criteria, most of the real cases in Great Britain will have to be assigned to a residual category and important information will be lost.

We have a classification system with more rubrics than used in ICHPPC-2 which just has not got enough rubrics. I say that categorically because when we used the ICHPPC-2 on its own, we ended up with something like 15% of episodes in residual or grouped categories. What we have done is to take ICHPPC-2 and hierarchically expand it. We have used our own numbering system because you cannot use the ICHPPC-2 numbering system if you expand in this way. We introduced our own terms where we thought them appropriate but we still have residual categories. Any episode going into a residual category has in addition the 4 digit ICD number written after it so that every entry will be identifiable to 4 digit ICD even if it is in a residual category. You can always catch up afterwards if you want to look at anything in more detail.

Figure 3 : Comparison of National Morbidity Survey with other Surveys



In fig. 3 the gross rates of the first year of the Second National Morbidity Survey are compared with the General Household Survey rates for the same year.(12)
The rates match well for the age groups 0-15 years and then the rates get further and further apart as the patients get older. This has never been adequately explained and I would like to show you some more recent data.

Table 14 Comparisons of NMS and GHS rates 1970-71
(Consultations per person at risk per annum)

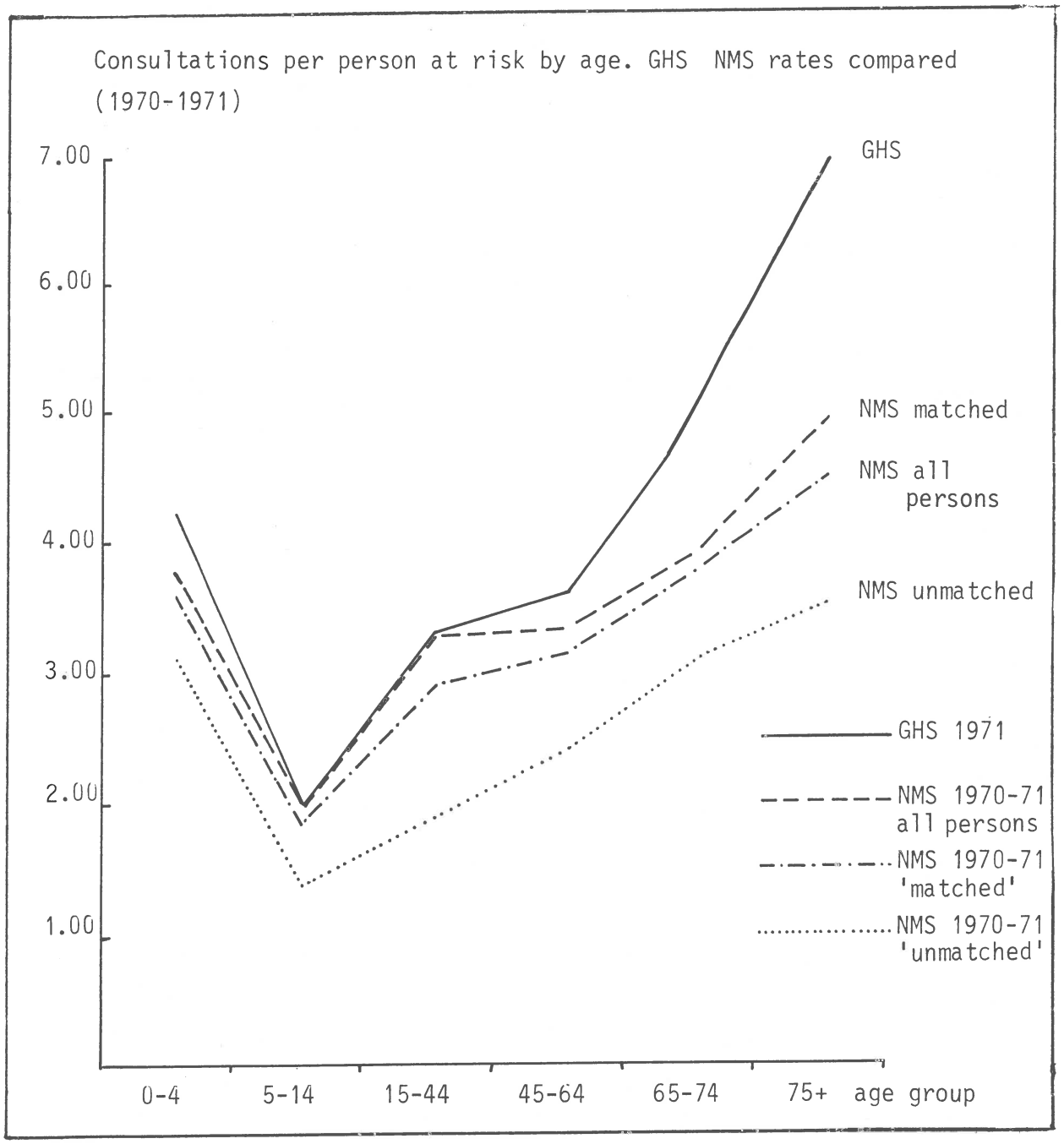
Age Groups	General * Household Survey	National Morbidity Survey		
		Total	Matched with Census data	Unmatched with Census data
0 - 4	4.19	3.63	3.76	3.11
5 - 14	1.96	1.93	2.04	1.38
15 - 24	3.28	2.85) 2.93	3.14) 3.29	2.15) 1.93
25 - 44		2.97)	3.37)	1.78)
45 - 64	3.64	3.17	3.35	2.39
65 - 74	5.03	3.76	3.96	3.12
75 +	6.99	4.47	4.93	3.54
ALL AGES	3.46	3.01	3.24	2.23
ALL AGES CONS/ PER PERSON CONSULTING	N.K.	4.48	4.60	3.99

* MINUS TELEPHONE CONSULTATIONS

The continuous thin black line (Fig.4) represents the total rates for the National Morbidity Survey that year. I mentioned that only 80% of the total file (the age/sex register file) formed a census match. We called this the 'matched file' and the residual 20% the 'unmatched file'. The interesting thing is that if you now look at these rates with the matched and unmatched separately, our matched file rates become very close to the General Household Survey figures (Fig.4, Table 14). Only the elderly are at all different. Incidentally these are after taking the 8% of telephone consultations out of the GHS general figures. About 8% of the GHS consultations are per telephone and we do not record telephone consultations in our Survey. Also the unmatched have much lower rates. The

intriguing thing is that the GHS material is a sample. They were only

Figure 4



able to interview 71% of those on the total file and gain information about a further 10% by questionning others so this is not a random sample. It is a random sample in terms of age, sex, social status and all the other things that were checked for but if you look at the difference between what we call matched and unmatched, then the GHS data deals with

'matched' individuals. The unmatched of course are the socially mobile and are not represented in the GHS sample. The consultation rates per person consulting are much the same whether they refer to matched or unmatched patients. We can assume therefore that the main thing about many of the unmatched patients is that they were not physically there at all. We have a feeling that a proportion of the General Household Survey patients who were not interviewed were not there either and that if we had rates for these GHS 'unmatched' it would certainly have made these figures look very much more like the figures that we have got in the National Morbidity Survey. These are intermediate results. We still have to finalise the explanation of this discrepancy. For a long time we assumed that it was a discrepancy on our side, that our doctors just were not representative of doctors in the community, that in some way their patients (the elderly particularly) consulted less than those in the community as a whole. I still think that is still partly true but the gap is much smaller than it was to start with. We now come to the biggest problem that we had with these surveys. That concerns the doctors themselves and not the patients. The patients behaved impecably statistically but not the doctors.

Doctor Variability : Tables 15 and 16 present information about the doctors or more correctly the practices which actually participated in the study. First let us look at the numbers of consultations given per 2 week period by the practices (Table 15). In Table 15 the title NMS I refers to the First year of the Second National Morbidity Survey and NMS II refers to the Second year of the Second National Morbidity Survey. The 2 week consultation totals range from an unbelievable minimum of 106 to the top 678. The figures for the second year are very similar. The figures for the 20 percentile divisions in the 2 years also match very closely. The other data refers to another group of College doctors who used a sampling recording system. They looked at their consulting pattern using what we call a Practice Activity Analysis sampling frame,[13-16] collecting information for 4 weeks only. We now have a picture of a much larger range of doctors, each PAA example is based on a minimum of 100 general practitioners. The rates from the PAA material match exactly and have the same distributions as our NMS recorders. These are non-parametric presentations of the distributions because the distributions are so wide. Everything about the activities we have looked at follows this sort of pattern. There is an

Table 15 NMS I
NMS II
& P.A.A. United Kingdom and Belgium

A comparison of mean values and range of results in 4 P.A.A. studies (Rates per 1000 consultations) with Data from NMS II (All Practices)

	Min Rate	Intervening Rates 20%	40%	60%	80%	Max Rate
CHEMOTHERAPY						
U.K. - P.A.A. Mean 99	5	66	83	108	137	275
Belgium Mean 122	3	69	100	117	143	280
INVESTIGATIONS						
U.K. - P.A.A. Mean 112	10	62	88	117	168	366
Belgium Mean 149	27	83	131	150	185	359
PSYCHOTROPIC DRUGS						
U.K. - P.A.A. Mean 189	40	110	160	218	267	415
Belgium Mean 146	39	97	120	144	196	358
REFERRALS						
U.K. - P.A.A. Mean 42	17	31	38	46	57	98
Belgium Mean 39	14	25	30	38	52	126
U.K. NMS I	18	25	31	36	45	76
U.K. NMS II	19	25	32	34	43	64
CONSULTATIONS IN 2 WEEK PERIOD						
U.K. NMS I Mean 321	106	236	288	334	402	678
U.K. NMS II Mean 329	107	234	291	362	437	674
Belgium Psycho Mean 327	60	208	284	356	420	866
U.K. Psycho Mean 320	143	236	266	324	416	568
Belgium Invest. Mean 371	104	220	308	394	462	886
U.K. Invest. Mean 320	105	218	296	337	400	682

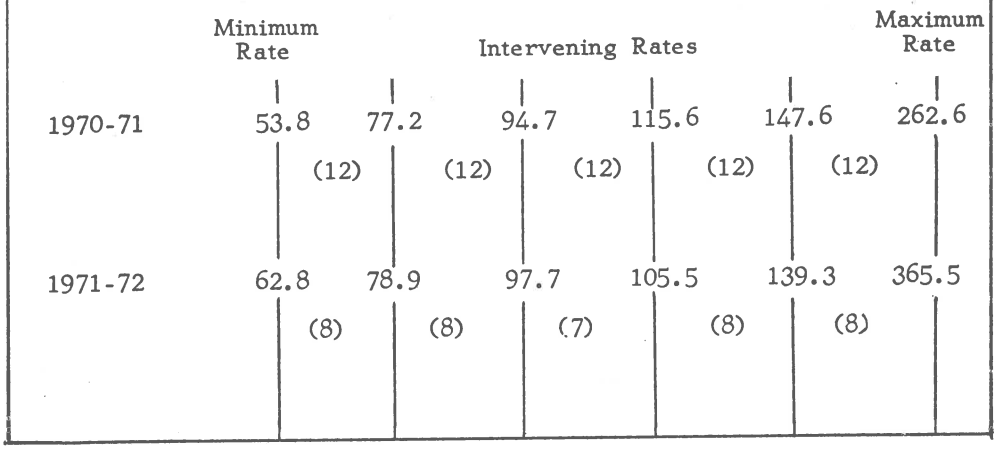
enormous range and at the same time an enormous consistency over time. The doctor may be peculiar in his personal performance but he is consistent about this peculiarity in the face of adversity, auditing or anything else you can do to him. In table 15 are rates for referrals per 1000 consultations. Most PAA results are presented as rates per 1000 consultations because our Practice Activity Analysis programme is oriented to use outside Great Britain where there is no denominator except the numbers of patients consulting. When you have ranges in rates like this, the denominator is totally insensitive. Rates per 1000 consultations give you what you are after. Is he low?, is he high?, is he in the middle?. With the referral rates we have the same enormous consistency over time

Table 16

Referral Rate per 1000 patients at risk.

Comparison of twenty percentile rates for Second National Morbidity Study

1970-71 & 1971-72



and the same enormous range of variability between doctors. There are also rates for some Belgium doctors as well who took part in the PAA-programme and they are surprisingly close to the patterns we find in Great Britain. In table 16 the equivalent rates for NMS II are given per 1000 patients at risk.

Let us look at singlehanded practices separately from group practices.

Table 17

	Mean rate	Min. rate	20th centile	40th centile	60th centile	80th centile	Max. rate
1970-71							
Single	3.3	1.9	2.8	3.1	3.4	3.6	5.8
Partnership	3.0	1.9	2.3	2.6	3.0	3.5	4.6
1971-72							
Single	3.3	1.7	2.7	3.2	3.4	4.0	6.3
Partnership	3.1	1.9	2.5	2.9	3.3	3.5	3.8

Consultations per patient at risk. Data from the National Morbidity Survey. 1970-71 and 1971-72.

We find the same sort of ranges. Now that is surprising. The group practices are as variable as singlehanded doctors. I suppose there are very good behavioural psychological reasons why this might be so. This opens up a whole new aspect for study. How can it be that a practice clusters itself and its performance around some one member. Once again we have the same consistency all the time. This consistency of performance from one year to another is further examined in table 18.

Table 18

Measures of Work Load comparison in NMS practices 1970-71 and 1971-72

(All Practices)

Workload Measure	1970-71		1971-72		Correlation Coefficient
	Mean	St. Dev.	Mean	St. Dev.	
Patients con./ 1000 pop. at risk	660	74	678	66	0.90
Episode rate per person at risk	1.80	0.41	1.87	0.41	0.92
Consultation per person at risk	3.17	0.74	3.28	0.73	0.93
In and Out patient referrals/1000 pop. at risk	111	42	111	49	0.87

Only one of the 4 correlation coefficients is below 0.9 and this is in the face of standard deviations which range from 10% to nearly 40% of the mean.

In table 19 are presented the rates at which the same 25 singlehanded practitioners perceived and recorded illness in 6 of the ICD chapters for two successive years. For infectious and communicable diseases the correlation coefficient is low which is as it ought to be for very good reasons. However, for the other 5 chapters the correlation coefficients are around 0.9 and for mental illness the least clearly defined an unbelievable 0.96. Once there is consistency from one year to another in the face of relatively large standard deviations for the individual practitioner's rates

Table 19

CHAPTER	70-71 MEAN (S.D.)	71-72 MEAN (S.D.)	r
1 Infective & Parasitic Dis.	127 (61)	135 (51)	.48
5 Mental Disorder	367 (180)	360 (189)	.96
6 Diseases of Nervous System	230 (59)	226 (61)	.84
7 Cardio-Vasc. Disease	294 (101)	288 (115)	.89
8 Respiratory Disease	642 (195)	613 (192)	.93
9 G.Urinary Disorders	173 (57)	168 (48)	.90
All Consultations	3458 (741)	3320 (792)	.94

- N.M.S.70-71 compared with 71-72
- Consultation rates x chapter
- Denominator - 1000 patients at risk
- Rates derived from 25 single-handed recorders

in any one year in the same chapter. There is no way that these 25 doctors perceive illness in the same way but they certainly go on seeing it the same way from one year to another. However peculiar is their perception, it is very personal and very rigidly followed for a long time.

I am spending some time showing you all these things because this is the nub I think of the whole business of what is happening in health care systems and why we have so many problems. I would now like to look at the way in which these rates vary between doctors on the one hand and compare these ranges with the equivalent ranges in rates between patients classified into conventional sub-groups. To do this we have taken the 5th and 95th percentile rates for doctors, somewhere near the bottom and the top for the rates

for the various measurements (tables 20 & 21).

Table 20

Mean 5th & 95th percentiles for selected rates (all ages) for all practices participating in the NMS II 1970-71 & 1971-72

	All practices		5th percentile		95th percentile		Ratios of 5th & 95th percentiles	
	70-71	71-72	70-71	71-72	70-71	71-72	70-71	71-72
Primary								
Patient consulting rate/1000 population	677.5	666.5	555.9	515.3	742.2	735.4	1.33	1.43
Episode rate per person at risk	1.85	1.86	1.30	1.18	2.37	2.53	1.82	2.14
Consultation rate per person at risk	3.16	3.24	1.96	1.90	4.51	4.27	2.30	2.25
Consultation rate per episode	1.72	1.72	1.39	1.50	2.10	2.12	1.51	1.41
Episodes per patient consulting	2.71	2.77	2.13	2.12	3.32	3.49	1.56	1.65
Standard Morbidity Ratio:								
Male	100	100	34	83	111	118	1.32	1.42
Female	100	100	85	82	110	112	1.28	1.37
Secondary								
Referrals as a % of all pts consltg								
All referrals	36.9	38.6	14.6	14.0	66.1	68.3	4.53	4.88
Inpatient	3.1	2.9	1.0	0.5	6.3	6.0	6.3	12.00
Outpatient	13.6	13.7	6.7	7.6	23.6	24.0	3.52	3.1

We can compare these rates for the doctors with the equivalent rates in patients where the patients are sub grouped by any of the conventional criteria such as age and social class. The results show that if anything there is more variation between the doctors' rates than there is between any of the characteristics that relate to the patient primarily.

Table 21

N. M. S. II - 1971 - 72

Comparison of doctor and patient dependent characteristics

Parameters	By practices 5th %	By practices 95th %	By age group Lowest	By age group Highest	By social status age group 15-64 Lowest	By social status age group 15-64 Highest
Pt.consulting rate/1000 population	515.3	735.4	614.4	674.4 (883.4)	591.6 m.I	777.0 f.III
Ep.rate per person at risk	1.18	2.53	1.45	1.90 (2.9°)	1.26 m.I	2.55 f.III
Con rate per person at risk	1.90 (1.90)*	4.27 (5.8)*	1.91	4.36	1.62 m.I	1.97 f.V
Ep.per patient consulting	2.12	3.49	2.3	3.0	(Not available)	
Inpatient & outpatient referrals/1000 pop.rat risk	54*	256* (365)	63.5	168.0	82.5 m.I	122.5 f III
Inpatient & outpatient referrals as % of all pts consulting	8.1	30.0	(Not available)		(Not available)	

° Children under 4

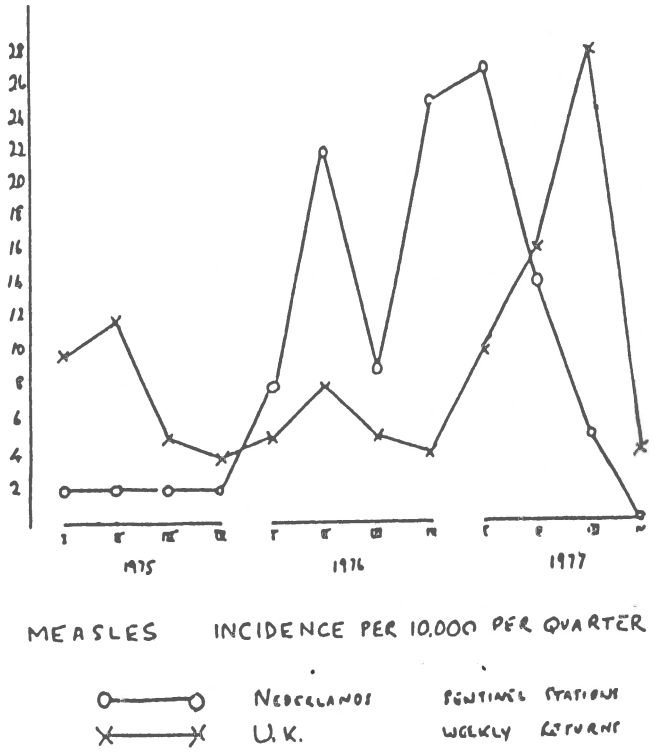
* Highest and Lowest

I have only shown the rates for age groups and social status but most other rates for patients show even smaller ranges than these in comparison with the rates for general practitioners.

Sampling problems : Obviously if you want to establish what is happening (a rate at which something is happening), you need a minimum number of events if you are going to have good confidence levels and some level of

statistical significance. We work on a minimum of 100 events. If we want to say anything very rigidly at the 5% level and with good confidence limits, we need 100 events in any tabulation cell. But of course we have got tabulation cells with less than 100 events in them but that is the ideal. The 100 events should represent the chances of 100 patients being represented in these events but in theory since we have variations among doctors as well, it should also represent the chances of 100 doctors being represented but there are few cells if any in the tabulations where 100 doctors are represented even in the Third National Morbidity Survey as we have set it up. It is the basic problem we have in our National Morbidity Survey run as we have been running it. This problem shows up here for example if we disaggregate data by the 13 regions. The range of these rates across the 13 regions are greater than the differences which we find between the urban and rural rates though no region is wholly urban or wholly rural. The reason is that the rates we are looking at here in the regions have nothing to do with the regional variation and influences as such, it is the doctors who happen to be in those regions who determine whether it has a high or low rate. Only one region has more than 4 doctors (4 practices). This is the big problem confronting us in any disaggregation of the data. We can disaggregate into 3 areas in Great Britain, North, Midlands and South. We can certainly go down to a 3 way split. There are enough doctors left as doctors in each of these three areas to be able to use the data across the board but we cannot use it for all the other things that the Department of Health would like to use it for. There are also some simpler epidemiological problems related to the use of the National Morbidity Survey data. In Fig.5 the quarterly returns for measles from the British and the Dutch Weekly Returns Systems for the same 3 year period are compared. For the whole of the 3 years the rate was exactly the same but no one year was it anything like the other because each had epidemics out of phase with the other. So a year's national British survey would have told us nothing about measles that matters in this epidemiological sense.

Figure 5



The ideal Morbidity Workload Survey : I want to finish off by describing briefly what I call the Ideal Morbidity Survey. Perhaps I can soften this a bit by saying what we wanted to do for the Third National Morbidity Survey comes very close to what I call the Ideal Morbidity Survey. What we have actually done in the Third National Morbidity Survey was what we called the 'hard core', that is a repeat of what was virtually the Second National Morbidity Survey. This 'hard core' is a survey of morbidity in the population of England and Wales as a whole. This 'hard core' was to be the first level of the ideal survey. The second level was to collect data about the general practitioners themselves and their range of variability in a wide range of practice activities. To look at general practitioners' performance in this way you do not have to collect everything about what they are doing for a year. In order to identify their place on a range of activities, you need very much smaller samples of the kind that we use in our practice activity analysis programme. Each is designed to collect just enough information to identify this personal perfomance in a variety of general practitioner activities: - referrals to hospital; range of his

consultation patterns; the range of his use of diagnostic and other services; and the range of his prescribing and so on.

We have a list of 15 separate activities that are relevant. We wanted a minimum of 100 events under each of these activity headings from a minimum of 100 general practitioners in each of the areas of disaggregation, the most important of these being the 13 regions. We would have gone to a representative sample of some 1300 general practitioners for this second level.The third level was the cross correlation study taking the General Household Survey approach to a representative sample of the patients in the 'hard core' practices. We would then correlate the information obtained from the General Household Survey type of interview with what doctors were recording from the consultations in the NMS study. We would then know once and for all what was going on and would not have needed much information to establish this.

For a variety of reasons of which money was the only one that was made explicitely, levels 2 and 3 were not carried out. We had to cancel 3 completely but we are carrying out 2 in a modified form as best as we can. This will be based on a PAA programme approach across as large a sample of general practitioners as we can reach. It cannot be truly representative a sample of general practitioners in that we cannot get hold of the doctors who do not want to record anything. However, we are going to get information about this group of doctors from a PAA type of approach which we are organising ourselves at the Birmingham Research Unit. It is not expensive. Without special arrangements we can get access to prescribing data from a much wider range of doctors and the information from that is probably going to help sort our whether doctors who are willing to record more than just their clinical records are different from those who just refuse to do so. I suspect they are not different. The recording doctors are so different amongst themselves that any differences between them as groups and with non-recording doctors are probably quite small. This is comparable to the finding that our NMS recording doctors have characteristics in their practice activity rates which seem to match very closely with those of doctors as a whole when compared with the General Household Survey.

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RECOMMENDATIONS FOR A DUTCH NATIONAL MORBIDITY SURVEY

by
J. van der Zee

RECOMMENDATIONS FOR A DUTCH NATIONAL MORBIDITY SURVEY

Introduction

If we should learn something from dr. Crombie's valuable and most interesting lecture, then it is that starting a Dutch version of the English National Morbidity Surveys without taking into account from the very beginning to study the sources of interdoctor-variability as a legitimate object of research, will only yield biased and one-sided results. The many examples dr. Crombie showed of doctors or groups of doctors being the most important determinant of variations in morbidity are just as many proofs of the thesis that morbidity surveys should be carried out simultaneously with a research programme to analyse causes and consequences of interdoctor-variability. This means two things : the first thing is that one shouldn't study just morbidity in general practice, but also interventions - the outcome of the doctor-patient interaction (prescriptions, referrals, doctor initiated contacts, diagnostic procedures, etcetera). It means secondly that one has to build in from the beginning of the project a health services research point of view. The major aim of this kind of research is to study how the health care system works by analysing the behaviour of consumers and providers of health care in a framework of financial and legal regulations. A good example of an analytical framework for studying the health care system is the framework proposed by the Canadian economist Robert Evans (Evans, 1981).

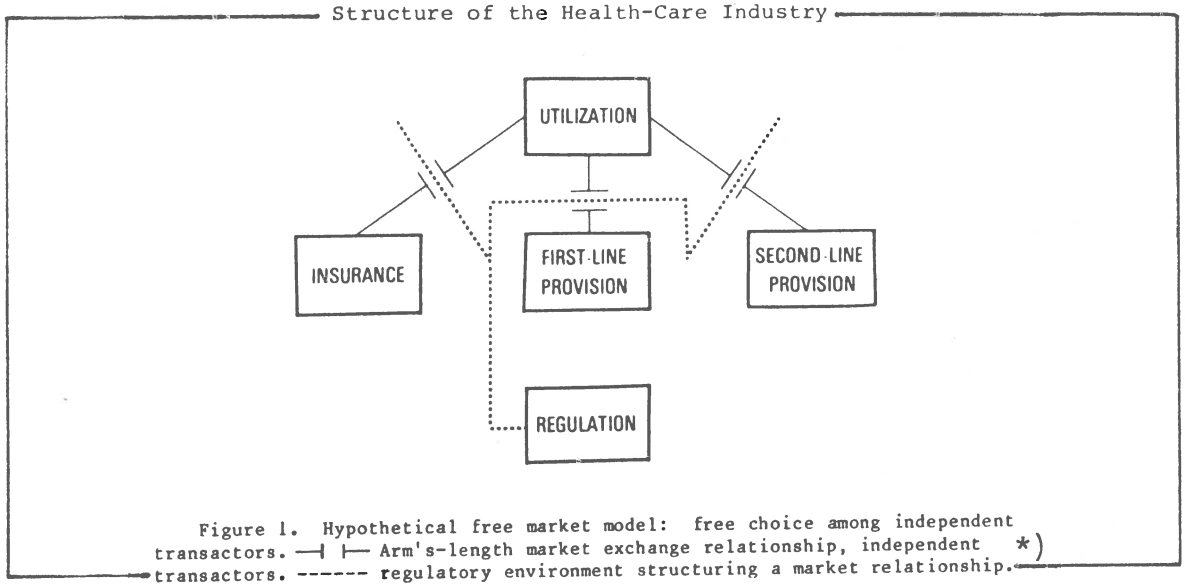

Figure 1. Hypothetical free market model: free choice among independent transactors. —| |— Arm's-length market exchange relationship, independent transactors. ------ regulatory environment structuring a market relationship. *)

*) Contributions to Economic Analysis,137,Health,Economics, and Health Economics, J.van der Gaag & M.Perlman,1981,Elsevier North Holland, Publ.cy.

Evans' main thesis is that utilization of health care is a function of the interaction between consumers on the one side and first-line and second-line providers on the other hand, under the conditions of a financial and legal system. Evans' analytical framework is a sound remedy against one sided approaches of the health care system. He doesn't state that providers of health care are the sole creators of demand, neither does he state that consumers are the most important source of utilization of health care. He points to the important role of financial and legal regulations. The insurance system and the way transactions between consumers and providers are paid for influence to a great extent the working of the health care system as a whole. First-line providers, directly accessible, are very important in each health care system because they determine partly the utilization of the services of second-line providers. If one analyses a particular health care system one always should determine first who are first-line providers and who provide health care in the second-line. The coverage of the insurance system and the way health care providers are paid (with a fixed salary, a capitation fee or a fee for each service) determine to a certain extent the nature of doctor-patient communication.
Interdoctor variability is an object of research in this field of study. One tries to establish structural characteristics of the practice location and organization (single handed practice, partnership or group practice, list-size, practice organization, distance to the nearest hospital, to mention a few examples of these characteristics) on the one hand, and for instance attitudes about acting as a professional in this field influence the utilization of health care on the other hand. The inclusion of structural characteristics is very important for those concerned with health care policy. Both the Dutch and the English governments lay emphasis upon primary health care as an important element in their health care policy. Nevertheless the costs of health care in both countries do not seem to be influenced to a great extent by the policy to strengthen primary care and to reduce secondary care, although the Dutch figures go up faster than the British ones, probably due to a much larger restriction of the secondary medical care in the National Health Service.

Health services research allows to establish which phenomena are :
- sensitive to minor policy measures (for instance reducing the list size

of general practitioners);
- sensitive to middle range policy measures (creating an out-of-pocket payment for prescriptions or exchanging social workers for especially trained psychologists as partners for the general practitioner in primary health care);
- sensitive to major policy measures (from capitation fee to fee for service as a way of remunerating the general practitioner);
- not sensitive at all for policy measures (as the use of advanced diagnostic techniques by physicians).

Health services research has proved to be a useful tool in preparing health care policy.

SPECIFIC RECOMMENDATIONS

The following six starting points should be considered as essential conditions for the success of a Dutch version of the English National Morbidity Survey.

1. *Periodic data collection.* There is no need for a continuous flow of information from general practice. The suffocating amount of data generated by the fee-for-service based second-line providers in the Dutch health care system proves that a continuous flow of information might have serious disadvantages. There is so much information that nobody knows how to handle it. If one chooses to collect information once every five or ten years (as is done in the English National Morbidity Surveys where information is collected at the same time as the national census takes place, i.e. once every ten years) one can use the intermediate years for the analysis of the information.
   If one lays aside one penny per patient per year there will be an amount of five million Dutch guilders (about one million pounds) available for data collection and analysis. With this almost neglectable small amount of money a fund can be created for collection of information from general practice where a capitation fee system prohibits spontaneously and routinely collected information.
2. *No interference with daily routines.* If one wants to know how the health care system really works, one shouldn't interfere with the daily routine of doctors and assistants. Forcing the participating practitioners to learn by heart a complicated or less complicated classification system

for morbidity, yields information about how the health care system should work if every practitioner knew a morbidity classification by heart. This might improve the quality of morbidity data, but on the other hand spoils the collected data for analysis in the field of health services research. Instructions should be minimal, only the most striking idiosyncrasies should be ruled out. This means that data should be coded preferably outside the doctor's office, either centrally in one place or by temporary additional staff.

3. *Sufficient variation on the supply-side.* Although a one percent sample of about fifty, sixty practices will contain information about 150.000 patients, the fact that the information about the patient is tied directly to the doctor and the behaviour of the doctor, will make disaggregation very difficult, although the number of patients would allow this without hesitation. Dr. Crombie has shown this by disaggregating his data for different regions and different types of urbanization. Per region there are generally only four or five doctors and their particular way of exerting their profession influences the results to a great extent. So one has to start with more doctors than a 1% sample and to take care that the subdivisions (regional, or type of practice) contain enough different practitioners. Cells in the table have to be filled sufficiently.
4. *More information on the demand side.* The social and cultural background of patients in the doctor's clinical notes usually is not very reliable. Age and sex of the patients are generally established quite well, but all other information should be checked. In the British National Morbidity Surveys a unique solution has been chosen to solve the problem of lacking information about the patient's social background. Census data and morbidity records are linked after the morbidity information has been collected. This daring solution of the problem will not be possible in the Netherlands. One reason is that there probably will be no more censuses in this country, but even if there were we don't think this sort of record linkage will be tolerated here. So one has to collect supplementary information by surveying the patient population and connect this information with the morbidity data in the doctor's file.
5. *Much attention to relation with other parts of the health care system.* Especially for a first-line provider of health care upon whose referrals a lot of different second-line providers are dependent, relations with

other parts of the health care system are very important. In a national morbidity and intervention survey attention should be paid to the relation with other providers of health care. Referrals to medical specialists, prescriptions of the services of paramedical providers like physiotherapists and also the input of clients from public health care are important topics of interest. Not only the input from the first-line provider to the other parts of the health care system, but also the output from for instance the discharged hospital patients back to the first-line provider should be studied carefully.

6. *A contractual base*

The provision of information should be based on a contract between the research institute and the participating practitioners. To ensure that not only highly motivated practitioners participate in the survey (and so biasing a representative view of the whole of Netherlands' practitioners), doctors should be paid for a provision of information. In the Dutch continuing Morbidity Registration called "Peilstations" (Sentinel Stations) all participating doctors get a certain fee for the information they provide. If one asks them to participate during a whole year and provide much more information, this fee should be accordingly higher, of course. In the contract should be recorded that afterwards the research institute may come back for additional information: questionnaires about specific parts of the general practitioner's profession; observation studies to explain the differences in behaviour of doctors and so on. This is one reason why the collection of data shouldn't be continuously but once every five or ten years, in the meantime additional information can be gathered with a very specific analytic goal.

Discussion

If a Dutch national morbidity and intervention survey will be based on these principles the results can be used not only for the development of family medicine, but also for broadening the insight in the way the health care system works. This leaves one question: does one need a national morbidity survey if one wants to study the operation of the health care system? The answer is : yes and no. Of course a health care system can be studied in many different ways: conducting a national (nationwide) morbidity and intervention survey is only one of the means. The reasoning is in fact the other way around.

If one spends so much money for collecting morbidity data from primary health care, then the collected information could be of considerably more value when, from the beginning, a health-services-research point of view has been implemented in the approach. So if a national morbidity survey has to be carried out, then a health services research point of view has to be adopted to take care that the money invested will be well spend.

DISCUSSION

DISCUSSION

After the two lectures an animated debate took place, containing several topics touched by Crombie and Van der Zee. The following topics were discussed:

1. Why remunerating doctors and carrying out an extensive survey when all the necessary data are available in the doctors' clinical notes?
2. Can a health services research point of view be combined with the epidemiological demands for proper morbidity data?
3. Is the existence of a considerable group of private patients in the Dutch health care system an impediment for the success of a Dutch national morbidity survey?
4. How are privacy problems solved in the English National Morbidity Surveys?
5. What is the use of all those extra data? Haven't we got enough data for policy measures?

Ad 1. **The quality of the doctors' own clinical notes**

If all general practitioners had the same methodical and systematical way of recording the complaints and morbidity of their patients, and if all doctors used the same principles in deciding what sort of diagnosis they they should assign to each episode of morbidity, then purposeful collection of morbidity and intervention data would not be necessary, but everybody knows that the doctors' clinical notes (or as they call it in Holland: the doctors' green card) form a collection of private **aide de memoires** and have no systematic contents.

Sometimes complaints are recorded, sometimes a diagnosis, sometimes the result of diagnostic tests and sometimes only the prescribed medicine. A lack of uniformity and system in these clinical notes, makes them unfit for the production of comparable data.

So, extra effort has to take place to produce comparable statistics for research and policy.

Ad 2. Purpose of a morbidity survey: health services research or epidemiology.

Here indeed is a serious problem. In health services research one should interfere as little as possible in the natural course of events. For epidemiological reasons definitions and inclusion or exclusion criteria are necessary instruments to evaluate the diagnostic quality of the data. There is one problem however: if a large scale survey is carried out no possibility exists of controlling the way definitions and criteria are applied by the participating practices. If a set of criteria is established for each diagnosis, one will see that most of the cases do not fit exactly in the established criteria. So all kinds of exceptions have to be made. The data collected in this way will create much more confusion than in cases where doctors are given more freedom to use diagnostic terms freely.

Only if a very small group regularly meets about criteria and definitions perhaps some uniformity can be maintained, although in this case too, doctors will differ in applying diagnostic labels to patients' complaints. The problem can be mitigated (not solved) by some measures: First coding instructions can be given. One of the first things that has to be told is that each diagnosis has to be as specific as possible. Secondly a diagnosis has to be preferred to complaints or symptoms. This can be promoted by recording episodes of illness and not just doctor-patient contacts. In the course of an episode a more specific diagnostic label can be attached and a probability diagnosis can be corroborated or can be confirmed. It's an illusion that a morbidity survey can be carried out on a scale like done in England and Wales, and proposed in the Netherlands, following the strict rules of epidemiology. Even in small groups doctors' opinions differ about validity of diagnoses,and the problem of all kind of illnesses meeting only part of the inclusion criteria is already metioned. So, for the English morbidity survey goes that no better methods exist and the usefulness of strict epidemiological rules are exaggerated. But clear instructions for the participating practices can help in improving the quality of the collected data.

Ad 3. Private patients

In a Dutch national morbidity survey the existence of a considerable group

of private patients could give some problems in establishing a valid denominator for the recorded morbidity and intervention figures. In the English National Health Service the existence of age/sex registers for the complete practice population, gives clear denominators but these registers are not as perfect as they seem. In areas where patients migrate from one part of the town or one town to another, the reliability of the age/sex registers is questioned. Patients have to direct themselves to their new general practitioner when they more to another house, but they usually do it when they need a doctor and until that time they are on the list of their former GP.
So, even in the National Health Service creating reliable denominators is less easy than it seems.
The existence of a group of private patients only makes it necessary to screen the practice before the survey starts, and that might be a better method than relying on administrative age/sex registers.

Ad 4. Privacy problems

When the National Morbidity Surveys were started about 20 years ago, the public debate about privacy was not as loud as it is nowadays. So at that time, the creation of a code-number (the Hogben-numbers consisting of the first three letters of the family name and the first letter of the first name, followed by 6 digits of the date of birth and one digit for sex) was considered to protect a person's privacy in a sufficient way. The Hogben numbers only were used to find the census file for the same persons. For both files (the morbidity file and the census file) Hogben numbers were created, and in a restricted area where the practice was located, both numbers were compared until they matched. In this way in 1971, 80% of the patients could be matched and with improved methods it is possible that for 1981 the match will be 90%.
Each time a new morbidity survey is about to be carried out however, questions are posed about the possible dangers for a person's privacy that are caused by linking census and morbidity files. Until now those who questioned our safety measures could be convinced by the arguments the Research Unit of the Royal College of General Practitioners and OPCS (the Office of Population Censuses and Surveys) produced. As the privacy debate goes on and people get even more sensitive than they used to be on this subject,

we don't know if other methods will have to be applied for a next survey, that will take place in the nineties.

Ad 5. Use of data collection

It is true indeed that usually there is no lack of information in the health care sector. Modern informatics produce rather an overflow of information than a proper amount of data suitable for scientific research and policy making, but in the English National Health Service few statistics are produced routinely or centrally.

Unlike the Netherlands, no institutes like the National Hospital Institute exist, where statistics about hospital beds and number of consultants are produced for the country as a whole and for different regions. In primary health care the capitation fee system prohibits the production of routinely collected information. The same goes for the Netherlands. There, much (and perhaps too much) is known about medical specialists and hospitals, but the only thing that can be collected from general practitioners is the number of referral cards for their publicly insured patients.

As we see how much research in the Netherlands is focussed upon the analysis of these referral rates, one can estimate the need for better and broader data than is collected now. The important question about substitution of the prescription of drugs, physiotherapy and referral to in- or out-patient clinic or hospital, can only be answered if one knows more than the usual referral rate. Nevertheless the question remains whether one needs a morbidity survey for an analysis of the health care system. The Research Unit of the Royal College of General Practitioners has developed so-called practice activity sheets, by means of which analysis can be carried out in a practice on various specific topics like referrals, prescriptions, diagnostic activities, etcetera. Recording these practice activity analyses is much easier than recording all morbidity, but if one really wants to know whether referred patients are comparable in their level of morbidity, additional information about morbidity has to be collected.

If one doesn't know how baseline data are distributed among patients and practices, specific analyses limiting theirselves to specific indicators can only be used for very limited purposes. But it is true that one has to weigh whether these extra efforts are worth the trouble.

APPENDICES I, II, III

These Appendices relate to the I.C.D. proposals for a new Impairment Disability Handicap code (ICIDH(13) - code) to supplement I.C.D.-9 as the Classification of Disease.

These include a note about a possible alternative or complement to ICIDH(13) for use in general practice, a code of relative dependency.

APPENDIX 1

List of two-digit categories of Impairment

(reproduced from the ICIDH (13))

LIST OF TWO-DIGIT CATEGORIES OF IMPAIRMENT

1 INTELLECTUAL IMPAIRMENTS

Impairments of intelligence (10-14)

10 Profound mental retardation
11 Severe mental retardation
12 Moderate mental retardation
13 Other mental retardation
14 Other impairment of intelligence

Impairments of memory (15-16)

15 Amnesia
16 Other impairment of memory

Impairments of thinking (17-18)

17 Impairment of flow and form of thought processes
18 Impairment of thought content

Other intellectual impairments (19)

19 Other intellectual impairment

2 OTHER PSYCHOLOGICAL IMPAIRMENTS

Impairments of consciousness and wakefulness (20-22)

20 Impairment of clarity of consciousness and of the quality of conscious experience
21 Intermittent impairment of consciousness
22 Other impairment of consciousness and wakefulness

Impairments of perception and attention (23-24)

23 Impairment of perception
24 Impairment of attention

	Impairments of emotive and volitional functions (25-28)
25	Impairment of drives
26	Impairment of emotion, affect, and mood
27	Impairment of volition
28	Impairment of psychomotor functions
	Behaviour pattern impairments (29)
29	Impairment of behaviour pattern
3	**LANGUAGE IMPAIRMENTS**
	Impairments of language functions (30-34)
30	Severe impairment of communication
31	Impairment of language comprehension and use
32	Impairment of extralinguistic and sublinguistic functions
33	Impairment of other linguistic functions
34	Other impairment of learning
	Impairments of speech (35-39)
35	Impairment of voice production
36	Other impairment of voice function
37	Impairment of speech form
38	Impairment of speech content
39	Other impairment of speech
4	**AURAL IMPAIRMENTS**
	Impairments of auditory sensitivity (40-45)
40	Total or profound impairment of development of hearing
41	Profound bilateral hearing loss
42	Profound hearing impairment in one ear with moderately severe impairment of the other ear
43	Moderately severe bilateral hearing impairment
44	Profound hearing impairment in one ear with moderate or lesser impairment of the other ear
45	Other impairment of auditory sensitivity

	Other auditory and aural impairments (46-49)
46	Impairment of speech discrimination
47	Other impairment of auditory function
48	Impairment of vestibular and balance function
49	Other impairment of aural function
5	**OCULAR IMPAIRMENTS**
	Impairments of visual acuity (50-55)
50	Absence of eye
51	Profound visual impairment of both eyes
52	Profound visual impairment of one eye with low vision in the other eye
53	Moderate visual impairment of both eyes
54	Profound visual impairment of one eye
55	Other impairment of visual acuity
	Other visual and ocular impairments (56-58)
56	Visual field impairment
57	Other visual impairment
58	Other ocular impairment
6	**VISCERAL IMPAIRMENTS**
	Impairments of internal organs (60-66)
60	Mechanical and motor impairment of internal organs
61	Impairment of cardiorespiratory function
62	Impairment of gastrointestinal function
63	Impairment of urinary function
64	Impairment of reproductive function
65	Deficiency of internal organs
66	Other impairment of internal organs

Impairments of other special functions (67-69)

67 Impairment of sexual organs
68 Impairment of mastication and swallowing
69 Impairment related to olfaction and other special functions

7 SKELETAL IMPAIRMENTS

Impairments of head and trunk regions (70)

70 Impairment of head and trunk regions

Mechanical and motor impairments of limbs (71-74)

71 Mechanical impairment of limb
72 Spastic paralysis of more than one limb
73 Other paralysis of limb
74 Other motor impairment of limb

Deficiencies of limbs (75-79)

75 Transverse deficiency of proximal parts of limb
76 Transverse deficiency of distal parts of limb
77 Longitudinal deficiency of proximal parts of upper limb
78 Longitudinal deficiency of proximal parts of lower limb
79 Longitudinal deficiency of distal parts of limb

8 DISFIGURING IMPAIRMENTS

Disfigurements of head and trunk regions (80-83)

80 Deficiency in head region
81 Structural deformity in head and trunk regions
82 Other disfigurement of head
83 Other disfigurement of trunk

Disfigurements of limbs (84-87)

84 Failure of differentiation of parts
85 Other congenital malformation
86 Other structural disfigurement
87 Other disfigurement

Other disfiguring impairments (88-89)

88 Abnormal orifice
89 Other disfiguring impairment

9 GENERALIZED, SENSORY, AND OTHER IMPAIRMENTS

Generalized impairments (90-94)

90 Multiple impairment
91 Severe impairment of continence
92 Undue susceptibility to trauma
93 Metabolic impairment
94 Other generalized impairment

Sensory impairments (95-98)

95 Sensory impairment of head
96 Sensory impairment of trunk
97 Sensory impairment of upper limb
98 Other sensory impairment

Other impairments (99)

99 Other impairment

APPENDIX II

List of two-digit categories of Disability

(reproduced from the ICIDH (13))

		Possible short list for General Practice :
	LIST OF TWO-DIGIT CATEGORIES OF DISABILITY	
1	BEHAVIOUR DISABILITIES	Behaviour disabilities
	Awareness disabilities (10-16)	Awareness disabilities (10-15)
10	Self-awareness disability	
11	Disability relating to location in time and space	Identification disabilities (10-12)
12	Other identification disability	
13	Personal safety disability	Personal safety disability(13)
14	Disability relating to situational behaviour	Knowledge acquisition and
15	Knowledge acquisition disability	other educational disability
16	Other educational disability	(14-16)
	Disabilities in relations (17-19)	Disabilities in relation(17-19)
17	Family role disability	
18	Occupational role disability	
19	Other behaviour disability	
2	COMMUNICATION DISABILITIES	Communication disabilities
	Speaking disabilities (20-22)	Speaking disabilities(20-22)
20	Disability in understanding speech	
21	Disability in talking	
22	Other speaking disability	
	Listening disabilities (23-24)	Listening disabilities(24-34)
23	Disability in listening to speech	
24	Other listening disability	
	Seeing disabilities (25-27)	Seeing disabilities(25-27)
25	Disability in gross visual tasks	
26	Disability in detailed visual tasks	
27	Other disability in seeing and related activities	

	Other communication disabilities (28-29)	Other communication disabilities (28-29)
28	Disability in writing	
29	Other communication disability	
3	**PERSONAL CARE DISABILITIES**	Personal care disabilities
	Excretion disabilities (30-32)	Excretion disabilities (30-32)
30	Controlled excretory difficulty	
31	Uncontrolled excretory difficulty	a) Uncontrolled urinary excretory difficulty
32	Other excretion disability	b) Uncontrolled faecal excretory difficulty
	Personal hygiene disabilities (33-34)	Personal hygiene disabilities (33-34)
33	Bathing disability	
34	Other personal hygiene disability	
	Dressing disabilities (35-36)	
35	Clothing disability	
36	Other dressing disability	
	Feeding and other personal care disabilities (37-39)	Feeding & other personal care disabilities (37-39)
37	Disability in preliminaries to feeding	
38	Other feeding disability	
39	Other personal care disability	
4	**LOCOMOTOR DISABILITIES**	Locomotor disabilities
	Ambulation disabilities (40-45)	Ambulation disabilities (40-45)
40	Walking disability	
41	Traversing disability	
42	Climbing stairs disability	
43	Other climbing disability	
44	Running disability	
45	Other ambulation disability	

	Confining disabilities (46-47)	Confining disabilities (46-47)
46	Transfer disability	
47	Transport disability	
	Other locomotor disabilities (48-49)	Other locomotor disabilities (48-49)
48	Lifting disability	
49	Other locomotor disability	
5	**BODY DISPOSITION DISABILITIES**	Body disposition disabilities
	Domestic disability (50-51)	Domestic disability (50-51)
50	Subsistence disability	
51	Household disability	
	Body movement disabilities (52-27)	Body movement disabilities (52-57)
52	Retrieval disability	
53	Reaching disability	
54	Other disability in arm function	
55	Kneeling disability	
56	Crouching disability	
57	Other body movement disability	
	Other body disposition disabilities (58-59)	Other body disposition disabilities (58-59)
58	Postural disability	
59	Other body disposition disability	
6	**DEXTERITY DISABILITIES**	Dexterity disabilities
	Daily activity disabilities (60-61)	Daily activity disabilities(60-61)
60	Environmental modulation disability	
61	Other daily activity disability	
	Manual activity disabilities (62-66)	Manual activity disabilities (62-66)
62	Fingering disability	
63	Gripping disability	
64	Holding disability	
65	Handedness disability	
66	Other manual activity disability	

	Other dexterity disabilities (67-69)	Other dexterity disabilities (67-69)
67	Foot control disability	
68	Other body control disability	
69	Other dexterity disability	
7	SITUATIONAL DISABILITIES	Situational disabilities
	Dependence and endurance disabilities (70-71)	Dependence & endurance disabilities (70-71)
70	Circumstantial dependence	
71	Disability in endurance	
	Environmental disabilities (72-77)	Environmental disabilities (72-77)
72	Disability relating to temperature tolerance	
73	Disability relating to tolerance of other climatic features	
74	Disability relating to tolerance of noise	
75	Disability relating to tolerance of illumination	
76	Disability relating to tolerance of work stresses	
77	Disability relating to tolerance of other environmental factors	
	Other situational disabilities (78)	Other situational disabilities (78)
78	Other situational disability	
8	PARTICULAR SKILL DISABILITIES	Particular skill disabilities
9	OTHER ACTIVITY RESTRICTIONS	Other activity restrictions

TOTAL 27 CATEGORIES

APPENDIX III

Handicap and Dependency Classification

"Handicap" and "Dependency" Classification.

The ICIDH(13) uses the concept of "handicap" for the third dimension of its supplementaty classification system. The table (fig. 3.5) is the summarised version of the "handicap" code. In the notes which accompany the ICIDH(13), it is made clear that "handicap" (though resulting from impairments and disabilities) will always be relative to the ad hoc demands of the environmental context.

An alternative for general practices is a simple classification of relative "dependency" rather than "handicap". Levels of dependency within social and economic resources available to the patient :

1. Total independence
2. Requires assistance for errands(shopping,banking,pensions etc.)
3. Requires assistance with housework (cooking,cleaning etc.)
4. Requires assistance with personal hygiene and/or dressings and treatment
5. Confined to bed (continent)
6. Confined to bed (incontinent) and
7. Twenty four hour care and supervision.

The ICDH(13) is still in a state of development and is not finalised, though the disability classification is obviously much more clearly thought out and much nearer to some sort of final state than the handicap classification. There is of course no need for any of these additional ICIDH sections to be included at all in the general purpose College Classification, but it would seem that at the minimum there is an opportunity to bring these classifications with their benefits and problems to the notice of general practitioners at this time.

Figure 3.5 Dimensions of the H Code (International Classification of Handicaps)

1	orientation handicap (Or)	fully oriented - fully compensated impediment to Or - intermittent disturbance of Or - partially compensated impediment to Or - moderate impediment to Or - severe impediment - orientation deprivation - disorientation - unconscious
2	physical independence handicap (P)	fully independent - aided independence - adapted independence - situational dependence - long-interval dependence - short-interval dependence - critical interval dependence - special-care dependence - intensive-care dependence
3	mobility handicap (M)	fully mobile - variable restriction of M - impaired M - reduced M - neighbourhood restriction - dwelling restriction - room restriction - chair restriction - total restriction of M
4	occupation handicap (O)	customarily occupied - intermittently unoccupied - curtailed O - adjusted O - reduced O - confined O - no O - unoccupiable
5	social integration handicap (S)	socially integrated - inhibited participation - restricted participation - diminished participation - impoverished relationships - reduced relationships - disturbed relationships - alienated - socially isolated
6	economic self-sufficiency handicap (E)	wealthy - comfortably off - fully self-sufficient - adjusted self-sufficiency - precariously self-sufficient - economically deprived - impoverished - destitute - economically inactive
7	other handicaps (D)	not subject to (other) disadvantage - minor disadvantage - nonspecific disadvantage - specific disadvantage

A NEW CLASSIFICATION OF DISEASE

Number and rates/1000 population of patients consulting for additional categories

(Extracted from N.M.S.II - 1971-1972)

ICD Code	No.	Rate		ICD Code	No.	Rate
036	14	0.0		281 .0	154	0.8
047	14	0.1		Rdr.181	29	0.2
053 .1	N/A			286 .9	2	0.0
054 .1	N/A			289 .0	4	0.0
078 .0	9	0.0		300 .1	N/A	
111 .0	20	0.1		306 .1	193	1.1
112 .0	N/A			323	7	0.0
135	17	0.1		333	8	0.0
136	N/A			350	146	0.8
137,138	N/A			351	50	0.3
140-149	24	0.1		354 .0	N/A	
150	14	0.1		355 .6	N/A	
151	53	0.3		357	N/A	
153	63	0.3		361	23	0.1
154	61	0.3		362	N/A	
157	13	0.1		362 .1	13	0.1
159	1	0.1		368(excd 368.5)	52	0.3
161	11	0.1		368 .5	5	0.0
162	138	0.8		374 .0	N/A	
170	3	0.0		374 .1	N/A	
180	41	0.4 F		379 .0	N/A	
182	18	0.2 F		379 .2	N/A	
183	14	0.1 F		379 .5	N/A	
184	8	0.1 F		388 .3	N/A	
185	63	0.7 M		415 .0	N/A	
186	4	0.0 M		415 .1	29	0.2
188	32	0.2		420	N/A	
189	10	0.1		426.2-427.2	49	0.3
191	19	0.1		401-405	58	0.3
233 .1	3	0.0 F		402	152	0.8
2.5	15	0.1		403	10	0.1
251 .2	N/A			404	10	0.1
255 .4	7	0.0		430	38	0.2
271 .4	N/A			441	33	0.2

cont'd 2

ICD Code	No.	Rate
443.0	75	0.4
443.1	5	0.0
443.9(pt)	N/A	
440.0-444.2	2	0.0
446	23	0.1
448.1	N/A	
455.4, 455.9, Rt of 455	1552	8.5
456.0-456.2	N/A	
456.4	150	0.2
457.0	N/A	
470	25	0.1
471	84	0.5
502,503,505	52	0.3
512	33	0.2
520.7	198	1.1
521.0	134	0.7
522.5	424	2.3
523.0,523.1	170	0.9
524.6,Rmr 520-526	N/A	
527.5	29	0.2
528.0	156	0.9
529.0	79	0.4
Rmr.527-529	990	5.5
555	26	0.1
556	133	0.7
569.6	N/A	
573.1-573.3	11	0.1
574.0-1-3-4	198	1.1
575.0,575.1	N/A	
577.0	21	0.1
585-586	133	0.7
599.3	N/A	
608.2	21	0.2 M
616.2,616.3	N/A	
617	18	0.2 F
620.1-620.2	24	0,3 F
621.0	N/A	
621.6,621.7	19	0.2 F
623.5	1964	20,8 F
643	N/A	
651	N/A	
652	38	0.4 F
653,654	14	0.1 F
660-662	36	0.4 F
670	8	0.1 F
671	8	0.1 F
675	133	1.4 F
676.1	N/A	
676.2	N/A	
676.4	N/A	
676.5	N/A	
680	2014	11.1
685	128	0.7
692.7	N/A	
695.1	26	0.1
695.2	17	0.1
695.3	81	0.4
695.4	10	0.1
697	35	0.2
701.3	13	0.1
701.4	17	0.1
705.1	38	0.2
705.8	109	0.6
709.0 pt	N/A	
725	N/A	
726.3	N/A	
726.7	N/A	
728.6	N/A	
729.5 Pt	N/A	
729.8 Pt	N/A	
727.0	N/A	
727.1	39	0.2
731.0	42	0.2
734,754.6	191	1.1
735.0-735.2	168	0.9
736.1	N/A	
736.4	N/A	
718.3	N/A	

cont'd....3

ICD Code	No.	Rate	ICD Code	No.	Rate
733.1	N/A				
740	Nil	Nil			
741	15	0.1			
744.2 Pt	N/A				
749	4	0.0			
750.5	4	0.0			
751.0	N/A				
754.3-5-6 -7 Pt	18	0.1			
757.3,757,6	19	0.1			
764,765	9	0.0			
766	N/A				
767	Nil	Nil			
768-770	Nil	Nil			
771.4	N/A				
772	1032	5.7			
773-774	4	0.0			
779.3	N/A				
781.2,781.3	48	0.3			
784.4	77	0.4			
787.6	16	0.1			
789.5	20	0.1			
782.4	54	0.3			
800-804	107	0.6			
830	11	0.1			
831	27	0.1			
860-869	26	0.1			
994.6	24	0.1			
V03.6	N/A				

CONSULTATION AND EPISODE CODING

Consultation or episode coding is essential for separating data about the incidence of illness from prevalence. These proposals contain a set of definitions which can be used for a unified approach to coding whether based on recording systems which utilise episode recording as the baseline or separate consultation recording. There are six basic coding categories, organised hierarchically for recording systems with different degrees of recording detail.

Code C = An episode (chronic, recurrent or acute) or the first consultation for such an episode for which a patient was already under the care of a registered general practitioner at the time the recording period started. (excludes temporary resident treatment). = Episode Type (1) in previous system.

Code N = A NEW episode for the first consultation for a new episode which began since the recording period commenced. = Episode Type (2) in previous system.

Code R = An episode or the first consultation for an episode which began during the period of recording for a RECURRENT condition which has been previously diagnosed either during or prior to the commencement of the recording period.= Episode Type (3) in previous system.

Code D = All other consultations in any episode of illness other than the first consultation recorded for that episode during the recording period.

Code X = Data entry for indexing an EXTRA item of information subsidiary but contemporaneous with the main reasons for consultation.
e.g. entry relevant to patient's blindness (registered as partially sighted) in addition to the primary cause such as cataracts.

Code T = Data of entry of TIME SPECIFIC information indexed for purposes not related to consultation but linked to the date of entry.
e.g. information from hospital stating the patient had acute appendicitis in circumstances where recorder was never consulted by the patient at the time.

Code H = Data entry of HISTORIAL INFORMATION indexed for purposes not related to consultation or date of entry.
e.g. thyrotoxicosis as part of a patient's medical history.

The sum of the Ns provides the new incidence rate for first episodes of illness involving the general practitioner.

The sum of C+N+R+T provides the total episode or prevalence rates(delete T if interested only in those for which the GP consulted).
The sum of C+N+R+D provides total consultation data

RULES FOR CODING

Rubrics of a Diagnostic Index have differing values. Some are preferred to others and in some circumstances it is difficult to decide whether to make multiple or single entries. These guidelines are set out to clarify ambiguous situations.

1. Always code to the most specific rubric available at the time. E.g. : Duodenal Ulcer is more specific than Peptic Ulcer unspecified.

2. Codes specifying symptoms "rather than diagnoses" should only be used where no diagnosis is available. E.g. Haemoptysis should not be used if the condition can be specified more precisely as Pulmonary Embolism.

3. Multiple diagnoses or problems which are for practical purposes independent of each other should all be specified where they relate to the reason for consultation as perceived by the recording doctor when evaluating the patient's problems. E.g. Patients with O.A. hip and hypertension - these are both coded provided both conditions are considered at the consultation. (a patient with O.A. hip and strangulated hernia by contrast is likely only to be coded to strangulated hernia because the problem relating to the hip would no doubt be ignored at this particular consultation).

4. Multiple diagnoses or problems which may be related to each other though not attributable to a common etiological process should be coded to all relevant codes if seen to be relevant by the evaluating doctor. E.g. Patient with O,A. hip and depression is coded to both conditions if either both conditions are considered or the evaluating doctor considers either:
   a) the patient is depressed because of the O.A. or;
   b) the complaint of O.A. is significantly influenced by the depressed state.

   Depression should not be coded where it refers specifically to the natural temporary reaction to life's misfortunes, the term being used in a

lay rather than a medical sense.

5. Multiple problems presented which stem from one etiological source (including specific complications of a primary disorder) are coded to the appropriate 'etiological' rubric wherever possible. Additional coding is undertaken where specified in the classification.

   e.g. Heart failure due to hypertensive disease is coded to hypertension with end organ damage (enter the number) and coded to heart failure ( ) in accordance with instructions to specify damage.

6. Complications of an established problem which themselves generate a consultation are coded specifically. The primary condition is not included as well unless it has nog been previously enetered as a diagnosis.

   e.g. 1. Epileptic fit in a known epileptic;
   2. Coma in a diabetic;
   3. Diabetic Retinopathy.

   Once the emergency situation has passed, recording is continued using the code of the primary condition - Epilepsy and Diabetes respectively in these examples. Further consultations concerned with a specific complication are coded specifically. Exceptions to this rule are specified in the Classification.

7. Although serving a number of related purposes, the Classification is primarily concerned with diseases. It is thus desirable that wherever possible consultations should be assigned 'disease codes' except where there is no disease.

   e.g. Immunisation and screening procedures are situations in which no disease exists.

   In some cases a variety of codes relating to the patient's problem(s) may be used but care should be taken to specify only those problems and diseases which are relevant to the consultation.

8. In some areas management information is more important than morbidity data. In these cases (e.g. pregnancy) the classification permits entries which detail management rather than morbidity, although the opportunity to code morbidity data independently is retained.

A NEW CLASSIFICATION OF DISEASE

The Research Executive is considering whether it will recommend the general use of a new classification of disease to replace the present College Clas-

sification and if so will it be ICHPPC-2, the Classification prepared for the Third National Morbidity Survey or some other Classification.

Background

Patients have *problems* which they present as *complaints*. These problems have *organic* and *psyche emotional morbidity, disabilities* resulting from this morbidity and *abnormal socio-economic conditions* as possible components of these problems.

Special classifications of illness were developed for primary care in the late 1950s because the then current International Classification of Diseases was oriented to causes of death and serious illness. Difficulty still exists because presently used problem classifications for primary care include elements of patient complaint, problem management and outcome as well as the classification of the morbid processes if any underlying the problem. Rational multi-dimensional classification systems for this sybthesis are proposed but any agreement is not imminent. For the time being a compromise general purpose classification has to fulfil the following conditions:

1. Be logically compatable with the current International Classification of disease;
2. Be logically compatable with any classification systems previously in general use;
3. Be as compatable as possible with any widely used current alternatives and in particular ICHPPC-2;
4. Have as few changes as possible in any code numbers used for the same rubric in previous classifications.

Logical compatability implies a one-to-one correspondence. Ideally for every rubric in one classification, there should be a corresponding rubric in the other. The included and excluded components for this rubric should be the same in each classification. In other words the only differences should be in the ordering of the rubrics and/or their numbering systems.

Provided this degree of logical compatability is achieved, cross referencing from one numbering system to another poses minor problems in manual and automated systems.

A satisfactory second level of logical compatability is achieved when rubrics in one classification system not matched exactly in the other will still correspond exactly with two or more rubrics added together in the other classification or be included in some larger category in the other classification system without any overlapping with other rubrics.

The need for 'short' lists is dictated by :

1. The maximum number of separate recording sheets that can be comfortably held and/or manipulated in manual systems (approximately 500 $\pm$). This restriction does not apply to automated systems.
2. The need to minimise the number of alternative code numbers that have to be memorised. This last restriction is often over emphasised because there will be the same basic list of serious/significant and commonly occurring problems whatever the list of total rubrics. All the others have to be looked up whenever they occur.
3. A need to restrict coding to a three digit system (999) if possible to minimise input effort. This restriction can be over emphasised also.

Diagnostic Classification for the Third National Morbidity Survey

Modifications to the RCGP Classification used in the Second National Morbidity Survey were necessary because of :

1. Defects of omission with important rubrics lost in residual or group categories;
2. The need to maintain logical compatability with the new Nineth International Classification of Disease and ICHPPC-2.

The new Classification for the Third NMS achieved these ends with certain compromises in :

1. Order of rubrics;
2. Allocation of rubrics to different main groupings of diseases;
3. Variations in actual position number codes used.

The Third National Morbidity Survey Classification follows the order of the Nineth revision of the International Classification and this differs in places from the ordering in ICHPPC-2.

Wherever possible the same definitions of inclusion and exclusion categories for the equivalent rubrics from ICHPPC-2 were used.

The ICHPPC-2 numbering system would still have been used if sufficient gaps in position numbers had been left between main categories and between specific rubrics in any main category and the final residual category.

Any residual logical imcompatabilities with ICHPPC-2 arise only because of inherent logical imcompatabilities of ICHPPC-2 with ICD-9.

Notwithstanding these discrepancies, the priority of logical compatability with ICD-9 has been achieved for over 99% of 5.000 rubrics or descriptive problem terms in common use.

Finally specificity of reference for most of the individual rarer but serious significant categories otherwise lost in grouped or residual categories of ICHPPC-2 and the basic NMS III Classification has been achieved by the asterisked system. For any diagnosis allocated to an asterisked category, the full 4 digit ICD number must be used. On the whole most asterisked categories will be used infrequently. These asterisked categories can of course be used selectively.

General Purpose RCGP Code

The NMS III Classification while fulfilling the more limited requirements of a classification for a national morbidity survey is still possibly inadequate for more general use in primary care where the focus is the wider context of patients' problems. A 'compromise' general purpose problem oriented classification should logically be arranged in sections where each section covers a separately exclusive dimension of problem content. These logical exclusive dimensions are as follows :

1. Patient complaints;
2. Organic and psyche-emotional components of the patient's problem (approx. equivalent to the ICD);
3. Socio-economic components of the patient's problem;
4. Any resultant or accompanying patient disability;

5. Any resultant or accompanying dependency and;
6. 'Process' of 'action' codes to describe the physician's response to the patient's problems.

Patient complaints and process or action codes

These dimensions while important are sufficiently separate and self contained to warrant entirely distinct classification systems. They are not considered further here.

Remaining components of compromise classification

We are left with the organic and psyche-emotional dimension, the socio-economic dimension and the dimensions of accompanying disability and dependency. Strictly speaking the organic and the psyche-emotional elements form separate exclusive dimensions. Conventionally they have been arranged within a unidimensional system as enshrined in the successive International Classifications of Disease. Where a patient's problem has organic and psychiatric components, these should be recorded separately. This convention has been extended in the more recent RCGP and ICHPPC Classifications to include subsidiary administrative and socio-economic sections. It is proposed here that this arbitrary convention be extended to include 'disability' and 'dependency' sections.

This compromise has had one unfortunate practical result. Where problems have several components physicians tend to record the most important single components physicians tend to record the most important single component usually the organic to the exclusion of the others. Paradoxically by adding yet other dimensions for disability and dependency, this bias may be eliminated.

The disability code has been adapted from ICIDH(13) (International Classification of Impairments, Disabilities and Handicaps). The ICIDH(13) distinguishes between impairments, disabilities and handicaps but the crucial component is the classification of disability; impairments are already largely implicit in the basic organic and psyche-emotional dimensions of the problem classification.

Disability component

The suggested structure of the disability component of the RCGP 'compromise'

general purpose classification is given in Appendix II. Also shown is its logical relation to the two digit version of ICIDH(13) which might be preferred.

Dependency component

The dependency component is outlined in Appendix III.

The organic and psyche-emotional components

Appendix I. If we take the NMS III Classification as a basis, the new compromise classification contains nearly 200 additional rubrics as sub divisions of grouped or residual categories. The majority of these are asterisked categories in the NMS III version but 26 rubrics are sub divisions of categories without asterisks. Three of the main 18 categories account for 15 of the 26. In order to ensure complete one-to-one compatability between NMS III and the new general purposes classification, these 26 categories should be asterisked in the NMS III version. Without these additional asterisks, the two classifications however are still logically compatable with one another and with the full ICD-9. In Appendix I the suggestions for this extension of NMS III to form the new general purposes classification also contains the original equivalent entries in ICHPPC-2 with the appropriate classification numbering from ICD-9. The equivalent numbering system used in the NMS III Classification is also given as well as those categories asterisked in NMS III and the 26 additional NMS III rubrics which would require to be asterisked for complete compatability.

An alphabetic index of the 5000 terms most commonly used in general practice to describe clinical problems has been prepared. It is cross referenced to the appropriate NMS III code number and also where asterisked to the appropriate 4 digit ICD code. It is also cross referenced to the set of additional rubrics addes to the NMS III code as the basis for the RCGP compromise general purpose code.

The socio-economic component

No alterations are suggested for this section from the NMS III Classification.

Using the various classifications

For practitioners using computers, it is immaterial which system is used though there are obvious advantages in the greater detail from the four digit division of residual and grouped categories in the NMS III version or even in the use of full ICD. There are a few occasions where ICD four digit detail is insufficient for general practice and ad hoc additions would be necessary. In situations where a true short list is indicated, in general for manual systems the 'general purpose' RCGP system has obvious advantages. However, where a manual system is a first step to computer processing, then the modified NMS III version still has advantages. All systems can be linked to the use of the alphabetic listing of the 5000 terms most commonly used in general practice to describe clinical problems.

Conclusions

The differences between ICHPPC-2, the Classification for NMS III and the general purpose RCGP Classification based on it, are as follows :

1. Approximately 69 grouped or residual categories in ICHPPC-2 have been sub divided for NMS III and a further 26 for the general purpose RCGP Classification;
2. Most of the other grouped or residual categories have been asterisked in NMS III for detailed 4 digit coding of specific conditions. These usually serious or significant conditions would otherwise be lost. The use of this mechanism is not mandatory.
3. The order in NMS III and in the RCGP general purpose Classification follows iCD-9;
4. The number systems are different but one-to-one compatability of rubrics is retained.

There are four possible lines of action:

1. Continue with present RCGP Classification as used in NMS II;
2. Switch to ICHPPC-2;
3. Switch to the NMS III Classification;
4. Switch to the RCGP general purpose Classification,

Any users of the RCGP general purpose Classification or of NMS III whether

using the asterisked mechanism or not can present their results in ICHPPC-2 terms but not vice versa except on an ad hoc basis. ICHPPC-2 does have the facility of ad hoc hierarchic extensions. Apart from the incompatabilities that result because the RCGP general purpose Classification and the NMS III Classification follow ICD more closely, the RCGP general purpose Classification and the NMS III Classification are virtually ad hoc hierarchic extensions of ICHPPC-2 with arbitrary numbering systems which do not follow ICHPPC-2 instructions. Unfortunately the numbering system used in ICHPPC-2 is incompatable with the asterisked 4 digit convention used in NMS III. This incompatability arises from the arbitrary use of 3 or 4 digit ICD-9 numbers to identify each grouped category in ICHPPC-2. Such grouped categories of course contain other closely related conditions with their own specific 4 digit codes.

The situation is to a certain extent further complicated by the fact that the Scandinavian nations have not switched to ICD-9 and may not at any time do so. The changes proposed in ICD-9 are very extensive indeed and it is unlikely that a new International Classification (ICD-10) will be prepared, let alone introduced within the next 15 years. Also WONCA is already working on a multi-dimensional classification to replace ICHPPC-2 and although this will not be available for some time, it is reasonable to expect that it will be introduced within the next 5 years. The present proposals for such a multi-dimensional system are heavily biased to the needs of the North American Primary Care situation and have inbuilt redundancy for any use in Great Britain.

WONCA are also developing a set of standard definitions and criteria for the rubrics in ICHPPC-2. Tentative definitions have also been developed for certain sections of ICD-9 in particular for Mental Disorders. If such definitions become obligatory then it will be necessary to add an additional coding system to indicate for each diagnostic entry whether :

1. The rubric chosen and coded conforms to the full definition or ;
2. The rubric chosen does not fulfil all the conditions of the standard criteria and definitions.

If this convention is not included then all the problems which do not fulfil the standard definition will be lost in residual categories.

The ICIDH(13) is still in a state of development and is not finalised, though the disability classification is obviously much more clearly thought out and much nearer to some sort of final state than the handicap classification. There is of course no need for any of these additional ICIDH sections to be included at all in the general purpose College Classification but it would seem that at the minimum there is an opportunity to bring these classifications with their benefits and problems to the notice of general practitioners at this time.

Proposed "compromise" RCGP Classification of Clinical Problems in Primary Care.

This draft has equated ICD-9 code numbers in Column 1 and equated NMS III code numbers in Column 3.

Any new rubrics are noted by "A" in Column 1.

Any number in Column 3 marked by an * requires the specific 4 digit ICD number to be added to any disease index entry.

This draft has still to be finally checked and an appropriate numbering system added.

REVISION THREE - RCGP COLLEGE CLASSIFICATION PLUS REVISION FOU

1. INFECTIOUS & PARASITIC DISEASES.

	ICD Code(s)		College Code
B	001-008,6	Intestinal disease of proven infective origin incl. Bacterial food poisoning, enteritis caused by a specified virus	001
B	008.8,009	Intestinal disease - presumed to be infective, of either unspecified viral or unknown origin incl. diarrhoea presumed to be infective excl. diarrhoea- not presumed to be infective, cause not yet determined and NOS(254): vomiting, not presumed to be infective, cause not yet determined and NOS(427): non-infective(specified)enteritis and gasroenteritis (254): functional digestive disorders(254, 256,263): chemical induced gastroenteritis(254).	002
	010-018	Tuberculosis, all sites incl. recent positive conversion of T.B. skin test excl. pleural effusion NOS(229) and late effects(code to condition)	003 *
A	032	Diphtheria	
B	033	Whooping Cough incl. parapertusis and pertusis syndrome	004
	034	Streptococcal sore throat and scarlatina	005
	035	Erysipelas	006
A	036,047 320-322	All meningitis, bacterial and viral	
	045,046,048,138	Poliomyelitis and other entero virus diseases of central nervous system incl. late effects(code to condition), slow virus infections	007 *
B	052	Chicken pox	008
A	053.1	Post-herpetic neuralgia	
A	053.2	Ophthalmic herpes(zoster)	
	053.9	All other herpes zoster	009
A	054.1	Genital herpes(simplex)	
	054(excl.054.1)	Herpes simplex all other sites except genital herpes	010
B	055	Measles incl. complications, excl. german measles (012)	011
B	056	Rubella excl. roscola infantum(013)	012
B	057	Other viral exanthems incl. pyrexia with rash NOS, roscola infantum	013

B	070	Viral hepatitis incl. all hepatitis presumed viral excl. hepatitis NOS(260)	014
B	072	Mumps incl. mumps orchitis	015
A	074.3	Hand foot and mouth	
B	075	Infectious mononucleosis, glandular fever	016
B	077	Conjunctivitis, presumed to be caused by a virus or chlamydia incl. viral pharyngoconjunctivitis excl. conjunctivitis NOS(151)	017
A	078.0	Molluscum contagiosum	
	078.1(pt)	Venereal warts incl. condyloma accuminatum	018
	078.1(pt)	Viral warts of other sites	019
	078.8(pt)	Chlamydiol infections(code e.g. pelvic inflammatory disease and urethritis as primary codes in addition)	
B	079.9	Viral infection unspecified excl. influenza(221)	020
B	084	Malaria	021
B	090-097	Syphilis, all sites and stages	022
B	098	Gonorrhea, all sites	023
	099.4	Non specific urethritis (i.e. urethritis apparently transmitted by intercourse which is not, or appears not to be caused by the gonococcus.) When due to Chlamydia code 078.8 (pt) as well excl. other urethritis (275)	024
A	111.0	Pityriasis-versicolor	
	110,111(excl. 111.0)	Dermatophytosis and dermatomycosis, incl. athletes foot, tinea, ringworm, onychomycosis (excl. pityriasis verticolor)	025
A	112.0	Oral candida	
	112(excl. 112.0, 112.1, 112.2)	Monilia infection, candidiasis, any site except urogenital and oral candida incl. thrush, rectal mucosal candidiasis	026
B	112.1, 112.2	Urogenital candidiasis incl. monilial infection of vagina or cervix	027
	120-129(excl. 127.4)	All other helminthiases	028
	127.4	Enterobiasis(incl. oxyuriasis)	029

B 131.0	Urogenital tricomoniasis excl. leukorrhea NOS(298)	030
B 132,134	Pediculosis and other skin infestations incl. larvae, maggots, sand fleas, leeches	031
B 133	Scabies and other acariases	032
A 135	Sarcoidosis	
137-139	Late effects of T.B., polio and other infectious and parasitic diseases	*
Rdr 001-136	Other and unspecified infections and parasitic diseases incl. vincent's angina, brucellosis, other venereal diseases NEC, Reiter's Disease, Coxsackie diseases, viral encephalitis, smallpox, cowpox, trochoma(see ICD for other inclusions)	033

II NEOPLASMS

Malignant neoplasms:-

A 140-149	Lip, oral cavity and pharynx	
A 150	Oesophagus	
A 151	Stomach	
A 153	Colon	
A 154	Rectum, recto-sigmoid junction and anus	
A 157	Pancreas	
A 152,155,156,158, 159	Other digestive organs, peritonium	
A 161	Larynx	
A 162	Trachea, bronchus and lung	
A 170	Bone and articular cartilage	
172	Melanoma of skin, malignant neoplasm	042
A 173	Other ~~melanoma~~ of skin and rodent ulcer	
B 174 175	Breast, female and male	043 *
A 179	Uterus, pt unspecified	
A 180	Cervix uteri	
A 182	Body of uterus	
A 183	Ovary and other uterine adnexa	

A 184	Other and unspecified female genital organs	
A 185	Prostate	
A 186	Testes	
A 188	Bladder	
A 189	Kidney and other and unspecified urinary organs	
A 191	Brain	
A 201	Hodgkin's Disease	
A 203	Multiple myeloma and immuno proliferative neoplasms	
A 204-208	Leukaemias(excl. lymphomas 203)	
A 233.1	Ca. in-situ of cervix	
Rdr.(140-208, 230-234)	Other malignant neoplasms, incl. secondary and metastatic neoplasms where primary site is unknown, lymphomas, carcinoma-in-situ(excl. ca. in-situ of cervix	

Benign Neoplasms:-

B 214	Lipoma, any site	048
B 216	Skin, incl. mole, pigmented nevus, excl. seborrheic (senile) warts(352)	049
B 217	Breast, excl. simple cysts, chronic cystic disease(285) skin of breast (049)	050
B 218, 219	Fibroids and others of uterus incl. myoma, cervical polyp(adenomatous) excl. mucous cervical polyp (288)	051
A 220	Ovary, excl. physiological and luteal cyst	
228	Hemangioma, lymphangioma excl. angiomatous and other birth marks(394)	052
Rdr 210-229	Other benign neoplasms incl. those of brain, digestive system, endocrine system, large bowel, rectum. anal canal and ind. polyposis of bowel, adenomatous polyp of cervix excl. polyp of larynx or nose(230), polyp of middle ear(167), mucous polyp of cervix(288), physiological cyst of ovary(298), and all benign neoplasms of ovary.	053 *

Unspecified neoplasms:-

A 237.7	Neurofibromatosis(von Recklinghausen's disease	
235-239(excl. 237.7)	Neoplasms of uncertain behaviour or unspecified nature, incl. polycythemia rubra vera excl. carcinomas-in-situ(044,047) atypical or abnormal NOS (449) mass, localised swelling (439,286)	054 *

III ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES & IMMUNITY DISORDERS

Excludes:- Abnormal unexplained biochemical test(448)

B 240,241	Goitre and thyroid nodule without throidtoxicosis excl. proven neoplasm of thyroid(047,053,054)	060
B 242	Hyperthyroidism, thyrotoxicosis, with or without goitre	061
B 243,244	Hypothyroidism, myxedema, cretinism	062
A 245.6	Thyroiditis and other disorders of thyroid NOS	
B 250	Diabetes mellitus(code complications separately) excl. hypoglycaemia NOS; abnormal glucose tolerance test(448)	063
A 251.0,251.1, 251.2	Hypoglycaemia (incl. coma and hyperinsulinism	
A 255.4	Cortico adrenal insufficiency(Addison's disease)	
260-269	Vitamin deficiency, other nutritional deficiencies and disorders excl. sprue, mal absorbtion syndrome(263), feeding problem(441)	064 *
A 271.4	Renal glycosuria	
B 272	Disorders of lipoid metabolism(hyperlipidemia, abnormalities of lipoprotein levels, and raised levels of cholesterol and triglycerides) incl. congenital xanthoma	065
273.8(bt)	Hypofibrinogenaemia	
B 274	Gout excl. pseudogout and crystal arthropathies(068) hyperuricemia(448)	066

B 278	Obesity	067
Rdr. 240-279	Other endocrine, nutritional and metabolic diseases and immunity disorders incl. congenital metabolic disorders, cystic fibrosis, disorders of fluids, electrolytes, or acid-base balance, fluid retention, amyloidosis, diabetes insipidus, hypopituitarism	068 *

IV DISEASES OF BLOOD AND BLOOD-FORMING ORGANS

Excludes:- Leukemia and the reticuloses(046), polycythaemia rubra vera(054)

B 280	Iron deficiency anemia excl. in pregnancy, childbirth and puerperium(317)	080
A 281	Pernicious anemia	
A Rdr 281	Other deficiency anemias	
B 282	Hereditory hemolytic anemias incl. sickle-cell anemia, sickle-cell trait, thalassemia, spherocytosis	082
283-285	Other anemias incl. acquired hemolytic, aplastic and anemias NOS. excl. inpregnancy, childbirth and puerperium(317)	083 *
B 286, 287	Purpura, hemorrhagic conditions, coagulation defects, abnormality of platelets	084 *
B 288	Abnormal white cells incl. leukocytosis, lymphocytosis, eosinophilia, agranulocytosis	085
B 289.1-289.3	Chronic and non-specific lymphadenitis incl. mesenteric lymphadenitis, acute or chronic excl. acute lymphadenitis apart from mesenteric(333), enlarged lymphnode NOS(420)	086
289.4-289.9	Other disorders of blood and blood forming organs incl. diseases of spleen excl. splenomegaly(431), abnormal red cells(447), raised ESR(447)	087 *

V MENTAL DISORDERS

Psychoses(except alcohol and drug induced):-

290	Senile and presenile organic psychotic conditions	100
293.8(pt)	Puerperal psychosis	101
293(excl. 293.8(pt) 294	Other organic psychoses incl. non-alcoholic acute or chronic delirium	102

B	295	Schizophrenia	103
B	296,298.0, 298.1	The affective psychoses incl. psychotic depression, involutional melancholia, mania, hypomania, manic-depressive reactive depressive psychosis	104
	297,298.3, 298.4	Paranoid states and reactions	105
B	298.2,298.8, 298.9,299	Other and unspecified psychoses excl. alcoholic(116)	106

Neurotic disorders, personality disorders and other nonpsychotic mental disorders:-

B	300.0	Anxiety disorder, anxiety state excl. anxiety causing a somatic complaint(116)	107
	300.2	Phobic states	109
	300.3	Obsessive - compulsive disorders	110
A	300.4,300.5 311	Depressive disorders (neurotic depression)incl. depression NOS and neurothenia, excl. brief depressive stress reactions(125)	111-112
	300.6,300.8, 300.9	Other neuroses incl. occupational neurosis, neurosis NOS	113
	300.7	Hypochondriosis	114
	306(excl. 306.1(pt)	Physiological malfunction arising from mental factors incl. fictitious disorders, anxiety causing a somatic complaint, hyperventilation syndrome, cardiac neurosis, excl. psychogenic disorders of sexual function(119) tension headache(124), insomnia(122)	115
A	306.1(pt)	Psychogenic aphonia	

Other mental and psychological disorders:-

B	291,303	Chronic abuse of alcohol incl. alcoholism, alcoholic psychosis excl. non-dependent alcohol abuse (120)	116
B	292,304, 305.2-305.9	Other drug abuse, habituation or addiction (incl. drug induced psychosis) incl. diazepam, cannabis, LSD, barbiturates, laxatives, glue sniffing etc.	117 *
B	301	Personality and character disorders	118

	302.7	Psychogenic disorder of sexual function incl. frigidity, impotence & loss of libido, psychogenic dysparcunia excl. marital problems (551), vaginismus NOS and dysparcunia NOS in female (291) and other psychosomatic disorders of genito-urinary system (115)	119
B	305.0	Acute alcohol intoxication, drunk, excessive alcohol intake NOS	120
B	305.1	Abuse of tobacco	121
A	307.1	Anorexia nervosa	
B	307.4	Insomnia and other sleep disorders	122
	307.6	Psychogenic and enuresis excl. enuresis not clearly of psychological origin(433)	123
B	307.8	Tension headache, psychogenic backache and other pain of mental origin(psychalgia) excl. headache NOS(414), migraine(143), lumbalgia(370)	124
B	308,309	Transient situational disturbance, acute stress reaction, adjustment reaction incl. grief reaction, bereavement, brief depressive reaction. May have addition code for cause(548-562)	125
B	312-314	Behaviour disorder (any age), disturbance of emotions specific to childhood and adolescence incl. hyperkinetic child, delinquency, cleptomania (any age) excl. character disorder(118)	126
B	315	Specific learning disturbance and delay in development of certain skills needed for schooling excl. mental retardation(128)	127
B	317-319	Mental retardation	128
	Rdr 290-319	Other mental and psychological disorders incl. sexual deviation, tic, habits spasm, stammering and stuttering, psychological causes of diseases classified elsewhere, psychologica effect of head injuries	129 *

VI DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS

Diseases of the central nervous system:-

excludes :- cerebro vascular disease, stroke(196), transient ischaemic attack(197)

A 323	Encephalitis, myelitis and encephalomyelitis incl. encephalitis due to infection or following immunisation	
A 331.2 B 332 333.6 A 333.9 A 333	Senile degeneration of brain. Parkinsonism, paralysis agitans. Torticollis Restless legs syndrome Other extrapyramidal disease and abnormal movement disorders	140
B 340	Multiple sclerosis	141
A 343	Infantile cerebral palsy	
A 345.1, 345.3	Generalised convulsive epilepsy incl. status epilepticus and Grand Mal	
345 (excl. 345.1, 345.3)	All other epilepsies excl. convulsions, febrile or NOS(410)	142
B 346	Migraine	143
A 350	Trigeminal nerve disorders	
A 351	Facial nerve disorders(incl. Bell's Palsy)	
A 354.0	Carpal tunnel syndrome	
A 355.6	Morton's Metatarsalgia	
A 357.0	Acute infective polyneuritis	
320-359	Other diseases of the nervous system incl. meningitis NEC, other peripheral neuropathy (primary or secondary), benign essential and familial tremor, reaction to lumbar puncture, restless legs syndrome excl. vertebrogenic compression syndromes(371, 372, 373, 374), post/paralysis(196), dementure (100, 102), effects of head injury on neurological(483) or psychological (129) function	

Diseases of the eye and adnexa:-

excludes: corneal abrasion(485), foreign body in eye(488), congenital blockage of tear duct(390).

A 361	Retinal detachments and defects
A 362.0	Diabetic retinopathy(code diabetes separately)

A 362.1	Other background retinopathy and retinal vascular changes (incl. hypertensive grade III/IV N.B. IV = papillodema	
A 362.5	Senile macular degeneration	
364	Disorders of iris and ciliary body	145
B 365	Glaucoma	146
B 366	Cataract	147
367	Disorders of refraction and accommodation excl. blindness and reduced visual acuity NOS(149)	148
A 368.5	Colour vision deficiencies	
369	Blindness(one or both eyes), reduced visual acuity (registered partially sighted or equivalent) code cause separately excl. snow blindness, night blindness	149 *
370	Keratitis, with or without corneal ulcer	150
372.0 -372.3	Conjunctivitis incl. bacterial NOS, allergic excl. allergic with rhinorrhea(219), conjunctivitis proven to be caused by specific organisms(in section 1), trachoma(033), viral conjunctivitis(017), hay fever(allergic rhinitis)(219).	151
373.0	Blepharitis	152
373.1, 373.2	Stye, hordeolum, chalazion, meibomian cyst	153
A 374.0, 374.1	Entropian and ectropian	
375.1	Dry eye syndrome(excl. Sjogren's Disease)	154
378	Strabismus	155
A 379.0	Scleritis and episcleritis	
A 379.2	Vitreous floaters and opacities and all disorders of the vitreous	
A 379.5	Nystagmus and other irregular eyemovements (congenital and NOS)	
Rdr. 360-379	Other diseases of the eye and lacrimal system incl. pinguecula, pterygium, retinopathies, red eye NOS, spontaneous sub conjunctival haemorrhage, photophobia, tired eyes, diplopia, blurred vision, eye pain, arcus senilis, snow blindness, night blindness, papilledema	156 *

Diseases of the ear and mastoid process:-

excludes:- foreign body in ear canal(489)

B	380.1,381.2	Otitis externa incl. eczema of external auditry meatus excl. boil of external auditry meatus(330)	157
B	380.4	Wax in the ear canal	158
	381.0	Acute non-suppurative otitis media excl. glue ear	159
A	381.1,381.3, 381.4	Chronic suppurative otitis media	
A	381.2	Glue ear	
B	381.5,381.6	Eustachian salpingitis or block	160
	382.0,382.9	Acute (suppurative)otitis media, acute myringitis,otitis media NOS	161
B	386	Vertiginous syndromes,disorders of the labyrinthitis,Menier's Disease,benign paroxysmal and positional vertigo,vestibular neuronitis excl. giddiness,dizziness,NOS(411)	162
	387	Otosclerosis	163
A	388.3	Tinnitus NOS	
	389.0	Conductive deafness NOS	164
	388.0,389.1	Sensoryneural deafness incl. presbyacusis	165
	388.2,389 (except 389.0,389.1)	Other and unspecified deafness	166
	Rdr.380-389	Other diseases of ear and mastoid process incl. ear pain NYD or NOS,mastoiditis, non-traumatic perforation of tympanic membrane, cholesteatoma,acoustic trauma, excl. deafness,NOS(164-166),traumatic perforation of tympanic membrane(482)	167 *

VII DISEASES OF THE CIRCULATORY SYSTEM(CODE SEPARATELY ANY ASSOCIATED HYPERTENSION)

Diseases of the heart:-

excludes:- congenital anomolies of heart and circulatory system(391), heart murmur NEC(419),cardiac neurosis(115),care of prosthetic device(525), abnormal ECG not classified elsewhere,unspecified abnormality of other tests of heart function(451))

B	390-398	Chronic rheumatic heart disease, rheumatic fever, Sydenham's chorea,with or without heart involvement excl. chronic disease of valve or endocardium when not specified as rheumatic,and where rheumatic origin is not suggested on clinical grounds(e.g.it would be in the	180

	390-398(contd)	mitral stenosis, combined disease of mitral and aortic valves, tricuspid valve disease)	
	410,411	Acute myocardial infarction, sub-acute ischaemic heart disease (code separately any associated hypertension)	182
	412-414(except 413 (pt))	Other chronic ischaemic heart disease incl. healed myocardial infarction, other angina asymptomatic ischaemic heart disease, ~~cardio~~ sclerosis, aneurysm of heart (coronary athero-) excl. athero sclerotic valve disease(185)(code separately any associated hypertension)	183
A	415.1	Pulmonary embolism and infarction	
B	415.0,416	Pulmonary heart disease(chronic)cor pulmonale	184
A	420	Acute pericarditis(excluding rheumatic carditis) incl. pericarditis of virus aetiology(code cause when known in addition)	
A	421	Acute and sub acute endocarditis incl. endocarditis of virus aetiology(code cause when known in addition)	
B	424	Disease of heart valve NOS, NYD, or specified as of non-rheumatic cause excl. rheumatic valvular disease(180)	185
A	425	Cardio-myopathy	
A	426	All forms of conduction disorders not classified as dysrhythmias	
B	427.0-427.2	Paroxysmal tachycardia(supra-ventricular, ventricular or unspecified) excl. tachycardia NOS(452)	186
B	427.3	Atrial fibrillation or flutter	187
B	427.6	Ectopic beat, all types incl. PVB, PNB, PAB excl. wandering pacemaker(192)	188
	428.0	Congestive heart failure (code separately the underlying cause)	189
	428.1	Left heart failure (code separately the underlying cause)	190
	428.9	Unspecified heart failure (code separately the underlying cause)	191
	417,422-423, 427.4,427.5, 427.8,427.9, 429	All other heart disease incl. cardiac arrest, other disturbances of heart rhythm, cardiomegaly NOS	192

HYPERTENSIVE DISEASE

Hypertensive Disease is classified (A - F) according to evidence of end organ damage. The following examples of end organ damage occurring as a result of hypertension are included within this section of the classification and require no additional code specifying end organ damage.

Retinal Disease	-	Grade 4 Retinopathy (papilloedema)
Heart Disease	-	Heart failure (CCF or Left Heart Failure, Cardiomegaly)
Renal Disease	-	Renal pathology arising as a result of Hypertension (and not vice versa).

All other associated morbidity is assigned to the specific rubric in addition. Examples include:-

Retinal Disease	-	Grade 3 Retinopathy ( ) (Grades 1 & 2 Retinopathy should be disregarded for this purpose)
Heart Disease	-	Ischaemic Heart Disease( ).
Cerebrovascular Disease		Cerebral arterio sclerosis ( ) Cerebral encephalopathy ( ).

401.1	Essential Hypertension incl. high blood pressure or hypertension with no evidence of end organ damage excl. secondary hypertension	A
401.0, 402.0, 403.0, 404.0	Hypertension with papilloedema with or without evidence of any other end organ damage incl. malignant hypertension	B
402.1, 402.9	Hypertensive Heart Disease without papilloedema incl. hypertension with left ventricular hypertrophy or failure or CCF (if attributable) excl. secondary hypertension	C
403.1, 403.9	Hypertensive renal disease without papilloedema excl. secondary hypertension (F)	D
404.1, 404.9	Hypertensive heart and renal disease without papilloedema excl. secondary hypertension (F)	E
405.0, 405.1, 405.9	Secondary hypertension with or without papilloedema	F

Diseases of the vascular system:

A 430 431-434, 436-438(except 437.2)	Subarachnoid haemorrhage Other cerebrovascular disease incl. all types of stroke, subacute and chronic cerebrovascular disease, post-stroke paralysis(code separately any associated hypertension)	196 *
B 435	Transient cerebral ischaemia, incl. transient ischaemic attack(TIA)	197
B 440	Atherosclerosis except of heart, brain, gut or lung excl. when causing arterial blockage(199)	198
A 441	Aneurysm of aorta	
A 443.0	Reynaud's syndrome	
A 443.1	Thromboangitis obliterans	
A 443.9(pt)	Intermittent claudication NEC	
443.8,443.9(pt) 444.8,444.9	Other arterial obstruction and peripheral vascular disease (excl. intermittent claudication and Raynaud's disease incl. other arterial blocks excl. aneurysm(205), gangrine(452), chilblains(495), blockage of messenteric arteries(263), retinal artery(156) renal arteries(277), coronary arteries(181-183), cerebral arteries(197,196), pulmonary arteries(184).	199 *
A 444.0-444.2	Arterial embolism and thrombosis of aorta and extremities	
A 446	Polyarteritis nodosa and allied arteriolar conditions (incl. temporal arteritis)	
A 448.1	Nawus, non-neoplastic	
451.2	Phlebitis and thrombo-phelbitis of lower extremities	200
451.8-451.9 452,453	Other venous embolisms and thrombosis incl. portal thrombosis excl. cerebral thrombosis(196), phelbitis or thrombophlebitis in pregnancy(317) or in puerperium (323)	201
A 454	Varicose veins of legs, with or without eczema but <u>without</u> ulcer	
A	Varicose veins of legs with or without eczema but <u>with</u> ulcer(excl. chronic ulcer of skin)	202
A 455.4	Thrombosed external piles	
A 455.9	Residual haemorrhoidal skin tags	
A Rdr 455	All other and unspecified haemorrhoids	
A 456.0-456.2	Oesphageal varices	
A 456.4	Varicocele	
A 457.0	Postmastectomy lymphoedema syndrome	

B 458	Postural hypotension, low blood pressure	204
442,447,448(pt), rdr.456,457(pt) 459	Other diseases of peripheral blood vessels incl. lymphangitis	205

VIII DISEASES OF THE RESPIRATORY SYSTEM

excludes:- Hyperventilation syndrome, restpiratory neurosis(115), foreign body(489)

461	Acute sinusitis	212
B 463,475	acute tonsillitis and quinsy excl. that of proven streptococcal origin	213
B 464	acute laryngitis, tracheitis, croup excl. influenza itself and chronic laryngitis	214
B 466,490		215
A 470	Deflected nasal septum	
A 471	Nasal polyps	
472 (pt)	Catarrh	216
473	Chronic sinusitis	217
B 474	Hypertrophy and chronic infection of tonsils, and/or adenoids	218
A 477	Hay fever,	219
A 477.9	All other allergic rhinitis excl. hay fever	
B 478.1(pt)	Boil or abscess in nose excl. boil of skin of nose(330)	220
460(pt)462(pt)	acute naso-pharyngitis (common cold) incl. coryza, nasal catarrh, nose-pharyngitis, acute infective rhinitis, acute sore throat (N.O.S) pharyngitis, viral pharyngitis excl. bacterial tonsillitis, influenza and influenza-like illness	210
465(pt)	Acute upper respiratory infections of multiple or unspecified site	
A 487.1(pt)	Influenza-like illness	211
487(except 487.0)	Epidemic influenza, without pneumonia, excl. gastric flu(002), viral infection NOS(020) Note: the rubric "epidemic influenza" should only be used during established epidemics of influenza or when the diagnosis is confirmed serologically or virologically. The rubric " influenza-like illness " should be used at all other times	221
487.0	Influenza with pneumonia	222
466 & 490	Acute bronchitis and bronchiolitis	
480-486	Other pneumonia incl. bacterial and viral pneumonia excl. aspiration pneumonia(230)	223

	491-496	Chronic bronchitis and chronic obstructive airways disease(excl. bronchiectasis (227))	224
	492	Emphysema	225
B	493	Asthma	226
	494	Bronchiectasis	227
A	495	Extrinsic allurgic alveolitis(incl. Farmers' and Bird Fanciers' lung)	
A	500 501.9,502, 503-505	Pneumoconiosis	
	511.0-511.8	Pleuresy, all types except tuberculosis excl. pleurisy with effusion(229), tuberculous pleurisy(003)	226
B	511.9	Pleural effusion NOS	229
A	512	Pneumothorax	
	Rdr.460-519	Other diseases of respiratory system, incl. other diseases of larynx, allurgic pneumonitis, empyema, lung complications of other diseases excl. cystic fibrosis affecting lungs(068)	230 *

IX DISEASES OF THE DIGESTIVE SYSTEM

A	522.5,522.7	Dental abscess	
A	523.0,523.1	Acute and chronic gingivitis	
A	524.6	Temporomandibular joint disorders	
A	Rdr.520-526	Other diseases of teeth and supporting structures	
A	527.5	Calculous of salivary gland or duct	
A	528.0	Acute ulcerative stomatitis(excl. herpetic stomatitis NEC)	
A	528.2	Aphthous ulcer	
A	Rdr.527-528	Other diseases of the mouth and salivary glands incl. mucocele, angular cheuosis and effects of dentures	
A	529	Diseases and other conditions of the tongue(incl. glossitis, geographic tongue)	
	530	Diseases of oesophagus, incl. oesophagitis, excl. oesophageal varices(205) Y Mallory-Weiss syndrome	242 *
	530.7 Mallory-Weiss syndrome		
	531	Gastric ulcer	243
B	532	Duodenal ulcer, with or without complications	244
	533,534	Other peptic ulcers incl. gastrojejunal, marginal and peptic ulcer NOS	245

535,537	Other diseases of stomach and duodenum incl. gastritis (incl. alcoholic), duodenitis excl. infective gastritis or duodenitis(001,002), vomiting, nausea NOS(427) excl. emesis gravidarum	246 •
536	Disorders of function of stomach incl. indigestion NOS, dyspepsia excl. emesis gravidarum	247
B 540-542	Appendicitis, all types	248
B 550	Inguinal hernia, with or without obstruction	249
551.0,552.0, 553.0	Femoral hernia	250
B 551.3,552.3, 553,3	Hiatus hernia, diaphragmatic hernia	251
Rdr.551-553	Other abdominal hernias incl. unbilical, incissional	252
A 555	Regional enteritis, Chron's Disease	
A 556	Idiopathic proctolitis, ulcerative colitis	
B 558,564.1, 564.5	Irritable bowel syndrome, (colo spasm, spastic colon, mucous colitis) and other non-infective, non-ulcerative disorders of intestines incl. allergic, diatetic and toxic gastroenteritis and colitis, diarrohea NOS presumed to be non-infective excl. intestinal disease which is either proven or presumed to be of infective origin(see Section I), regional enteritis(253), vascular insufficiency of gut(263), psychogenic diarrhoea(115)	254
B 562	Diverticular disease of intestines incl. diverticulosis, diverticulitis	255
564.0	Constipation(if no cause identified) excl. faecal impaction(263)	256
B 564.6,569.4(pt)	Rectal and anal pain NOS incl. anal spasm, proctalgia fugax, proctitis	257
B 565,566	Anal fissure and fistula, peri anal abscess	258
A 569.1	Rectal prolapse	
569.3	Bleeding per rectum NOS excl. (gastro)intestinal haemorrhage NOS(262), haemorrhoids(203)	259
A 569.6	Colostomy or enterostomy mal-function. excl. normal management (V55.2, 55.3) and estomy states without problems(V44.2, 44.3)	

A	573.1,573.2,573.3	Acute hepatitis in infectious diseases classified elsewhere and hepatitis unspecd.	
	570-573(Rdr)	Cirrhosis and other liver diseases excl. viral hepatitis(014)	

(Gall Bladder Disease is classified according to the presence or absence of calculi and the occurrence of acute infection. Include only where strong clinical evidence of gall bladder disease exists, otherwise code non-specific symptoms to ICD 787(or College equivalent)).

	574-576	Disease of gall bladder and biliary tract(574-576) (code any episodes of acute cholecystitis separately in addition)	
	574-575	Episode of acute cholecystitis(always code to ( ) as well	
A	577.0	Acute pancreatitis	
B	578	Haematemesis, melena incl. (gastro)intestinal haemorrhage NOS	262
	579	Coeliac disease	
B	Rdr.520-579	Other diseases of the digestive system incl. messenteric vascular insufficiency and block, intestinal obstruction, intussusception, ileus, dumping syndrome and other functional results of gastrointestinal surgery, secondary megacolon, diseases of pancreas, malabsorption syndrome, sprue, rectal polyp.	263 *

X DISEASES OF THE GENITO-URINARY SYSTEM

Diseases of the urinary system:

excludes:- unexplained abnormal urine test NEC(444-446)

	580-583	Glomerulonephritis, acute and chronic incl. nephrosis + diabetic nephropathy. (code to any underlying condition in addition (e.g. diabetes))	270
A	584-586	Renal failure (code to underlying condition in addition)	
B	590.1, 590.3 590.8, 590.9	Pyelonephritis and pyelitis, acute incl. kidney infection NOS excl. pyelonephritis, chronic(277), in pregnancy, puerperium(316)	271
B	592, 594	Urinary calculus, all types and sites	272
B	593.6	Orthostatic albuminuria (postural proteinuria)	273
B	599, 599.0	Cystitis and urinary infection NOS incl. asymptomatic bacteriuria excl. in pregnancy, puerperium(316)	274
B	597	Urethritis(non-venereal) NEC, NOS incl. meatitis, urethral syndrome excl. non-specific urethritis(urethritis which is apparently transmitted through intercourse and which is not, or appears not to be, of gonococcal origin) (024)	275
A	599.3	Urethral caruncle	
B	599.7	Haematuria NOS	276
	Rdr. 580-599	Other diseases of the kidney, ureter, bladder and urethra incl. chronic pyelonephritis, hydronephrosis, urethral stricture	277

Diseases of the male genital organs:-

B	600	Benign prostatic hypertrophy incl. hyperplasia, fibroma, median bar prostate, prostatic obstruction NOS	278
B	601, 608.0	Prostatitis, seminal vesiculitis	279
B	603	Hydrocele	280
B	604	Orchitis, epididmytis excl. mumps(015), gonococcal(023) tuberculous(003)	281
	605	Redundant prepuce and phimisos	282
	606	Infertility, male (excl. impotence)	283
	607.1	Balanitis	283

A	608.2	Tortion of testis	
	602,607(except 607.1),608(except 608.0),608.2)	Other diseases of the male genitalia incl. spermatocele	284 *

Diseases of the breast:-

B	610	Chronic cystic disease of the breast(fibroadenosis) and other benign mammary dysplasia	285
B	611	Other disorders of breast incl. gynecomastia,non-puerperal breast abscess, fat necrosis,galactorrhea(not associated with childbirth),lump in breast NOS,mastodynia,nipple discharge	286 *

Diseases of the female genital organs:-

excludes:- uterine fibroid(051),ivarian cyst:-benign(053), -malignant(044),pap smear:- procedure(529),-abnormal,NEC(449)

	614,615	Pelvic inflammatory disease including salpingitis, oopheritis,endometritis, excl. venereal diseases(022,023,033)	287
	616.0 622	Cervicitis and other abnormalities of cervix incl. cervical leukoplakia,old laceration, mucous cervical polyp,cervical dysplasia excl. abnormalities of cervix in pregnancy,childbirth or puerperium(317,320,323), adenomatous cervical polyp (051),abnormal pap smear NOS(449)	288
	616.1	Vaginitis NOS,vulvitis excl. leukorrhea(non-infective) senile vaginitis(293),proven specific causes (in Section 1)	289
A	616.2,616.3	Bartholin's cyst or abscess	
A	617	Endometriosis	
B	618,625.6	Uterovaginal prolapse incl.cystocele rectocele,stress incontinence NOS	290
A	620.0,620.1, 620.2	Ovarian cyst physiological	
A	621.0	Uterine polyp	
A	622.0	Erosion of cervix	
A	623.5	Leukorrhoea(not specified as infective)	
	625.0,625.1	Vaginismus,dyspareunia in the female not specified as psychogenic	291

625.4	Premenstrual tension syndromes(serious psychiatric conditions coded separately)	292
B 627	Menopausal symptoms (climacteric) incl. senile vaginitis, post menopausal bleeding	293
	Disorders of the menstrual cycle:-	
B 625.2,625.3	Menstruation painful(dysmenorrhea) and inter-menstrual pain(Mittelschmerz)	294
B 626.0,626.1	Menstruation absent, scanty, or rare (amenorrhea, hypomenorrhea, oligomenorrhea) excl. pregnancy(544)	295
B 626.2-626.4	Menstruation excessive(hypermenorrhea, menorrhigia), frequent(polymenorrhea) or irregular incl. puberal bleeding, menometrorrhagia	296
B 626.5-626.9	Inter-menstrual bleeding and other disorders of the menstrual cycle incl. metrorrhagia, ovulation bleeding, postcoital bleeding excl. post-menopausal bleeding (293)	297
616.4-616.9, 619-621,623,624, 625.5,625.8,625.9, 629	Other diseases of female genitalia incl. genital tract fistula, pelvic congestion syndrome	298
	Fertility problems:-	
628	Infertility female	299
XI	PREGNANCY, CHILDBIRTH & PUERPERIUM:	
	excludes:- diagnosis of pregnancy(544), prenatal care without abnormality(542), post natal care without abnormality(543)	
B 632,634,637	Abortion, spontaneous and NOS incl. missed and incomplete and any complications	310
B 633	Ectopic pregnancy	311
B 635,636	Abortion, induced, legally or illegally incl. any complications	312
640	Haemorrhage in first 22 weeks of pregnancy (including threatened abortion)	313
641	Antepartum haemorrhage(after 22 completed weeks), abruptio placentae and placenta previa	314
B 642	Toxemia, pre-eclampsia and eclampsia of pregnancy, childbirth, and puerperium incl. hypertension alone or with one other or more of the triad excl. odema, excess weight-gain, albuminuria as a complication of pregnancy, childbirth or the puerperium(317)	315

			22
B	646.5,646.6	Urinary infection in pregnancy or puerperium incl. asymptomatic bacteruria	316
B	Rdr. 630-648	Other complications of pregnancy(prenatal) incl. emesis and hyperemisis, false labour, post-term, oedema and/or albuminuria without hypertension, anemia excl. complications of abortion	317 *
	650	Normal delivery with or without episiotomy	318
A	651	Multiple pregnancy	
A	652	Malposition and malpresentation of feotus	
A	653,654	Disproportion or abnormality of pelvis and soft tissues	
A	660-662	Obstructed and prolonged labour	
A	664	Delivery with trauma to the perineum and vulva	
A	666	Delivery with post-partum haemorrhage	
A	667	Delivery with retained placenta without haemorrhage	
	Rdr. 650-6669	Other complicated delivery and some conditions (diagnosable either during labour and delivery, or before) which requires special care to avoid complications in pregnancy, labour or delivery, (e.g. large-for-dates, small-for-dates, elderly primipara, old Caesarean section, etc.)	320 *
A	670	Sepsis of childbirth and puerperium	
A	671	Puerperal thrombosis and phlebitis	
A	675	Infections of the breast and nipple	
A	676.0	Retracted nipple	321
A	676.1	Cracked nipple	
A	676.2	Engorgement of breasts	
A	676.4	Failure of lactation	
A	676.5	Suppressed laptation	
	676.4,676.6, 676.8,676.9	Disorders of lactation	322
	Rdr. 672-676, 646.6(pt)	Other complications of puerperium(postnatal) incl. infection of genital tract, post-operative complications of obstetrical surgery excl. urinary infection(316), anemia(317), toxemia syndromes(315)	323 *

XII DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE

excludes:- purpura(084), dermatophytosis(025), dermatomycosis(025), monilial skin infection(026), herpes zoster(009), herpes simplex(010), pediculosis(031), scabies(032), molluscum contagiosum(033), warts, all sites(018,019), mole and pigmented naevus(049), skin tumours:- benign(049), -lipoma(048). -malignant(042)

A 680	Carbuncle, boil, furuncle	330
681	Cellulitis and abscess of fingers and toes (incl. paronychia)	331
682	Other cellulitis and abscess ~~incl. finger, toe~~, with or without lymphangitis excl. cyclid(153), perianal(258), male external genitalia(284), female external genitalia(298), inside nose(220), infected surgical wound(498), tissue of breast(286, 321), if also lymphadenitis (333)	332
B 683	Lymphadenitis, acute incl. abscess of lymphnode excl. chronic lymphadenitis(086) mesenteric lymphadenitis (086), enlarged lymphnode NOS(420)	333
B 684	Impetigo incl. secondary impetigo	334
A 685	Pilonidal sinus	
686	Other local infections of the skin and subcutaneous tissue	335
690	Seborrheic dermatitis and other erythematosquamous dermatoses incl. dandruff excl. seborrheic(senile) warts(352)	336
B 691.0	Diaper rash (337)	337
B 691.8	Atopic dermatitis or eczema incl. infantile eczema and flexural dermatitis excl. diaper rash(337)	338
692(pt)	Contact dermatitis, occupational	339
A 692.7	Sunburn	
692(pt), 693	Other contact dermatitis, other eczema or dermatitis incl. due to cold, due to drugs taken internally, dermatitis NOS, eczema NOS excl. allergy NOS, allergic reaction NOS(496), diaper rash(337), rash NOS(438), varicose eczema(202), stasis dermatitis(202)	340
A 695.1	Erythema multiforme	
A 695.2	Erythema nodosum	
A 695.3	Rosacea (acne rosacea)	
~~A 695.4~~	~~Lupus erythematosus (ex discoid lupus)~~	
B 690.0, 696.1	Psoriasis with or without arthropathy	341

B	696.3	Pityriasis rosea	342
A	697.0	Lichen planus	
B	698	Pruritis and related conditions incl. lichen simplex chronicus, neurodermatitis, dermatitis factitia, anogenital pruritis, itch NOS	343
B	700	Corns, callosities	344
A	701.3	Striae atrophicae	
A	701.4	Keloid scar	
B	703	Ingrowing toenail, onychogryphosis, other diseases of nail	345
B	704	Alopecia, folliculitis and other diseases of hair incl. psychosis barbae	346
	705(except 705.1, 705.8)	Other diseases of sweat glands incl. sweat rash, heat rash, dyshydrosis excl. hyperhidrosis(437)	347
A	705.1	Prickly heat	
A	705.8 (pt)	Cheiropompholyx	
B	706.0, 706.1	Acne excl. acne-rosacea(352)	348
B	706.2	Sebaceous cyst	349
B	707	Chronic ulcer of skin incl. bed sore excl. varicose ulcer(202)	350
B	708	Urticaria excl. angioedema, allurgic oedema(496) drug allurgy(497), oedema NOS(417)	351
A	709.0(pt)	Cafe au lait spots, cholasma and vitiligo	
	Rdr. 680-709	Other diseases of the skin and subcutaneous tissue incl. intertrigo, erythema NOS, ichthyosis, localised lupus erythenatosis	352

XIII DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE

Arthritis and arthrosis:-

excludes:- gout(066)

	714	Rheumatoid arthritis and allied conditions excl. psoriatic arthropathy(341), ankylosing spondylitis (720)	360
	715	Osteoarthritis(osteoarthrosis) and allied conditions of all joints excl. of spine(371)	361
B	716.1	Traumatic arthropathy(arthritis) excl. effusion(363), internal derangement of knee-acute (471)-chronic(376)	362

	ICD Code(s)		College Code
B	719.0	Swelling of joint, effusion of joint with or witout pain	363
B	719.4,719.5	Pain in joint, arthralgia, stiffness in joint	364
A	725	Polymyalgia rheumatica	
	710-713,716(except 716.1),719.2, 719.3	Other types of arthritis and diffuse connective tissue disorders incl. dermatomyositis, systemic rupus erythematosis, scleroderma(progressive), pyogenic arthritis, arthritis secondary to other diseases, the chondrocalcinoses, arthritis NYD or NOS, villonodular synovitis, palindromic rheumatism	365 *
	720	Ankylosing spondylitis	
		Non-articular rheumatism:-	
B	726.0-726.2	The shoulder syndrome incl. rotator cuff syndrome, frozen shoulder, bursitis of shoulder, synovitis of shoulder, tendinitis around shoulder	366
A	726.3	Tennis elbow	
A	726.7 (pt.)	Calcaneal spur	
	726.4-726.9, 727(except 727.1, 727.4)	Other bursitis, tendinitis, tenosynovitis, synovitis and peripheral enthesopathy incl. synovial cyst, peritendinitis, bone spur, calcified tendon excl. of shoulder (366), ganglion(378), bunion(377) of spine (370,373,374)	367
	728,(except 728.6), 729(except 729.5, 729.8)	Other non articular rheumatism and disorders of muscle, ligament and fascia incl. fibrositis, muscle pain, myalgia, myositis, panniculitis, fasciitis, foreign body granuloma excl. epidemic myositis(Bornholm Disease X033)	368
A	728.6	Dupuythen's contracture	
~~A~~	~~729.5(pt)~~	~~Growing-pains~~	
A	729.8	Leg cramps	
	729.5 (pt)	Pain and other symptoms referrable to limbs incl. growing pains excl. from spine (370,373,374), restless legs syndrome (144	368
		Syndromes related to the vertebral column:-	
		Excl: Paget's disease of spine(381), Scheuermann's disease(379), Osteoparosis(380), tuberculosis of spine(003), osteomyelitis(381)	
	720.1-720.9, 724.1,724.2, 724.5-724.9	Non-specific back pain(lumbar, thoracic or sacroiliac)without radiating symptoms incl. backache NOS, lumbalgia, lumbago, coccydynia excl. recent strain(478), psychogenic backache(124)	370

	721.0	Osteoarthritis of cervical spine(cervical spondylosis	
	721.3	Osteoarthritis of lumbar spine	
	722.0,722.4,723	Other syndromes related to the cervical spine incl.cervicalgia,cervical disc lesion, cervicobrachial syndrome,radicular syndrome of upper limbs excl. osteoarthritis of spine (371),cervical strain (479), psychogenic tension headache (124)	372
	722.1,724.3	Prolapse or degeneration of lumbar intervertebral disc, with or without sciatica	373
	722.5,724.4	Other back pain with radiating symptoms (incl.displacement of thoracic disc) excl. recent strain (478),spondylolisthesis(394)	374
B	737	Acquired deformities of spine incl. scoliosis,kyphosis,kyphoscoliosis,lordosis, curvature NOS excl. congenital deformities(394),ankylosing spondylotis (360)	375

Other musculoskeletal and connective tissue disorders:-

B	717	Chronic internal derangement of knee incl. longstanding meniscus tear,loose body in knee, chondromalacia patellae excl.acute,current injury(471),recurrent dislocation (381)	376
A	718.3	Recurrent dislocation of joint	
A	727.0(pt)	Trigger finger	
A	727.1	Bunion	
A	731.0	Paget's disease of bone	
A	734	Flat foot (excl.known congenital abnormalities (754.6))	
A	735.0,735.2	Hallux valgus and rigidus	
A	736.1	Mallet finger	
A	736.4	Genu Valgum or varium (excl.known congenital abnormalities (755.6))	
	727.1,734-736	Other acquired deformities of limbs excl.pes planus(flat foot),hallux valgus-varus-rigidus, bunion,mallet finger,genu valgum-varum,congenital deformities and anomolies(393,394)	377 *
B	727.4	Ganglion of joint (capsule) and tendon(sheath)	378
A	730.2	Osteomyelitis	
A	730.9	Costochondritis(unspecified)	

B 732	Osgood-Schlatter's Disease, other osteochondroses and osteochondropathies incl. Scheuermam's Disease, Legg-Calve-Perthe's disease, slipped femoral epiphysis, osteochondritis dissicans	379
B 733.0	Osteoparosis	380
A 733.1	Pathological fracture (code cause and site separately)	
Rdr. 710-739	Other diseases of musculoskeletal system and connective tissue incl. weakness in limb muscle or joint NOS., post-surgical back pain, arthrodesis, malunion or non-union of fracture, joint mice(excl. knee) excl. trigger finger, (367), curvature of spine(375), late effects of polio (007)	

XIV CONGENITAL ANOMALIES
excludes:- mole, pigmented naevus(049), haemangioma, lymphangioma(052), cretinism (062)

A 740	Anencephalus	
A 741	Spina bifida(with or without hydrocephalus)	
A 742.3	Congenital hydrocephalus	
B 743.6 (pt)	Blocked tear duct, agehesis of lacrimal punctum	390
A 744.2(pt)	Bat ear	
B 745-747	Congenital anomolies of heart and circulatory system	391 *
A 749	Cleft palate and/or cleft lip	
A 750.5	Congenital hypertrohic pyloric stenosis	
A 751.0	Meckle's diverticulum	
B 752.5	Undescended testicle	392
A 752(Rdr), 753	Other genito urinary anomalies	
A 754.3	Congenital club foot	
A 754.5, 754.6, 754.7(pt)	Congenital dislocation of hip(excl. diagnosis based only on clicking hips during the first two weeks of life.	
A 754.4, 754.7(pt)	Certain congenital anomalies of lower limb, incl. genu recurvatum, bowing of long bones of leg, all other congenital deformities of foot excl. pes planus (acquiredX377)	
A 757.3	Birth marks	
A 757.6	Supernumerary nipples	

A	758.0	Down's syndrome
	758.1-758.9	Other and unspecified chromosonal abnormalities
	Rdr.740-759	Other congenital anomolies incl. spondylolisthesis, webbed fingers, Darwin's tubercle, tongue-tie, congenital polycystic kidneys excl. congenital metabolic disorders e.g. cystic fibrosis (Section III)

XV CERTAIN CONDITIONS ORIGINATING IN THE PERI NATAL PERIOD
Excludes:- well baby care (532)

A	760,761,762,763	Foetus or new born affected by maternal conditions, by complications of placenta, cord and membranes, or by other complications of labour and delivery (code any associated pathology separately.
A	764,765	Slow foetal growth, foetal malnutrition, disorders relating to short gestation and unspecified low birth weight
A	766	Disorders relating to long gestation and high birth weight
A	767	Birth trauma
A	768-770	Intra uterine hypoxia and birth asphyxia, respiratory distress syndrome and other respiratory conditions of foetus and new born
A	771.4	Unbilical sepsis
A	771.6	Neonatal conjunctivitis (excl. gonococcal infections
A	772	Foetal and neonatal haemorrhage
A	773	Haemolytic disease of new born
A	774	Other perinatal jaundices
A	779.3	Feeding problems in new born
A	Rdr.760-779	Other perinatal morbidity and mortality conditions
A		Pneumonia of new born see (ICD 770.1) See 400
A		Diarrhoea of new born see (ICD 009.3) see 002
A		Ophthalmia neonatorum see (ICD 771.6) see 400
A		Other sepsis (code at infection site)

29

XVI SYMPTOMS, SIGNS AND ILL-DEFINED CONDITIONS
Excludes:- conditions related to limbs and joints (Section XIII)

Central nervous system and peripheral nerves:-

Excludes:- conditions related to eyes and ears (Section VI)

B	780.3	Convulsions incl. febrile convulsions excl. convulsions in new born (400)	410
B	780.4	Dizziness, giddiness excl. specific vertiginous syndromes (162)	411
B	781.0	Abnormal involuntary movement incl. tremour spasms, fasciculation excl. tic, habit spasms (139), restless-legs syndrome (144)	412
A	781.2, 781.3	Abnormal gait and ataxia	
B	782.0	Disturbance of sensation, parasthesiae excl. restless-legs syndrome (144)	413
B	784.0	Headache incl. pain in head or face NOS excl. tension headache(134) migraine(143), atypical facial neuralgia (144)	414
A	784.4 (pt)	Aphonia (excl. psychogenic)	
A	784.3-784.5(except 784.4 (pt))	Disturbance of speech incl. hoarseness excl. stammering, stuttering (129)	415

Cardiovascular & lymphatic systems

B 780·2	Syncope, faint, blackout	416
B 782·3	Edema—localized or dependent *excl.* fluid retention (068), in pregnancy (317), allergic (496),	417
B 785·1	Palpitation (aware of heartbeat)	418
785·2, 785·9 (pt) B	Heart murmur NEC, or NYD; functional, innocent	419
B 785·6	Enlarged lymph nodes, not infected *incl.* lymphadenopathy *excl.* lymphadenitis—acute (333), —chronic (036)	420
B 786·5	Chest pain, *incl.* precordial pain, painful respiration, pleurodynia, pleuritic pain	421

Respiratory system

Excludes:- hoarseness (413), painful respiration (421), pleural effusion:- NOS (229), - known cause, not TB (228), - tuberculosis (003)

B 784·7	Epistaxis	422
B 786·0, 786·1	Dyspnea *incl.* orthopnea, wheezing, stridor, tachypnea *excl.* hyperventilation of psychogenic origin (115), respiratory distress of newborn (400), respiratory failure (452)	423

B 786.2	Cough				424
B 786.3	Hemoptysis				425

Gastro-intestinal system & abdomen:
excludes:- indigestion (247), haematemesis melena (262), bleeding per rectum Nos (259), rectal & anal pain (257), diarrhea, Nos: - presumed to be infective (002), - presumed not to be infective (254), constipation (256)

B 783.0	Anorexia				426
B 787.0	Nausea and/or vomiting excl. of pregnancy (317), of newborn (400)				427
B 787.1	Heartburn				428
B 787.3	Gas problems (wind) Incl. eructation, bloating, gas pains in the adult, flatulence, passage of excess gas per rectum				429
9. 787.6	Faecal incontinence	✓	16	0.1	
B 789.0	Abdominal pain Incl. infantile colic				430
B 789.1, 789.2	Hepatomegaly and/or splenomegaly				431
7 789.5	Ascites	✓	20	0.1	

Genito-urinary system :-
Excludes :- haematuria (276), bacteriuria (274), other abnormal urine findings (444-446) frigidity, impotence, reduced libido, psychogenic dyspareunia (119), dyspareunia NOS - female (291), - male (284), vaginitis (289), breast pain (286), nipple discharge (286), breast lump (286), menses absent, scanty, or rare (295), menses excessive, frequent or irregular (296), menses painful (dysmenorrhea) or intermenstrual pain (294), menses otherwise abnormal, incl. intermenstrual bleeding, metrorrhagia (297), menometrorrhagia (296), menopausal symptoms (293)

B788.1	Dysuria	432
788.3	Enuresis, bedwetting, urinary incontinence *excl.* clearly of psychogenic origin (123), stress incontinence NOS (290)	433
B788.4	Frequency of urination *Incl.* polyuria, nocturia	434

General signs & symptoms :-
Excludes :- pruritis (343), allergy NOS (496), allergy to medications (497), contact dermatitis (339, 340), atopic eczema, atopic dermatitis (338), urticaria (351), allergic edema, angioneurotic edema (496), allergic reaction to insect bite or sting (484), allergic reaction to immunization (498), allergic reaction NOS (496), allergic rhinitis (219), allergic asthma (226), allergic gastro-enteritis or colitis (254), allergic conjunctivitis (151), obesity (067), headache NOS (414), behaviour disorder (126)

B 780.6	Fever of undetermined cause (pyrexia of unknown origin), hyperpyrexia	435

B 780·7, 799·3	Malaise, debility, fatigue, tiredness *incl.* postviral syndromes *excl.* neurasthenia (112)	436
B 780·8	Excessive sweating, hyperhidrosis	437
B 782·1	Rash & other non-specific skin eruptions	438
A 782.4	Jaundice (not elsewhere classified)	
782·2, 784·2, 786·6, 789·3 B	Mass, lump, or localized swelling in abdomen, pelvis, chest, head & neck, skin & subcutaneous tissues *excl.* breast (286), swelling of joint (363), enlarged lymph node (4·20)	439 *
B 783·2, 799·4	Weight loss, cachexia	440
B 783·3	Feeding problems baby or elderly *excl.* feeding problem in neonatal period (400)	441
B 783·4	Lack of expected physiological development, failure to thrive	442
B 797	Senility, senescence *excl.* senile dementia (300)	443

ilie Investigations with unexplained abnormal results :-

lic Urinanalysis :-

Excludes:- haematuria NOS (276), bacteriuria NOS (274)

791.0	Proteinuria, albuminuria	444
791.5	Glycosuria	445
B Rdr. 791	Other abnormal urine test finding excl. orthostatic albuminuria (273), metabolic disorders involving amino acids & certain carbohydrates (065)	446

talie Hematology :-

Excludes:- abnormal quantity or quality of white cells (085), abnormal platelets and coagulation tests (084)

790.0, 790.1	Hematological abnormality, other than of white cells, platelets, or coagulation incl. abnormal red cells, raised ESR excl. anemia (080, 081, 082, 083, 317), polycythemia rubra vera (054)	447

lic Blood chemistry :-

B 790.2-790.9	Abnormal unexplained biochemical test incl. glucose tolerance test, multiphasic biochemical screening (SMA), bacteremia excl. disorders of: fluids, electrolytes, acid-base balance (068), aminoacids & certain carbohydrates (065), lipids (065), renal failure, uremia (277), hyperuricemia (066), hypoglycemia (063), hyperglycemia (063)	448 *

B 795·0	Non-specific abnormal pap smear *excl.* cervical dysplasia (288), carcinoma-*in-situ* of cervix (044)		449
B 796·2	Elevated blood-pressure without a diagnosis of hypertension (hyperpiesia, hyperpiesis)		450
B 792-794, 795 (except 795·0) 796 (except 796·2)	Other investigations with unexplained abnormal results *Incl.* ECG, X-rays, ultrasound, function studies, serology, histology		451
Italic	All other signs, symptoms, & ill-defined conditions :		
Rdr. 780-799	All other signs, symptoms, & ill-defined conditions *Incl.* ~~abnormal gait, anuria, jaundice,~~ cyanosis, pallor, halitosis, gangrene, hiccough, ~~fecal incontinence, ascites~~ death of unknown or undetermined cause, respiratory failure, other poorly understood condition which is under observation *excl.* stridor (473), fluid & electrolyte disturbance (068)		452

XVII. ACCIDENTS, INJURY, POISONING, & VIOLENCE

Fractures (excl. malunion, non-union (M81)

A 800–804	Skull ~~fracture~~ ... with or without facial bone fracture	
B 805, 806	Vertebral column, with or without co lesion	461
B 807.0, 807.1	Ribs	462
B 810	Clavicle	463
B 812	Humerus	464
B 813	...pdius, ulna *Incl.* Colles' fracture	465
B 814, 815, 825	Carpal, metacarpal, tarsal, ~~...~~tarsal bone(s)	466
B 816, 826	Phalanges of foot or hand	467
B 820, 821	Femur	468

B	823, 824	Tibia, fibula *Incl.* Pott's fracture	469
B	Rdr. 800–829	All other specified, or ill-defined fractures	470

Italics Dislocations :

A	830	Dislocation of jaw
A	831	Dislocation of shoulder

471

Rdr. ~~830~~ 832 – 839	All other dislocations & subluxations	472

Italics Sprains & strains (of joints, muscles, & ligaments)

B	840, 841	Shoulder, upper ....., elbow, forearm	473
B	842	Wrist, hand, finger	474
B	844	Knee, (lower) leg	475
B	845.0	Ankle	476
B	845.1	Foot, toe	477

B	846, 847.1 847.9	Rest of vertebral column *Incl.* sacroiliac region, coccyx	478
B	847.0	Neck *Incl.* whiplash	479
B	Rest. 840–848	All other sprains & strains *Incl.* ill-defined	480

Other trauma:

B	850–854	Head injury, concussion, intracranial injury; without skull fracture *excl.* late effects (429), psychological effects (129)	481
A	860–869	Internal injury of chest, abdomen & pelvis	
B	870–897	Laceration, open wound, traumatic amputation *Incl.* injuries to teeth & eardrum, puncture wound & animal bite	482
B	905–909	Late effects of trauma *Incl.* scarring, deformities, disabilities *excl.* non-union, malunion of fracture (391)	483
B	910–919 (N) 989.5 (N)	Insect bite & sting	484
B	910–919 (N)	Abrasion, scratch, blister *Incl.* eye abrasion	485

B	910 – 919 (pc)	Foreign body in superficial tissues *excl.* foreign body in eye (448), residual or old foreign body in tissues, foreign body granuloma (368)	486
B	920 – 929	Bruise, contusion, crushing with intact skin surface *incl.* hematoma, contusion of eye *excl.* spontaneous subconjunctival hemorrhage (156) internal organ injury (491)	487
B	930	Foreign body in eye *incl.* adnexae *excl.* residual or old foreign body in eye (156)	488
	931 – 939	Foreign body entering through orifice excl. eye	489
B	940 – 949	Burns, scalds—all degrees *incl.* chemical burns, radiation burns, burns of eye	490
	955-957	Injury to peripheral nerves	
	Rdr. 850 – 959	Other injury or trauma *incl.* multiple trauma, ~~internal injury of chest, abdomen and pelvis~~ [illegible] early complications of trauma NOTE: for *suicide* or *attempted suicide*, code the nature of the self-inflicted injury or adverse effect as well as any known underlying emotional or social problem	491 *

Italic Adverse effects:

B 960-979	Poisoning by medicinal agent, accidental or deliberate overdose	492
B 980-989 (except 989.5(pt))	Toxic effects of other substances *Incl.* lead, carbon monoxide, industrial materials, poisonous plants	493
990-994 (except 994.5) 9C14 6	Other adverse effects of physical factors. incl. heat, other effects of cold, pr[illegible]e motion, lightning, drowning, radiation (natural, industrial, diagnostic or therapeutic) *excl.* sunburn (360), snowblindness (1561), radiation-burn (490)	494
994.5	Chilblains	495
B 995 (except 995.2)	Certain adverse effects not elsewhere classified *Incl.* anaphylactic shock, angioneurotic edema, allergic edema, allergic reaction NOS, anesthetic shock	496
B 995.2	Adverse effect of medicinal agent correctly administered in proper dosage. May also code the nature of the adverse effect *excl.* reaction to immunization & transfusion—(495)	497

B 996-999

Complications of surgery & medical treatment
incl. post-operative wound infection, hemorrhage, and disruption; complications of prostheses, devices, and implants; immunization & transfusion reactions
excl. adverse effects of diagnostic & therapeutic X-rays (496)

498

XVIII. SUPPLEMENTARY CLASSIFICATION

:talic Preventive medicine :—
Excludes:- positive skin test conversion for tuberculosis (003), allergy tests (code the allergic condition)

B	V01, V02, V07 (except V07.1)	Contacts & carriers (suspected or proven) of infective or parasitic diseases *Incl.* prophylactic therapy *excl.* rheumatic fever prophylaxis (180)	510
		Prophylactic immunization, innoculation, & vaccination against	
	V03.C	Cholera alone	511
	V03.1	Typhoid/paratyphoid TAB	512
	V03.2	Tuberculosis BCG	513
A	V03.6	Whooping Cough (pertussis) alone	
	V03.7	Tetanus toxoid alone	514
	V04.0	Poliomyelitis alone	515
	V04.1	Smallpox	516

V04·2	Measles alone	517
V04·3	Rubella alone	518
V04·4	Yellow fever	519
V04·8	Influenza	520
V06·1	Diphtheria - tetanus - pertussis	521
V06·1 (pt)	Diphtheria - tetanus	522
V03·3 - V03·4, V03·8, V03·9, V04·5 - V04·7, V05, V06 (except V06·1)	Other	523 *

B. No equivalent ICD-9 code

Observation & care of patient on high risk medication
Requires: additional code for primary diagnosis

524

V10-V13, V15-V19, V42-V46 (except V45.5)	Observation & care of other high-risk patients *Incl.* patient-care management of prosthetic devices & implants, status post-surgery, family history of certain diseases, personal history of certain diseases code underlying condition if applicable	525
V70.3, V70.5 (pt)	General medical examination for administrative purposes or employment incl. adoption, insurance, school admission	526
V72.0	Special examination of eyes and vision	527
V72.1	Special examination of ears and hearing	528
V76.2	Cervical cytology smear Note:- Code any abnormal findings elsewhere.	529
V79.3, V82.3, V82.4	Special screening in early childhood for developmental handicaps; congenital dislocation of hip, chromosomal anomalies	530
V81.1	Special screening for hypertension	531

V20, V21, V28, V30–V39, V65.2, V65.5, V70–V82 (except V70.3, V70.5 (pt), V72.0, V72.1, V72.4, V72.7 V76.2, V79.3, V81.1, V82.3, V82.4)	Other medical examination, incl. other health screening, complete or partial check ups, care of well child or infant, pre-operative examination, examination or investigation to exclude specific disease	53

Italic Family planning:

V25.0 (pt)	Advice regarding sterilization	533
V25.0 (pt)	Advice regarding termination of pregnancy	534
V25.0 (pt)	General advice on contraception excl. attendances related to specific methods (533–539 and 312)	535
V25.2	Sterilization of male or female incl. attendance related to the operative procedure excl. advice only regarding sterilization (533)	536
V25.0 (pt), V25.4 (pt)	Oral contraceptive excl. complication of oral contraceptive (497)	537
V25.1, V25.4 (pt), V45.5	Intrauterine contraceptive device excl. complication of intrauterine device (498)	538

	Cap/diaphragm (with or without spermicidal agent)	
	Rhythm method	
V25.3, V25.4(pt), V25.8, V25.9	Other methods of contraception (+ multiple)	539
V26.3, V26.4	Procreative management incl. genetic, general counselling and advice about reversal of sterilization excl. consultations specifically for male infertility (606) or female infertility (682)	

Administrative procedures:-

V68 (except V68.8(pt))	Letters, forms, certificates and prescriptions without need for additonal examination or interview of patients excl. prescription for oral contraceptive (537) and other prescriptions where consultatic relates in any way to the patient's clinical condi'.on	540
B V68.8(pt)	Referral of patient without need for exa nination or interview	541

Italic Miscellaneous :

B V26·3, V26·4, V65·3, V65·4 — Advice, health instruction & education
Incl. class instruction
excl. contraceptive instruction (525) — 545

V50, V51, V59 — Medical or surgical procedure without reported diagnosis
Incl. surgical assist, piercing of ears, circumcision without disease, blood donor — 546

Consultations relating to normal management of ostomy states (V55) and ostomy states without problems (V44)
excl. colostomy and enterostomy malfunctions (569·6)

V65·1 — Patient consulting on behalf of another person.
excl. manifestations of anxiety in a third party, consulting about another sick person — 547

Italic Social, marital, & family problems and maladjustments

Note: this section is for social problems and maladjustments (inside the family or outside) which have been explicitly discussed and which are accepted by the patient as a significant problem. More than one of these codes may be applied to a patient. These codes may be used alone to describe the substance of an encounter, or may be used as additional codes to show the interdependence between organic or mental disease and the social milieu of the patient
excl. contact with person acting as emissary for another person who is experiencing problems (547)

B V60·0, V60·1 — Housing problem — 548

B V60·2 — Economic problem, poverty. — 549

B V61.0	Family disruption, with or without divorce, affecting the couple or others *excl.* bereavement (112 5)	550
B V61.1	Marital problem *incl.* problems of the relationship between a man & a woman, whether married or not *excl.* problems limited to sexual activity (119)	551
B V61.2	Parent–child problem *incl.* concern about behaviour of child, problems related to adopted or foster child, child abuse, battered child, child neglect	552
B V61.3	Problem with aged parents or in-laws	553
B V61.4	Problem of caring for sick person (e.g. alcoholic family member) *excl.* patient lacking person able to render care (559)	554
B V61.5, V61.7–V61.9	Other problem of the family relationship NEC	555
B V61.6	Pregnancy out of wedlock (illegitimate pregnancy), illegitimacy	556

V62·0 – V62·2 B	Occupational problem *Incl.* unemployment, difficulties at work or in adjusting to work situation, career choice problem or frustration	557
B V62·3	Educational problem	558
V62·4, B V60·3 – V60·6	Social maladjustment *Incl.* social isolation, persecution, cultural deprivation, political, religious, or sex discrimination	559
B V62·5	Legal problem *Incl.* imprisonment, prosecution, litigation, legal investigations	560
B V62·8 (pt)	Phase-of-life social problem NEC	561
V60·8, V60·9, B V62·6 – V62·9 (except V62·8(pt))	Other social problems *Incl.* refusal of treatment for reasons of religion or conscience	562

.lic Other problems not classifiable elsewhere:

Rdr. V01 – V82 B	All other problems not classifiable in codes 001 to 562 *Incl.* disfigurement or cosmetic problem NOS, other supplementary classification options detailed in ICD.	563