



**Wonca**

**International  
Classification  
Committee**

**Open Day**

**Book of abstracts**

**Nova Medical School, Lisbon**

**September 6, 2014**



**INDEX**

Oral presentations ..... 4  
Poster presentations..... 12  
Panel discussions ..... 18  
Workshops ..... 31

## ORAL PRESENTATIONS

### Research

- O01 Assessing Portuguese national priority programs using ICPC-2 coding ..... 5
- O02 Content analysis of abstracts of communications of GP during congresses, a step forward ..... 6
- O03 ICPC use around the world ..... 7
- O04 Fluctuation of unemployment in a health care unit and comparison with unemployment rates in its municipality ..... 8
- O05 How frequently does Vertiginous Syndrome present itself with Vertigo as its initial Reason for Encounter? ..... 9

### Practice

- O06 Using ICPC in the Chiawelo community practice in Soweto .10
- O07 Teaching ethics of prevention while defining fields of activities in GP/FM, a success of WICC ..... 11

## 001 Assessing Portuguese national priority programs using ICPC-2 coding

**Authors** Ana Vaz Ferreira, José Mendes and David Brito

**Organizations** USF Mondego

**Contact** [anavazferreira@gmail.com](mailto:anavazferreira@gmail.com)

**Keywords** Portugal; Primary Health Care; Health Policy

**Background:** Portugal has nine “National Priority Programs” (NPP), in which epidemiological surveillance and analysis of indicators are a transversal objective. The International Classification for Primary Care 2 (ICPC-2), when associated with electronic medical records it can be crucial in the clinical practice, allowing to measure the burden of disease in patients files and compare it to the national and international realities. Objectives: Observe if epidemiological surveillance objectives of the NPP can be achieved using the ICPC-2 coding and demographic characterization (age and sex) of patients with the adequate codification.

**Methods:** A descriptive, cross-sectional study was performed in July 2014. The data regarded December 2013 and was obtained from five medical files in one Primary Health Care Unit in the center of Portugal using the clinical statistical software SAMestat®. The number of encodings of diseases in the list of active problems was collected using ICPC-2 codes: B90; D75; K: 74, 75, 76, 86, 87, 89, 90, 91; P: 06, 70, 74, 76; R: 95, 96C; T: 89, 90; W85; X: 75, 76. Also, risk factors were searched using ICPC-2 codes: P17, T: 82, 83, 93. The demographic data of users, age and sex, was also collected. Data were processed using Microsoft Excel® 2010.

**Results:** Data was obtained on the prevalence of diseases, risk factors targeted in NPP and demographic characteristics of users with these encodings and compared with national data.

**Discussion:** Broader codes than our objectives were found, for example, in Obstructive Sleep Apnea which has the same code as insomnia and nightmares. We found there is not any code that enable specifically complications of diabetes. This gap could be solved by creating a new code or sub code, similarly to the K87 “Hypertension complicated” or simplifying the process of adding notes in ample codes. Furthermore there are no codes for “Impaired Fasting Glucose” or “Impaired Glucose Tolerance”, fixable by creating a new code, similarly to the K85 “Elevated Blood Pressure”. In general, ICPC-2 is useful for quick information retrieval and uniform characterization of populations, comparison with the national and international context and identification of risk groups. It is also useful in monitoring and investigating the achievement of goals. However, they have their greatest benefit when associated with good information systems that allow rapid and reliable data collection, and there is still room for improvements.

## 002 Content analysis of abstracts of communications of GP during congresses, a step forward

**Authors** Marc Jamouille

**Organizations** Espace Temps health center, Département Universitaire de Médecine Générale, University of Liège

**Contact** marc@jamouille.com

**Keywords** publication; classification; knowledge management; family physician

**Context** To succeed to have an accepted communication in a congress is a quite challenging and time consuming process. The gathered knowledge will often remain an ephemeral work as more than 50% of abstracts of Wonca congresses never reach the step of publication. Despite the effort to publish online the abstracts of Wonca Europe congresses, those remains largely useless as they are not indexed. The Medical Subject Heading (MeSH) are often recommended but 25.000 descriptors are a lot of and frequently not fit for GP/FM

**Methods** Following the seminal idea of the late Henk Lamberts, the author has proposed to index the abstracts of communications of GPs with the 17 chapters and rubrics of the International Classification of Primary Care while using the letter Q for indexation of non-clinical matters. The opening of the letter Q for coding Wonca 2007 abstracts has given rise to a proposal for a classification called Core Content Classification of General Practice (3CGP/FM). 3CGP encompasses 8 domains and a rag bag. The 8 domains are open in categories and subcategories. Remained dormant during several years the project kind of woke up in Portugal during the 2013 APMGF( Associação Portuguesa de Medicina Geral e Familiar) congress. Two congresses of the French association of teacher, the Confederation Nationale des Généralistes Enseignants (CNGE 2013 & 2014) have been submitted to careful content analysis using the Atlas.ti software and ICPC and 3CGP as coding items.

**Results** The analyze of 998 abstracts in Wonca 2007, 125 in APMGF Covilha 2013, 205 CNGE in Clermont 2013 and the ongoing process to code the CNGE Lille Nov. 2014 submitted abstracts has provoked the evolution of 3CGP and demonstrates the interest to combine ICPC and a non-clinical classification for indexing Family doctor's work. Next phases of the projects will be to link 3CGP to Wonca dictionary definitions, to corresponding MeSH where possible, and to edit in Protégé, the semantic web editor, a reference terminology for coding keywords in a domain-specific General Practice thesaurus. Indeed semantic knowledge technology is waiting general practice and will permit indexing congresses automatically or in a helped way to face the need of knowledge management for the family medicine of the future.

**Discussion** The collaboration of WICC will be asked for further work.

## 003 ICPC use around the world

**Authors** Nuno Basílio<sup>1</sup>, Sofia Figueira<sup>2</sup>, Carla Ramos<sup>2</sup> and Daniel Pinto<sup>3</sup>

**Organizations** 1 UCSP Barcarena; 2 USF S. Julião; 3 Department of Family Medicine, NOVA Medical School / Faculdade de Ciências Médicas, Universidade Nova de Lisboa

**Contact** [anasofiafigueira@gmail.com](mailto:anasofiafigueira@gmail.com)

**Keywords** ICPC; primary health care

**Background** The International Classification for Primary Care (ICPC) was developed to be used in primary health care in order to respect its specificities. Information on the use of clinical classifications, including ICPC, around the world has not been updated in a systematic fashion recently.

**Objectives** To characterize the worldwide use of ICPC and other classifications in Primary Care settings and to identify specificities of use in each country.

**Methods** Self-completion questionnaire consisting of multiple choice questions, short answer and open response emailed to members of the WONCA International Classification Committee (WICC) and family physicians from each of the countries recognized as such by the United Nations (UN).

**Results** From the 200 countries listed on the UN's website we obtained e-mail contacts from representatives of 109 countries. We received 60 responses from 51 different countries which correspond to 26% of all states listed on the UN website: 30 from Europe, 7 from Asia, 1 from Oceania, 6 from Africa and 7 from Americas. In 33 countries (17%) there is a version of ICPC available in a national language. ICPC is used in primary care in 27 countries (14%), but it is mandatory standard in only 6 (3%). Concerning the countries that use ICPC in primary care, 14 use it to classify both episodes and encounters. Regarding the topics accounted for in clinical records, 10 countries use it to classify only reasons for encounter and diagnosis and just 5 countries use ICPC to classify reasons for encounter, diagnosis and processes of care. Regarding the 24 countries that answered they don't use ICPC for clinical records in primary care, the International Classification of Diseases 10th edition (ICD-10) is used in 19 countries, other classifications are used in 3 countries and 2 countries use no classification.

**Conclusions** Although the response rate to the questionnaire was low, we can conclude that ICPC use around the world is not widespread and it's unevenly applied. Even when considering the countries that use ICPC in primary care, in most of them it's not a mandatory standard. In spite of not being adapted for primary care, ICD-10 is the most used classification after ICPC.

## 004 Fluctuation of unemployment in a health care unit and comparison with unemployment rates in its municipality

**Authors** José Mendes, Ana Vaz Ferreira and David Brito

**Organizations** USF Mondego

**Contact** josemendes.web@gmail.com

**Keywords** Unemployment; Portugal

**Background:** Unemployment is a problem common to many countries including Portugal. This problem is a major economic and social indicator that helps to characterize a population. The impact on patients and families can be assessed indirectly through the chapter “Social Problems” of the ICPC-2 coding, specifically the code for unemployment – Z06.

**Objectives:** To compare the variation in the coding of unemployment (Z06) in our Primary Care Health Unit (PHCU) with the actual unemployment in its municipality.

**Methods:** A descriptive, cross-sectional study was performed in July 2014. Data related to unemployment, in the Municipality of Coimbra and regarding each trimester since January 2012 until March 2014, were collected from the Portuguese Institute of Employment and Professional Training. The number of ICPC coding “Z06 – unemployment problem” was collected for the same periods, in the patient files of the five doctors of a PHCU, in Coimbra, Portugal, using MIM@uf. The data was adjusted to the size of the population in each given time and the growth dynamics were calculated. The software Microsoft Excel® 2010 and IBM SPSS® v.20 was used to process and analyze the data.

**Results:** The variation over time of the rates of unemployment among males and females of our PHCU was similar among themselves and in relation to total unemployment. The variation in coding unemployment has large fluctuations over time for both sexes. There is a growing trend for encoding since the third quarter of 2013. This variation in coding was considerably different from the variation in the unemployment rate.

**Discussion:** Comparing the encoding of the unemployment problem with the unemployment rates of the area of influence of our PHCU, we find that these have a fairly different variation over time. Since it is important to characterize a population, there is a need to raise the awareness of health professionals to be alert to this problem and to conduct more of its encoding. Such studies should be performed in more Health Units in order to obtain a regional characterization, and for other types of problems, to ensure parallelism between reality and the actual coding. The encoding using the Z codes chapter of ICPC-2 is not yet widely used in clinical practice day-to-day. We are also aware that unemployment (Z06) particularly is often not coded, which makes a distorted picture of reality.



## 005 How frequently does Vertiginous Syndrome present itself with Vertigo as its initial Reason for Encounter?

**Authors** Stephanie de Castro<sup>1</sup> and Ana Ribeiro<sup>2</sup>

**Organizations** 1 USF +Carandá, 2 USF São João de Braga

**Contact** stephaniedecastro@gmail.com

**Keywords** Vertigo;Dizziness; Vertiginous Syndrome; International Classification of Primary Care; Reason for Encounter

**Study design** Cross-sectional retrospective study.

**Introduction** In the International Classification of Primary Care (ICPC) the Vertiginous Syndrome diagnosis, classified in the Ear Chapter as H82, includes Benign Paroxysmal Positional Vertigo, Labyrinthitis, Meniere Disease and Vestibular Neuronitis, and requires true rotational vertigo as inclusion criteria. All four of these diseases represent the most common causes of peripheral vertigo. However, Vertigo/dizziness is classified in the ICPC in a different Chapter, the Neurological System as N17.

**Objective** Determine and analyze the frequency in which Vertiginous Syndrome presents itself with Vertigo/dizziness as main Reason for Encounter (RFE) during a Primary Care consultation. Describe the demographic characteristics of the sample of patients with Vertiginous Syndrome and identify and analyze the other RFE associated with H82 problem codification.

**Population** A random sample of 144 patients, that had a first consultation with the diagnosis codification H82, between January 2009 and December 2013, in Unidade de Saúde Familiar (USF) São João de Braga and USF +Carandá (Braga).

**Methods** Data were collected during August 2014 by consultation of medical records. Demographic variables (age and sex) were collected. Presence of N17 as well as other RFE associated with the diagnosis H82 were gathered. An univariate descriptive analysis was conducted with the determination of absolute and relative frequencies and measures of central tendency.

**Results** 106 out of 144 patients with Vertiginous Syndrome presented Vertigo/dizziness, corresponding to 73,6% of RFE for the diagnosis H82. The next three most prevalent RFE were Tinnitus, ringing/buzzing ear – H03 – (14,6%), Nausea – D09 – (11,1%), and Vomiting – D10 – (5,5%). 18,8% of patients with H82 problem codification had no symptom associated. From these patients, 37% had their diagnosis made by an Otorhinolaryngologist (only 1,4% of these patient presented the RFE H61– Results Examination/Test/Record/Letter from Other Provider) and 22,2% had no RFE registered.

**Conclusion** Vertigo/dizziness is the most prevalent RFE related to the Vertiginous Syndrome diagnosis, however they belong to two distinct ICPC Chapters. Since ICPC determines classification by anatomical systems, and vertigo may be attributed to neurological and ear alterations, the creation of a new rubric classifying Vertigo/dizziness in the Ear Chapter – H17 – may be pertinent.

## 006 Using ICPC in the Chiawelo community practice in Soweto

**Authors** Shabir Moosa

**Organizations** Department of Family Medicine, University of the Witwatersrand

**Contact** shabir@drmoosa.co.za

**Keywords** ICPC; Community-Oriented Primary Care; Morbidity

**Background** PHC Outreach Teams, based on Brazilian experience and Community Oriented Primary Care (COPC), are a core part of PHC Reengineering and National Health Insurance (NHI) plans in South Africa. Whilst government is implementing NHI pilots there has been little work on information to develop strong costed models of service delivery.

**Discussion** The Chiawelo Community Practice (CCP) was set up in Soweto (South Africa), as a part of implementation of PHC Outreach Teams, to cover a population of 12 000. The Community Practice started in January 2014 with an iterative process of CHW mapping / registration of the community; a strong person-, family and community-centred practice integrating almost all services in the Chiawelo CHC; stakeholder engagement; and growing health promotion. Doctors, nurses and clinical associates are collecting paper-based ICPC data. Community health workers are also being engaged on the use of ICPC for their daily work. The presentation will include the dynamics of this process, the experiences and the outputs so far, including an insightful demographic, morbidity and utilization profile of this community.

**Conclusions** There is material value in strong models of COPC. Chiawelo Community Practice is allowing us an opportunity to explore use of ICPC in very team-based and community-oriented practice. We see it affording us an opportunity in the near future to explore outcomes for COPC and costs for the NHI.

## 007 Teaching ethics of prevention while defining fields of activities in GP/ FM, a success of WICC

**Authors** Marc Jamouille

**Organizations** Espace Temps health center, Département Universitaire de Médecine Générale, University of Liège

**Contact** marc@jamouille.com

**Keywords** quaternary prevention; medical ethics; family physician

**Context** When presented in Durham during the 1995 WICC workshop, the concept of quaternary prevention, born in 1986, has attracted the consensus of the whole audience. In 2003 it has been discretely published in the Wonca dictionary of general practice.

**Method** Since this time, medicine has changed. The diffusion of knowledge and the sagacity of some researchers has shown that medicine could become dangerous for health. The concepts of overinformation, overdiagnosis, overtreatment and overscreening are now the bread and butter of numerous medical journals and the themes of numerous books and disputes throughout the world. Quaternary prevention encompasses all those domains and supersedes them by putting the relationships between patient and doctor at the center of the ethical reflection.

**Result** WICC has been instrumental in the genesis and dissemination of the concept of quaternary prevention. This concept is now known and distributed worldwide under the acronym P4. Family physicians form interlinked P4 groups in various countries. It is the theme of many congresses and was propelled to the forefront of the recent Wonca Europe Congress. This concept could induce profound changes in the role of the family physician in health care. Moreover, the combination of the four definitions of prevention provided an amazing view of the activity of family physicians and could renew basic job description in GP / FM.

## POSTER PRESENTATIONS

### Research

- P01 Psoriasis population characterization on two primary care units .....13
- P02 Incidence evolution of mandatory declaration sexually transmitted diseases in two primary care units ..... 14
- P03 Does sleep apnoea have its due place in ICPC-2? ..... 15

### Practice

- P04 Is there an association between risk factors and depression? The Tejo's experience ..... 16
- P05 How to code for ICPC female genital mutilation?..... 17

## P01 Psoriasis population characterisation on two primary care units

**Authors** Andreia Ramôa<sup>1</sup> and Pedro Costa<sup>2</sup>

**Organizations** 1 USF Gualtar; 2 USF Maxisaúde

**Contact** andrea\_ram@hotmail.com

**Keywords** Psoriasis; Risk Factors

**Introduction** Psoriasis is a chronic inflammatory skin disease affecting 1-3% of the population. Disease severity and incapacity degree are diverse, with the patient quality of life seriously diminished in many cases. Risk factors associated with disease exacerbation are the focus of many current studies.

**Goal** Characterise psoriasis population in two primary care units in the north of Portugal.

**Methods** Retrospective transversal study. MIM@UF was used to identify psoriasis diagnosed patients (S91) on 30 of June 2014. SAM was later used to identify patients with codes (ICPC-2): Tobacco Abuse (P17), Overweight (T83), Obesity (T82), or HIV/AIDS Infection (B90) on the list of problems. Alcohol consumption was analysed, based on the individual registry made during the six months previous to disease exacerbation. All consultation episodes were studied, for identifying the episodes of disease exacerbation, all the consultations of the previous six months were then subject of analysis, verifying if one of the following factors was codified: stress (P01; P74; P76), skin lesion, (S16, S17, S18) or respiratory infection (R72, R74, R76). Data was analysed using Excel 2013®.

**Results** 252 users were studied, 54,4% (n=137) masculine, with 48,6 years average age, minimal age of 10 years, and maximal age of 87 years. Global disease prevalence is 9,1/1000 users. On psoriasis patients, 17% had a stress codification on the previous six months to disease exacerbation, 10,3% had respiratory infections and 4,8% skin lesions. On the list of problems, 55,2% had codification for overweight or obesity, 26,2% had tobacco abuse and none had HIV/AIDS infection. On Alcohol consumption, 28,6% consume in excess.

**Conclusions** Population psoriasis prevalence was slightly inferior to the current literature. Only approximately 19% of psoriasis patients have no associated risk factors. To know the weight of each factor is of crucial importance, given that several factors can be minimised with the family doctor support and, eventually, help reduce the disease reappearance and exacerbations, improving the patient quality of life.

## P02 Incidence evolution of mandatory declaration sexually transmitted diseases in two primary care units

**Authors** Pedro Costa<sup>1</sup> and Andreia Ramôa<sup>2</sup>

**Organizations** 1 USF Maxisaúde; 2 USF Gualtar

**Contact** pedrojocosta@gmail.com

**Keywords** Sexually Transmitted Diseases; Incidence

**Introduction** Sexually transmitted diseases (STD's) are one of the world's biggest public health problems. STD's have serious socio-economic consequences for people's lives, not only by their morbimortality, but also for the associated social stigma. In Portugal, STD's incidence is still a matter of concern.

**Objective** Analyse mandatory declaration STS's incidence and evolution in two primary care units in the north of Portugal between 2009-2013.

**Methods** Retrospective transversal study. MIM@UF was used to identify individuals with codification (ICPC-2) of syphilis (X70 e Y70), gonococcal infection (X71 e Y71), viral hepatitis (D72) and HIV/AIDS infection (B90) between 2009-2013. Afterwords, using SAM, consultation episodes were studied to confirm it was a new diagnosis. Data were analysed using Excel 2013\*.

**Results** 80 cases of mandatory declaration STD's were diagnosed between 2009-2013, in the two primary care units. The majority of cases occur on men (73,8%), with ages between 20-80 years (average age 42,6 years). The disease incidence, on the study period, showed an increased tendency, both for men and women. Viral Hepatitis (HBV, HCV) was the most frequent disease, corresponding to 68,8% of the cases. Of these, 45,5% were HBV, 45,5% HCV, and 9% were co-infection of HBV-HCV. Of the remaining diagnosed cases, 18,8% corresponded to gonorrhoea, 7,5% to HIV/AIDS and 6,3% to syphilis. During the study period, an increase in all diseases incidence was observed, with exception to gonorrhoea, which kept stable.

**Conclusion** In Portugal, STD's are still a serious problem. However, in recent years, a decreased incidence of HBV, HCV and HIV/AIDS infections has been reported, along with an increase in incidence of syphilis and gonorrhoea. In this study, results for syphilis and gonorrhoea are similar to the general literature, but differ from those with regard to infections with HBV, HCV and HIV. Authors believe the results should be interpreted with caution, since it may reflect the growing concern with quality records and greater support to chronic disease codification, instead of translating an opposite trend to the one observed nationally.

## P03 Does sleep apnoea have its due place in ICPC-2?

**Authors** Mónica Teixeira and Dyna Torrado

**Organizations** UCSP Faro

**Contact** monicbas@gmail.com

**Keywords** sleep disturbance; sleep apnoea; insomnia; ICPC; categorize; research

Sleep disturbance (P06) contain in the same category different and important inclusion criteria, such as sleep apnoea, along with sleep disorders and/or symptoms that are highly prevalent such as insomnia or somnolence, but also nightmares and sleepwalking.

According to some authors, more than 50% of patients who consult a family doctor have symptoms related to sleep disturbance, such as insomnia, which is the most common. On the other hand, Sleep Apnoea Syndrome (SAS) is an important public health problem, not only because its increasing prevalence, estimated between 2-6% in the Western population, but also because the high rates of morbidity and mortality, due to increased cardiovascular risk and traffic accidents. Another problem concerning that pathology is its underdiagnosis.

Given the potential impact and repercussions of SAS it is crucial to categorize it correctly in Primary Health Care (PHC), not only by the importance of the data obtained by the ICPC for epidemiological or research purposes, but also because of the clinical relevance that it has in the medical history of a patient.

This study aims to draw attention to the need of categorizing SAS into one single category, separating it from other sleep disorders, usually very prevalent though less severe.

A casuistic study was carried out on a list of patients where we found that half of the patients coded with P06 had SAS, while the other half manifested symptoms of insomnia.

## P04 Is there an association between risk factors and depression? The Tejo's experience

**Authors** Ana Morgado, Diana Duarte and Avelina Moniz

**Organizations** USF Tejo

**Contact** catarina.amorgado@hotmail.com

**Keywords** primary health care; code clinical; depression; cardiovascular disease; risk factors; corporate practice

**Originality and relevance** In Portugal cardiovascular diseases are responsible for 32% of all deaths. These diseases and depression have high morbidity and health cost and they course with less quality of life. Depression is associated with higher cardiovascular risk. However, this complex relation could be bidirectional.

**Description of the setting** At Tejo's Health Unit (USF Tejo) the major population is over 65 years old (30.8%); that could explain why cardiovascular risk factors are one of the top morbidities coded accordingly to ICPC2 (K86, K87, T90, T89, T93, T82, T83, P17). It seemed important to study the prevalence of depression in this population. We used our database (Mim@Uf) during the first six months of 2014 and we included coded patients (active problems) with those risk factors and depression. Results showed a higher prevalence of depression in this population. The risk factors with higher association with depression are dislipemia - T93 (8.3%); smoking - P17 (8.2%) and hypertension - K86, K87 (7.8%). The feminine gender is the most affected, as well as the population over 65 years old.

**Reflective thinking regarding the experience** With this analysis we were able to establish a relation between the chosen cardiovascular risk factors and depression, identify one subpopulation with higher risk. The screening of risk factors should be evaluated in mental health practice. However, these results may not show Tejo's reality due to sub-encoding of active problems accordingly to ICPC2. In this way it is clear, the importance that encoding accordingly to ICPC2 may have in clinical practice to identify subpopulations at risk or with certain characteristics and for which it is necessary to adopt specific strategies in medical care.

**Implications and consequences** This study established an association between cardiovascular risk factors and depression. This may justify a specific approach in daily practice, including hypertension and diabetes programs. The discussion of these results by the medical team allows a greater awareness and alerts to the association between those diseases and the improvement of quality in medical care delivery. Great efforts should also be made in systematic ICPC2 encoding in order to allow more studies and analyzes. Prevention and health promotion are essential in primary care practice and should be a priority.



## P05 How to code for ICPC female genital mutilation?

**Authors** Antonio Amorim<sup>1</sup>, Claudia Guerreiro<sup>2</sup>, Alexandra Fernandes<sup>3</sup> and Leonor Monjardino<sup>4</sup>

**Organizations** 1 USF Amora Saudável; 2 UCC Seixal; 3 Director of medical internship ARSLVT; 4 Hospital de Santo Espírito da Ilha Terceira

**Contact** antoniodecastroamorim@hotmail.com

**Keywords** ICPC; female genital mutilation

**Introduction** The WHO estimates that between 100 and 140 million women and girls worldwide have undergone some form of genital mutilation. Each year, three million girls and women worldwide are subjected to the practice of Female Genital Mutilation (FGM); which means that each day 8,000 girls and women are genitally mutilated. In Europe it is estimated that 500,000 girls and women suffer the consequences of FGM. Every year, about 20,000 women and girls from countries where FGM is common practice, seeking asylum in the European Union (EU) - 20% of female applicants in 2011 Nearly 15,000 girls - mainly from countries such Somalia, Eritrea and Guinea Conakry - are affected by FGM. FGM has been documented especially in the African continent (28 countries) in some Middle Eastern countries (eg Yemen Kurdish communities, Saudi Arabia) and Asia as well as among certain ethnic groups of Central and South America. Few testimonies and studies report cases of FGM practice in several European countries, although this continent is of women who flee their countries for not being mutilated receiver. The main recipients countries of asylum applications from women and girls at risk of FGM are Belgium, France, Germany, Italy, Netherlands, Sweden and the UK. Over 20% of all applicants in Finland, Ireland, Spain and Portugal are from countries where FGM exists. This proportion increases to 90% in Malta.

**Methodology:** Literature review.

**Discussion** The ICPC is a method of registering in primary Health care. By ICPC-2, we can register a female genital mutilation in two ways: 1<sup>st</sup> - When we observe that only a woman has her mutilated genital, but this mutilation is not recent, and that may or may not be an associated complication. (CODE ICPC-2= X-82) 2<sup>nd</sup> - Apart from female genital mutilation, observe that this is recent, due to complications associated as infection, bleeding, and others. Besides the registration of genital mutilation, and the associated complication, we also recommend the registration of Z-25 "violent act". (CODE ICPC-2= X-82 and Z-25) Conclusion Portugal is a frequent destination for women victims of FGM, accepting and observing them this barbaric crime, and trying to protect new victims of this cruelty done in the XXI century, while respecting the ethnic-cultural differences, is that we come to expose this issue, because only encode the and we know. Also remember that this practice is a crime in Portugal, with punishment provided under the universal and human rights laws.

## PANEL DISCUSSIONS

D01	The use of ICPC in Denmark to measure population-level morbidity and managing health services . . . . .	19
D02	Measuring morbidity in Finland . . . . .	20
D03	Studying morbidity in Portuguese primary care. . . . .	21
D04	What do users feel when they try to classify processes, and what do they need? . . . . .	22
D05	Updating processes rubrics in ICPC 2 to make them more usable. . . . .	23
D06	How should we deal with processes in ICPC 3? . . . . .	24
D07	What are the advantages for clinicians in using clinical terminologies? . . . . .	25
D08	Developing and validating a primary care SNOMED CT Ref-Set. . . . .	26
D09	Adopting SNOMED CT in Portugal. . . . .	27
D10	Why do we need ICPC-3? . . . . .	28
D11	Planing the development of ICPC-3. . . . .	29
D12	Developing a chapter for ICPC-3 - the skin. . . . .	30

## **D01 The use of ICPC in Denmark to measure population-level morbidity and managing health services**

**Authors** Preben Larsen

**Organizations** DAK-E – Danish Quality Unit of General Practice  
WONCA International Classification Committee

**Contact** preben\_larsen@dadlnet.dk

**Keywords** ICPC; morbidity; feedback

Danish general practices and conditions for the development of data capture program for the use in quality improvement in Danish general practice is demonstrated.

The use of data capture feedback reports is demonstrated with emphasis on the use of reports use as a tool for quality improvement in the individual practice and monitoring the individual patient.

The use of data from general practice to support the local and regional health status in relation to risk factors is demonstrated.

Estimated effect of use of data capture program on the cost of diabetes care is demonstrated.

## D02 Measuring morbidity in Finland

**Authors** Tuija Savolainen

**Organizations** The Association of Finnish Local and Regional Authorities  
WONCA International Classification Committee

**Contact** Tuija.Savolainen@kuntaliitto.fi

**Keywords** ICPC; morbidity; health services management

Using ICPC to measure population level morbidity and managing health services. Measuring morbidity in Finland

ICPC is one of the nationally approved classification systems used in electronic health records, in the national patient data repository (eArchive) and in the Register of Primary Health Care Visits in Finland. It is mandatory for all public healthcare organizations to use either ICPC or ICD-10 in coding patients' health problems starting from the point of joining the eArchive.

The latest developments in the arrangement and provision social and healthcare services in Finland have accelerated the need to understand the burden of health problems in primary care as well as to understand the overall process of care and costs per patient and the episode.

A Finnish ICPC-based case-mix system, pDRG is introduced as a tool for transparency in healthcare and towards a better understanding on patients' pathways and use of resources.

## D03 Studying morbidity in Portuguese primary care

**Authors** Nuno Sousa

**Organizations** Barómetro de Ideias  
Portuguese Health System Administration consultant

**Contact** nsousa@acss.min-saude.pt

**Keywords** ICPC; quality indicators; pay for performance

**Background** Portugal has 55 groups of primary health centers (ACES). Each ACES has several functional units (FU) responsible for providing primary health care to the population. The FU where general practitioners (GP) work are of 3 kinds:

UCSP - Personalized health care unit

USF-A - Family Health Units - type A

USF-B - Family Health Units - type B

These 3 types of FU are responsible for providing the same kind of services to patients but have different levels of organization, technical autonomy, contracting and payment schemes.

**Review** The author makes a brief review of the portuguese primary health care (PHC) system organization, of the framework of contracting in PHC. Also describes the portuguese experience on using ICPC-2 for morbidity level measurement, health services management and pay for performance (P4P).

## D04 What do users feel when they try to classify processes, and what do they need?

**Authors** Luiz Miguel Santiago

**Organizations** Beira Interior University

**Contact** lmsantiago@netcabo.pt

**Keywords** ICPC; process of care

After an introduction based on what has been published in Portugal, the ambience is that doctors using ICPC2 prefer annotating to classifying specially in the P chapter of the Weed-Soap method.

Questions arise from the absence of inclusion criteria for the components, the difficulty of choosing the exact alphanumeric code and the need to better define what they wish to translate, hence preferring the annotation.

This problem probably arises from the lack of teaching ICPC2 both in pre and after graduation. In fact and diversely from hospital ambience it is the GP the one who performs the task of coding.

What does he gain with it?

The future needs are centered on the need of much precise codes of components, need of more pathology components as well as more strict components for the P chapter.

## D05 Updating processes rubrics in ICPC 2 to make them more usable

**Authors** Laurent Letrilliart

**Organizations** WONCA International Classification Committee

**Contact** laurent.lettrilliart@wanadoo.fr

**Keywords** ICPC; process of care

Unlike rubrics in components 1 and 7 of ICPC-2, the process rubrics in components 2 to 6 have no information for the inclusion, exclusion, criteria, consider, and note elements. This makes it harder for users to decide how to classify the process of care and increases variability among users, as titles are often ambiguous or insufficient to decide upon a class. The WONCA International Classification Committee has developed inclusion, exclusion, criteria, consider, and note elements for process rubrics. This should allow for improvements in classification accuracy and consistency among users.

## D06 How should we deal with processes in ICPC 3?

**Authors** Mårten Kvist

**Organizations** WONCA International Classification Committee

**Contact** marten.kvist@pp.inet.fi

**Keywords** ICPC-2; ICPC-3; Classification; Primary Health Care; Process; Coding

The Wonca Classification Committee (WICC) has appointed a group, which have had the task to develop inclusion and exclusion criteria for the Components 2-6 in the ICPC-2 Classification. The draft is now and will be discussed at the WICC meeting in Lisbon, Portugal 7.9.-11.9.2014.

The process codes in ICPC-2 needs more elaboration in order to be effectively used. Because of a missing convenient tool for classifying processes in Primary Health Care (PHC), national classifications have been developed in many countries. Their problem is that they are not internationally comparable. The new elaborated process classification will become a part of the next version of the classification (ICPC-3).

Crucial questions are for whom the coding of processes are made. Is it for the provider itself, for the individual patient care, for the health care manager, for statistical reasons or for specific research purpose. In order to achieve reliable results from coding of processes, the entry of codes should be as easy as possibly for the provider, preferably mnemonic in its structure, - maybe even automatically done in places where the health records are computerized- and they should fit in a logical structure.

WICC has decided that the basis for further development should be the IC-Process Classification, which was published by NACFP and Wonca in 1986. However, it is not more available and it may also be partly outdated. The Process Group will have a challenging task to update the content, include new procedures and see how the coding structure best fits with the overall coding structure in ICPC-3.

The interchangeability with other classifications (e.g. International Classification of Health Interventions, ICHI) has to be dealt with. It may require a linkage structure – like the relationship between ICPC and ICD. The terminology of SNOMED-CT may be used, in order to

Special emphasis should be put on procedures, which are done with a high frequency in Primary Health Care. The same principle as for the entries in the other components of the Classification should be applied, i.e. to include only procedures, which are more frequent than 1/1000 of contacts (or procedures?). The Process Group should make its proposal, based on data which are collected from countries, who use data collection in the PHC.

Billing should not be leading principle for the development of Process codes in ICPC-3. The billing varies from country to country, and would require fundamental changes in the Classification. Nevertheless, when it is feasible, billing components may be included in the classification, but then they should fit into the logical structure of the Classification.



## D07 What are the advantages for clinicians in using clinical terminologies?

**Authors** Graeme Miller

**Organizations** Family Medicine Research Centre, University of Sydney  
WONCA International Classification Committee

**Contact** [graeme.miller@sydney.edu.au](mailto:graeme.miller@sydney.edu.au)

**Keywords** ICPC; SNOMED CT; classification; terminology; electronic health record

All over the world there is a move to recording GP patient clinical data in electronic health records (EHRs). In some countries almost 100% of GP-patient encounters are recorded in EHRs. However the lack of a uniform approach to data collection has limited the value of the data collected both at the practice and health system level. The proliferation of different coding/terminology systems and different methods of implementation cause significant problems of communication between different computer systems and different health care professionals and limit the value of the data in clinical care.

This paper will describe the different kinds of clinical terminologies used in electronic health records and the role each plays in entering and using patient data. The role of interface terminologies, reference terminologies and classifications in improving patient care and in clinical research will be discussed. The advantages of using terminologies will be presented and the various approaches to implementation of terminologies in the EHR will be outlined.

The use of SNOMED CT as an international reference terminology in combination with classifications such as ICPC-2 and ICD-10 will be discussed. The agreement between the World Organisation of Family Doctors (Wonca) and the SNOMED CT organisation to improve the GP content in SNOMED CT will be outlined.

## D08 Developing and validating a primary care SNOMED CT RefSet

**Authors** Julie Gordon

**Organizations** Family Medicine Research Centre, Sydney School of Public Health | Sydney Medical School, University of Sydney  
WONCA International Classification Committee

**Contact** [julie.gordon@sydney.edu.au](mailto:julie.gordon@sydney.edu.au)

**Keywords** ICPC; SNOMED CT; classification; terminology

Between 2010 and 2013, a collaborative project between the World Organisation of Family Doctors (Wonca) and the International Health Terminology Standards Development Organisation (IHTSDO) led to the development of a subset of concepts from the Systematized Nomenclature of Medicine – Clinical Terms (SNOMED CT) for use in general/family practice internationally (called the GP/FP RefSet), and a map from these concepts to the International Classification of Primary Care, Version 2 (ICPC-2).

An overview of this project will be presented, outlining: the aims of the project; methods used to create the SNOMED CT GP/FP RefSet; methods used to create the map from the GP/FP RefSet to ICPC-2; and the field test of the RefSet and map to ICPC-2.

It is expected that these products will be released by the IHTSDO as candidate baseline releases in September 2014. Implementation scenarios for the GP/FP RefSet and map to ICPC-2 will be presented, and maintenance and future development discussed.

## D09 Adopting SNOMED CT in Portugal

**Authors** Anabela Santos and Licínio Mano

**Organizations** Portuguese Ministry of Health, Shared Services (SPMS)

**Contact** [anabela.santos@spms.min-saude.pt](mailto:anabela.santos@spms.min-saude.pt)

**Keywords** SNOMED CT; terminology; Portugal

SNOMED CT (SCT) is a clinical terminology that allows physicians to register patient's conditions into an EHR by entering terms which are close to the 'natural' clinical language used by professionals. It is composed of more than 300.000 concepts, ranging from clinical finding to social context. These concepts are organized into hierarchies and are interconnected, so the information can be more accurate.

IHTSDO is the international organization that maintains SCT, and Portugal joined the organization early this year, belonging now to a group of twenty eight countries. Being a worldwide clinical terminology standard, SCT allows cross boarder sharing of data, an important issue not only to Portugal, due to the immigrants and emigrants flow, but also to the International Community.

The presentation will give an overview of what SCT is and its potential benefits, namely the cross mapping with other terminologies like ICPC-2. Portugal's SCT adoption strategy will be briefed. A perspective of the work already done and the ongoing projects will be outlined. The presentation closes with an insight on possible initiatives that can be established in Portugal towards a fruitful and value added orchestration between SCT and ICPC-2.

## D10 Why do we need ICPC-3?

**Authors** Michael Klinkman

**Organizations** Department of Family Medicine, University of Michigan Medical School  
WONCA International Classification Committee

**Contact** [mklinkma@med.umich.edu](mailto:mklinkma@med.umich.edu)

**Keywords** ICPC; classification development

First introduced in 1987, ICPC has become a standard classification tool to support primary health care in many countries. Where used, it has provided invaluable and previously unavailable data about the content and process of primary health care. ICPC has three major strengths. It includes components (reason for encounter, symptoms and complaints, social problems, and interventions) that reflect the core content of primary health care, it accommodates the episode of care data model, and its level of granularity is based on epidemiologic data from primary care practices worldwide and is optimal for data retrieval and analysis. In current use, ICPC-2 is often embedded in electronic health records (EHRs) and linked to other standard classification and terminology tools.

We have seen significant changes in the content of primary health care since 1987. In many areas, we have moved from acute care episodes to chronic disease management, multimorbidity and management of risk factors for disease. The Wonca International Classification Committee (WICC) has begun a major revision of ICPC, focused on preserving the simplicity and clinical utility of the classification while adding new components and concepts that capture the new content of primary health care. Our 3 main goals for this work are:

- Improving ICPC-3 “core content”: making space for new conditions and expanding social and psychological problem content without making the classification too large for use.
- Adding new components that can capture person-related information, including patient goals and preferences and functional status.
- Linking ICPC to other classification and terminology tools in EHRs through use of thesaurii (for example, the Belgian 3BT thesaurus) and maps to ICD and SNOMED-CT.

We believe that this developmental path will allow us to develop a ‘modular’ ICPC-3 that can be used in diverse settings around the world.

## D11 Planing the development of ICPC-3

**Authors** Helena Britt

**Organizations** Family Medicine Research Centre, University of Sydney  
WONCA International Classification Committee

**Contact** [helena.britt@sydney.edu.au](mailto:helena.britt@sydney.edu.au)

**Keywords** ICPC; classification development

In 2008 WICC agreed that we need to move to ICPC-3. In updating ICPC-2 and with extensive experience using it in different settings, we had found some things could not be fixed in ICPC-2 because a 'fix' in one rubric has an impact on other rubrics within the chapter, and sometimes on other chapters.

In reviewing the content of ICPC-2 we are currently limiting work to component 1 (symptoms and complaints) and component 7 (Diagnosis/disease).

We have to consider:

- Is there a place for everything and is there only one place?
- Are there concepts currently coded in rag-bags (e.g. -29, -99 and others), that have grown in prevalence /incidence, that should be considered as needing its own rubric?
- Are some rubrics never or rarely used, and if so, should they be merged with more general rubrics?
- Are there emerging diagnoses that need to be included?
- Are issues common to multiple chapters treated the same way in each chapter?

To ensure compatibility of data collected in Version 2 and Version 3 over time you cannot re-use an ICPC-2 rubric in ICPC-3, with a new or altered content.

We agreed to test a new structure when developing ICPC-3, to allow improved structural consistency across all chapter, to provide more space to ensure rubrics correctly allocated to component or class, to allow additions to be mad with future discovery without negatively affecting the structure and to facilitate reliable epidemiological analyses of data. The test structure is 2 alpha + 2 numeric codes.

WICC members have been allotted to one or more chapter working groups, with a delegated lead, to facilitate wok in each chapter review.

Data have been collected from multiple countries on frequency of use of each rubric, and on frequency of use of more specific terms within rubrics from Australian interface terminology system.

These have been made available in an Access database for use by chapter working groups to assess changes that may be required.

## D12 Developing a chapter for ICPC-3 - the skin

**Authors** Daniel Pinto

**Organizations** Department of Family Medicine, NOVA Medical School /  
Faculdade de Ciências Médicas, Universidade Nova de Lisboa  
WONCA International Classification Committee

**Contact** [daniel.pinto@fcm.unl.pt](mailto:daniel.pinto@fcm.unl.pt)

**Keywords** ICPC; classification development; skin

To build ICPC-3 we first need to find the problems with ICPC-2. General problems have been identified, but chapter-specific problems can provide further insights for the development of the new classification. This presentation will show how a small group of WICC members made a problem diagnosis of the skin chapter.

A workflow was developed with the following sequence of questions: 1. Does it belong in this chapter? 2. Does it belong in this component? 3. Should it stay as a separate rubric in the classification? 3.1. How frequent is it as a reason for encounter or episode? 3.2. If it's a symptom, does it have a different predictive value than the rubric with which it will be merged? 4. Should it be subdivided? 4.1. Does it have enough frequency as a whole, to make subdivisions possible? 4.2. Are there subcategories with enough frequency to create a new rubric? 4.3. Does the new rubric make clinical sense?

The workgroup proposed to create five additional rubrics from four existing ones, to move one rubric from another chapter to the skin chapter, to move five component 1 rubrics to component 7, and to reorder several rubrics.

## WORKSHOPS

W01 Integrating ICPC in the electronic health record.....	32
W02 Capturing information outside of ICPC.....	33
W03 Using primary care data for research .....	34

## W01 Integrating ICPC in the electronic health record

**Authors** Kees van Boven<sup>1,2</sup> and Thomas Kühlein<sup>1,3</sup>

**Organizations** 1 WONCA International Classification Committee, 2 Department of Primary Care and Community Care Radboud University Nijmegen, 3 Universitätsklinikum Erlangen - Allgemeinmedizinisches Institut

**Contact** [cvboven@hetnet.nl](mailto:cvboven@hetnet.nl)

**Keywords** ICPC; classification; electronic health record

ICPC is a classification that can be used for registration but it is not developed for that goal. The workshop participants receive a number of recommendations for coding with ICPC using casuistry. In addition, there are recommendations for the use of the ICPC in a patient information system and many possibilities for discussion.



## W02 Capturing information outside of ICPC

**Authors** Diego Schrans<sup>1,2</sup> and Thomas Kühlein<sup>1,3</sup>

**Organizations** 1 WONCA International Classification Committee, 2 Department of Family Medicine and Primary Health Care, Ghent University, 3 Universitätsklinikum Erlangen - Allgemeinmedizinisches Institut

**Contact** [diego.schrans@ugent.be](mailto:diego.schrans@ugent.be)

**Keywords** ICPC; person related information; patient ideas, concerns and expectations

Primary care is person centered. However, no classification so far, not even ICPC-2, allows for comprehensive coding of person related information (PERI). We therefore asked what classes of PERI would be found in case histories as told by family physicians of cases where PERI played a role in the health care process. A study was done mainly among WICC members and followed the methodology of qualitative research. The results will be presented in the session. The study might serve as an empiric basis and starting point for an additional future classification tool for ICPC in order to better describe the content of family medicine. In the session we show, which classes of PERI found can be coded with ICPC-2 already now and what might be missing.

The reason for encounter (RfE) is an important component of the primary care consultation and should be thoroughly understood by the General Practitioner and agreed upon by the patient. Therefore it is most useful to elicit the Ideas, Concerns and Expectations (ICE) of the patient. This is a central issue in good consultation and communication skills. Is ICPC-2 suitable to code ICE appropriately and what codes might be missing for this use case of the classification? Data concerning ICE were collected by GP-trainees in 36 different GP teaching practices in Belgium, during 613 consultations of their trainers. The trainees were instructed to observe and record patients' expressions of ICE narratively as elicited by their trainers in the consultations. Two researchers are coding independently the RfE and ICE recorded with ICPC-2. ICE not encodable with ICPC-2 are collected in residual classes. The content of these residual classes are analyzed to identify missing concepts. The content of the codes assigned and the inter-rater correlations are analyzed quantitatively. Coding of ICE with ICPC-2 is feasible in a majority of the registered consultations, mainly for the expectations.

We will discuss the results of both studies, the making of future classification tools and the options of conducting further research.

## W03 Using primary care data for research

**Authors** Ana Carvalho<sup>1</sup>, Matilde Padrão Dias<sup>2</sup>, David Rodrigues<sup>3</sup>, Catarina Viegas Dias<sup>2</sup> and Thomas Kuehlein<sup>4,5</sup>

**Organizations** 1 USF LoureSaudável, 2 USF Dafundo, 3 NOVA Medical School, 4 WONCA International Classification Committee, 5 Universitätsklinikum Erlangen - Allgemeinmedizinisches Institut

**Contact** Thomas.Kuehlein@uk-erlangen.de

**Keywords** ICPC; electronic health record; health database

The aim of this workshop is to disclose why and how using classifications such as ICPC-2 can be useful for family doctors and their patients. First there will be a short introduction to the topic of classification and coding. Then an example of a question will be presented that once was asked to the electronic health record of a German colleague. The question was “How do I care for my patients with osteoporosis?”. The resulting answer leaves some room for improvement. The workshop then gives an introduction and simple tutorials on how to ask such questions to the Portuguese electronic health records. The workshop closes with a common discussion on the utility and meaningfulness of such an approach to patient care.

Organizing committee: Daniel Pinto, Isabel Santos - NOVA Medical School

Secretariat support: Ana Isabel Rosa, Paula Fernandes, Rita Trindade

A joint organization:



Department of Family Medicine  
NOVA Medical School



Portuguese Association of General  
Practice and Family Medicine



**PH3C**  
Primary Health Care  
Classification Consortium

WICC / Primary Health Care  
Classification Consortium