Letters to the Editor

The Journal welcomes Letters to the Editor; if found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with journal style.

Diagnostic Coding Systems

To the Editor:

I greatly appreciated reading Filiatrault et al's article in the November issue of *The Journal of Family Practice (5:819, 1977)* entitled "Construction of an Automated Health Problem Inventory." We have recently implemented a very similar computer-assisted patient data system here in Cedar Rapids. I have three comments relating to the article.

First, it is interesting to note that the authors are using the H-ICDA-2 code for problem coding in the Department of Family Practice at the University of Minnesota. This is in contradistinction to the International Classification of Health Problems in Primary Care, which is felt by many to be the most appropriate code available at the present time for widespread use in family practice. In discussing their results, the authors make brief reference to Marsland, Wood, and Mayo's landmark study in Virginia *(A data bank for patient care, curriculum, and research in family practice: 526,196 patient problems. J Fam Pract 3:25, 1976)*. The lack of a similar code between the two studies is mentioned. This certainly disallows any good comparison of the two works and should further emphasize the need for all of us interested in family practice encounter data to strive towards a universal code. This must be regardless of our location in a university or a community hospital setting.

Secondly, the authors mentioned the use of episode types labeled "new diagnoses" or "follow-up diagnoses" (p 820), and emphasize the importance of "definition of terms" (p 821). However, when they present their data labeled "most frequently seen problems" (Table 4, p 823 and Table 5, p 824), it is unclear if these "most frequent problems" are most frequent new diagnoses or most frequent problem encounters. When chronic diseases (such as hypertension) are mixed with acute diseases (such as otitis media) it is impossible to interpret which is truly the most frequent new diagnosis. Alternatively, one cannot interpret how often a chronic problem is being seen in follow-up.

To improve this situation, we in Cedar Rapids are using a simple (N)

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for new diagnoses and (C) for continued diagnoses on our encounter form. Then with our quarterly computer print-out (both for each resident and for the total practice), we will receive a listing of the most frequent new diagnoses (whether they be acute problems or chronic problems, first diagnosed) and a listing of the most frequent continued diagnoses. This will prevent the repeated encounters for a chronic problem, such as hypertension, from appearing falsely elevated on one master list. This simple system separates out all new diagnoses into one table of data. Furthermore, in the table of most frequent continued diagnoses, it offers insight into how often each diagnosis is being seen in follow-up over a given period of time.

In future publications concerning the contact of family practice, I believe we must make an effort to take the simple yet sophisticated step of separating all new diagnoses from all follow-up diagnoses. This will allow a more accurate picture of the content of ambulatory family medicine.

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The preceding letter was referred to Dr. Filiatrault who responds as follows:

I can understand Dr. Shank's frustration with the lack of similarity between H-ICDA-2 and ICHPPC, and agree with him that this disallows a precise comparison between the two studies he mentioned.

Our reasons for using H-ICDA-2 were explained in the paper. Our clinic was an integral part of the University Hospital outpatient clinics, and the information that we generated had to be shared with and used on the university's computers. It was pooled with a wide variety of subspecialist data, and the one code that suited everyone's purpose was H-ICDA-2.

I would also agree that the ICHPPC code is more suitable for primary care practices. I think there is some danger, however, in retrospectively comparing two studies and drawing absolute conclusions from them. If one was going to participate in a cooperation prospective study, then the use of similar coding systems and similar protocols is imperative.

Finally, with respect to coding, Dr. Shank may or may not be aware that in 1973, when this project was designed, ICHPPC had not yet developed into a universally accepted primary care code.

The problem encounter data that are displayed are total problems encountered. That seems clear in Table 1, but not clear in Tables 2, 3, 4, and 5. I apologize for that oversight.

I agree with Dr. Shank that any good system should be able to differentiate between new and old problems, and as we indicate in the paper, ours did do that. It was not our intent to separate them for purposes of this paper.

L. J. Filiatrault, MD
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