Guest Editorial

Restructuring the International Classification of Diseases: Need for a New Paradigm

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An irreverent observer of the medical scene once commented that "disease exists in the minds of doctors; you don't have it until they name it!" And name it we do. Depending on where you look and whom you consult, there are anywhere from 17 to about 3,000 and even tens of thousands of different "labels" to assign to the health problems that beset mankind. For our diverse manifestations of ill health and related suffering, there are lay and colloquial terms; there are symptoms, complaints, and problems; there are functional and feeling states; there are chromosomal, molecular, and behavioral aberrations; there are impairments, handicaps, and disabilities; there are accidents, injuries, and poisonings; there are fetal deaths and "voodoo" deaths; and then, there are "diseases." For perhaps one third of all these entities, at most, the web of causality has been usefully unraveled; the origins of the remainder are largely a mystery, requiring further biomedical, behavioral, epidemiological, and clinical research.

Over the years, the so-called diseases in this panoply of health problems have been described, named, and classified. Nomenclatures have been refined and expanded. The basic and senior classification, the International Classification of Diseases, Injuries and Causes of Death, the ICD, on the other hand, has simply grown in complexity and heterogeneity; in trying to satisfy everybody, it now satisfies nobody. Through nine revisions, at roughly ten-year intervals, the current iteration consists of 17 chapters based on unrelated axes devoted to body systems, clinical manifestations, age groups, clinical specialties, and known or suspected etiological "causes." There is no coherent conceptual or organizing theme, to say nothing of theory, and yet this classification and its modifi-

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cations seek to meet the needs of policy makers, statisticians, third-party payers, managers, clinicians, and investigators of all persuasions and preoccupations in a wide range of socioeconomic and cultural settings around the world. Is there little wonder that a growing chorus of dissatisfaction with the ICD has arisen from many quarters and, more recently, with the World Health Organization's (WHO) proposal to maintain the current format in the forthcoming tenth revision of the ICD? This proposal is now under active consideration by the governmental statistical authorities and national committees on vital and health statistics of WHO member countries, including the United States.

Through all this, family physicians have not been idle. Around the world they have been engaged actively in seeking feasible solutions to the problems of classification that would recognize the existence of a continuum from the earliest manifestations of ill health to the fullest understanding of the necessary, sufficient, precipitating, and perpetuating factors associated with its origins and its outcome. As a direct consequence of the early initiatives of John Fry in England in 1959 and, a decade later, of Robert Westbury in Canada, the current WONCA Classification Committee under the chairmanship of Jack Froom in the United States has developed the latest version of the *International Classification of Health Problems in Primary Care–2–Defined,* published by WHO and Oxford University Press. A related WHO Working Party to Develop a Classification for Primary Care under the chairmanship of Maurice Wood has just produced an "International Classification of Primary Care" (ICPC) that has been scheduled for publication in the near future. This classification emerged from a "reason for encounter" classification, which sought to capture the patient's reason for seeking help, in contrast to the physician's interpretation of that reason, as represented in the ICHPPC-2-Defined.

What the WHO Working Party has also done, however, may, in the long run, be of much greater importance. It has created a conceptual framework or matrix that allows clinicians, investigators, and statisticians to follow the flow of both the natural history of ill health and the natural history of medical care through their different phases of differentiation, specificity, management, and

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outcome. The practical feasibility of using both the matrix and the "International Classification of Primary Care" has been demonstrated clearly in a field trial involving almost 100,000 encounters in nine countries. In short, for the first time, a scheme exists in which the full range of classifications for a variety of purposes can be accommodated with the ICD remaining as the core classification to which all the others can be logically related.

Adoption of this new matrix will require modest changes in the chapter structure of the ICD, changes that have been advocated in the past by other groups including the WHO Collaborating Centre for Disease Classification in England. In the proposed format, there are 13 body system chapters, including one each for female and male genital problems, a chapter for pregnancy, childbearing, and family planning, one each for psychological and social problems, and a general chapter, 17 altogether. The four ICD-9 chapters for infectious and parasitic diseases, neoplasms, congenital anomalies, and for injury and poisoning are distributed among the body system chapters and given a second-order, but consistent, priority with a three-digit alphanumeric code. Nomenclatures would remain unchanged and statistical analyses of trends over time and place could easily be traced.

All this may sound unduly complex to those unfamiliar with the history of nosology, the traditions imbedded in disease classifications or even the recent origins of the poorly conceived diagnosis-related group (DRG) enterprise. Be assured, however, it is no trivial matter. If this new matrix is adopted, it would be possible to call our patients' problems by their "right" names and, perhaps, even be reimbursed for them appropriately! But more important, it would be possible to study the earliest manifestations of ill health in the natural habitats of patients where these manifestations are usually first experienced and their relationship to subsequent clinical events and to biomedical, behavioral, and epidemiological observations and investigations. The dreams of James Mackenzie and Will Pickles could come true. Family physicians and all those concerned with the worldwide rennaissance of primary care, prevention, and health promotion would have a rational means of linking observations in the submerged mass of the iceberg of disease with the tiny visible tip that preoccupies so much of the medical establishment's efforts and preempts so much of the world's health resources.

There are strong forces opposing change. The voices supporting the status quo are to be found principally among those with a vested interest in high technology, procedurally oriented, superspeciality medicine, those with a narrow view of the role of vital and health statistics, those who seem to reify disease as manifested in the DRG system, and those who succumb to the inertia often associated with life in a bureaucracy.

If the dreams of Mackenzie and Pickles are to be realized, and if the breakthrough generated by the WHO ICPC Working Party is to be implemented, family physicians and other primary care physicians will need to speak out. They should join the many voices expressing the need for a new paradigm about which health statistics and information bearing on medical education, research, and practice can be organized. From many institutions and organizations, it will be necessary to press for a modest restructuring of the ICD, so that it may become the core of a logically integrated family of classifications that would be known as the International Classifications of Health Problems and Diseases. It will be necessary to urge the director-general of the World Health Organization, the director of the US National Center for Health Statistics, and the directors of similar entities in other countries as well as the National Committees for Vital and Health Statistics in the United States and similar organizations in other countries, to examine the new proposals developed by the WHO ICPC Working Party and those from other sources in the interests of creating this new family of classifications.

Time is short, and this once-in-a-decade opportunity is fleeting. Primary care and family physicians now have a thoughtfully constructed rational basis for urging that classifications and information systems bearing on health and health services be built upward from the people and their problems as well as from the top down. Helping the living with their health problems must surely be as important as counting the troubles of the dead!