

**8. Write the final copy.** The final copy should be in a concise and legible form. We chose to print one resource per page, whenever possible, and to develop charts for easy reference.

**9. Package the directory in a three-ring binder.** A binder allows the user to insert or delete pages to update entries, an important feature for prolonging usefulness.

**10. Distribute the directory to the intended recipients.** We recommend mailing or hand-delivering directories to the intended recipients rather than expecting someone to come pick them up.

**11. Evaluate the project.** A 1-year followup evaluation is recommended for two reasons. First, changes will have occurred in the descriptions of resources, ranging

from new telephone numbers to a change in services. Second, the sponsoring body will want feedback on how useful the directory is, and whether changes in format are desirable.

## References .....

1. Vaughan, W. P., et al.: The Frederick cancer project. *Md State Med J* 31: 38-40, March 1982.
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## Classification of Reasons Why Persons Seek Primary Care: Pilot Study of a New System

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### Synopsis .....

*In 1978, the World Health Organization formed a group to begin work on the Reason for Encounter Classification (RFEC), which is designed to classify the reasons why patients seek care at the primary level.*

*The relatively simple classification is based on two axes—chapters and components—and uses a three-character alpha-numeric code. Chapters, which are named by body systems or more general terms, are the reasons that health care was sought. Five of the seven components, or subdivisions of chapters, contain rubrics identified by the same two-digit numerical code.*

*A pilot study with a training exercise was carried out in The Netherlands by nine family physicians to confirm the feasibility of using the new classification system in primary care settings. Training consisted of viewing videotapes of encounters and an exercise of coding 76 vignettes by the RFEC. Within 2 months, the physicians in the subsequent pilot study had collected and coded 7,503 reasons for encounters.*

*Results of the pilot study confirm that the RFEC is feasible, easy to use in practice, and different from disease-oriented classifications in its system of classifying the reasons for encounter. The pilot study results have been used to modify the RFEC in preparation for a field trial in ambulatory care settings worldwide.*

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**A**T THE 1978 CONFERENCE ON PRIMARY HEALTH CARE in Alma Ata, Union of Soviet Socialist Republics, the primary health care goal of the World Health Organization (WHO), "health for all by the year 2000," was

conceived (1). It was concluded at the conference that the main social target of governments, international organizations, and the whole world community in the coming decades should be attainment of a level of health for all

*Construction of the Reason for Encounter Classification was influenced by major classification systems in use today and by the need to provide space for incorporating future systems in its structure.*

people which would allow them to lead socially and economically productive lives. Adequate primary care was recognized as the key to attaining this goal.

WHO conference participants also recognized that new kinds of information were essential to reassess health care priorities and enable the planning and administration of health care services. The expressed reason why a person enters the health care system would provide such new information (2). At the time there was no acceptable international classification system to facilitate the collection of such data in primary care settings. This deficiency prompted WHO to invite several experts in the fields of primary care and classification systems to meet in Geneva in 1978. The group now consists of Dr. Bent Bentsen, Norway; Prof. Charles Bridges-Webb, Australia; Dr. Karel Kupka, WHO, Geneva; Dr. M.K. Rajakumar, Malaysia; and the authors, with Dr. Wood as chairman.

After several years of effort, the WHO Working Party produced a Reason for Encounter Classification (RFEC) in field test form (2). A discussion follows of the classification system, testing methods, and findings and recommendations based on the test results.

## Conceptual Design

The RFEC was designed to classify the reasons why people seek care at the primary level. During the initial contact, or encounter, the health care provider questions the patient and identifies the stated purpose or reason for seeking care. Then, as the information base increases, the provider defines the problem and takes appropriate action.

RFEC is used to classify information obtained at the first contact with the patient, when the reason for the encounter is stated by the patient and confirmed by the physician or nonmedical provider and before the information base is increased to allow diagnosis and interpretation of the patient's condition.

By definition, the reason for encounter statement is an agreement of the reasons why a person enters the health care system. The terms written by the provider should be

recognized by the patient as an acceptable description of those reasons; the terms are also the starting point for action by the provider.

## Classification Scheme

The RFEC is designed along two axes: chapters and components. Thirteen chapters have titles related to body systems, and the other three are "general," "psychological," and "social" (fig. 1). There are no chapters on infectious diseases, neoplasms, injuries, and congenital anomalies like those in International Classification of Diseases, 9th revision (3); these conditions are represented on the other axis in the diagnosis and diseases component. Each chapter carries an alphabetical code that is the first character of the basic RFEC 3-character alpha-numeric code.

Each chapter is subdivided into the seven components, each of which is represented by the two digits in the RFEC code. Thus, the relatively simple 3-character biaxial classification system has five "process" components, numbers 2–6, which have two-digit codes that are identical in all chapters (figs. 1 and 2).

The RFEC format permits the option of adding another digit to the basic code to designate more detail if it is required. For example, the RFEC code D64 is "digestive, result of radiological examination." An extra digit in that code could give greater specificity: 64.1 result of barium swallow X-ray; 64.2 gall bladder contrast X-ray; 64.3 barium enema. The Working Party has made no formal recommendations for such optional expansion.

## RFEC and Existing Classifications

Construction of the RFEC was influenced by major classification systems in use today and by the need to provide space for incorporating future systems in its structure (4). It was designed to be useful in classifying the process of ambulatory care in both developed and developing countries. Therefore, the RFEC incorporated an expanded version of the existing Reason for Visit classification of the National Ambulatory Medical Care Survey (NAMCS), which was the first attempt to classify patients' reasons for visiting physicians (5,6). The International Classification of Diseases, 9th revision (ICD-9), is the basis for component 7, "diagnosis and diseases"; the International Classification of Health Problems in Primary Care (ICHPPC-2) is a version of the 9th revision modified for primary care (7). The rubrics found in component 7 are the same as those in ICHPPC-2.

Symptoms and complaints, component 1, drew heavily from the NAMCS Reason for Visit classification in the United States (5,6). Components 2 and 3, "diag-

Figure 1. Components of digestive chapter, Reason for Encounter Classification pre-field trial version

COMPONENTS	CHAPTERS															
	A-General	B-Blood, blood forming	D-Digestive	F-Eye	H-Ear	K-Circulatory	L-Musculoskeletal	N-Neurological	P-Psychological	R-Respiratory	S-Skin	T-Metabolic, Endocrine, Nutr.	U-Urinary	X-Female genital	Y-Male genital	Z-Social
1. Symptoms and complaints																
2. Diagnostic, screening prevention																
3. Treatment, procedures, medication																
4. Test results																
5. Administrative																
6. Other																
7. Diagnoses, diseases																

Symptoms and Complaints

- D10 Symp/Compt. Teeth & Gums
- D11 Symp/Compt. Lips
- D12 Symp/Compt. Mouth & Tongue
- D13 Symp/Compt. of Swallowing
- D14 Nausea
- D15 Vomiting (Excl. Blood)
- D16 Heartburn, Indigestion
- D17 Gen. Abdominal Pain
- D18 Localized Abd. Pain
- D19 Incr. Appetite
- D20 Decr. Appetite
- D21 Gastro. Intest. Bleeding
- D22 Feeding Prob. Infant
- D23 Flatulence (Excl. Gas Pain, D18)
- D24 Constipation
- D25 Diarrhea
- D26 Jaundice
- D27 Change Abd. Size
- D28 Fear of Digest. Disease
- D29 Other Symp/Compt. Digest.

Diagnostic Screening, and Preventive Procedures

- D30 Spec. Exam./Routine Physical
- D32 Blood Test
- D34 Urine Test
- D35 Sensitization Test
- D36 Feces Exam/Test
- D37 Endoscopy, Proto/Sigmoidoscopy
- D39 Biopsy
- D40 Radiology, Diagnostic
- D42 Cytology

- D45 Exposure, Infect. Disease
- D46 Other Diagnostic Procedure
- D48 Other Screen. Prev. Proc. High Risk

Treatment, Procedure, and Medication

- D50 Medications
- D51 Visit: Preoperative
- D52 Visit: Postoperative
- D53 Physical Med/Rehab.
- D54 Radiation Therapy
- D55 Tube Insert/Removal
- D56 Surgery: Minor
- D57 Ext. Prosthetic/Apply/Remove
- D58 Counseling, Medical
- D59 Other Therapeutic Proc. NEC

Test Results

- D60 Results: Blood Test
- D61 Results: Urine Test
- D62 Results: Cytology Test
- D63 Results: Tissue Exam
- D64 Results: Radiology Test
- D65 Results: Other Test/Exam

Administrative

- D66 Administrative

Other

- D67 Other Reason for Contact, NEC

Diagnoses and Diseases

- D71 Intest. Dis. Presumed Infect.
- D72 Herpes Simplex, Mouth Lips NOS
- D73 Mumps
- D74 Infectious Hepatitis
- D75 Oxyur. Pinworms, Other Paras.
- D76 Mal. Neop. Esoph. Bowel, Anus
- D77 Mal. Neop. Oth. Unspec. Sites
- D78 Benign Neoplasms
- D79 Other Neopl. Spec. & NOS
- D80 For. Body Thr. Orifice
- D81 Other Injur. & Adv. Eff.
- D82 Cong. Anomal. Digest.
- D83 Disease of Teeth & Gums
- D84 Dis. Mouth, Tongue, Saliv. Glan.
- D85 Dis. Esophagus
- D86 Duodenal Ulcer
- D87 Oth. Peptic Ulcer
- D88 Gastritis, Duodenitis
- D89 Appendicitis
- D90 Inguinal Hernia
- D91 Hiatus Hernia (Diaph.)
- D92 Other Abd. Hernias
- D93 Divert. Dis. Intestines
- D94 Irrit. Bowel Syndrome
- D95 Chr. Enteritis, Ulc. Colitis
- D96 Anal Fiss/Perinal Abscess
- D97 Cirrhosis/Other Liver Disease

Figure 2. Components of general chapter, Reason for Encounter Classification pre-field trial version

COMPONENTS	CHAPTERS	A-General	B-Blood, blood forming	D-Digestive	F-Eye	H-Ear	K-Circulatory	L-Musculoskeletal	N-Neurological	P-Psychological	R-Respiratory	S-Skin	T-Metabolic, Endocrine, Nutr.	U-Urinary	X-Female genital	Y-Male genital	Z-Social
	1. Symptoms and complaints																
2. Diagnostic, screening prevention																	
3. Treatment, procedures, medication																	
4. Test results																	
5. Administrative																	
6. Other																	
7. Diagnoses, diseases																	

<p><u>Symptoms and Complaints</u></p> <p>A11 Chills  A12 Fever  A13 Gen. Weakness, Tiredness  A14 Gen. Ill-Feeling  A15 Fainting (Syncope)  A16 Swoll. Ankle Oth. Symp. Fluid Abn.  A17 Pain, Site NOS  A18 Bleeding, Site NOS  A19 Gen. Symp. of Infants, NEC  A20 Allergy, NOS/Allergic React, NEC  A21 Fear Having Disease, Inspec.  A22 Other General Symp/Complaint</p> <p><u>Diagnostic Screening, and Preventive Procedures</u></p> <p>A30 Spec. Exam/Routine Physical  A32 Blood Test  A34 Urine Test  A35 Sensitization Test  A36 Feces Exam Test  A39 Biopsy  A40 Radiology, Diag.  A42 Cytology  A45 Exposure Infect. Disease  A46 Other Diagnostic Procedure  A48 Other Screen Prev. Proc. High Risk</p>	<p><u>Treatment, Procedure, and Medication</u></p> <p>A50 Medications  A51 Visit: Preoperative  A52 Visit: Postoperative  A53 Physical Med/Rehab.  A54 Radiation/Therapy  A55 Tube Insert/Removal  A56 Surgery: Minor  A57 Ext. Prosthetic/Apply/Remove  A58 Counseling, Medical  A59 Other Therapeutic Proc. NEC</p> <p><u>Test Results</u></p> <p>A60 Results: Blood Test  A61 Results: Urine Test  A62 Results: Cytology Test  A63 Results: Tissue Exam  A64 Results: Radiology Test  A65 Results: Other Test/Exam</p> <p><u>Administrative</u></p> <p>A66 Administrative</p> <p><u>Other</u></p> <p>A67 Other Reason for Contact, NEC</p>	<p><u>Diagnoses and Diseases</u></p> <p>A70 Tuberculosis, Gen.  A71 Measles  A72 Chickenpox  A73 Whooping Cough  A74 Rubella  A75 Syphilis, Gen.  A76 Gonococcal Infect. Gen.  A80 Carcinomatosis (Unkn. Prim. Site)  A82 Mult. Trauma/Int. Inj. Chest. Pelvis, Ab.  A83 Poisoning by Med. Agent  A84 Adv. Effect Med. Agent Proper Dose  A85 Toxic Effect, Other Subst.  A86 Complicat. Surg/Med. Treatment  A87 Adv. Eff. Phys. Factor Ther. X-ray  A89 Cert. Adv. Eff. Nec/Anaph/Anest. Shock  A90 Multi, Synd. Cong. Anomalies  A95 Other &amp; Generalized Disease Nec.</p>
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nostic, screening, and prevention” and “treatments, procedures, and medications,” contain broad categories that either interface with or are similar to the 9th revision’s International Classification of Procedures in Medicine (8) and the North American Primary Care Research Group’s (NAPCRG–1) new Process Code for Primary Care (9,10).

The WHO-sponsored Triaxial Classification (11), which is under development, focuses on the classification of psychological, social, and organic problems. The axes for psychological and social problems have been replicated in the RFEC as chapters P and Z, respectively. Thus the schema of the RFEC emerges as a possible core classification for the 10th revision of the International Classification of Diseases as proposed by Dr. Kupka of the ICD Unit, WHO, in his presentation of the concept of a “family of classifications” (12).

### Pilot Study

To confirm that the RFEC was feasible for classifying primary care encounters, a pilot study with a training exercise was undertaken by nine Dutch family physicians. The physicians chosen to participate were already collaborating in a computerized patient information system (13) in which they coded their diagnosis of the patient’s disease or problem and diagnosis by using ICHPPC–2. For the study the physicians were asked to classify the reason for the encounter as expressed by the patient, using the RFEC, in addition to their final diagnosis, using ICHPPC–2 and RFEC.

**Vignette exercise.** The physicians were already familiar with the coding process, and little training was required. Videotapes of encounters and an exercise of classifying 76 case vignettes were used for training. Vignettes were composed by the Classification Committee of the World Organization of National Colleges, Academies, and the Academic Associations of General Practitioners–Family Physicians (WONCA). The committee is also responsible for development of ICHPPC–2 and is actively engaged in the joint WONCA–WHO effort to develop RFEC.

The family physicians classified the vignettes, and some of the results are summarized here. The nine physicians agreed in their RFEC coding 53.3 percent of the time. Closer scrutiny of the results revealed that for 40 of the 76 vignettes there was agreement 50 percent or more of the time.

For example, there was strong agreement in classification of the following vignette:

A 57-year-old woman, whom you have only seen once before, complains of increasing breathlessness the past week. She

*‘It was designed to be useful in classifying the process of ambulatory care in both developed and developing countries.’*

has had no cough or upper respiratory symptoms. Her past history is noncontributory. Physical examination reveals a typical early diastolic murmur in the mitral area. There are no signs of heart failure. The rest of the physical examination is negative. Chest X-ray shows a normal cardiac outline, but a moderate amount of fluid is present in the pleural space. You admit her to hospital for further investigations.

Eight physicians coded the vignette R19 (respiratory symptoms and complaints, shortness of breath), and one coded it R25 (disorder, voice).

In 36 vignettes, the physicians were in agreement less than 50 percent of the time. Evaluators judged disagreement to be due to poor construction of the vignettes, coding errors, or both for 24 vignettes. For the remaining 12 vignettes with less than 50 percent agreement, the evaluators attributed disagreement to a lack of clarity and consistency in RFEC itself, thus confirming that a field trial was necessary.

There was strong disagreement in classification of the following example:

A 55-year old woman suddenly develops a tendency to suffer attacks of pain on the left side of her face, over the cheek, coming on when eating or when her face is exposed to cold. She has no temporal artery tenderness. Her ESR is normal. Analgesics had some dulling effect, but did not properly control the pain.

Two physicians coded the vignette A22 (general symptoms and complaints—chills), three coded it A17 (pain: head-face NEC), two coded it N15 (neurological symptoms and complaints—sensation disturbances), one coded it N50 (neurological treatments, procedures, and medications—medications requested or renewed), and one coded it N99 (neurological diagnoses and diseases—other disease of neurological system).

Subsequent to training with the vignettes, the nine physicians undertook the following pilot study at their family practices.

**Field trial.** Within 2 months of beginning this study, the participating family physicians collected 7,503 prob-

*The expectation that the Reason for Encounter Classification would be more effective in describing the nondisease reasons for encounter than other classification systems was confirmed in the pilot study.*

lems coded by using RFEC. The number of 7,500 problems was chosen because it reflects the variety of problems dealt with in 1 year by a "standard" Dutch family physician with a "standard" practice (that is, 2,000 registered patients with an average of 2.5 encounters per patient per year, 1.5 problems per encounter). Physicians were free to discontinue their recording during some days. At a minimum, however, it was required that the physician classify all problems presented during a 24-hour period.

For each encounter, the physician used a self-copying encounter form. The details of the encounter were recorded, and additional items of information were coded in special boxes. The original encounter form was taped

Table 1. Percentage distribution of 7,503 problems classified by chapter and component of the Reason for Encounter Classification in a pilot study

Chapter	Absolute number of reasons for encounter	Percent of total	Percentage distribution of component per chapter					Diagnoses and diseases
			Symptoms-complaints	Diagnostic, screening, prevention	Treatment, medication	Test results	Administrative + Other	
Total	7,503		57.5	9.3	11.0	4.1	2.1	15.4
A-General	623	8.3	67.7	5.1	6.1	4.2	11.7	5.1
B-Blood, blood-forming organs	71	0.9	22.5	7.0	8.5	28.2	2.8	31.0
D-Digestive	579	7.7	70.3	2.8	6.4	7.8	1.0	11.7
F-Eye	170	2.2	65.3	1.2	5.3	0	5.9	22.4
H-Ear	330	4.3	58.5	6.1	5.5	3.6	1.8	24.5
K-Circulatory	868	11.5	14.1	31.7	19.5	3.9	1.2	29.7
L-Musculoskeletal	1,014	13.5	78.3	0.9	5.5	4.7	1.0	9.6
N-Neurological	289	3.8	70.6	2.8	14.2	1.4	1.4	9.7
P-Psychological	585	7.7	72.0	0.3	25.6	0.3	0.6	1.0
R-Respiratory	885	11.7	62.8	4.0	9.2	4.3	1.0	18.8
S-Skin	750	9.9	55.6	1.1	10.3	0.3	0.8	32.0
T-Metabolic, endocrine, nutrition	233	3.1	32.6	9.4	15.5	15.5	1.3	25.8
U-Urinary	169	2.2	43.8	8.3	4.7	24.9	1.2	17.2
X-Female genital	576	7.6	33.2	42.4	13.7	3.5	1.4	5.9
Y-Male genital	58	0.7	62.1	3.4	6.8	5.2	0	22.4
Z-Social	275	3.6	94.2	0	2.5	0	3.3	0

NOTE: Percentages total less than 100 due to rounding.

Table 2. Quantitative use of rubrics of the "process" components, numbers 2–6, in at least 0.5 percent of all reasons for encounters

Component	Code	Rubric	Percentage of 7,503 reasons
2. Diagnostic, screening, prevention procedures	30	Special examination-routine physical	4.9
3. Treatment, procedures, medication	50	Medications	8.9
	56	Minor surgery, delivery	0.5
	58	Counseling	0.8
4. Test results	60	Result, blood test	1.6
	61	Result, urine test	0.6
	64	Result, radiology test	1.1
	65	Result, other test	0.8
5. Administrative	66	Administrative	0.8
6. Other	67	Other reason for contact not elsewhere classified	1.3

into the patient's record, and information in the copy was entered into the computer system. Apart from the reason for encounter statement agreed to by patient and physician, the following data were considered necessary to a basic data set: patient identification, place and date of encounter, provider identification, RFEC code, status of the reason for encounter, use of primary care facilities, therapy, referral to specialist, ICHPPC-2 (International Classification of Diseases No. 9—General Medicine) diagnosis code, and certainty of diagnosis.

Before the pilot study began, it was recognized that some encounters could be initiated by patients and some by other resource persons, including the health care provider. Therefore, it was necessary to define the status of each reason for encounter by creating four status codes, numbered 1-4.

Status code	Status of reason for encounter
1	Encounter presented for the first time, at patient's initiative
2	Encounter presented by the patient for the first time, referred by a community resource
3	Encounter previously presented by the patient; followup initiated by the patient
4	Encounter previously presented by the patient; followup initiated by the provider

## Results

**Summary** The percentage distribution of 7,503 problems by the chapters and components of RFEC in the pilot study is presented in table 1.

The expectation that the RFEC would be more effective in describing the nondisease reasons for encounter than other classification systems was confirmed in the pilot study. Symptoms and complaints accounted for 57.5 percent of all reasons presented. The proportion of reasons stated in the form of a diagnosis or a disease was limited to 15.4 percent. A few patients, 11.0 percent, requested a prescription or a treatment. Still fewer reasons for encounter, 9.3 percent, were represented by the component for diagnostic, screening, and preventive procedures. Obtaining a test result or an administrative reason were also given infrequently, at 4.1 and 2.1 percent of all reasons.

Only a few rubrics of the process components, numbers 2-6, were used frequently. Table 2 identifies those component rubrics representing at least 0.5 percent of all encounters. It is evident that reasons for encounter are classified differently when RFEC and other systems of classification are used.

**Chapters and components.** Apparently, the quantitative importance of several components is different for different chapters. Symptoms and complaints are of major importance for the following chapters—digestive

(code D), musculoskeletal (L), neurological (H), psychological (P), and social (Z). In the chapters for blood and blood-forming organs (B), the circulatory systems (K), the endocrine system (T), and the female genital system (X), symptoms and complaints are less important.

The chapter on blood and blood-forming organs and the chapter on the male genital system appear to cover only a limited number of reasons (each less than 1 percent of all reasons). All components are relevant to at least one chapter (for example, "administrative" to the "general" chapter) and often to more than one or to all chapters—such as symptoms and complaints.

Table 3. 37 RFEC rubrics classified at least 50 times<sup>1</sup>

Rubric		Times classified	Percentage of 7,503 reasons for encounters
K30	Special examination.....	262	3.4
R17	Cough.....	184	2.4
K83	Uncomplicated hypertension.....	175	2.3
X48	Contraceptive medication.....	175	2.3
P10	Feeling anxious and nervous.....	167	2.2
K50	Medications.....	161	2.1
P50	Medications.....	143	1.9
R20	Symptoms-complaints, throat, including infection.....	118	1.5
D18	Local pain, excluding groin.....	104	1.3
A13	General weakness, tiredness.....	104	1.3
L12	Low back symptoms.....	102	1.3
L14	Leg symptoms.....	98	1.3
N13	Headache head pain, excluding sinus.....	90	1.1
S15	Skin irritation, not elsewhere classified except rash.....	84	1.1
L11	Back symptoms.....	80	1.0
D17	General abdominal pain.....	77	1.0
R50	Medications.....	75	0.9
L10	Neck symptoms.....	74	0.9
L17	Foot and toe symptoms.....	73	0.9
A14	General ill feeling.....	73	0.9
H10	Pain, ear ache.....	73	0.9
L15	Knee symptoms.....	72	0.9
N17	Vertigo-dizziness.....	72	0.9
S80	Injuries, including late effects, scar..	71	0.9
R19	Breathing problem, excluding pain..	69	0.9
S12	Growths of skin.....	68	0.9
Z10	Family conjugal problem.....	66	0.8
Z20	Occupational problem.....	62	0.8
P11	Feeling depressed.....	61	0.8
S13	Skin rash, not otherwise specified..	61	0.8
A21	Fever.....	59	0.7
A67	Other reason for contact.....	57	0.7
X50	Medications.....	57	0.7
L18	Shoulder symptoms.....	56	0.7
S50	Medications.....	53	0.7
T13	Weight gain.....	53	0.7
D25	Diarrhea.....	52	0.6
Total.....		3,481	46.4

<sup>1</sup> Distribution: males, 37.8 percent; females, 62.2 percent.  
NOTE: Percentages total less than 100 due to rounding.

**Use of RFEC rubrics.** Only 193 rubrics were used eight or more times—a frequency of .001 percent. These core codes can, therefore, be considered the most important rubrics in the RFEC. Table 3 lists the 37 RFEC rubrics that were used 50 or more times. These rubrics were responsible for classifying 46.4 percent or 3,481 reasons for encounter.

**Status of reasons for encounter.** Of all reasons for encounter, 56.5 percent were coded as a new reason presented by the patient (status code 1). Only 107 reasons, or 1.4 percent, were presented by the patient for the first time and referred by a community resource (status code 2). Another 34.2 percent were coded as followup encounters on the patient's initiative (status code 3); 5.5 percent were followups on the physician's initiative (status code 4). Status 4 reasons were found to be appropriate when some special examination was warranted, such as for known hypertension, ongoing psychological and social problems, or weight gain.

The small number of encounters initiated on the basis of a referral by a community resource suggests that status code 2 may not be relevant in The Netherlands.

In table 4, the frequency distributions of the reasons for encounter are shown by comparing the status of the reason with the RFEC component. Both "symptoms and complaints" and "administrative" reasons for encounters usually involved new reasons for encounter at the patient's initiative, with 73.6 percent and 67.2 percent, respectively, of all reasons coded to those two components. Followup encounters on the patient's initiative, status code 3, were most often for treatment and medication or to obtain test results. About 39 percent of all reasons for encounter described in terms of a disease or diagnosis, component 7, were presented by patients during their first encounter (status code 1). It is evident that a referral by a third party, status code 2, was mainly for administrative reasons.

The most important finding demonstrated in table 4 is that if symptoms and complaints are the reason for the encounter, the contact is initiated 74 percent of the time by the patient.

## Discussion

During the pilot study, the nine physicians were asked to classify the patient's reason for encounter using the RFEC and, in addition, their final diagnosis using RFEC with the ICHPPC-2. In a future paper, the complete results of this dual exercise will be reported. At this time, an important conclusion from those results is that the RFEC nomenclature can be used not only to clarify the patient's subjective statement of his or her reason for the encounter but also to allow diagnosis at the highest level of specificity possible by the provider of primary care.

The disease rubrics in component 7 are a duplication of those in ICHPPC-2 and are, therefore, appropriate for classifying any medical diagnosis following examination by the provider. Although the code numbers are different, comparability has been maintained at the rubric level (fig. 2). Any nonmedical "diagnosis" can be classified by using one of the other six components.

We suggest that the use of RFEC in a patient information system could enable comparison between the patient's expressed reason for the encounter and the results of the patient-provider interaction, both of which constitute a health care encounter. RFEC is a classification system that is easy to use. It has a strong nondisease orientation and, therefore, classifies differently from disease-oriented classifications like ICHPPC-2. On the other hand, RFEC has close ties both with ICHPPC-2 and the proposed WHO triaxial classification system for psychological and social problems (11).

The rubrics of the process components, numbers 2-6, evidently need to be specified in greater detail. Other classifications that are being developed, for example, the

Table 4. Percentage distribution of status codes of reasons for encounters, in seven components

Component	Status code of reason for encounter			
	1. New contact, own initiative	2. New contact, referral	3. Followup, own initiative	4. Followup, physician's initiative
1. Symptoms and complaints . . . . .	73.6	1.5	20.1	4.7
2. Diagnostic, screening, prevention . . . . .	41.7	0.7	50.7	7.4
3. Treatment, procedures, medication . . . . .	33.6	0.5	63.2	2.8
4. Test results . . . . .	13.8	0.9	82.9	2.4
5. Administrative . . . . .	67.2	9.9	18.0	4.9
6. Other reasons . . . . .	57.0	2.0	15.0	26.0
7. Diagnoses and diseases . . . . .	38.6	1.9	50.6	9.0
Total . . . . .	46.50	2.49	42.93	8.18

NOTE: Percentages may not total 100 due to rounding.



NAPCRG-1 Process Code for Primary Care (9), should enable this to be done.

The results of this pilot study are similar to data coded by the NAMCS Reason for Visit classification (6,7). This is reflected in the distribution of the symptom and complaint component for all chapters. Patients often seek care because they have a complaint or symptom, not because they see themselves suffering from a well-defined disease.

Considering these results, the goal of the WHO Working Party—to produce a classification of the patient's reasons for encountering the primary health care system—does appear to be realistic. The pilot study results have been used to modify the RFEC in preparation for a field trial in ambulatory care settings worldwide.

In both developing and developed countries, there is an acute need to define more precisely the complicated relationship between health care needs and demands (15). Wide discussion on issues like medicalization of social problems (16), the effects of iatrogenic damage, the lack of efficacy of a number of medical treatments, and the impact of self-care and family care are increasingly leading to an agreement on the necessity to change health care policies. One of the most relevant aspects in this development is the growing skepticism about the existence of a logical, consistent, and presumably straightforward connection between the reason why a person enters a health care system, thus becoming a patient, and what happens thereafter. It is on these topics that the new RFEC can be focused, especially when it is used not only for clarification of the patient's reason for encounter, but also to interpret that reason or problem at the highest diagnostic level possible for primary care providers.

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*The nomenclature can be used not only to clarify the patient's subjective statement of his or her reason for the encounter but also to allow diagnosis at the highest level of specificity possible by the provider of primary care.*

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