Original Research Paper

Making Read Codes easy and useful in New Zealand general practice: a simplified approach to the classification of Reasons for Encounter

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Key Points
• Being able to classify the reasons for patient consultation in a simple, standardised way would have benefits for general practice research and the allocation of health care resources • If GPs do not initiate their own system, it is possible other agencies may eventually impose one • The Read Code system, as the most widely used in New Zealand, was revised by the authors for this purpose • The authors invite comments on this proposal

INTRODUCTION

In general practice in New Zealand we lack a simple system of looking at the types of interactions we have with patients each day. We also have difficulty answering the relatively simple questions of why, and with what problems do patients present, and how do GPs deal with these problems?

There is value in documenting both the common presentations, and the less common but important presentations in general practice, and we believe this is relevant to the care of individual patients, the health care of the wider community and the allocation of health care resources.

Conversely, there is little value in trying to record every possible diagnosis or the minutiae of a particular condition, unless the practitioner has a special reason to do so.

To do this, general practice needs a system that is accessible, userfriendly and which can be used with a fair degree of consistency by GPs nationwide.

BACKGROUND

Of the several possible alternatives, the Read classification system[1] is the most widely available in New Zealand general practice. Other countries use different systems to classify patient reasons for encounter (RFEs) such as the International

Classification of Primary Care (IPCP).[2] Although ICPC appears to be a valid tool for looking at RFEs in general practice[3] it is not as widely used as Read in the New Zealand setting. To the authors, it seems more appropriate to modify a system that already has acceptance, rather than attempt to introduce a new coding system.

Unfortunately, there is considerable variation in the use of Read between practices and between GPs within a practice. We believe we need a system that allows practitioners to enter data for each consultation easily, avoiding ambiguity and duplication, and encouraging rather than discouraging data collection.

Furthermore, there is a need for GPs to take the initiative in data collection and to develop a system relevant to general practice, before other agencies introduce systems that may be more suited to their own needs.

In this paper, we present a template for recording consultation data that are able to be modified by users to meet their own particular needs, but which are presented at least initially, from the viewpoint of "mainstream" general practice. The template uses existing Read Codes, and with a minor modification to existing practice software (so that a Read Code rather than a text entry is used by the GP), consistency of data collection would be readily achieved. There is no restriction on more "in-depth" coding by those already familiar with Read or who have a need to go beyond the template that we propose.

METHOD

Using data from the RNZCGP Research Unit,[4] each chapter of the Read system was scrutinised for the top 10 presenting Read terms. The data were collected over a three-month period from 12 general practices, and comprised 86,211 consultations from 81,890 patients, in which 32,989 Read Codes were recorded in 27,894 (32.4 per cent) of the consultations.

This process highlighted the duplication that exists when Read is used by different practitioners, eg, in Chapter G (circulatory system disease), code G34 00 *Other chronic ischaemic heart disease*, G3 00 *Ischaemic heart disease*, G33 00 *Angina pectoris* and G3 13 *IHD-Ischaemic heart disease* were all in the top 10 entries.

Where appropriate, the authors modified the entries to avoid confusion, so the above Read terms would all be entered as G3 *Ischaemic heart disease*.

The new list of top 10 terms were then compared with the data from the WaiMedCa study[5] and modified to account for every condition found there.

The lists were then compared with a classification system from the Hawkes Bay Independent Practitioner's Association,[6] which suggested the code of "NYD – Not Yet Diagnosed", which takes into account uncertainty in general practice, and the early presentation of disease to the GP.

We then searched Read for the code that most closely matched the heading in each section, mindful that the Read title is what will appear on the practitioner's records. Often Read lacked a title that exactly matched the template's heading and the closest appropriate title was chosen, eg, *Pancreatitis* is coded as J67, which is *Diseases of the pancreas*, rather than having several headings for different types of pancreatitis.

RESULTS

The Table presents the coding lists under diagnostic and consultation groupings,

with a Read Code entry that closely approximates the clinical heading used. Most groupings start with a "Not Yet Diagnosed" category, and end with an "Other" entry.

These headings are not exhaustive of all the conditions found in general practice, and are not intended to be. They are indicative though, of commonly encountered conditions and reasons for consultation that a GP, practice or group of practitioners may want to know about.

The headings do not follow strict organ systems, but are largely consistent with groupings used in Read and are clustered in a clinically appropriate way, eg, Breast disorders are found under the *Genitourinary* heading, along with several other women's health topics.

The headings are easily modified to allow practices of special interest such as musculoskeletal medicine, sexual health or student health to record data of particular relevance to them.

They could be presented as a single-sided A4 hard copy for easy desktop reference, or be adapted as the "first level" of access to Read on existing general practice software. They specifically avoid the use of text entry, which promotes confusion and ambiguity when Read is used.

DISCUSSION

In widespread use, these headings would allow ongoing information about the nature of general practice to be gathered.

The information could be analysed by looking at the consultation frequency per code at the level of the individual GP, groups of practitioners or at the conditions themselves.

The Research Unit of the RNZCGP has the facility to analyse the results from a large number of GPs. This would enable the impact of health care initiatives and changes in diagnostic and therapeutic strategies to be evaluated over both short and long time frames – a task our current data collection strategies struggle with.

At all levels of practice, from the solo practitioner to large groups of practices, the allocation of health care resources would be facilitated by an improved understanding of the tasks of general practice, and the chance to correlate RFEs with measures of outcome.

CALL FOR COMMENTS

The Research Unit of the RNZCGP, based in the Department of General Practice, Dunedin School of Medicine, invites comments and welcomes the opportunity to discuss this proposal with interested providers of health care. We believe the challenge at this point is for GPs to start using the system, to try it and see how useful it is, and to let the authors know their findings.

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