AGENDA WICC MEETING CRETE, 22 -26 SEPTEMBER 2019,
MINUTES FROM THE SESSIONS

WICC Annual Meeting Crete
22 Sept. – 26 Sept. Pre-meeting process group 20 Sept. – 21 Sept.

Dear colleagues

Goals of the meeting

A: To bring everyone to the same level with regard to: the working method of the Consortium and the choice of classes and the structure of the ICPC-3. Everything is still work in progress.

B: Reflections on the present mission, goals and role of WICC also in relation with the further improvement of ICPC-3.

Pre-meeting Process group, Friday and Saturday 20-21 September

Date/time	Activity	Speaker(s)	Discussion leader	Minutes
Full days, Friday and Saturday, same program	Pre-meeting activity of the process group	Two days lead by Laurent from 9-17 hr		
900-10.30	1th (Friday) and 5th (Saturday) session			
103011.00	break			
1100-1230	2th (Friday) and 6th (Saturday) session			
1230-1400	lunch			
1400-1530	3th (Friday) and 7th (Saturday) session			
1530-1600	break			
1600-1730	4th (Friday) and 8th (Saturday)session			

The discussion will be presented by Laurent as a topic on the agenda

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Sunday 22. Sept.

Sunday	Activity	Speaker(s)	Discussion leader	Minutes
0900-1000 **1000-1030**	WICC FULL SESSIONS BEGIN Welcome to meeting; Practical info on meeting; Distributing documents; Introductions – members/observers: Review and revise agenda Goals and agenda for meeting; . How to have the discussion as effective as possible State of WICC 2019 - Upcoming meeting site possibilities Minutes Lviv meeting, discussion	Thomas and Dimitris Thomas Thomas	Mikko	Preben

Minutes by PL

The meeting is opened by Thomas Kühlein with a welcome. 23 participants, including 3 associate members. At this year's meeting no guests or observers attend.
Dimitiris is thanked for organizing the meeting. Practical information on location, hotel and social events was reviewed.
TK reviews the objectives of the WICC work:

- **WICC MISSION:**
  To develop and maintain classifications that accommodate the complete domain of family / general practice
- **SPIRIT**
  T**o ensure that these classifications are interoperable to the highest degree possible with standard international health care terminologies and classifications**
- **IN ORDER TO**
  Contribute to equitable quality health care worldwide.

- **GOALS:**
- **To achieve widespread international use of ICPC**
- **To maintain and revise ICPC to accommodate expanded health care knowledge**
- **To develop productive working relationships with others international standards development organizations**
- **To support the work of WICC and Wonca through licensing of ICPC**
- **To create and disseminate additional classification tools as needed to capture and codify the complete domain of family / general practice.**

The preliminary agenda for the meeting reviewed by TK

Discussion leader during the session: Mikko Härkönen (MH)

The preliminary agenda for the meeting reviewed by TK
Discussion leader during the session: Mikko Härkönen (MH)

Action Plan for 2018-2019 from Lviv, Ukraine 2018 was discussed and the completed and outstanding tasks from 2018 marked.

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The accompanying presentation can be found on the WICC website (http://wicc.news/wp-content/uploads/2019/09/WICC-Opening-Session_Crete_TK-2019_09_22.pdf)

1. **Discussion of organization membership is dealt with separately on the agenda**
2. **Updated membership list for website use is provided by the governance committee.**
3. **Aims for monthly meetings in executive committee - skype meetings**
4. **WHO collaboration:**
   ongoing activity around icd-11 development
   Encourage everyone to seek involvement in regional collaboration. Taran explained the Nordic collaboration activity in which she is a participant.
   WHO-FIC:
   Cooperation in WHO-FIC remains problematic. A primary care group has been set up without the participation of primary care representatives and without a mandate.
   WONCA-WICC
   Modest WICC presentation of ICPC at WONCA congresses in 2018/2019. A single workshop has been held. WONCA-Europe Congress in Berlin 2020 calls for a workshop on ICPC.
5. **PERI - nothing new about PERI classification. Thomas and Diego**
6. **Blue Book available on the website. (http://wicc.news/wp-content/uploads/2019/01/Wonca-ICPC-2-R_OUP2005-complete2.pdf) for non-commercial use – will be stated on the website stating the copyright to Oxford University Press. Jean Karl Soler will clarify and handle formalities regarding the pdf version on the website and align these with Oxford University Press**
7. **Logo for WICC – not done.**

Discussion on goals:
Kees Van Boven – KvB/TK: Main goal for this meeting Continuing the development of ICPC-3 and demonstrating the work done by the ICPC-3 Consortium and who the work is done technically. Discuss the work done by the task-force-A.
TK: Continuing reviewing the agenda for the coming days.
During the review of the agenda, Gustavo proposed reducing future meeting length.
In reviewing the agenda brief discussion on licensing matters. Kees states that licensing matters are not really a matter for WICC, but really only a decision under WONCA. JKS states that clarification of the ICPC-3 consortium's future position in relation to ICPC-3 license payments is needed. Recognizes that this is a WONCA matter, but that the WICC should be the group that guides WONCA on licensing policy.
Kees states that no licensing policy has been discussed until now in the consortium but must be subject for the consortium next year.

Minutes from Lviv:
Minutes from Lviv, 2018 are after the meeting sent to the WICC members and available on http://wicc.news/wp-content/uploads/2019/09/Agenda_with_Minutes_WICC-Annual-Meeting-Lviv.pdf. These were approved without objection.

WICC status 2019:
Illustrated by a review of survey sent out to the represented countries immediately prior to the Lviv meeting. The presentation is available on the WICC website.
22 out of 41 answered the survey. 6.2% of all countries have a national license. ICPC is most often used in research. 36% of respondents state that ICPC is used at national level.
Kees‘ and Thomas‘ disagreement:
Should we try to publish this „land mark study“ to promote ICPC?
Or should we better not, as it shows how little ICPC is used?
JKS: does not find the result of the survey to be true. A literature search has assessed several users without a national license who use ICPC for research purposes. Proposes to review studies in the literature and assess the frequency of use of ICPC classification in these studies.
TK: the use of ICPC may well be greater if you look at studies where e.g. the use of ICPC is used in quality assessment. But that does not change with a limited prevalence of the ICPC as a national classification. The presentation – as it is shown on the website - demonstrates the concrete use of the ICPC for the representatives of the answered countries.
Kees: It will be more relevant to show how ICPC is used rather than marking the number of licenses. This also applies to other classifications eg. SNOMED that a national license may not necessarily reflect

the use of the classification.
DS: Thinks it should be published, with discussion including the value of using the thesaurus and the value of a classification in daily work
GG: does not think the result of the survey should be published. Does not find the methodology of the study to allow this.
TK: Survey not intended for publication, but primarily internal use for WICC. It will be interesting to review the literature to get a picture of how the use of ICPC is in studies and what role it may have in practice organization and quality.
LL: Calls for visibility and information for practice on the development of ICPC-3 and linking to other classifications.
TB: Want a discussion on why we want ICPC-3 and obstacles to using ICPC.

1100-1230	Presentation: Topic; General principles of the ICPC-3: a first look at the new ICPC-3. Aim: to explain the necessity of the ICPC-3, basic principles for developing a primary care classification, the leading principles and the change in the structure in the ICPC-3, first look at the ICPC-3 browser supplemented with an overview of the number of classes. Open floor/questions	OO, MV, DS, MH, LL, KvB Kees	Anders	Simone

Minutes Sunday 22 August 2019 11:00
Simone Postma

Presentation Kees van Boven: Topic; General principles of the ICPC-3: a first look at the new ICPC-3. Aim: to explain the necessity of the ICPC-3, basic principles for developing a primary care classification, the leading principles and the change in the structure in the ICPC-3, first look at the ICPC-3 browser supplemented with an overview of the number of classes.
Slide 1-9: Kees: Personalized information and functioning is still not in the classification. Is it possible to integrate functioning in the ICPC? Why change the ICPC-2? Use case for primary care, general practice and first contact care. Basic principles for developing a primary care classification. Leading principles fort he selection of the classes are still the same; frequency and evidence based still most important. New; links to other relevant classifications icd11, icd10, icf, ichi, snomed-ct, old versions icpc, DSM V (?). Why change the code structure? Lack of coding space, regional needs for specific codes, etc. The new ICPC-3, see browser. +/- 710 classes in the core ICPC, 242 symptom/complaint/abdnomral finding classes, 365 diseases, 103 classes in new chapters Z and chapter for functioning. How dit we develop ICPC-3. Review the present content oft he icpc-2. Input from TFA WICC and by the consortium core group. WICC as think tank providing information, ideas and advice.
Questions/remarks

- **Discussion about functioning, should it be in the new classification?**
- **Contradiction between being a simple classification and being personalized classsification. Purpose of ICF is different than other classifications.**
- **Classification should represent what we do as a GP.**
- **Worries about a classification that contains all the information**
- **ICF is too detailed for ICPC**
- **Current episode of care: too much focused on diagnosing, diagnostic concepts, but should be more directed to functioning. Functioninig is not an episode of care.**
- **You cannot integrate classes from another classification system into the ICPC.**
- **Linking vs mapping: it is not possible to map ICF to ICPC, but it is possible to link it. Different concepts of linking and mapping.**
- **Episode of care: too much focused on diagnosing, diagnostic concepts, but should be more directed to functioning.**

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1400-1530	**Plenary presentation: Topics;** **General principles of ICPC-3.** **The Content model. Use of classes. Aim: To show how we work within the Consortium, to get acquainted with the Content model and the explanation how classes are used and linked**	**OO, MV, DS, MH, LL, KvB** **Kees**	**Sebastian**	**Oystein**

Minutes Sunday 14.00 - 15.00

General topic ICPC-3 – content model
Introduction by Kees, presented content model
Issues that were raised during the discussion:

- One major issue is proposal of additional chapters, function could be an extension rather than a chapter, a new chapter are breaking the rules
- Should we have more distinct disease definition in the classification? I.e in ICPC2 there were criteria in mmHg to define diagnosis, these are now taken out.
- The majority of comments supported having a description of diagnosis, and refer to guidelines for diagnostic criteria
- But, different criterias are used internationally for diagnosis of i.e hypertension internationally, problems to compare.
- Better to have "criteria" than "descriptions" in content model ?
- Why use the label of section "disease", rather "condition" ? i.e since hypertension is included there
- ..however, Component 7 is disease and riskfactors. Tara – linkage to ICD-11? Hard to understand if it is 1-to-1 map or not ? How to do this automatically in EPR?
- Mapping /linking: Based on mapping ICD10, new links for entities changed, some classes no corresponding classes…..
- attributes vs extensions, Why this distinction ? Causality as attribute ? in ICD 11 the term "properties" are used.
- Chronic vs acute, use same principal across all chapter, either two rubrics or extension code
- Need rules for handling extensions and code with not extension. Some argue for always having a residual extension code as one of the extension code, or else problems with interpretation if the higher level code include the residual, codes without extension are residuals or just "lazy coding" ?
- A lot of labels used to justify treatment
- A lot of time used to work with risk factors, prevention often label as disease, also a burden of patients, must show in classification
- Why extension in inclusion, all they will be included
- By using extension codes, you introduce "terminologi" blurring the "classification"

Øyh

1600-1730	Presentation of the work done by TFA Focusing on the input of TFA	TFA: NB, EC, SP, JKS, MV	Zorz	Sebastian

Minutes taken by Sebastian Juncosa
Sunday 22- Sept 1600-1730
Plenary presentation: Presentation of the work done by TFA. Focusing on the input of TFA

Presentation
Jean Karl Soler explains the origin, task profile and work profile of the group.
He underlines that ICPC 2 has been a basis of ICPC-3 development. He describes the work flow of the group.
Review the ICPC principles and the task group alpha rubric rules,
He reviews the work done and the decisions for specific rubrics for each Chapter. Also proposals for new rubrics. At the end many minor changes to inclusions, exclusions, considerations and notes and few major changes.

They decide to continue the work and open to new members.

Discussion
Gojimir Zorz and Dimitris Kounalakis would like to join the group.
Simone Postma and Marc Verbeke would like to leave the group.
Kees van Boven appreciates the contribution to the group. He explains why the Consortium exists. The group TFA wants to review the Consortium work and come with new proposals.
JK want to point out that the final decision about changes and ICPC-3 is for WICC.

Nicola and Jean Karl would like to reconsider the new structure 2ª2N and go back to the old one since not so many spaces is needed. The proposal does not obtain support.

Monday 23. Sept

	Activity	Speaker(s)	Discussion leader	Minutes
0900-0945	Nominations for WICC positions Report on WICC engagement in Wonca and other Conferences Report on Wonca/WHO ICD-11 PC/SNOMED issues	nomination group/ no nominations Thomas/Kees	Krishna	Tara

Minutes Monday 21 September 2019 – session

Nominations for WICC positions
Report on WICC engagement in Wonca and other Conferences
Report on Wonca/WHO ICD-11 PC/SNOMED issues

Membership – four new full members
Ana
Simone
Øystein
Bjørn
All agree by acclamation
Report on activities: Wonca in Asia – Kees participated
Wonca/WICC/WHO – by Thomas Kuhlein
Little correspondence between WONCA and WHO besides classification and the WICC Google group
Summary of history and main features of ICD-11, and the lack of involvement from primary care
A new PC-group for the FDC, but again, without PC-physicians. WICC added after protest.
Letter by Wonca leadership to Robert: "…We have received numerous promises and undertaking, and yet nothing has come to them.
Discussion:

- Important to be a member of the WHO-FIC as a related classification. WHO is a governmental organization and strongly political
- The line between GP physicians and other health care providers in primary care
- Its impossible to accept the product because its not involvement of primay care doctors and classification experts in classification

- WICC has not to have the money to go to the meetings in WHO FIC
- A possibility is to see what happens when ICPC-3 is ready
- Idea to plan an appointment with the vice director (ask Francois for contact information)
- Need of people who support from the inside og WHO
- People from Norway don't stand up for ICPC
- Is it possible to have influence in other specialty groups?
- What is the strategy from WICC – Thomas describe objective of one classification in the future in which WICC is in control
- African question to the WHO – where is the place of GPs in the classification
- Chronic disease is an issue. If we accept the shift of standardized chronic disease management, this will push the agenda of treatment and patient care in direction of specialist care
- Nordic Collaboration Centre represents four countries (N, S, DK, Ic)
- First contact care is important for ICPC and includes for instance use by nurses and paramedics
- The world is changing, and we have to find a way to cope. Rely more on task shifting (ie pharmacist overlooking treatment of hypertension), information must be accessible for more than one doctor and support the new primay care team
- Big primary care picture – the role of the GP is not the only one. Reports and discussion lack GPs in the areas of governance. We need to step out of the "little kingdom"
- The diagnoses and the "gate keeper"- role is at the heart of GP. The strength of ICPC is to capture the RFE and diagnoses/not diagnoses.
- What to expect from the family physician in the light of advanced technology, for instance blood test for cancer? Will this influence the role of the family physician
- Need to meet both politicians and patients. If we reduce primary care to the single process of diagnoses this will limit the progress of primary care. Politicians will find walk-arounds
- Ex from Switzerland: ICPC is excluded. The work of GPs is not easy to count. The numbers can't show the work of family physicians
- General practice has not an interest because the pharmaceutical companies are leading the priorities

Summary: Many questions we can't answer. Thomas puts his position in the WHO FIC open for replacement. Urege all WICC-member to search contact in our collaboration centres to speak up ICPC in the WHO FIC context.

0945-1030	WICC website	Heinz	Krishna	Tara
No minutes from this session, Heinz demonstrated the website http://wicc.news/				
1100-1230	Plenary presentation: Topic Prevention and risk factors in the ICPC-3, a new component in chapter Z. Aim: to explain why prevention and risk factors classes changed to another Chapter. Introduction and small group discussion (risk factors, looking after one's health).	OO, MV, DS, MH, LL, KvB Marc	Francois	Bjorn

Minutes Monday 1100 – 1230.
Prevention and risk factors in the ICPC-3, a new component in chapter Z. Aim: to explain why prevention and risk factors classes changed to another Chapter.
Introduction by Marc. Minutes: Bjørn.

Primary care paradigm shift – from diagnosis to person centered medicine.

All this information is forced into A 98 and A97

We miss a lot when only using diagnostic concepts.

Person care
Health influencing factors

New part of ICPC3 – chapter Z – chapter V – extensions.
Fundation layer
VF 50 (example)
Proposal for reconstruction of chapter z.
ZR contact with health services – not a contact for complaint or diagnosis.

Lead of discussion: Sebastien
Jean Karl: You cannot have prevention in several places. The components. Disagree that we have no way to report no disease.
I would suggest: a coding system for person related information, linked to icpc.
ICPC-2 is in some way a foundation layer for the development of ICPC-3, and we cannot change the rules in the middle of the project. However, the personal factors and health status information may be studied and reduced in a system which is not part of the core ICPC. ICPC is a classification of primary care, not a classification of health or of the person,s goals.

Diego: Opposing JK.
Sebastian: Confusion on levels.
Anders: Good idea with the Z chapter, to extent into the social and environmental factor. But we focus too much on risk factors, not on positive patient factors. The notion of health promotion/patient perspective.
Kees: Social factors can be classified in a functioning part.
Anders: More research about chronic diseases and childhood experiences.
Kees: We asked about life events. What is important to have in the classification?
Marc: How do we manage contacts without symptoms/problems, which is not an episode of care?
Q-codes?
JK: Follow the rules. Problem if the denominator is different.
Kees: We propose a new chapter z, for what is now in A 97-98. It is an episode.
For other things. Functioning is not an episode of care. If a person has kidney failure, it I a chronic condition. We do not fracture the system. This is extra important information.

Function contains more than physical factors, also environmental factors like family, living conditions.
Overall functioning or connected to a specific disease?

Øistein: How much should be reported? This is very much patient information, not what doctors do and think.
Laurent: it is a change of icpc. Should be registered in the episode of care.
Kees: Function related to personal an environmental is in chapter V.
JK: Chapter V does not follow the structure. Overlap will break the classification. Should be handled separate, but linked.
Gustavo:
Mikko: In Finland, nurses use icpc. This extensions will help to make more complete registrations.

Sebastian: I see two views: Extending ICPC or making a separate classification?
Anders: The social determinants have been into icpc. It should not be taken out. When ICD included social factors, we already had it. We use this information, and should show that we use.
Simone: ICPC should represent the whole of primary care, therefore include these factors.
Diego: We need these data. Support that we should register these data.
Elena: Simone – what do you need? The GP will receive documents already coded by specialists. You can not expect that a GP can register all details of a disability.
Diego: Goal oriented care, will include coding of functioning, not only diagnoses.
Elena: ICF could be used and combined. The physician should be aware of the need for extending coding.
Laurant: This is around the episode of care notion. The GP cannot manage this.
Marc concluding: There is controversy. We need to get rid of only the diagnoses thinking, we must include all the other data we need to take care of the person.

The new website:
Heinz:
The web site: We want to have new photos – good ones! Need information from the members, send more information.

1400-1530	Plenary discussion Topic: Cross chapter issues.	TFA: NB, EC, SP, JKS, MV	Preben	Laurent

Minutes Monday 23/09 14h: 15h30

Cross chapter issues (JKS)

- ICPC structural integrity: it's a working plan rather than a position
  ICPC is a classification, with mutually exclusive classes and residual classes. The foundation layer is based on ICPC 2 (v2.7). It is empirical, and additions and deletions should be based on frequency and evidence.

- ICPC principles and rules
  Importance of empiricism: ICPC was originally based on large studies that collected data from general practice in a consistent way. Classification principles: everything has a place, and a place for everything (avoid ambiguity, use residual classes, etc.). The granularity is appropriate and based on empirical data (prevalence≥0.5 per 1000 py).

- Codes moving across chapters

  8 changes recommended or suggested. The changes from ICPC-2 to ICPC-3 should be tagged
- 26-, -27, -28, functioning

  Not many calls for major change for -26; Removing all such -28 codes in each chapter is not justified by frequency data; Creating a new chapter should follow all the ICPC rules, including having 7 components, being appropriate for RfE and Problem labelling, based on empiricism, and consonant with the rule of mutual exclusivity and domain completeness.
- ZP and personal information

  Creating a new chapter should follow all the ICPC rules, including having 7 components, being appropriate for RfE and problem labelling, based on empiricism, and consonant with the rule of mutual exclusivity and domain completeness.
- Joining X and Y and the role of W

Many codes in G (the great majority) will still be sex linked, such as “prostate cancer”, “penis pain, ”vulval pruritus” and “ovarian cyst.” As such, the join does not resolve the sex issue. Rubrics will not be unisex. W is also quite similar. Proposal from JK: only join those codes in chapter X and Y which are genuinely unisex; they could be moved to chapter A, for example.

- Archetypes and rubric tags

  The use of an archetype model may solve many issues such a several groupings.
- Renumbering

  Not change for re-ordering purposes only, since this de-values people familiar with prior codes.
- Prevention

  Coding the appropriate RfE and intervention adds much specificity to the A98 class, which is very large.
- Clinical findings

  There is no complete classification of clinical findings in ICPC, and to give this impression would be wrong.

KvB explained that sometimes we need to make the rules evolve. It was stated that we should improve the communication between TFA and the Consortium.

1600-1730	Plenary discussion Topic: process in the ICPC-3.	Laurent and the process group	Diego	Francois

Process Group
Laurent leads

2010-09-23

Work started 2008 (Mårten Kvist)

Make ICPC Process rubrics use easier
RFE
encounters
interventions

Organisation and content
sub-categories mapped to it
based on IV process pC

distinguish screening from diagnosis by coding associated health problem associated as A98
biological tests using LOINC
ICPC3 hardly mapped to ICHI (multi-axial, pre-coordinated and does not include items such as administrative procedures)

medication codes (-44, -50) should be mapped to ATC
process codes to be kept in every chapter, use of hyphens for analysis to be allowed in certain cases

automatic coding of procedures whenever possible

Components of the process rubrics
2 diagnostic and preventive
3 medication, vaccination, treatment, therapeutic interventions
4 results
5 administrative
6 coordination, referral, and a

split -41 (diagnostic radiology/imaging) into radiology and ultrasound
move -44 to component 3
move -46 and -47 to component 6

add new rubric for a care plan (management/treatment/intervention) in component 3

remove 63 (followup encounter, unspecified)

mapping to SNOMED CT

updating IC-process-PC
simple linkage, not integration
distinction between mapped to ICPC3 (sections 2 to 8) or not (1 and 9)

Recommendations
precise the rules for coding
indicate to software developers which process rubrics that should be automatically coded

data from various countries needed, with their mapping to SNOMED CT
classification of clinical signs as an appendix
based on work from Japan (Shin)

2019-09-24

ICHI
Currently available online only.
Is it interesting to link with a WHO classification? ("linking" more appropriate than "mapping")
Mapping is one to one linkage at the level of concepts. Complete one to one mapping between classifications would imply that those classifications would be identical.
The interest of linking one ICPC code to many ICHI ones is questionable.
Marc's plea is that ICHI ontology can provide a model that would help us to re-construct our process codes.
François: let's not be drifted away from the issue that's at stake here. It is neither a technical nor a philosophical issue, but a political one: to be recognised by other communities than primary health care providers, do we need to systematically seek linkage with all international terminological systems, at the risk of having our specific work diluted into unsolvable technical debates? We should not

renounce our specificity. Marc: as an individual GP in solo practice, ICPC is fine to me. But we need to communicate with others.
François: While we are bound to recognise others, but they also have to recognise us.
Dimitris: it is also an issue of marketing among potential users. Users are attracted by the simple system that ICPC represents.
Jean-Karl: ICPC is the only classification in the world to appropriately handle symptoms in primary care. There are many use cases, none has to win over the others.

Tuesday 24. Sept.

	Activity	Speaker(s)	Discussion leader	Minutes
0900-1030	*Plenary discussion* *Topic: process in the ICPC-3.* Plenary presentation and small group discussion using the browser Aim: To explain how these concepts are defined and used in the ICPC-3.	 OO, MV, DS, MH, LL, KvB	*Diego* Diego	*Francois* Elena

24 Sept Minutes WICC 2019, Elena

Diego moderates the session:
The Process group discussion continued to decide if we want to include mappings/links to other classifications that includes procedures (e.g. ICHI, Currently available online only).

Diego: we do not have to had the links into the classification but have them as separated mappings.
Dimitri: Not linkage, but mappings from one to the other, also for machine readable data.
JK: Question: what is a map and what is a link. Mappings is not only 1:1, we have mapping between ICD-9-CM and ICD10 that are not 1:1 but 1:N and it is valide. Seggested to have a document produced by the people who wanted to add linkage to clearly define what is link.
ICHI or LOINC? We can map process codes to ICHI.
What is the idea? To map just 1:1? It is good for transcoding, but you can't have in this context. There are differences in granularity and classification structure, so it is not possibile to have only 1:1 mappings. If you have them is good but you wont have only this type of mappings. You will have M.1 and M:n too.
Clarify the differences betwen mappings and linkages.
Francois: mappings is 1:1 at the level of the concepts, not the term. If the concepts are exactly corresponding we have one to one.
Thomas: linkage to ICHI at a high level granularity. We can create the mappings at high level to have 1:1, it could be a solution, and it could be easy if we have a system to find them.
Create new high level categories to find the semantic relationships at a high level in ICHI?
Marc VB: the construction of mappings is universal. ICHI is a model of construction of process, gives inspiration. Reconstruct process codes to harmonise as ICHI did. Same idea of ICPC ATC-drug codes. We can do more or less the same thing.
Laurent: Map to the concept, the main category and not to the specific code inside?
JK: resumes all the things that are going to be different (conceptually) from the ICPC2 principles (e.g., no reasons for encounters but findings, person-centered, functioning, etc).
Answer to Marc. If we want to link to snomed by cooperating (e.g. putting findings because in snomed a clinical finding is a symptom), so if we try to link to snomed by changing the structure ….
ICHI has a different conceptual framework, and we cannot change ICPC conceptual framework.
Marc: add other dimension in using it, not only the one of primary care.

The interest of linking one ICPC code to many ICHI ones is questionable.
Marc thinks that ICHI ontology can provide a model that would help us to re-construct our process codes.
François: It is neither a technical nor a philosophical issue, but a political one: to be recognised by other communities than primary health care providers, do we need to systematically seek linkage with all international terminological systems, at the risk of having our specific work diluted into unsolvable technical debates? We should not renounce our specificity.

MIKKO: professionals use ICPC2 with snomed in Finland, nurses, etc.
Dimitri: reports greek experience in using the classification. If we want to sell something we need to think about proper linkage. So, it is also an issue of marketing among potential users. Users are attracted by the simple system that ICPC represents.
JK: some of the data from the blue book come from the maltese GPs …there were also data from nurses.
ICPC is the only classification in the world to appropriately handle symptoms in primary care. There are many use cases, none has to win over the others.
Diagnoses or not!

Oystein: what is the need of having ICHI mappings and other process codes classification? It would be useful to have snomed mappings to extend classification, but process codes in ICPC have not the same objective of ICHI ones or other.

Kees: There is also a political view also. Proposal of the process group are easy to manage.
Diego: Who is using ICPC as coding system and not as terminology or thesaurus? 4 people in the group.
Gustavo: Put outside the terminology …
JK: there are different use cases for using ICPC (some people use it for accessing the read code, other with snomed, etc.). What is important to address all use cases (analysing public health data, terminology, classification, coding system). At the end of the day we should address as many use cases as possible.
Marc is suggesting that ICHI is something we want to consider to restructurize ICPC processes and this is the problem. If we think, we already have a paradigme that is patient centred care, the reasons for encouters, the episode of care structure the model we have for the encounter. If we try to link to snomed by changing our principles and structure (e.g. using clinical finding instead of symptoms) we are gonna have a problem, and the same is for functioning, we cannot take ICF and putting in a chapter of ICPC because that has a different task, different rules, etc. And about ICHI, again, ICHI has a different conceptual framework, so if you take ICHI and its conceptual framework and put into ICPC, you are changing ICPC conceptual framework, and you cannot change this to have a 1:1 mapping to other classifications (ICD, Snomed, ICF, ICHI). This is the problem we are having. And the solution is only one. We have to decide if we want a classification with rules or a coding system which is linked at a conceptual level and at a philosophical level to other coding systems we are going to use.

Kees: propose the process group to go into the mapping to ICHI.

OO, MV, DS, MH, LL, KvB,Mikko

Plenary presentation and small group discussion using the browser
Topic: Double coding, congenital-hereditary and clinical findings.
Aim: To explain how these concepts are defined and used in the ICPC-3.
Biorn moderates
Diego Presentation:
How to capture Person behind the Patient. He starts from his PhD thesis
Concepts of coordinate and continues care
Patient-Centered vs Person-Focused care
Differences
Showed use cases provided by Oystein

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Excercise for WICC members on two use cases: Man 45 years old, Woman 82 years old.
Discussion about the results of the excercise.
First case discussion:
Thomas and Bjorn summary of the discussion related to the importance of capturing social problems according to the documentation and narrative given by the patient, and about the need for detailing functioning.
Thomas: it is not just a matter of coding but a problem of documentation.
Kees: He wouldn't put everything as the reason for encounters…
Diego: needs for describing social and context, not only to code…
According to Bjorn, we only need the last set codes (Assessment of functions with details, details on impairment, etc.).
Second use case discussion:
Dimitri: form this use case it can be captured social, economical problems of the patient that are not immediately described by the patient.
We need to take a decision of having focus group working on functioning in ICPC3.
Everybody approved.
What kind of information they want to have in primary care about functioning, looking also at frequency.
What kind of information in ICF could be important in ICPC.
Simone: no separate group in WICC with expertise about functioning, but all WICC can work on this giving feedback, idea etc. about functioning.

Syndrome, Disease, Disorder, Diagnosis, Sign, Symptoms
Kees Presentation

1100 - 1300	Plenary presentation and small group (?) discussion: Topic: Functioning (1)	OO, MV, DS, MH, LL, KvB Diego	Bjorn	Heinz
No minutes yet received				
1400 - 1530	Plenary discussion about functioning. How do we update/manage functioning. Do we need a special group for ICF in WICC Syndrome, disease, disorder in the ICPC, plenary introduction and small groups discussion using the browser	Simone, Diego and Thomas Kees	Elena	Ana

Minutes Tuesday 24 September 2019 – session

Syndrome, disease, disorder in the ICPC, plenary introduction
small groups discussion using the browser

Syndrome, disease, disorder, Symptom, Sign. in the ICPC, plenary introduction- by Kees

Kees explained how we are using Syndrome, disease, disorder, Symptom, in ICPC3 what are the meaning of this term from Wonca dictionary.
small groups discussion using the browser- by Kees
Discussion:

1. Thomas was interested in of explanation what abnormal physical or mental condition are.
2. Jk opinion was that if you search for the meaning of disorder on the internet the definition will be more related to psychological. He wanted to avoid using the word Disorder in the ICPC in any other form then a condition which is in the international literature called disorders, such as hyperactivity disorders, because he thinks that it means more than a disease and it is used

more related to mental health.

3. Dimitri did not agree that it is always communicated with mental disorders
4. Elena's opinion was that these are different terms and she uses them differently in the coding system. So there are differences between this concepts and the meaning is wider then a disease
5. For Norway This discussion has some legal aspect- as an e.g it is excepted in the insurance only disease, injuries or so on and doctors are always avoid to use it because it has consequences for patients functioning.
6. Kee's suggested to think about it a little bit more because it is not always so clear
7. JK suggested to make rules for exception, because you will always find an exception to rule the syndrome. it is complex of signs and symptoms all accrue together often characteristic a disease that meaning is close enough. And he suggested Syndrome should be in a component seven without any exception.
8. Kees suggested to discuss in a small groups and to go in through ICPC browser why it is wrong or why it is should be in the rubric one or rubric 7
9. All syndrome should be on component seven–Jk
10. Premenstrual symptom/complaint is in component of SYMPTOMS/COMPLAINTS and Premenstrual tension syndrome is in component seven which is not appropriate and should be changed. Jk agreed
11. Jk sad that they had suggestion from the chapter group and then discussion with the task group and they all agreed except in one issue Chronic fatigue syndrome. It was suggested that in the exclusion should be more then weakness, tiredness general and it should be in " N99" as a ragbag and as it is increasing in frequency over time it will need its code. But minority objected.
12. Putting Chronic fatigue syndrome in a component seven you are excepting it as being a disease, which is not excepted in medicine.

Wednesday 25 sept

	Activity	Speaker(s)	Discussion leader	Minutes
	WICC Open Session			
0900-1230	*PRESENTATIONS related to primary care classifications* Presentation Greek colleague How to develop a core set for Functioning A reference terminology for PC Health problems managed Malian GP as compared to French GP Big data from FaMe-net/Transition project Poster Marc Jamoulle The network approach ICPC-2 in Georgia Health care for people with most needs.	Call for people who whish to speak about implementation in different countries in health records or other classification related issues Prof Christos Lionis (se documents from Dimitris) Thomas, Diego Laurent Kees Marc by Zoom? Simone Postma Ana Karelina Anders Grimsmo	Thomas and Kees	Nicola

No minutes taken, the presentations are available at http://wicc.news/meeting2019/

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1400-1530	**How to achieve the goals of WICC (Policy document, see below the agenda)** **Who will actively participate? How do we get money to achieve the goals? See below a summary of our present mission and goals.**	**Thomas and Kees**	**Heinz**	**Anders**

Minutes Wednesday 25th 14:00, AG

Topic: How to achieve the goals of WICC (Policy document, see below the agenda)? Who will actively participate? How do we get money to achieve the goals?
Wonca support is close to none for both WICC and the Consortium. Wonca has the rights and license to ICPC, but does not undertake the financing of neither further development nor maintenance. Wonca's license strategy hardly give income and should be renewed. Licensing is also a matter of policy.

WICC should put more weight on preparing the ground for making it easier to implement ICPC in the EHR. One idea would be connecting ICPC to a suggested information model that would make easier for programmers to implement ICPC into the EHR. Former CONTSYS, adopted as an ISO standard (EN ISO 13940:2016) in 2016. The standard is problem oriented and build on the episode of care concept. Other proposals were to publish an ICPC demo online, assess people in power position, and focus more interests and needs of clinicians. Communicating/marketing ICPC is hampered by too little time for WICC members. Implementation in large scale is also much more costly than developing ICPC, and needs skills that health personnel normally do not have. Lack of resources is also do to health authorities prioritizing Snomed CT.

We could also be more efficient at Wicc meetings, get the agenda earlier and appoint members to prepare an introduction and presentation according to each topic.
More or updated educational material is needed. Material was published together with the ICPC-2-R book. Usecases should be developed. The GP college in Norway is planning to make video and could make possible translation and dubbing into other languages. Wicc should also be better to "sell" the benefits of using ICPC, like better overview/practice profile, higher documentation quality, possibilities for decision support, easier and timesaving billing and so on.

1600-1730	Topic: Double coding, congenital-hereditary and clinical findings.	Mikko	Jean Karl	Dimitris

No minutes yet recieved

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Thursday 26. Sept

		Speaker(s)	Discussion leader	Minutes
0900-1030	Plenary presentation and small group discussion using the browser: Topic: Chapter ZR (the old chapter Z) and Chapter G (X/Y). Aim: to explain the changes	OO, MV, DS, MH, LL, KvB Kees	Gustavo	Simone

Minutes 26 September 2019 0900-1030

Topic: Chapter ZR (the old chapter Z) and Chapter G (X/Y).

Plenary presentation by Kees
Kees explains why prevention and risk factors related to a RFE or episode of care are in chapter ZR: contact with health services
Description chapter ZR:
'In some cases a patient has a contact which the provider cannot interpret as a complaint or diagnosis within the other chapters of ICPC-3. This contact is related to first contact, prevention, screening and case finding, certification, family planning or specific care programmes'

Plenary discussion about chapter ZR
General comments:

- Some codes from the ZR do not follow the rule. Some codes from A and W have been moved to ZR.
- Some members WICC mention they agree with consortium that prevention codes are removed from organ chapters and A. A was not well organized.
- Questioning about why ZR and ZC are related.
- Suggestion to move ZR to another letter instead of Z, because it is not really clear why it is related to the ZC, this should be clarified.
- Proposal Anders to change the title of ZR to Health promotion as a new title
- Prevention, screening, family planning has to be apart from the other organ chapters, by putting it in a separate part of ICPC you emphasize this is also a job of a GP.
- Thomas: why not make a difference in the kind of prevention: primary, seondary, tertiary and quaternary (Marc Jamoulle). Quaternary prevention is not well represented in ICPC
- Marc V: suggestion to move codes from ZR to new chapter AR (related with A)?

Small plenary discussion about chapter Chapter G
Kees: Reason for consortium to put X and Y in chapter G is that it was already decided by WICC. 24 classes are the same in X and Y. ICD-11 also has one chapter of the urogenital system (within this chapter a distinction is made between male and female). This way we worked it out. Jean Karl: we have to look at ICD. Genital chapter: distinction between male and female. (X and Y codes). Task force A is going to work on it and will come with a proposal.

Kees demonstrates how the work of taskforce work A is presented to the consortium.
Discussion about what to do with disagreement? All comments from the taskforce A are taken over. Gustavo: register the information that is coming from the discussions, it's important.

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1100-1130	On whose behalf are you in WICC? Do you represent your college? Membership discussion Policy document	Lead: Thomas, Preben and Diego	Øystein	Jean Karl

Thursday 26th September 2019. 11.00 am. Minutes JK Soler
Thomas – thanks Anders who is now leaving WICC.
Topic: On whose behalf are you in WICC? Do you represent your college?
Discussion of Policy document.
Preben – introducing topic with presentation from Governance Committee. New proposal to allow Executive Committee to accept a member directly as a full member if he or she is a national or international organisational representative. Another new proposal is to allow former members to re-join with full voting rights, up to five years after leaving.
Oysten leads the discussion.
Thomas – asks for clarification. Regarding the first proposal, does the Governance committee decide, or does the EC decide directly.
Sebastian – it is not clear on the website who are actual or historical members, also on the website.
Diego – agrees a list of all, including former, members should be on the website
Kees – supports first proposal
JKS – again asks for clarification after Preben,s response to Thomas, and it is clarified that the Governance Committee screens and makes a recommendation to the EC, which then decides. JKS accepts this.
Gustavo – WICC should even invite Colleges, especially those which hold a licence, to send a representative to WICC
Anders – asks if our rules are consonant with WONCA membership rules
Diego – asks for clarification about Gustavo,s suggestion. Diego asks whether a new, first time college representative should follow the usual rules, and the more direct route for college representatives approved by EC only should apply for replacement representatives
Mikko – states he is the only non-GP member of the organisation, so should more such allied healthcare professionals b included to widen our perspectives
Gustavo – all primary care organisations can join, including non-medical colleges
Gustavo, JK, Kees – follow Wonca rules, do not allow direct Government representatives
JKS – asked if all are individual or institional Wonca members, and these were identified
Kees – we should vote
General agreement to add the first proposal for fast-track membership for college representatives, but Governance committee should check the proposal is in line with Wonca general membership regulations
The second proposal is now discussed.
Thomas gives an individual example of a member who does not attend for valid reasons, but can still be a full member
Diego explains that this exception is allowed for in the current rules, as long as the absence is justified
The second proposal is accepted without comment
Additional points outside the agenda
Interlude - JKS tells a light joke to reflect on the different perspectives on reduction and complexity
Preben – explains that the Google group is only for members
Kees asks to discuss length of meetings, and presence as a group, at Wonca meetings. The proposal is to have the WICC meeting just before the Wonca meeting every two years, at the same location, but then have the normal separate meeting every second year.
General discussion. Who will organise such a meeting at the Wonca meeting venue? Maybe accept as a general rule, but allow exceptions if the timing of the Wonca conference is inconvenient or the meeting venue/city is too expensive. There are advantages and disadvantages. In general there is agreement to try this, and to have the next meeting in June in Berlin just before the next Wonca Europe meeting. A suggestion is to have a short meeting before the Wonca conference in Berlin, and also a second meeting as traditionally organised by a WICC member next year. The agreement is to have a pre-meeting of three days before Berlin, and then organise a traditional WICC meeting either in 2020 or 2021 depending on the amount of work needed and the outcomes of the Berlin meeting.

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1130 - 1300	Topic neoplasms. Aim to explain the neoplasm classes in the ICPC-3 Plenary session and discussion in small groups using the browser:	OO, MV, DS, MH, LL, KvB Marc or Kees	Nicola	Mikko

Mikko took minutes, Nicola as lead of conversation.
Neoplasms in the ICPC-3, presented by Kees. Look for the presentation. http://wicc.news/wp-content/uploads/2019/09/ICPC-3-PPT-Crete20190920-1.pdf

ICPC-3 Consortium propose, that we want to have them both. If freuquent is high, then separate class, if not then one class. Please, check ICPC-3 browser. Proposal all the chapters
JK: this is difficult discussion and in many ways step backwards. Localization is present in anatomy, neoplasm is pathology.

Nature of neoplasm. this mean, we remove malignant codes that is not what GP think. Suggestion: we have handled this in the past. ICD- other handle this. If you propose a new rule, we take out like extension. We could take another way. You can't have both. Pancreatic cancer and colon cancer should be as own class.
Kees. there are already there, we don't put them all together. new malignancy. We propose, that certain thing (that is okay), we have solved this way.

JK: you have right to propose. You need benign neoplasm of stomache. It should be in DD29. You can capture all of the malingnant and benign and in situ is together. Best way to choose other. Maybe wecan have a rule(?), how to handle two competing access. Kees: it is not ready. we have tried to think about it. there is only one class for these problems in ICPC-2. We have rules to be practical. you create like nothing because other, other etc. If there is almost nothing, then goes to one class.
JK: You are right, but if you take out some class malignant, it will be rackbag. practical issue. it tells you that don't change.
Kees: We don't want to use NOS or NOC in ICPC-3. Other specified is our solution in ICPC-3.
Nicola: It is difficult to suggest anything.
JK: Propose to end the discussion now and TFA will make a proposal.

Kees: it is good to explain now. if you can specify then we can specify. ICD-11 has less linkages, because they use NOS in their classification.
Diego: Is that a problem to use NOS in ICPC-3?

JK: Problem is that if doesn't map, then you have complete map between ICD-10 and ICPC. Problem is then you don't find cons

Kees: Only thing is that it is possible to use Snomed CT.
Laurent: other neoplasm-
Kees. we wanted to be very clear.
Nicola: Conclusion: TFA will come back with Contortium and come back with proposal and discuss briefly.

Kees: you need to look the browser. there are mistakes so look carefully and we will can put it to browser. Kees will take emails about these proposals.
JK: Open for comments for particular time and then have history and version control. Use some color or other marks.
Nicola: Thank you for your comments. We end up discussion now.

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1130 - 1300	**Summarizing the discussions of Sunday, Monday, Tuesday, Wednesday and Thursday morning and Goals for next year.** **Presentation of meeting place for WICC 2019**	**Thomas**	**Kees**	**Gustavo**

- Thomas presents Berlin; discussion about the option to to at Erlanger and then move to Berlin
- Tasks:
  - up date list of member lists - Governance committee
  - discussion about role for youtube channel: Gustavo got into the group
  - create a logo: Kees will look for the old logo
  - ICPC 3: every member has to go to all chapters and send feedbacks
  - actively invite GP specialists to WICC
- Next WICC meeting: 21 to 23rd June 2020 – Berlin
- Executives and elections – everybody of executives (Jean Karl, Kees and Thomas can have another 4 years term)
- Governance committee – Preben continues, Diego and Julie can´t reapply
- Final words; feed back from the group:

Please notice if you are mentioned as Discussion leader at any session

Please notice if you are mentioned as responsible for taking minutes at any session.

Please send minutes to preben_larsen@dadlnet.dk