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Revision of the primary care version of the ICD-10. Mental disorders

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Although the difficulty of applying psychiatric classifications to primary care has been widely criticized, there have been few investigations up to now to define and systematize the real demands in regards to these nosological systems.

Recently, the revised version of the Mental and Behavior Disorders Chapter of the ICD 10 has been published. The new tool is the result of an elaboration process mainly developed by a group of 971 primary care physicians coordinated by 55 psychiatrists. The project was organized into three phases: *a)* evaluation of the current version and collection of proposals for change; *b)* definition of objectives for an optimized version; and *c)* writing a proposal of revised text.

The result is a text that is more assimilable to a diagnostic and therapeutic guide than a mere coding system, more adapted to the role that the primary care physician can play in each disorder, more up-dated (especially in the treatment section) and more specific in many aspects.

Key words:
Psychiatry in primary care. Revised diagnostic classifications. General Practitioners. ICD10-PHC Mental Health Guidelines. Adapted nosological systems.

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Revision de la versión para atención primaria de la CIE-10. Trastornos mentales

Aunque se ha denunciado ampliamente la dificil aplicabilidad de las clasificaciones psiquiátricas a la atención primaria, hasta el momento son escasas las investigaciones destinadas a definir y sistematizar las demandas reales con respecto a dichos sistemas nosológicos.

Recientemente, ha visto la luz la versión revisada para atención primaria del capítulo de trastornos mentales y del comportamiento de la CIE-10. La nueva herramienta es el resultado de un proceso de elaboración desarrollado primordialmente por un grupo de 971 médicos de atención primaria coordinados por 55 psiquiatras. El proyecto se organizó en tres fases: *a)* evaluación de la versión actual y recogida de propuestas de modificación; *b)* definición de objetivos para una versión optimizada, y *c)* redacción de una propuesta de texto revisado.

El resultado es un texto más asimilable a una guía diagnóstica y terapéutica que a un mero sistema de codificación, más adaptado al papel que los médicos de atención primaria están en condiciones de desempeñar en cada trastorno, más actualizado (especialmente en el apartado del tratamiento) y más específico en muchos aspectos.

Palabras clave:
Psiquiatría en Atención Primaria. Revisión de las clasificaciones diagnósticas. Médicos de cabecera. Guía Diagnóstica y Terapéutica de los Trastornos Mentales y del Comportamiento CIE-10 AP TR. Sistemas nosológicos adaptados.

INTRODUCTION

The International Conference at Alma-Ata on September 12, 1978 declared primary care (PC) as a key piece in the strategy of «health for all»[1]. The basic objective of building an «essential, participative, universal and pertinent» PC in the developing countries and programs focused on the diagnosis of quality and improvement of efficacy of this first level in developed countries continues to be of priority in world health planning and management.

A holistic health concept in which aspects related with psychic well being stand out is being increasingly imposed. Due to sociological, cultural and commercial reasons, mental health has been becoming a prominent cause of health care resource usage and has been revealed as one of the fundamental factors of the individual's social productivity. The samples of this tendency are varied:

– Some studies conducted in Europe have estimated mental health costs as the percentage of all the health care costs: in the Netherlands, it was 23.2%[2]

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and in the United Kingdom, the costs of hospitalized patients alone reached 22%[3]. The cost of «brain disorders» in Europe accounts for 35% of the global economical burden of disease and exceeds that of diabetes and cancer together[4].

- Considering the ranking by amount of Public Sales Price in 2004 by subgroups of major consumption in Spain, psychotropic drugs occupied positions such as the third one of SSRI antidepressants or the eleventh of the anticonvaulsivants (the first place being for statines and other cholesterol lowering drugs and the second for the proton pump inhibitors such as omeprazole)[5].
- According to the Murray et al. Study in 2000[6], mental and neurological disorders account for 30.8% of the disease load worldwide and three neuropsychiatric disorders are included among the 20 main causes of disability adjusted years of life lost for all the ages.
- Besides the direct load, lost opportunities should be taken into account since the families usually must make certain adaptations and concessions that unable the members not affected by mental disease to develop all their potential in areas such as work, relationships and leisure activities[7].

These events have a significant repercussion in the first health care level:

- Between 19% and 43% of the patients who come to the primary care physician have a mental problem[8,9] and a large percentage of those patients with psychic complaints (33.7%) are seen exclusively by a GP (general practitioner)[10].
- Psychotropic drugs are the main category of drugs prescribed in many primary care out-patient clinics of the so-called first world. In Spain four psychotropic drugs are included into the group of the «top ten» substances according to the highest consumption in relation to their costs during 2004 (data collected by de National Health System)[5].

Various aspects frequently underestimated are added to the unquestionable advantages of accessibility and potential reduction of costs that developing adequate attention to mental disease in primary care has: its power in order to get the medicalization of psychiatric care and destigmitization of mental disorders or its invaluable role conditioning the potential efficacy of specialized care as it is the main source of reference of patients to the psychiatric care services[11,12].

These potential benefits are confirmed by studies that show there are lower health care costs, better patient's satisfaction with medical services, greater health levels of the population, less use of psychodrugs[13], and fewer psychiatric admissions[14] in those countries that have more developed primary care systems.

However, assistance on this first level to mental and behavior disorders in our country still seems to find obstacles in its original aspiration to be «essential» (capable of assuming the most frequent problems under its responsibility) and «pertinent» (assigning the resources in such a way that the costs are acceptable to the community). There are many references to failures in detection of psychiatric disorders in primary care[15-17], and to diagnostic errors as well as wrong, if not abusive, use of the prescription of psychodrugs[18,19] that could find an explanation in terms of a deficient preparation of the primary care physician in this field.

In response to this situation, the WHO indicated in its Report on Health in the World of 2001 (especially dedicated to «Mental health: new knowledge, new hopes») the need for psychiatric care focused on the community[20]. Among the ten action recommendations, it included the following in a privileged first place: «Provide treatment in primary care: [....] mental health should be included in education plans, with refresher courses that increase the efficacy of the general health services in the treatment of mental disorders.»

REFERENCE TO HELSINKI 2005

The following are found among the most universally accepted strategies that are useful to achieve this objective:

- Development of educational programs for primary care physicians (such as continuing education or workshops).
- Education programs in psychiatry during the family and community medicine residence program.
- Appearance of clinical guides, specific monographies and other types of publications in the field of psychiatry in primary care.
- The design of plans focused on coordination between primary care physicians and psychiatry.
- Creation of specific nosologic systems for primary care.

However, the efficacy of these measures adopted enthusiastically in the 1980's (when there was a real bibliographic explosion on this subject) has recently been questioned[21-26]. Basically, the unidirectional information flow model → psychiatry primary care physician in which the specialist is the only vector of knowledge has been criticized. This crisis of the previous model occurred when it was seen that the efficacy of the education programs increases as the participation of the general practitioners gets more active, even becoming their only teachers, and the primary-specialized coordination is more effective when the general practitioners have greater access to supervision or counselling of the specialist with freedom to establish their own needs. The claim of psychiatry in primary care as an independent and distinct reality from that of the specialized setting is added as a main reason to this inversion of the sense from specia-

lists offering to general practiotioners requesting[27]. The differences between the specialized setting and that of primary care would explain the so-extensively denounced applicability deficiencies of current psychiatric classifications to first care level and would reduce authority as a vector to anyone who was not aware of this reality. It is not rare that primary care physicians perceive the obligatoriness of coding their activity with the current international classifications as an expression of hospital-centrism and request greater participation in the development of a nosology of which they are users and that is being constructed «with us, Spanish general practitioners or family doctors, having no chance to say much about it but to accept what is presented to us as a fait accompli»[28].

Consequently, the process of reviewing the ICD-10 PC has been designed with the aim to respond to the needs defined by its users who thus become the legitimate coauthors. It has also permitted better, although indirect, knowledge of that unique reality, so far sufficiently studied, which constitutes psychiatry in primary care.

THE PRIMARY CARE VERSION OF CHAPTER V (F) OF THE 10th VERSION OF THE INTERNATIONAL CLASSIFICATION OF DISEASES (WHO)[29]

The specific version for PC of the current ICD 10 was originated in 1996 as a result of the coordinated work of the collaborating sites of the WHO in 32 countries in which general practitioners, family doctors, social workers, experts in public health, psychiatrists and psychologists with special interest in the subject participated. In our country, representatives from the three most significant scientific societies in primary care participated: Sociedad Española de Medicina General (SEMG) (in English, the Spanish Society of General Medicine), Sociedad Española de Medicina General Rural (SEMERGEN) (in English, the Spanish Society of General Rural Medicine) and the Sociedad Española de Medicina Familiar y Comunitaria (SEMFYC) (in English: the Spanish Society of Family and Community Medicine). The field studies of the ICD-10 PC included more than 500 primary care physicians and their objective was to evaluate the use of the classification in different points of the world, in different cultures and health systems to include the pertinent changes.

The ICD-10 PC is distinctive in several aspects. It is a «user friendly» classification that focuses on only 25 diagnostic categories (in comparison with the 440 of the origin classification). It provides information on the most frequent presentation forms and differential diagnosis corresponding those complaints and, what is the newest, it offers clear advice for the treatment of each disorder. Thus, each one of the categories (the codes coincide with those of the «mother» classification, the ICD 10, although they can be included in some case in more than one entity) is developed, to facilitate its use, in an individualized data sheet that is made up of the same sections separated into two sections:

Diagnostic guidelines

- Present complaints (it describes the usual problems in primary care patients).
- Diagnosis guidelines (complete version of ICD-10 guidelines without such strict diagnostic criteria or cut-off).
- Differential diagnosis (brief list of the entities that deserve special attention in which the reader is referred to the corresponding data sheets).

Action guidelines

- Essential information for the patient and his/her family (what they should know about the disorder).
- Specific advice for the patient and his/her family (psychotherapeutic guidelines with a predominantly cognitive-behavior orientation).
- Medication (brief description of the therapeutic alternatives available for treatment and some practical aspects for their management).
- Consultation to the specialists (very general criteria of referral to specialized care).

The combination of disorders included may vary from one country to another although most of them are common to all the countries. Besides the 25 data sheets, the classification includes other material of interest for the clinician, such as an index of symptoms, two decision trees and different educational material to give to the patients and family.

Although the birth of a new version of this adaptation for primary care of the ICD-10 was not planned to occur until ten years after the publications of the first one, in some countries, such as Great Britain, the system has undergone a continuous process of improvement and has been consequently modified (up-date of the psychopharmacological treatment guidelines, including more specific criteria for referral to the specialist). This improvement process has been based on the work of a group of psychiatrists and primary care physicians who discussed the proposals and added information on the evidence for each one of the changes (using Cochrane criteria as far as possible). This material has been published by the Royal Society of Medicine and is available in www.whoguidehpcuk.org.

METHODS

Quality circles

A total of 55 quality circles distributed throughout the country were created to conduct the investigation. Each one of them was formed by a group of 15 to 20 primary care physicians coordinated by a psychiatrist. The circles met periodically (once a month or every month and a half) in four hour-long sessions with an eminently educational and interdisciplinary approach purpose.

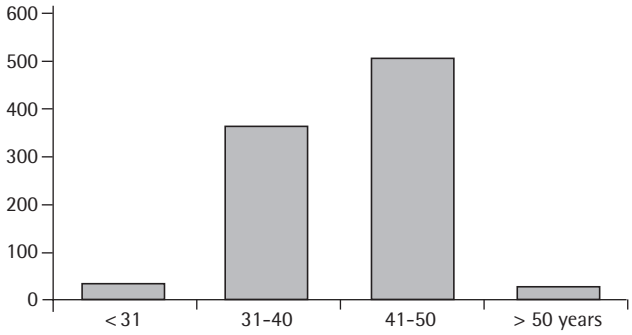

Figure 1 *Distribution by ages.*

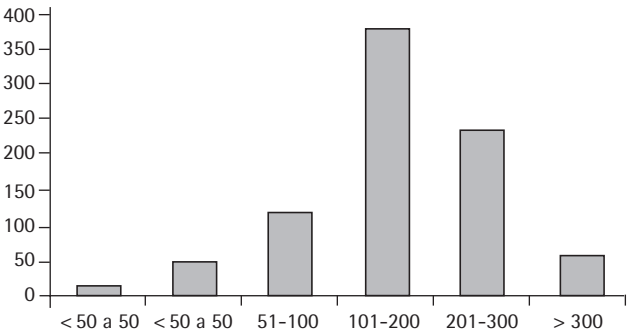

Figure 3 *Patients seen per week.*

A total of 971 primary care physicians and 55 psychiatrists (one coordinator per group) participated. The participation of the general practitioners was voluntary and they obtained a number of continuing education credits endorsed by the Ministry of Health and Consumer Affairs.

Description of the participants

Among the primary care participants who came to the first session, the following data were collected: age, years of professional practice, number of patients seen in the medical office in one week, type of population (according to the number of inhabitants) where they have the practice.

The analysis of this information defined a participating population as that shown in the charts:

Distribution by age ranges of the participants is shown in figure 1.

According to the years of professional practice in primary care of the doctors, the participants were divided as shown in figure 2.

Based on the number of patients seen per week in the primary care medical office, the distribution is shown in figure 3.

Distribution of the participants according to number of inhabitants/population in which the doctor works is shown in figure 4.

REVIEW AND OPTIMIZATION PROCESS OF THE CURRENT VERSION OF ICD-10 PC

Phase 1: consensual evaluation protocol

It consisted in an evaluation, data sheet to data sheet, of the quality of the current version and collection of proposals of modifications from the quality circles. The information that arose from the review process of the current version was collected in a consensual evaluation protocol of the data sheets (one for each diagnostic category) that the current version of the ICD-10 PC has. The conclusions agreed by the group was collected by the psychiatrist who coordinated each circle. For the evaluation, a series of variables were previously defined and were scored according to 7 point analogue scales:

- Utility for usual clinical practice (from 1: «it has no utility», to 7: «it has great utility»).
- Technical level regarding level of knowledge on mental diseases of the group (from 1: «excessively low, very elemental», to 7: «very high and complex»).

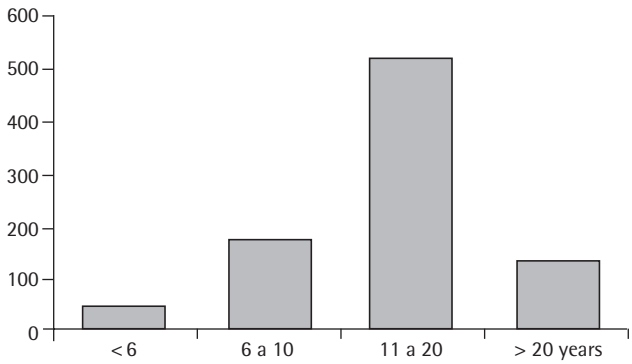

Figure 2 *Years of experience.*

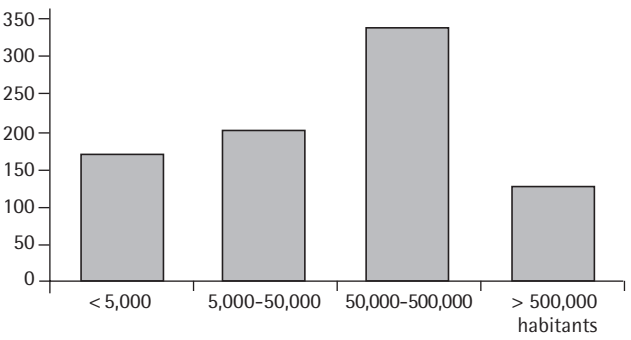

Figure 4 *Site where the physician has his/her practice.*

- Management grade and ease of use in work setting (from 1: «very unfavorable», to 7: «very favorable»).
- Quality of different sections of each data sheet (from 1: «very unfavorable», to 7: «very favorable»).

Furthermore, specific proposals for improvement in the different sections of each data sheet in form of free text written by the coordinator were obtained expressing agreement in the suggestions:

- Elements that were unnecessary.
- Extension suggestions.
- Modifications that the users would introduce into the current text.

Phase 2: analysis of the data from the consensual evaluation protocol

Quantitative analysis of the quality parameters

Central measurements (means) of the three endpoints (practical utility, facility of management and theoretical level) used for the evaluation of the quality of the data sheet and of the scores given to each one of the sections were obtained.

These measurements were used as reference to evaluate the score obtained by a data sheet or section in particular, without aiming to draw conclusions regarding the statistical significance of the possible differences. Since the objective was to improve the totality of the text, this comparison was used not to obviate the possibility of optimizing the data sheets or specific sections with more favorable evaluations but rather to identify those in which the improvement effort should be more intense.

Qualitative analysis of the modification proposals

Once the consensual evaluation protocols were received (between thirty and fifty for each data sheet, as described in the analyzed data table), the analysis process of the modification proposals was done with the following system organized into different stages:

- General reading of the protocols corresponding to each data sheet, aiming to obtain general impressions, section by section, of the main sense of the criticisms and suggestions for improvement.
- Separation of the comments into the most general and non-specific, as «extend», «update» or «specify more», and the more specific ones or those referring to specific subjects, as «change the writing of a paragraph» or «include a new psychopharmacological treatment.»
- Organize the comments by subjects, following an order of general to specific (first those corresponding to the data sheet in general, then those non-specific ones referring to a certain section and to finish, those that concern more specific subjects), and calculate the number of quality circles that coincided in a remark (repetition of demand was used as indicator of its relevance. Thus, in the optimization process, the suggestions that obtained greatest consensus were considered of priority).
- Associate the possible specific proposals for the new text with the criticisms that had originated them. In some cases, many circles coincided in indicating the need to make a change in a specific sense, but only one or two offered a proposal of an alterative text. When several writing alternatives were obtained, the choice was based on the appropriateness with which the suggested text responded to most of the criticisms that had originated it.

Phase 3: description of the demands and definition of objectives for an optimized version

In this process, the aim went from specific data sheet to data sheet analysis to indicate the common aspects to most of the data sheets and sections making them up. Thus, it was a process of deduction and abstraction in which importance was given not only to content but also to the sense of the criticism. The previously described quality measurements served to establish preferential objectives, but never to establish significant differences in the effort of subsequent improvement. Thus, the analysis followed a direction going from the particular to the general:

- Evaluation of scores obtained by sections and data sheets and definition of those that would be objectives of priority for improvement due to their low evaluation (identification of weaknesses).
- Analysis of modification proposals suggested by each one of the sections in the different data sheets and extraction of the most frequently criticized contents and of the common guidelines of these criticisms.
- Extraction of those most common objectives of the suggestions referring to different sections and data sheets to make a general profile of the sense of the modifications proposed.

In this way, it was possible to define a «general philosophy» for an optimization process whose principal failure was that it did not collect general suggestions but rather specific ones referring to each data sheet and to each section and not to the classification in general and its organization.

Definition of objectives to elaborate an optimized version includes different aspects of the classification that can be summarized into three: contents, structuring and theoretical level.

- After the analysis of the modification proposals of the different sections, the adaptation of the current organization of the classification was reviewed, seeking to satisfy the demands of manageability and ease of use of the ICD-10 PC in the primary consultation.
- Definition of minimum contents by sections, result of analysis of proposals and elaboration of the general sense of the criticism. This definition of minimums applicable to the data sheets in general would make it possible to unify the quality of the different diagnostic categories, getting a higher quality standard than that of the current version.
- According to the results of the evaluation of the theoretical level the different categories had compared to the level of knowledge of the primary care physicians, a standard applicable to vocabulary and to the specific concepts to be used in the new version was established.

Phase 4: elaboration of a proposal of complete text for the new version

When organizing the priority of the criteria to consider in the writing of the new text, the general objectives and their agreement with the global philosophy occupied the first place as a common reference to all the data sheets. Thus, if there was any proposal that contradicted these general principles in form or contents, only that part of it that agreed with these objectives was taken into account.

In this hierarchy, the specific suggestions were taken into consideration for each data sheet following an order of more general to more specific (e.g. in the medication section, the proposals of «extend, specify more or up-date» would have priority over more specific comments of contrary sign such as «do not include dose regimes of one or another medication»). Furthermore, if there were contradictory suggestions, the main criterion was the number of times that this proposal was repeated, in order to give more weight to those suggestions that had the greatest consensus.

Other attempts to optimize the ICD-10 PC developed in recent years were also taken into account and, more specifically, the version available in internet of the Classification subjected to continuous improvement by the Royal Society of Medicine of the United Kingdom (as long as the improved text was shown to agree with the previous criteria in the hierarchy).

Thus, the writing of each new data sheet followed a clearly established and identical order in each data sheet and each section:

- Consideration of the minimum objectives common to all the data sheets regarding contents, theoretical level and structuring of the sections.
- Inclusion of the general proposals obtained for each section and considered in regards to their sense: extend, restructuring the section, modifying the writing, including some missing content, getting a certain point more specific, etc.
- Search among the suggestions of definitive text of more specific comments in the same sense (e.g., for the differential diagnosis section, the proposals of «extend» («include organic problems, substance abuse and other mental disorders» («specify the laboratory tests necessary to rule out organicity»). In some cases, the quality circles not only required modification in a specific sense but also offered writing alternatives to satisfy their own demands. When these modified text proposals complied with the requirements established in the general objectives, they were given priority to be included.
- Lacking more specific suggestions to carry out the general modifications proposed, first an analysis of the optimized text of the WHO Guide of Health for Primary Care was done in search for possible solutions for the demand. The alternate text was adapted to the differences between countries (pharmacy policies and drug's commercial names, characteristics of the national health system, community resources available, etc.).
- If the proposal did not find a parallelism in that optimized version, its inclusion was offered in a new text, coming out from a consultation of recent literature on the specific subject, if possible, specifically referring to the PC setting of our country. In this case, the contributions of those responsible for the project were included based on their experience with the quality circles, always in agreement with the general philosophy received from the users.

RESULTS

It must be stated that the participation and collaboration of the primary care physicians were very satisfactory. The participants even established, once the program had started, the demand to increase the space available for comments in the protocol sheet, where suggestions for modifications and even new text porposals were writen. Given the enormous utility of the collection of specific and detailed proposals in order to write the new version, the possibility was offered to send a text attached to the protocol sheet. Several circles have supported this option, and make it a habit, so that the information obtained gained in quality and amount.

Information obtained from the consensual evaluation

Qualification and proposals for change of the data sheets

The evaluation of the data sheet quality corresponding to the current version of the classification manifested a

frank heterogeneity. Approximately half of the data sheets obtained scores indicating a considerable degree of satisfaction in regards to the different parameters, specifically those of acute psychosis, bipolar disorder, disorders related with anxiety (phobic, panic and generalized anxiety), insomnia, adaptation disorders and mourning, conversive syndromes, attention deficit and hyperactivity disorder and enuresis.

However, those disorders whose data sheets obtained low values on at least two out of the three general quality parameter (utility, manageability and theoretical level) also obtained poor scores in each one of the data sheet sections (at least half of the sections below the mean), consequently became priority objectives of optimization based on these qualifications and also on their epidemiological importance in primary care. In this way, a priority ranking was obtained by:

- Somatomorphic disorders.
- Depression.
- Disorders due to alcohol consumption.
- Disorders due to tobacco consumption.
- Chronic psychotic disorders (schizophrenia).
- Eating behavior disorders.
- Mental retardation.
- Adaptation disorder.
- Drug use disorder.

Global evaluation, principal weaknesses

Since the evaluation protocols did not include questions regarding classification in general, but rather an analysis of the classification that was exclusively data sheet to data sheet and section by section, the general conclusions were made from a subsequent process of generalization and deduction from the specific gradings and proposals. It seems to be unquestionable that the demands of the primary care physicians in relationship with the current version of the ICD-10 PC confirm its character of diagnostic and therapeutic guide (beyond its nosological function) while they require greater adaptation to its daily reality and specific needs, expressing their willingness that it included information with more direct applicability to the common clinical practice. The demands correspond more accurately with the requirements that would be made for a paperback or small book manual to consult specific doubts about the diagnosis or treatment of a disorder.

Related with the implicit request for a more specific text of psychiatry in primary care are the modification demands (constant for almost all the data sheets) in regards to the sections of «complaints present» (including motives for consultation that initially do not clearly correspond to manifestations of a mental disease) and the «differential diagnosis» (including a list of medical diseases to be ruled out and laboratory test protocols for this purpose). In relationship with this same specificity demand, the information and advise sections for patients and their families, that were specifically designed for health care professions without a speciality in mental disease, obtained excellent scores.

The demand for greater adjustment to the role that the primary care physicians currently have in the care of mental problems was also clearly seen, both in the suggestions collected for the section of referral to the specialist and in the amount and extension of the modification proposals for the data sheets that collect the disorders usually treated in primary care in comparison with those referring to rare problems, generally seen in specialized services.

The suggestions aimed at improving the section dedicated to treatment perfectly expressed that need of information with more direct applicability: up-dating of psychopharmacological treatments, inclusion of different alternatives according to the eligibility order, specification of dose, guidelines of initiation and withdrawal, duration of the treatment, they are demands clearly oriented in this sense.

The definition of the general and specific objectives for the elaboration of an optimized version was based on the information collected in the quality circles

General objectives

- Achieve greater adjustment of the management guidelines offered in the classification to the role which, in agreement with their own perception, primary care physicians are now a days able to develop in care of psychic problems. Based on the task mostly assumed by the clinicians in the diagnostic and therapeutic approach of each disorder, when writing the new data sheet, priority should be given to the information on one or another aspect. The theoretical levels of the text should also be adjusted to the differences existing between degree of knowledge the clinician has of the disorders that he/she commonly treats or with less frequent problems that are generally referred to specialized care.
- Extend the contents, especially those referring to differential diagnosis and to the treatment of the disorders that the primary care physicians assume as treatable in their setting and the referral criteria and possible role of the clinician in those problems basically sent to the specialist.
- Specify more the information offering more detailed guidelines responding to the more frequent approaches with direct applicability in the medical office. This demand for expecificity was also extended to the section of diagnostic guidelines, questioning the ac-

ceptance of a «milder» categorial system that characterizes the current version. Thus, more clearly defined categories with inclusion of time criteria and other quantitative parameters are required and will make the nosological aspect of the text more similar to the classification used by the specialists.

— Clarify the contents and reorganize the texts with two objectives:

  • Give priority, in the order of presentation of information within each section, to the most essential or frequent aspects.
  • Confirm a common structure to all the data sheets in which the adjudication of the contents by sections avoids the free repetition of information and facilitates the search process of specific partial information.

— Up-dating of the text according to the new tendencies, especially therapeutic ones.

Specific objectives

In regards to achieving a better adjustment of the contents of each data sheet to the most frequently assumed functions of the primary care physician in the treatment of said disorder, the distinction of two differentiated strategies aimed at each group of disorders is expounded:

— For the data sheets defined as having high utility and manageability by the primary care physicians and with high frequency indexes in primary care: depression, dementia, alcoholism, tobacco, adaptation disorder, mourning, insomnia, anxiety related disorders (panic, phobias, generalized anxiety, etc.), somatomorphic disorders, enuresis, attention deficit hyperactivity disorder, mental retardation; a text will be written that approaches the problem as manageable within the primary care context, especially stressing the following aspects:

  • Diagnostic guidelines that make it possible to differentiate the subthreshold disease, that can receive non-drug therapeutic alternatives, from those that fulfill seriousness criteria to be a candidate to psychodrug treatment from the onset.
  • Extensive development of Information and recommendations sections for the patient and his/her family (that will have special use in the case of subthreshold disease), with a section that gives a detailed description of the therapeutic alternatives and includes some referral criteria focused on defining the rare cases that will be referred to specialized care and even those that may require urgent hospitalization.

— In the case of less frequent disease in this setting or those more commonly referred to specialized care services: drugs, sexual disorders, dissocial disorder, conversive disorders, schizophrenia, acute psychotic disorders, bipolar disorder, priority care is devoted to two aspects:

  • A detailed description of the possible most common presentation forms in the context of primary care (in order to potentiate adequate detection) and facilitate differential diagnosis that has more therapeutic importance.
  • The early detection of relapses and supervision of maintenance treatment with health promotion activities.

The modifications finally introduced into the text

The modifications finally introduced into the text of the new edition respond completely to the objective of a more satisfactory adaptation to the specific needs of primary care. In the following, and serving as an introduction to the complete text, we describe those related with the reorganization and extension of the contents of each data sheet, with the definition of the minimum information necessary for the sections and renaming of some sections according to the new content. Thus, the sections that each data sheet includes in the text of the new version are:

— *Presentation in primary care (in substitution of «present complaints»).* It contemplates ways to detect psychiatric problems different to that referred from the verbalization by the patient of any complaint related with some type of psychic discomfort (during a consultation for another reason, after demand for help of some family member, etc.).

— *Diagnostic guidelines.* Hardly modified, it tries to establish the clearest possible borderline between subthreshold clinical pictures and those clearly pathological and approaches the specificity of the classification used by the specialists.

— *Differential diagnosis.* In the first place, it deals with the exclusion of organic causes (in some cases indicating a protocol of laboratory tests, if necessary) and then describes in greater detail the differentiating elements of those disorders that are most frequently used to establish the differential diagnosis.

— *Essential information and advise for the patient and his/her family.* Both sections have required few changes, the most relevant of which has been defining a minimum of contents to be observed in all the data sheets.

— *Approach strategies for all primary care physicians.* This is a new section only included in the data sheets corresponding to disorders treated at least initially in primary care in which a special difficulty of the clinicians with the management of therapeutic relation-

ships has been detected (such as somatomorphic disorders and alcoholism, etc.).

- *Treatment (before «medication»).* It includes information regarding other non-pharmacological modalities of treatment. The change to stress is the considerable extension and up-date of the therapeutic guidelines carried out.
- *Referral to specialists.* It contains a clearer definition of the role that primary care physicians will commonly have in relationship with the disorder and a more specific description of the referral suppositions to the specialist and of the hospitalization criteria.

DISCUSSION

There are many scientifically rigorous criticisms that can be made on this work. Desiring to act methodically, the first of them will affect the object of the study itself: A study dedicated to a nosological system that has still not defined well enough what is that it classifies? Some authors advocate[30] a review of the psychiatric nosology due to its fragility and inconsistency as it is very difficult to classify, using the criteria of the symptoms when «the concept of symptom is not sufficiently clear»[31]. However, millions of persons all over the world come to the primary care physician's office while this discussion about nosology takes place, and their request aid for a constellation of manifestations that it is usually, properly or not, called a depression. And as long as not only the relief of the patient but also his or her financial and social performance as well as that of those who live with the patient quite often depend on the general practioner capacity to detect, distinguish from other problems and treat these symptoms, the utility of any theoretical construct that may improve the efficiency of these millions of consultations seems to be unquestionable. This is a reality that is not at all incompatible with the aspiration of elaborating new classifications based on the evolution of the knowledge on mental disease.

With this pragmatic and even «utilitarian» argument[32], the rationale of this study is found in another important question: is developing a new optimized and adapted classification going to be a suitable and efficient way to reach the pursued target, that is, to improve the quality of attention to the psychic problems in primary care? The results of the Croudace et al. Work[26] lead to the impression that the repercussions in the daily practice of the primary care physicians would be questionable. The study did not find significant differences between a group of patients treated by primary care clinicians who had participated in an optimization and disclosure project of the ICD-10 PC in Great Britain, very similar to that of the quality circles, and another group of patients seen by primary care physicians who had not participated in that project, in regards to the capacity to detect the psychiatric disease (according with the GHQ), to the treatment results after three months measured by the self-perceived quality of life (measured with the QoL scale) or to incapacity (a part of the BDQ was used). Even when greater, but non-significant, specificity was reached in the diagnoses of the first group and those patients demonstrated more satisfaction with the attention to their problem, the results could have a discouraging effect. However, the limitations of the study must not be overlooked. The most important one is its distancing from the common clinical conditions in primary care. The study considered a patient population waiting for surgery that agreed to participate and the diagnostic and therapeutic intervention of the primary care physicians occurred outside of the common procedure with self-administered evaluations of efficacy.

Thus it is unquestionable that it is essential to develop reliable methods to evaluate the efficacy of any program with educational aims. However, the question of applicability has even more priority since it could lead to an original failure of the system (that would not work as it was not applicable in the specific context), a failure that has already been sufficiently denounced by the clinicians of this first care level. It is in this sense that the meta-objective underlying the elaboration process of specific instruments for primary care should not be overlooked, an objective that transcends that of efficiency as it is an essential conditioner of its possibility; that of superseding a simplistic and specialization-centered vision of the primary care setting that caricatures and undervalues it. On the contrary, a valid reference would be the existence of an epidemiological and clinically different reality: that of primary care, a field of knowledge that requires its own access, different from that each one of the specialities may have. In this way, the elaboration of specific instruments arises from this recognition and aspires to its spreading.

Having said this, the work done has two limitations. The first one is related with the enrolment of the primary care physicians participating in the study. Even though the interest in psychiatric subjects by the clinicians of this first level has been extensively described, it is unquestionable that the enrolment secondary to the agreement to participate in the project introduces a bias (with unquestionable benefits for performing the work of improvement but that could artificially increase the level of theoretical knowledge and that of the daily clinical practice in dealing with the psychiatric problems). On the other hand, the evaluation procedure of the current version, consisting in a data sheet to data sheet review and, within each data sheet, section by section, did not permit direct elaboration by the participants of the more global proposals regarding the classifications. This could explain the fact that questions of some clinical daily relevance for de GPs such as the management of work incapacities due to a psychiatric cause seem to have been left out.

In spite of these limitations, the results of the present work revalidates much of the conclusions of the few studies related with psychiatry in primary care done up to now. Most of the characteristics described as defining of this

specific area of knowledge, considered by some authors an independent discipline, such as epidemiological and clinical characteristics of the population, attitudes and skills of the professionals when dealing with mental problems or peculiarities of the setting[33-40], have been confirmed in the quality circles. Similarly, the optimization process based on the improvement proposals of our primary care physicians has been developed in agreement with some of the guiding lines already mentioned in the literature as crucial in the shaping of new classifications adapted to this context: need for active participation of the users in the authorship[41], or the objectives defined by Goldberg et al.[42] in 2002 for future diagnostic classifications in primary care (accessibility and pertinence, with adaptation to common clinical reality of the primary care physicians).

Even when the agreement between our results and the literature underlines the scientific value of our work, are novelties what make it relevant to enrich the knowledge of Primary Care's reality. In a sense, the most important conclusion out of this study would be the need to get the so-named «adapted for primary care version» to reach its whole meaning. Perhaps the most paradoxically surprising aspect of our work is the discovery that users' demands do not exactly coincide with «what was expected from them». For instance, primary care physicians would not show satisfaction with the description of the ways mental disorders present in their consultations reflected in the classification (Present complaints was supposed to be a section specially designed for this setting), and this lack of satisfaction expresses the best how uncompleted our knowledge of this particular setting of psychiatry is. Primary care physicians, against what's mostly reflected in the literature, claim for some more specific and delimiting diagnostic criteria that would lead to more clearly defined categories and not to a «light» version of the diagnostic entities of the psychiatrists. In conclusion, through this review we get to discover that if we want to know what are we talking about when we talk about psychiatry in primary care, it's worth asking general practioners!

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