An International Glossary for Primary Care

Report of the Classification Committee of the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA)

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Precise definitions of terms that describe the process of primary care are essential to the collection of primary health care data. Whenever possible, these definitions should be uniform and unambiguous. Research workers who wish to collaborate with or interpret work of colleagues from other countries can benefit from a standard glossary of commonly used health terms.

In response to these needs, the Classification Committee of the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians present this international glossary for primary care.

Consensus on the definitions was reached by the Classification Committee with consultation from general practice-family practice organizations and individuals. Existing primary care glossaries from several countries and the World Health Organization were also consulted.

The definitions provided are intended as guidelines, rather than absolute dicta, for primary care providers and researchers who desire comparability. New knowledge, drifts in use of language with time, and new processes will inevitably require revision of definitions and the addition of new terms. A comprehensive dictionary is not intended, but rather terms most commonly used are included.

Equivalent terms are enclosed in parentheses with the country of origin bracketed. It should be understood, however, that exact equivalence may not be present. It was not always possible to include fine shades of differences of meaning. For convenience, the male pronouns have been used throughout.

Research activity in family medicine and general practice has increased exponentially in recent years, with reports in medical journals and presentations at medical meetings often receiving international attention. It has become apparent that some terms have different meanings in different countries. For example, the terms "surgery" and "consultation" have very different connotations in the United Kingdom and in North America. Even within the same country, terms like "patient population" and "standard age groups" receive different interpretations from different investigators.

The need for standard definitions and a delineation of terms with equivalent meanings in different countries prompted the development of this glossary. The Classification Committee of the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians developed this glossary for family practice researchers to facilitate reporting their findings in a standard fashion and to help readers interpret these reports. The glossary can be especially helpful for research collaborators from different countries. The Classification Committee intends this glossary to be a dynamic instrument subject to periodic revisions.

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I. General

A. *Health*—A state of optimal physical, mental, and social well-being, and not merely the absence of disease or infirmity (Modified World Health Organization definition).

B. *Health Care*—Assessment, health maintenance, therapy, education, promotion of health, prevention of illness, and related activities (provided by qualified professionals) to improve or maintain health status.

C. *Health Care System*—The organizational structure through which health care is provided.

D. *Primary Care (Primary Health Care)*—Health care that emphasizes responsibility for the patient, beginning at the time of the first encounter and continuing thereafter. This includes overall management and coordination of health care, such as appropriate use of consultants, specialists, and other medical/health care resources. In addition, maintenance of continuity on a long-term basis, including coordination of secondary and tertiary care, is required.

E. *Recorder*—The person who records or supervises the recording of information under study.

F. *Practice Register*—The list of all registered patients in a practice. See Section IV-B-1 for the definition of a registered patient.

G. *Age-Sex Register*—The list of all registered patients by age and sex. The primary purpose of this register is to provide a defined population against which rates of observed occurrence of phenomena in a practice may be calculated. It can also be used to monitor immunization programs, identify groups at special risk, monitor practice size, plan physician education priorities, as well as be used for other purposes.

H. *Diagnostic Index* (Morbidity Index, Problem Index, E Book)—A system in which the diseases, illnesses, and social problems in a patient population are recorded by diagnosis or problem, date of presentation, patient name, age, and sex. This index helps in retrieval of medical records for cohorts of patients with similar health problems, and it may be used to facilitate follow-up.

II. Provider Descriptors

A. *Health Care Provider*—A qualified person who renders health care services.

1. *Family Physician/General Practitioner*—A physician who provides and coordinates personal, primary, and continuing comprehensive health care to individuals and families. This physician provides care for both sexes of all ages, for physical, behavioral, and social problems.
2. *Physician of First Contact*—The first physician seen by a patient during an episode of illness or injury, or for preventive and/or health education matters.
3. *Primary Physician* (Primary Care Physician)—A family physician/general practitioner or other specialist who practices primary care.
4. *Community Physician*—The primary concern of the community physician is the health status of the population within a defined geographic area. Usually responsible for assessment and evaluation of the community's health needs and for the organization of health services to meet those needs, the community physician will generally not render primary health care, except for specific disease entities such as selected communicable diseases. The role of a community physician varies from country to country, but he or she is usually employed by a government agency.
5. *Locum Tenens*—A practitioner employed for a stated period of time by a physician to assume responsibility for the care of the practice population during an absence. Responsibility reverts to the principal physician upon the physician's return.
6. *Specialist*—A physician with special competence and approved training in a particular field of medicine.
7. *Consultant*—A physician with special competence in a particular area of medicine who provides services related to this area at the request of another health care provider.
8. *District Physician*—A primary physician who accepts continuing responsibility for the general health care of all persons living in a defined geographic area. In addition to functioning as a general practitioner/family physician, the district physician often functions as a community physician, and is usually employed by a government agency either on a full- or part-time basis.
9. *Physician in Training* (Trainee Assistant/Trainee/Assistant)—The terms undergraduate, graduate, postgraduate, vocational, and continuing medical education have different meanings in different countries and at times are used inconsistently within a single country. Table 1 approximates common usages.

Table 1. Physicians in Training

Training Level	North America	United Kingdom New Zealand Australia South Africa	Continental Europe
1. Basic sciences	Undergraduate	Undergraduate	Undergraduate
2. Medical school	Graduate	Undergraduate	Undergraduate
3. Initial postmedical school training	Internship (also used in Australia)	Preregistration (House man, (junior intern)	Prelicense or postgraduate
4. Specialization	Residency	Vocational	Graduate
5. Lifelong education	Continuing	Continuing	Postgraduate Continuing

10. *Ancillary Staff*—Nonmedical personnel working in a practice, including nurse or practice sister, health visitor, medical social worker, secretary, practice aide, receptionist, administrator, business manager, bookkeeper, and others. The ancillary staff differs from practice to practice and from country to country.
11. *Other Health Care Providers*—Qualified graduates (professionals and paraprofessionals) of disciplines other than medicine who also render health care. These include, for example, dentist, pharmacist, physician associate, medex, physiotherapist, nurse practitioner, graduate nurse, public health nurse, psychologist, social worker, minister of religion, and others. (The Classification Committee invites these provider groups to submit definitions that describe their discipline.)

B. *Health Care Team*—A group of health care providers, who may represent several disciplines, and ancillary staff working cooperatively to provide health care.

III. Practice Descriptors

Practice—The organizational structure in which one or more physicians provide and supervise health care for a population of patients.

A. *Manpower Classification of Practice*

1. *Solo Practice* (Single-Handed)—A practice in which a single physician provides and supervises health care for a population of patients.
2. *Group Practice* (Cooperative Practice [Denmark])—A practice in which the patient population is cared for by a number of associated/affiliated physicians. The principal responsibility for subgroups of the population may be assigned to one or more physicians, but the group accepts the responsibility for continuity of patient care. In a legal sense, however, the individual physician usually has the ultimate responsibility for each patient.
   a. *Single-Specialty Group*—A group practice in which all physician members belong to the same specialty.
   b. *Multi-Specialty Group*—A group practice in which the physician members belong to more than one specialty.
3. *Association of Practices* (Group Practice [Netherlands])—Practices of physicians who share premises, but not patients.

B. *Geographic Classification of Practice Populations*—European recommendations for the 1970 population censuses (United Nations publication No. ST/CES.13 1969) suggest that a distinction be made between urban, semiurban, and rural areas. "Since conditions vary considerably between coun-

tries, it is recognized that countries should be given latitude in selecting dividing lines between the three categories that are appropriate to their own conditions. However, in the interest of international comparability, countries should endeavor to select limits that approximate as closely as possible to 2,000 and 10,000. The definitions and limits should be clearly stated in the census report." For the purposes of this glossary, the precise populations used to define urban, semiurban, and rural areas were chosen arbitrarily. It is recognized that physicians within the various countries using this glossary may have different requirements. It is recommended that physicians who define geographic configurations of different population sizes state the numerical range they have chosen to define a geographic area.

1. *Urban Practice Population*—A practice serving a population, a majority of which are located in a city with a population of 50,000 or more (20,000 in New Zealand). For countries with a smaller population, a figure of 10,000 may be used, but it should be specified. The designation *Metropolitan Population* may be used for a conurbation with population of 250,000 or more.
2. *Semi-Urban Practice Population*—A practice serving a population, a majority of which is located in a city with a population between 2,000 and 50,000. For countries with smaller populations, the range shall be between 2,000 and 10,000 population.
3. *Rural Practice Population*—A practice serving a discrete population, a majority of which is located in a town or scattered dwellings of less than 2,000 population.
4. *Other*—Additional geographic population descriptors, such as central city population, suburban population, and primitive or remote practice population, may be used, but the population size should be specifically defined in each case.

C. *Practice Sites*

1. *Private Office* (Surgery or Surgery Rooms [United Kingdom], Consulting Rooms [New Zealand], Consulting Rooms or Surgery [South Africa])—The premises in which a physician conducts his practice. More than one practitioner and paramedical services may be accommodated in these premises.
2. *Residential Office* (Residential Surgery Rooms [New Zealand and United Kingdom])—An office (surgery) that is located in a physician's home.
3. *Satellite Office* (Satellite or Branch Surgery [United Kingdom], Satellite Rooms [New Zealand], Suburban Surgery [South Africa]—An office (surgery) located at a distance from the main site, office (surgery), or health center. Staffing and the provision of health services are the responsibility of administration of the primary site.
4. *Health Center*—A center that emphasizes both total medical care and preventive personal health services. Staffing is varied and may include a group of family physicians/general practitioners, a multidisciplinary team, ancillary staff, specialists, and other health care providers. The center may be owned by private physicians, government, or public agencies.
5. *Polyclinic*—The definition of polyclinic varies in different countries. Usually it is a clinic attached to a hospital with a medical staff largely comprised of specialists, often working independently rather than as a team.
6. *Day Hospital*—A health care facility, providing day health care and monitoring facilities, with full medical and paramedical services available.

D. *Mechanisms for Reimbursement*

1. *Fee for Service* (Private Fees)—A fee is assessed for each service or patient contact provided. Reimbursement may be from the patient and/or a third party.
2. *Prepayment*—The physician receives advance payment to provide specified health services for a particular patient or group of patients during a specified time period.
3. *Capitation* (Allowances)—A form of payment based on the number of registered patients, usually covering the full range of medical services provided.
4. *Government Sponsored/ Subsidized*—Participating physicians receive reimbursement directly or indirectly from the government for services rendered to that portion of the population covered by the government plan. State insurance programs include Medicare in North America and the National Health Service in the United Kingdom.
5. *Salary*—The physician is an employee and receives a fixed wage for rendering medical care.

E. *Special Function Practices*

1. *Teaching Practice* (Training Practice)—A practice in which students (residents/registrars and medical students) are taught as an integral part of the practice.
2. *Industrial Practice*—A practice conducted within the confines of

an industrial organization. Usually the physician is reimbursed by salary or according to the terms of a specific contract. Ancillary staff are usually employees of the industry.

3. *Hospital Practice*—A practice conducted within the confines of a hospital. The source of patients, method of reimbursement, and relationships with ancillary staff are extremely variable and should be defined for each specific instance.
4. *Research Practice*—A practice organized and equipped for data collection and research studies.

F. *Characteristics of Practices*

1. *Appointment System*—The system used by a physician to plan and regulate the timing of patient encounters. It may be *complete,* in which no patients other than emergencies are seen except by appointment, or *partial,* in which there is greater flexibility.
2. *Clinic or Special Sessions*—Occasions when patients of a similar type, or those suffering from the same condition, are grouped together for supervision, examination, treatment, discussion, or advice. Appointments may or may not be required. The type of clinic should be specified. For instance, use *obstetric clinic* for antenatal and postnatal care, *child health clinic* for care of children and babies, or *special clinics* for obesity, geriatrics, diabetes, and other conditions.

The use of the word *clinic* varies from country to country. In Australia "special sessions" are held, and the term *clinic* is reserved for group practices and/or their premises. In North America *clinic* may also mean a charitably operated practice or session. In Norway *clinic* can mean either a little hospital or an outpatient department.

IV. Patient Descriptors

Physicians who do not have registered or assigned lists of patients and families may require different definitions of the following terms, some of which are based on attendance frequencies, in order to facilitate calculations of practice populations. In some countries (ie, United Kingdom or Denmark) the registered lists often reflect the patient population with acceptable accuracy. In other countries (ie, North America, Australia, or Norway) populations can only be estimated from utilization patterns.

Family—A group of persons sharing a common household. A relationship (including, but not necessarily limited to, blood or marriage ties) is implied. For purposes of this definition, persons who temporarily reside away from the household are included.

Household—Either (a) a *one person household,* ie, a person living alone in a separate room, suite of rooms, or housing unit; or (b) a *multiperson household,* ie, a group of two or more persons who combine to occupy the whole or part of a housing unit. The group may pool their incomes to a greater or lesser extent. The group may be composed of a family or of unrelated persons, or both, including boarders and excluding lodgers.

A. *Family*

1. *Registered Family*—A family containing two or more members who receive health care from a practice.
2. *Active Registered Family*—Registered family containing at least one member who has received health care at least once in the past two years.
3. *Attending Family*—A registered family containing at least one member who has received health care in the past year.
4. *Inactive Registered Family*—A registered family in which no member has received health care within the past two years.
5. *Formerly Registered Family*—A previously registered family that is no longer considered (by the practice or by personal determination) to be part of the practice population and is removed from the register.

B. *Patient*—A person who receives or contracts for professional advice or services from a health care provider.

1. *Registered Patient*—A patient who receives ongoing health care from a practice (excludes former, temporary, or transient patients).
2. *Visiting Patient*—A registered patient who has received services from the practice at least one time in the last two years. This includes attending patients.
3. *Attending Patient*—A registered patient who has personally received services from the practice in the past year.
4. *Nonvisiting Patient*—A registered patient who has received no services from the practice within the last two years.
5. *Temporary or Transient Patient*—A patient who receives one or more services from a practice, but who usually receives health care elsewhere.
6. *Formerly Registered Patient*—A patient (excluding temporary

or transient) who has previously been registered but who is no longer considered (by the practice or by personal determination) to be part of the practice population and is removed from the register.

7. *For Practices Registering by Families*
   a. *Active Registered Patient*—A registered patient who has received services from a practice at least once and belongs to a family, one member of which has received services within the last two years.
   b. *Inactive Registered Patient*—A registered patient who has received services from the practice at least once, but neither the patient nor any member of the patient's family has received services within the last two years.

C. *Statistics and Analysis*—The collection of the following demographic data is desirable:

1. *Patient Identification*—Should be unique.
2. *Residence*—There are several options for the classification of residence, including address, telephone exchange, census tract, postal or zip code, grid, or municipal jurisdiction.
3. *Date of Birth*—Should include month, day, and year.
4. *Sex of Patient*—Male or female.
5. *Marital Status*—Married (includes common-law), single, seperated, divorced, or widowed.
6. *Ethnic Origin*—Black, white, other (patient determined).
7. *Socioeconomic Status*—May be derived by several techniques that use occupation, education, income, method of payment, area of residence within census tracts, or a combination of two or more of these parameters to determine status.

V. Population Descriptors

A. *Practice Population*—The total number of active registered patients in a practice.

B. *Study Population*—All patients included in a study during the period of a project.

C. *Registered Population*—The total number of active registered patients in a practice taken at the midpoint of a study. It is often difficult to count this population with precision. It may be possible to calculate the population from encounter data; if this is done, the method used should be specified.

D. *Standard Age Groups*—Less than 1 year, 1 to 4 years, 5 to 14 years, 15 to 24 years, 25 to 44 years, 45 to 64 years, 65 years and older. These groups may be subdivided into smaller cohorts (eg, 5 to 9 years) provided the standard division points are retained.

E. *Patients at Risk*—Patients from the practice population considered to be at greater risk for a disease than other individuals in the same population.

F. *Population at Risk*—A population of persons with a geographically defined area, a random sample, or a group selected for specific criteria from the greater population may be used. At times the registered patient population may be considered the population at risk.

VI. Morbidity Descriptors

A. *Problem*—A provider determined assessment of anything that concerns a patient, the provider (in relation to the health or the patient), or both. Problems should be recorded at the highest level of specificity determined at the time of that particular visit. The *International Classification of Health Problems in Primary Care (ICHPPC-2)* should be used to classify and code problems.

1. *New Problem*—The first presentation of a problem, including the first presentation for a recurrence of a previously resolved problem, but excluding the presentation of a previously assessed problem to a different provider.
2. *Continuing Problem*—A previously assessed problem that requires ongoing care. It includes follow-up for a problem or an initial presentation to a provider of a problem previously assessed by another provider.

B. *Episode* (Attack, Bout)—A problem or illness in a patient over the entire period of time from its onset to its resolution.

C. *Diagnosis*—The formal statement of the provider's understanding of the patient's problem.

1. *Principal Diagnosis* (Main Diagnosis)—The most important problem, as determined by the health care provider. This should be coded to ICHPPC-2.
2. *Associated Diagnosis* (Concurrent Diagnosis, Subdiagnosis)—Another diagnosis made at the same time as the principal diagnosis.
3. *Diagnostic Criteria*—Those signs, symptoms, and investigative findings that are essential to making a diagnosis.

D. *Disease*—The failure of the adaptive mechanisms of an organism to counteract adequately the stimuli or stresses to which it is subject, resulting in a disturbance in the function or structure of any part, organ, or system of that body.

1. *Acute Disease* (Short-Term Disease)—An episode of disease with a duration of four weeks or less.
2. *Subacute Disease*—An episode of disease with a duration of between four weeks and six months.
3. *Chronic Disease* (Long-Term Disease)—An episode of disease with a duration of six months or more.

E. *Illness*—The patient's subjective perception of the disease process.

F. *Impairment*—Any reduction of functional, psychological, physiological, or anatomical capacity to participate in activities of daily living.

1. *Temporary Impairment*—Impairment with an expected complete recovery.
2. *Permanent Impairment*—Impairment in which a complete recovery is not expected.

G. *Disability*—Any restriction or lack of ability (resulting from impairment) to perform an activity in the manner or within the range considered normal for a human being.

H. *Handicap*—A disadvantage for a given individual, resulting from an impairment or a disability that limits or prevents the fulfillment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual.

VII. Encounter Descriptors

A. *Encounter*—Any professional interchange between a patient and one or more members of a health care team. One or more problems or diagnoses may be identified at each encounter. Analyses of encounter data should distinguish encounters from problems.

1. *Direct Encounter* (Face-to-Face Meeting)—An encounter in which there is a face-to-face meeting of a patient and professional.
   a. *Office Encounter* (Surgery Encounter, Attendance, Consultation [United Kingdom and South Africa]—A direct encounter in the provider's office or surgery.
   b. *Home Encounter* (Housecall, Visit [United Kingdom and Australia], Home visit or Housecall [South Africa])—A direct encounter occurring at the patient's residence (this includes home, a friend's home where a patient is visiting, a hotel room, and so on).
   c. *Hospital Encounter*—A direct encounter in the hospital setting. One encounter is counted for each patient visit.
      (1) *Hospital Inpatient Encounter*—A direct encounter with an inpatient.
      (2) *Outpatient Encounter*—A direct encounter with an outpatient in either the emergency room or the outpatient clinic.
   d. *Problem Contact*—A patient-provider transaction in regard to one problem. There may be several problem contacts during each encounter.
2. *Indirect Encounter*—An encounter in which there is no physical or face-to-face meeting between the patient and the professional. These encounters may be subdivided by the mode of communication, such as telephone encounter, written encounter, or encounter by message or through a third party.

B. *Referral*—A referral is made when resources outside of any health care provider's command (whether in or outside the practice) are requested on the patient's behalf. Patients may be referred for a specific service, a general opinion, or for other desirable reasons.

C. *Consultation*—In the United Kingdom, Australia, and New Zealand, a consultation is an occasion on which a patient receives professional advice, help, or treatment at the physician's premises. A domiciliary consultation occurs when the physician and a consultant meet at the patient's home to assess the patient. In North America a consultation is an exchange of information between physicians about a patient. The consultation may be informal (corridor consultation) or may involve the examination of the patient by the consultant in a more formal fashion, either in the presence of the primary care physician or in his absence, with a later exchange of information by verbal or written communication.

D. *Time of Encounter*—The time at which the encounter occurs.

1. *Encounter During Scheduled Hours*—Encounters that occur during usual or posted working hours of the health care providers. These hours should be clearly stated.
2. *Encounter During Unscheduled Hours*—Encounters that occur at times other than the usual working hours of the health care providers, but that exclude night encounters. These hours should be clearly stated.
3. *Night Encounters*—Encounters made between the hours of 2300 and 0700. If other time periods are chosen, these should be indicated.

E. *Duration of Encounter*—The segment of time occupied by a single patient encounter.

VIII. Service Descriptors

Service—An action taken by the provider in order to improve or maintain the health and well-being of the patient and/or the family.

A. *Diagnostic (Investigative) Services*—The assessment of any problem by history, physical examination, laboratory, x-ray examination, or other examinations performed either inside or outside the office setting.

1. *General Assessment*—A full history and detailed examination of those factors that determine the physical, mental, and social well-being of the patient with appropriate investigations, including a complete record of findings and advice for the patient.
2. *Specific Assessment*—Includes a full history and detailed examination that relates to a specific diagnosis or problem with appropriate investigations, including a complete record of findings and advice for the patient.

B. *Therapeutic Services*—These include pharmacological therapy, surgical therapy, physical therapy, psychotherapy, and others.

1. *Supportive Care*—Services that promote the maintenance of bodily functions but are generally not considered to be curative.
2. *Emergency Call Service* (Deputizing Service-Emergency Roster [Australia])—A service that provides temporary medical care for patients whose primary physician is off duty or absent from his or her practice.
3. *Rehabilitation Service*—A service that promotes restoration of activities and social functioning following illness or injury as nearly as possible to the premorbid level.

C. *Preventive Services*—These include immunizations, screening tests, risk assessment, education, pre- and postnatal checkups, well-baby care, family planning, and other services.

1. *Maternity Services/Care*—Comprises the diagnosis of pregnancy, antenatal care, delivery, and postnatal care, including a final follow-up examination.
2. *Newborn Care*—Routine care of the well baby, including all visits and necessary instructions to the mother. The time period used to designate this care should be specified. The perinatal period includes the first 7 days following birth, while the neonatal period includes the first 28 days after birth.
3. *Well-Baby Care*—Periodic office encounters with well babies during the first two years of life for routine supervision, assessment of growth and development, and any required parental instructions. These would include measurements and immunizations as necessary.
4. *Premature Baby Care*—All hospital encounters with premature babies with a birth weight of less than 5.5 pounds or 2.5 kilograms.
5. *Primary Prevention*—Measures designed to reduce the incidence of disease in an individual or a population by reducing the risk of onset, prevention of occurrence, and control of spread.
6. *Secondary Prevention*—Measures designed to reduce the effect and prevalence of disease in an individual or population by shortening its course and duration.
7. *Tertiary Prevention*—Measures designed to reduce the effect and prevalence of a chronic disability in an individual or a population by minimizing the functional impairment consequent to the disease or accident.
8. *Screening*—The attempt to identify unrecognized disease or defect in an individual or population by means of tests and/or other methods that discriminate between those who probably have or are at risk for a given disease and those who are not so affected.
9. *Health Promotion*—Services designed to help the patient avoid illness and maintain good health.

D. *Administrative Services*—Services that derive from the responsible position accorded to health care providers by the community, such as witnessing of signatures, attestations about character, and certifying fitness for certain functions (driving, work, sports) and unfitness for certain functions.

E. *Community Care*—The care and supervision of persons outside the hospital by medical and social agencies that are based in the community.

IX. Standard Reporting

Rates—Rates are defined as the number of events occurring in a study population in a given period of time divided by the size of the study population. According to previous definitions, a study pop-

ulation may be made up of any of the described groups (eg, registered patients, active patients, inactive patients, and so on). Rates per 100 or per 1,000 are typical, but this may change to per 10,000 or per 100,000 as the frequency of the event decreases. For some rates the study population of patients may not constitute the denominator, which instead may refer to the provider (eg, the number of patients seen per week per provider). Thus, rates may be constructed with one of the following numerators: problems, encounters or services, patients, or families; and one of the following denominators: provider, team, practice, study population, registered patient population, census population, or random sample population.

Adjusted Rates—Two practices may generate different rates for reasons unconnected with the underlying morbidity or operation of a practice. Thus, the direct encounter rate per 100 patients in an active patient population will vary according to the age and sex composition of that population. To compare crude rates between practices, it may be necessary to standardize them by age and sex. The "adjusted rates" become comparable in spite of age and sex differences of the study population.

A. *Encounter Rates*—Encounter rates may be tabulated using various numerators and denominators, and it is important to define clearly the content of each. Thus, for numerators, direct encounters must be distinguished from indirect encounters, first encounters from repeat encounters, active patients from inactive patients, and so on. For denominators, the method used to define the practice population should be specified. The following rates are examples chosen from numerous possible encounter rates.

1. *Patient Encounter Rate*—The number of patients who attend during the survey (counting each patient only once) divided by the practice population at the midpoint of the survey.
2. *Workload Rate*—The number of encounters (direct, face-to-face) during the survey divided by the practice population at the midpoint of the survey.
3. *Late Encounter Rate*—The number of visits out of scheduled hours may be tabulated in several ways; for example, (a) per 1,000 active registered patients, (b) per 100 direct patient encounters, or (c) per 100 patients attending (counting each patient only once).
4. *Hospitalization or Referral Rates*—The number of patient hospitalizations or referrals during the survey divided by the practice population at the midpoint of the survey.

B. *Morbidity, Mortality, Incidence, and Prevalence*—As with encounter rates, the content of both the numerator and the denominator must be specified.

1. *Episode of Illness Rate*—An episode of illness may be difficult (indeed impossible) to define; for example, it is difficult to know when an episode of peptic ulcer in an individual starts and ends (ie, did it heal and reactivate, or did it continue without symptoms), but this can be circumvented for most such conditions by counting each single diagnosis as an episode, however often during the survey that patient may visit for it. Thus, if a patient with a peptic ulcer visits a physician on one or more occasions during the survey for this condition, it is counted as a single episode, however far apart in time the encounters may be. For conditions such as injuries, it is usually simple to differentiate one episode from another. Usually episodes of illness are recorded by diagnosis, so one may calculate the number of episodes of a given illness per 1,000 patients in a practice population.
2. *Mortality* (Crude Death Rate)—The number of deaths that occur among a population during a year divided by the average number of persons at risk during the same year (expressed per 1,000 persons).
3. *Fatality Rate*—The number of deaths from a disease recorded during a defined period divided by the total number of cases of that disease recorded during the same period (expressed per 100 cases per year).
4. *Incidence*—The number of new cases of a given disease arising within a defined population during a defined period of time.
5. *Prevalence*—The number of cases of a given disease present in a defined population at one point in time (point prevalence) or during a defined period of time (period prevalence).

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