## Condition Resource

<table>
<thead>
<tr>
<th>FHIR Element 3 STU Definition</th>
<th>Binding Strengths 3 (STU)</th>
<th>Questions/Proposal to the group</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>clinicalStatus</strong>&lt;br&gt;The clinical status of the condition.</td>
<td>Required [0..1]&lt;br&gt;HL7 [hi7.org/fhir /condition-clinical</td>
<td>Add guidance this information can be captured in the condition, code as the clinical condition: if the ClinicalStatus can be represented from the codeableConcept Condition.code, it should not be entered here.</td>
<td>Ex: Asthma - currently active (finding) Ex: Inactive thyroid disease (finding) Ex: Recurrent anxiety (finding) Ex: Diabetes resolved (finding)</td>
</tr>
<tr>
<td><strong>verificationStatus</strong>&lt;br&gt;The verification status to support the clinical status of the condition.</td>
<td>Required [0..1]&lt;br&gt;HL7 [hi7.org/fhir /ValueSet/condition-ver-status]</td>
<td>Should this element include 'suspected'</td>
<td>Add an example when a Condition is provisional or differential and then becomes confirmed</td>
</tr>
<tr>
<td><strong>Category</strong>&lt;br&gt;A category assigned to the condition.</td>
<td>Example [0..*]&lt;br&gt;HL7 [hi7.org/fhir /ValueSet/condition-category]</td>
<td>This element seems to allow categorisation of types of information found in the resource, such as: symptom, sign, diagnosis, event, complaint, etc. Is it used for other purposes?</td>
<td>Should there be guidance to use the list resource with this element?</td>
</tr>
<tr>
<td><strong>Severity</strong>&lt;br&gt;A subjective assessment of the severity of the condition as evaluated by the clinician.</td>
<td>Preferred [0..1]&lt;br&gt;Include these codes as defined in <a href="http://snomed.info/sct">http://snomed.info/sct</a>&lt;br&gt;Severe, Moderate, Mild</td>
<td>Change binding the proposed intensional definition for this value set: &lt; 272141005</td>
<td>[Severities] Add guidance on validation of content that is a normal condition, to avoid inappropriate information, e.g. pregnancy.</td>
</tr>
</tbody>
</table>

Ex: Fatal infectious mononucleosis (disorder) Ex: Mild gingivitis (disorder) Ex: Moderate head injury (disorder) Ex: Severe myopia (disorder)
## Code

**Identification of the condition, problem or diagnosis.**

**Example**

<table>
<thead>
<tr>
<th>0..[1]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Include codes from <a href="http://snomed.info/sct">http://snomed.info/sct</a> where concept is-a 404684003 (Clinical finding)</td>
</tr>
<tr>
<td>Include these codes as defined in <a href="http://snomed.info/sct">http://snomed.info/sct</a> 160245001</td>
</tr>
</tbody>
</table>

No current problems or disability

**Change binding strength to Preferred so SNOMED CT is the Clinical Terminology of choice for this data element, and change binding the proposed intensional definition for this value set:**

```
(< 404684003 [Clinical finding] |
INCLUDE << 420134006 [Propensity to adverse reactions] |
INCLUDE << 473010000 [Hypersensitivity condition] |
INCLUDE << 79899007 [Drug interaction] |
MINUS << 69449002 [Drug action] |
MINUS << 441742003 [Evaluation finding] |
MINUS << 307824009 [Administrative status] |
MINUS << 385356007 [Tumor stage finding] |
MINUS << 80631005 [Clinical stage finding] ) OR < 413350009 [Finding with explicit context] OR < 272379006 [Event])
```

**Corrected ECL expression**

```
((< 404684003 [Clinical finding] |
OR << 420134006 [Propensity to adverse reactions] |
OR << 473010000 [Hypersensitivity condition] |
OR < 413350009 [Finding with explicit context] |
OR < 272379006 [Event] )
```

There is a proposed change to the Scope and Usage of this resource to better reflect the in scope elements for this resource.

Add guidance when the `condition.code` may include the Severity, the ClinicalStatus even the verificationStatus (confirmed) as the clinical condition; if the `Condition.code` includes the severity and/or the clinical status and/or the verification status these elements should not be captured to avoid duplicated information.

Ex.: Tuberculoma of spinal cord confirmed (disorder)
Ex.: Suspected fetal abnormality affecting management of mother (disorder)

There is a proposed change to the Scope and Usage of this resource to better reflect the in scope elements for this resource.

Suggest that the 'Allergic to X' be recorded in the `condition.code` when this is not a reason for an encounter. Use both the `Condition` and the `AllergyIntolerance` resources when there is an acute state.

Add an example for when the `Condition.code` is not required.

**bodySite**

The anatomical location where this condition manifests itself.

Comments: Only used if not implicit in `code` found in `Condition.code`. If the use case requires attributes from the Body/Site resource (e.g. to identify and track separately) then use the standard extension body-site-instance. May be a summary code, or a reference to a very precise definition of the location, or both.

**Example**

<table>
<thead>
<tr>
<th>0..*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Include codes from <a href="http://snomed.info/sct">http://snomed.info/sct</a> where concept is-a 442038009 (Anatomical or acquired body structure)</td>
</tr>
</tbody>
</table>

The binding strength should be changed for Preferred [0..*]
| **stage.summary** | A simple summary of the stage such as “Stage 3”. The determination of the stage is disease-specific. | Example: [0..1] Include codes from http://snomed.info/sct where concept is-a 385356007 (Tumour stage finding). | The binding strength should be changed for Preferred [0..*]. |

| **stage.assessment** | Reference to a formal record of the evidence on which the staging assessment is based. | There is no Terminology binding currently [0..*]. | Is there a dependency between this element and the verificationStatus? |

| **evidence.code** | A manifestation or symptom that led to the recording of this condition. | Example: [0..*] Include codes from http://snomed.info/sct where concept is-a 404684003 (Clinical finding). | Change binding strength to Preferred so SNOMED CT is the Clinical Terminology of choice for this data element and change binding to the same as for the Condition.code unless there is a rationale for the bindings to be different, knowing that the SNOMED CT clinical finding hierarchy does not have specific sub-hierarchies that are signs or symptoms. Will include the values from the Observation Resource plus items from the Condition Resource. |

| **evidence.detail** | Links to other relevant information, including pathology reports. | There is no Terminology binding currently [0..*]. | Is there a dependency between this element and the verificationStatus? The detail field here allows a reference to be made to 0..* Observation Resources. |

In the examples f202 and f203, we can see a major discrepancy between the Condition.code and the BodySite. Should there be guidance when this element is used and how should data be consolidated for analysis and retrieval?

The Content Logical Definition does not seem aligned on the Expansion shown on the page. Add the following to the Content Logical Definition: http://snomed.info/sct where concept is-a 80631005 Clinical stage finding (finding).

Add a «Comment» similar to the Severity element. Comments: Coding of the Stage with a terminology is preferred, where possible.

Add guidance this information can be captured in the condition.code as the clinical condition; if the Condition.Stage.Summary can be represented from the codeableConcept.Condition.code, it should not be entered here.

Ex: Pressure ulcer stage 3 (disorder)
Ex: Systolic heart failure stage D (disorder)
Ex: Mamography assessment (Category 1) - Negative (finding)
Ex: Stage 2 pulmonary sarcoidosis (disorder)

Is there a dependency between this element and the verificationStatus?

Please review the Example f204 which does not seem to comply to the definition of this element.

There is no Terminology binding currently [0..*]. Is there a dependency between this element and the verificationStatus?

Please review the Example f201, f002 and f003 which do not seem to comply to the definition of this element.

Provide guidance for when to use the evidence.code vs the Observation Resource

Please review the Example f201, f002 and f003 which do not seem to comply to the definition of this element.

How are the other data element adjusting when a value is populated in this field? Are there validation on all associated fields? Refer to example f202-malignancy.

Refer to example f203-sepsis. In this use case, if the report is only sepsis, how and will the code be validated against that information?