Condition Resource

FHIR Element 3 STU Definition	Binding Strengths 3 (STU)	Questions/Proposal to the group	Comments
clinicalStatus The clinical status of the condition. Comments: This element is labeled as a modifier because the status contains codes that mark the condition as not currently valid or of concern.	Required [0..1] HL7 hl7.org/fhir/condition-clinical	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. Ex: Asthma - currently active (finding) Ex: Inactive thyroid disease (finding) Ex: Recurrent anxiety (finding) Ex: Diabetes resolved (finding)	
verificationStatus The verification status to support the clinical status of the condition.	Required [0..1] hl7.org/fhir/ValueSet/condition-ver-status	Should this element include 'suspected'	
		Add an example when a Condition is provisional or differential and then becomes confimed	
Category A category assigned to the condition. Comments: The categorization is often highly contextual and may appear poorly differentiated or not very useful in other contexts.	Example [0..*] hl7.org/fhir/ValueSet/condition-category	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?	
		Should there be guidance to use the list resource with this element?	
Severity A subjective assessment of the severity of the condition as evaluated by the clinician. Comments: Coding of the severity with a terminology is preferred, where possible.	Preferred [0..1] Include these codes as defined in http://snomed.info/sct Severe, Moderate, Mild	Change binding the proposed intensional definition for this value set: < 272141005 |Severities|	
		Add guidance on validation of content that is a normal condition, to avoid inappropriate information, e.g. pregnancy.	
		Add guidance this information can be captured in the condition. code as the clinical condition: if the Severity can be represented from the Condition.code codeableConcept, it should not be entered here. 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 [0..1] Include codes from http://snomed.info/sct where concept is-a 404684003 (Clinical finding) Include these codes as defined in http://snomed.info/sct 160245001 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 << 79899007 |Drug interaction|) MINUS (<< 69449002 |Drug action| OR << 441742003 |Evaluation finding| OR << 307824009 |Administrative status| OR << 385356007 |Tumor stage finding| OR << 80631005 |Clinical stage finding|)) 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 BodySite 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 [0..*] Include codes from http://snomed.info/sct where concept is-a 442083009 (Anatomical or acquired body structure)	The binding strength should be changed for Preferred [0..*]	

		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?	
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..*]	
		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: Mammography 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 whcih does not seem to comply to the definition of this element.	
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, knowinf 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.
		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.	
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.
		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?	