

# Problem/Diagnosis

Entity: EVALUATION

Concept description:				Identification:	
Details about a single identified health condition, injury, disability or any other issue which impacts on the physical, mental and/or social well-being of an individual.				Id: openEHR-EHR-EVALUATION.problem_diagnosis.v1 Reference model: openEHR_EHR	
Purpose	Use	Misuse	Copyright	References	Contact
For recording details about a single, identified health problem or diagnosis. The intended scope of a health problem is deliberately kept loose in the context of clinical documentation, so as to capture any real or perceived concerns that may adversely affect an individual's wellbeing to any degree. A health problem may be identified by the individual, a carer or a healthcare professional. However, a diagnosis is additionally defined based on objective clinical criteria, and usually determined only by a	Use for recording details about a single, identified health problem or diagnosis. Clear definitions that enable differentiation between a 'problem' and a 'diagnosis' are almost impossible in practice - we cannot reliably tell when a problem should be regarded as a diagnosis. When diagnostic or classification criteria are successfully met, then we can confidently call the condition a formal diagnosis, but prior to these conditions being met and while there is supportive evidence available, it can also be valid to use the term 'diagnosis'. The amount of supportive evidence required for the label of diagnosis is not easy to define and in reality probably varies from condition to condition. Many standards	Not to be used to record symptoms as described by the individual - use the CLUSTER.symptom archetype, usually within the OBSERVATION.story archetype. Not to be used to record examination findings - use the family of examination-related CLUSTER archetypes, usually nested within the OBSERVATION.exam archetype. Not to be used to record laboratory test results or related diagnoses, for example pathological diagnoses - use an appropriate archetype from the laboratory family of OBSERVATION archetypes. Not to be used to record imaging examination results or imaging diagnoses - use an appropriate archetype from the imaging family of OBSERVATION archetypes. Not to be used to record 'Differential Diagnoses' - use the EVALUATION.differential_diagnosis archetype. Not to be used to record 'Reason for Encounter' or 'Presenting Complaint' - use the EVALUATION.reason_for_encounter archetype. Not to be used to record procedures - use the ACTION.procedure archetype. Not to be used to record details about pregnancy - use the EVALUATION.pregnancy_bf_status and EVALUATION.pregnancy and related archetypes. Not to be used to record statements about health risk or potential problems - use the EVALUATION.health_risk archetype. Not to be used to record statements about adverse reactions, allergies or intolerances - use the	© openEHR Foundation	Problem/Diagnosis, Draft Archetype [Internet]. National eHealth Transition Authority, NEHTA Clinical Knowledge Manager [cited: 2015-03-12]. Available from: <a href="http://dcm.nehta.org.au/ckm/#showArchetype_1013.1.896">http://dcm.nehta.org.au/ckm/#showArchetype_1013.1.896</a> . ISO/DIS 13940 Health informatics -- System of concepts to support continuity of care., International Organization for Standardization [Internet]. Available at: <a href="http://www.iso.org/iso/catalogue_detail.htm?csnumber=58102">http://www.iso.org/iso/catalogue_detail.htm?csnumber=58102</a> (accessed 2015 -04-09). Common Terminology Criteria for Adverse Events (CTCAE) [Internet]. National Cancer Institute, USA. Available from: <a href="http://ctep.cancer.gov/protocolDevelopment/electronic_applications/ctc.htm">http://ctep.cancer.gov/protocolDevelopment/electronic_applications/ctc.htm</a> (accessed 2015-07-13). Weed LL. Medical records that guide and teach. N Engl J Med. 1968 Mar 14;278(11):593-600. PubMed PMID: 5637758. Available from: <a href="http://www.nejm.org/doi/full/10.1056/NEJM196803142781105">http://www.nejm.org/doi/full/10.1056/NEJM196803142781105</a> (accessed 2015-07-13).	Heather Leslie, Ocean Informatics, <a href="mailto:heather.leslie@oceaninformatics.com">heather.leslie@oceaninformatics.com</a>

healthcare professional.	committees have grappled with this definitional conundrum for years without clear resolution. For the purposes of clinical documentation with this archetype, problem and diagnosis are regarded as a continuum, with increasing levels of detail and supportive evidence usually providing weight towards the label of 'diagnosis'. In this archetype it is not necessary to classify the condition as a 'problem' or 'diagnosis'. The data requirements to support documentation of either are identical, with additional data structure required to support inclusion of the evidence if and when it becomes available. Examples of problems include: the individual's expressed desire to lose weight, but without a formal diagnosis of Obesity; or a relationship problem with a family member. Examples of formal diagnoses would include a cancer that is supported by historical information, examination findings, histopathological findings,	EVALUATION.adverse_reaction archetype. Not to be used for the explicit recording of an absence (or negative presence) of a problem or diagnosis, for example 'No known problem or diagnoses' or 'No known diabetes'. Use the EVALUATION.exclusion-problem_diagnosis archetype to express a positive statement about exclusion of a problem or diagnosis.
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radiological findings and meets all requirements for known diagnostic criteria. In practice, most problems or diagnoses do not sit at either end of the problem-diagnosis spectrum, but somewhere in between. This archetype can be used within many contexts. For example, recording a problem or a clinical diagnosis during a clinical consultation; populating a persistent Problem List; or to provide a summary statement within a Discharge Summary document. In practice, clinicians use many context-specific qualifiers such as past/present, primary/secondary, active/inactive, admission/discharge etc. The contexts can be location-, specialisation-, episode- or workflow-specific, and these can cause confusion or even potential safety issues if perpetuated in Problem Lists or shared in documents that are outside of the original context. These qualifiers can be archetyped separately and included in the 'Status' slot, because their use varies in different




settings. It is expected that these will be used mostly within the appropriate context and not shared out of that context without clear understanding of potential consequences. For example, a primary diagnosis to one clinician may be a secondary one to another specialist; an active problem can become inactive (or vice versa) and this can impact the safe use of clinical decision support. In general these qualifiers should be applied locally within the context of the clinical system, and in practice these statuses should be manually curated by clinicians to ensure that lists of Current/Past, Active/Inactive or Primary/Secondary Problems are clinically accurate. This archetype will be used as a component within the Problem Oriented Medical Record as described by Larry Weed. Additional archetypes, representing clinical concepts such as condition as an overarching organiser for diagnoses etc, will need to be developed to support this

approach. In some situations, it may be assumed that identification of a diagnosis fits only within the expertise of physicians, but this is not the intent for this archetype. Diagnoses can be recorded using this archetype by any healthcare professional.

## Data



Structure: Tree

Concept	Description	Constraints	Values
 <b>Problem/Diagnosis name</b>	Identification of the problem or diagnosis, by name.	<i>Text</i> 1..1	Text;
 <b>Clinical description</b>	Narrative description about the problem or diagnosis.	<i>Text</i> 0..1	Text;
 <b>Body site</b>	Identification of a simple body site for the location of the problem or diagnosis.	<i>Text</i> 0..*	Text;
	Slot Structured body site [Cluster]	Include : Cluster anatomical_location(-[a-zA-Z0-9_]+)*\v1 anatomical_location_clock(-[a-zA-Z0-9_]+)*\v0 anatomical_location_relative(-[a-zA-Z0-9_]+)*\v1	Exclude : Cluster
 <b>Date/time of onset</b>	Estimated or actual date/time that signs or symptoms of the problem/diagnosis were first observed.	<i>DateTime</i> 0..1	Allow all
 <b>Date/time clinically recognised</b>	Estimated or actual date/time the diagnosis or problem was recognised by a healthcare professional.	<i>DateTime</i> 0..1	Allow all
 <b>Severity</b>	An assessment of the overall severity of the problem or diagnosis.	<i>Text</i> <i>Text</i> 0..1	Internal; 'Mild', 'Moderate', 'Severe' Text;
	Slot Specific details [Cluster]	Include : Cluster	Exclude : Cluster
 <b>Course description</b>	Narrative description about the course of the problem or diagnosis since onset.	<i>Text</i> 0..1	Text;
 <b>Date/time of resolution</b>	Estimated or actual date/time of resolution or remission for this problem or diagnosis, as	<i>DateTime</i> 0..1	Date only

	determined by a healthcare professional.		
	Slot Status [Cluster]	Include : Cluster problem_status(-[a-zA-Z0-9_]+)*\v0	Exclude : Cluster
 <b>Diagnostic certainty</b>	The level of confidence in the identification of the diagnosis.	<i>Text</i>	Internal; 'Suspected', 'Probable', 'Confirmed'
		<i>Text</i> 0..1	Text;
 <b>Comment</b>	Additional narrative about the problem or diagnosis not captured in other fields.	<i>Text</i> 0..1	Text;

Protocol

Structure: Tree

Concept	Description	Constraints	Values
 <b>Last updated</b>	The date this problem or diagnosis was last updated.	<i>DateTime</i> 0..1	Allow all
	Slot Extension [Cluster]	Include : Cluster	Exclude : Cluster