

## EDITORIAL

## International Classification of Diseases: A Call for Adaptation in Developing Countries

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Having a well-designed and functional health system is the cornerstone of maintaining the health of human subjects. Such systems require solid infrastructure, continuous evaluation, and ongoing enhancements. Having a correct diagnosis is one of the initial steps in successfully treating illness which returns humans to a productive life. In addition to the need for well-kept data, filing, and information technology, the diagnosis remains a vital step for outcome indicators and performance. Establishing a correct diagnosis is a function of cooperation and teamwork from different medical subspecialties. Once the diagnosis is made, it needs to be classified and occasionally sub-classified according to the disease and death coding and nomenclature.

The international classification of disease (ICD) is recognized by many countries. It covers the areas of health interventions, disability, disease, and death. The aim of ICD coding is to provide health information that can be compared among different hospitals and clinics in many countries, and it helps to monitor the system's progress. ICD-10 (1) that is in use by some countries is

a replacement for ICD-9. During the preparation for the tenth revision, The World Health Organization (WHO) felt the need for a stable classification, which would not need revision for several years (2). North America introduced this classification more than 100 years ago. It has undergone local adaptation and clinical modification several times (3, 4). ICD-9 remains the most widely used system.

It is time to implement use of a well-known classification by all members of the WHO. It is the responsibility of physicians worldwide to encourage the use of the international classification of disease as well as the procedure coding system. Such responsibility is paramount among physicians and quality assurance officers from developing countries. It will require training courses for physicians, coding officers, quality assurance and health system biostatisticians.

The time has come also to develop up to date medical records and hospital information systems. Well-kept medical records will require legislation and regulations that dictate adequate documentation by physicians and

other health care professionals. Development of well-kept medical records improves the feasibility and accuracy of medical research as well as quality of services offered.

This editorial is primarily a call for developing countries to come into the 21st century of medical documentation and self-auditing.

We would propose the creation of quality management departments, coding department, and strong biostatistics support systems to start this process of training and implementation of such codes. This means creating new jobs for hospital coders and training those coders to obtain graduation certificates from qualified institutions. It also means creating jobs for quality management and proper training for such jobs. Outcome studies and proper resources allocations are nearly impossible without accurate data and analysis.

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