

EDITORIAL

ICF APPROVED AS THE SUCCESSOR OF ICIDH

In May 2001, the World Health Assembly of the World Health Organization approved the final version of the new International Classification of Functioning, Disability and Health, and assigned the acronym ICF. The ICF succeeds the ICIDH, the International Classification of Impairments, Disabilities and Handicaps. During the revision process, various versions have been discussed under ICIDH-2, an acronym now abandoned. The ICF has moved on from “consequences of disease”, as in the ICIDH, to a classification of human functioning and disability. It takes a neutral stand with regard to etiology, such that research can more freely explore the causal factors and relationships between different aspects of the ICF.

One umbrella term is functioning, which covers body function and activity as well as participation. Another is disability, which is used to mean impairment (of body function and body structure), activity limitation and participation restriction. Thus, we are having to modify our use of the word disability, which in the ICIDH referred only to limitations on the individual level. It should be noted that while functioning is an overall term, body function is used to mean physical as well as psychological functions on an organ level. It is important that we become familiar with the new uses of these terms and use them in our writing, teaching, research and clinical work.

Activity is defined as the execution of a task or action by an individual. It can refer either to an individual's capacity to carry out a task or to that person's actual performance of the task, and the distinction must be explicit in all reports. Activity limitations are difficulties that an individual may have in executing activities. To render such an assessment meaningful in rehabilitation, however, the environment too should be described, and this is now possible.

Participation is defined as involvement in a life situation and participation restriction as problems an individual may experience while involved in life situations. This differs from the handicap concept in the ICIDH, which emphasized the disadvantage for an individual only in certain (and limited) vital life roles. The ICIDH has been criticized for not emphasizing environmental aspects and also for its normative approach. The word handicap can now be used more “freely”. Indeed, it has been used to mean different things in different cultures. In Sweden, the environment-related handicap concept has been strongly advocated by consumer organizations but also among rehabilitation professionals and behaviour scientists. The areas for participation are also much broader in the ICF and cover a greater variety of aspects of the life situations an individual can encounter.

Several authors have pointed to the difficulty in making a distinction between the terms disability and handicap as used in

the ICIDH, but with the ICF we may find that there are problems distinguishing activity from participation. During the final process in the autumn of 2000, new proposals introduced for the definition and content of those terms led to intense discussion, but ended up with a “consensus” solution. The same list of domains with aspects on functioning from both an individual and societal perspective is now used for activities (tasks or activities) and for participation (life situations), but with the possibility to perform the evaluation from one or both of these aspects. This could give rise to initial confusion and it is necessary to read carefully and further develop the instructions concerning the use of those chapters. Evaluation of the domains in some chapters should probably be limited to activity assessment and in others to participation assessment. For some domains, both aspects will be applicable. The type of assessment should be carefully defined and characterized when reporting results. It is hoped that such slightly confusing aspects will not hinder implementation of the ICF, and that they will be resolved through information, teaching and practical use.

Much remains to be done before the ICF can be fully implemented – most importantly the further development of qualifiers rating degree of difficulty, problems, barriers and facilitators. The numeric codes, actually ordered categorical scales, are not scientifically based. It is stated that the qualifiers are “quantification to be used in a universal manner” and that “assessment procedures have to be developed through research”. For the qualifiers to be used in rehabilitation research, their psychometric characteristics will need to be analysed for the specific domains and types of individuals studied. As they are ordinally scaled, they will have to be treated with adequate statistical techniques. The number of scale steps should presumably not be the same for all domains or categories, but, without qualifiers, the codes have no meaning. Thus, the minimum must be: no problems, no difficulty, etc., versus appearance of any degree of problems, difficulty, etc.

Something that could fruitfully be explored further is to link already established instruments with identified psychometric characteristics to the codes in the ICF. Preliminary experience indicates that this would be possible for a number of commonly used instruments. New measures should also be developed based on the structure of the ICF. There is also a need to further explore the practical uses of the ICF for different specific purposes in clinical and social work, its application in the social insurance field as well as in research in clinical medicine, epidemiology and the social sciences.

In contrast to development of the ICIDH, which was led by Dr Philip Wood, many organizations and professional groups have been involved in developing the ICF, all under the leadership of

Dr Bedirhan Éstn and his co-workers at WHO. This process has resulted in a broad input, but at the same time has led to a number of compromises having to be made. Although certain details may therefore be criticized, on the whole we consider the present content of the ICF to be an important step in the process towards a generally accepted model for communication around, and classification of, functioning and disability with many applications.

Many actors and professions will be involved in further studies and development of the ICF. There are established centres for coordination of this process through the WHO

Collaborating Centres for ICD and ICF, the Nordic one based in Uppsala. It is necessary for representatives of different rehabilitation professions, active in research, teaching or clinical work, to become engaged in the implementation of the ICF. With their experience, the rehabilitation professions will surely be able to contribute meaningfully. We hope to see the ICF used as a conceptual framework in many scientific papers, just as was the ICDH, but also eventually in the description and analysis of different aspects of functioning and disability in rehabilitation research.

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BOOK REVIEW

Hand Recovery after Stroke by Johannes G. Smits & Else Smits-Boone, eds. 216 pages. Price £20.00. ISBN 075067272 2. Butterworth-Heinemann, Oxford, 2000.

This book is written by a stroke survivor, Dr Johannes Smits, and his wife, Else Smits-Boone, who devised exercises for his hand after his stroke and noted recovery long after the time of recovery was expected to end. Dr Smits then decided to write this book and encourage others to follow his example. He starts by describing the expected recovery after stroke, and how recovery can be described graphically. The language makes it easy to follow the description of the construction of graphs that can be used to monitor the recovery process. After an introduction to the set-up for monitoring recovery, the book proceeds to describe in detail 26 exercises that can be done at home using everyday objects. Each chapter has an empty table and graph for the reader to use when monitoring their own exercises and recovery. The author describes the importance of realizing the time needed for recovery after a stroke, which is much longer than the recovery times reported by stroke researchers. His own experience shows that recovery can continue for as

long as exercises are performed, which can be for years after a stroke, and that it does not level off as long as the person continues to do daily exercises.

A scientific report of the author's recovery was published in the *Journal of Neurovascular Disease* (September–October 1997, pp. 211–219) and is included as an appendix at the end of the book. This book is unique in the sense that it is written by a stroke survivor who has designed and carried out the exercises described himself and who has therefore shown that daily practice does have an influence on the long-term recovery of hand function after a stroke.

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