

Introduction

Functional capacity assessment

The concept and implementation of Functional Capacity Assessment (FCA) sounds simplistic enough; yet, nothing could be further from the truth. Its complexity rivals that of the assessment and treatment of chronic pain. Just as it is true that there are no two pain centers or pain programs that are alike, it appears that the same can be said for FCA. In short, FCAs are not standardized and the variables are endless. There are also many deficiencies in the field of functional capacity testing including the lack of an operational definition.

There is disagreement among the experts concerning the disciplines and the qualifications of evaluators who should do FCAs as well as the number of disciplines required to do a useful assessment. Inter-rater reliability is always an issue. Semantics and confusion over terminology create further difficulty in standardizing testing and in the interpretation of results. The FCA design, length of time to complete the battery, time of day, time since onset of the problems for which the person is to be tested, the type of and appropriateness and reliability of equipment used to measure functional capacity, how the equipment was normalized, what it was designed to measure, what the FCA is measuring, what is the role of fatigue, pain, pathology, effort, motivation, medication, testing instructions, goals and biases of the evaluatee, and of the referrer, selection of the candidate, spouse or attorney presence or involvement, litigation issues and how test results are to be used, are just some of the issues which must be explored.

A lack of understanding concerning test results is fraught with problems for providers, patients, referrers and payors. Ideally, an FCA should be done pre- and post-rehabilitation. Testing done pre-rehabilitation will not provide information concerning full functional capacity if the evaluatee were rehabilitated. It will provide a baseline. Therefore, when the payors request FCA for the sole purpose of making a disability determination to achieve an expedient settlement without rehabilitation, the results obtained will be less than optimum and may distress the payor and delight the claimant's attorney. Interestingly enough, while the medico-legal field uses 'objective medical findings' as the basis for disability determinations, in reality the ratings are often based upon limitations found during the impairment evaluation and not on the traditional 'objective medical findings' such as neurological deficits which are often absent or non-existent. Therefore, limitations found on FCA can equate to significant disability settlements. This is an interesting paradox.

FCA results can be used to justify rehabilitation or be used in a pejorative manner. Objectivity versus subjectivity on the part of the evaluator and evaluatee is often a 'gray' area. Pain and its relation to function has long been a source of speculation. Issues of 'true maximum effort' and the whole area of 'real pain' are troublesome and are potentially damaging to the evaluatee and to the validity of FCA results.

Given the complexity and the multifaceted na-

ture of this subject we do not pretend to adequately address the numerous dilemmas outlined. In this issue, we share the logic of our approach to understanding and conducting FCAs from a process-analysis point of view. Dr. Abdel-Moty et al.'s paper emphasizes the fact that FCA is not a mere measurement process and that there are many crucial components that can affect testing results and their interpretation. Dr. Vasudevan reviews the complex nature of pain disability and the role of FCA in the medical determination of disability. Dr. Rudy and his colleagues review models of pain and highlight how FCAs of pain patients adhere to behavioral conceptualization of chronic pain. They also review some of the factors that influence FCAs and propose an integrated, multidimensional model of FCA. Dr. Simonsen shares his attempts at devising ways of objectively determining sincerity of effort in performance during an FCA. A method of evaluating

work capacity of injured persons is presented by Dr. Matheson and his colleagues. Drs. Jackson and Ross describe the use of aerobic capacity and repetitive lifting as a method of assessing functional capacity of workers.

The contributors to this issue have brought us different perspectives to consider. We hope this publication will serve to challenge others to join us in further studies to address the myriad of questions and issues raised concerning the utility and validity of FCA.

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