Work 38 (2011) 197–199
DOI 10.3233/WOR-2011-1122
IOS Press

Letter to the Editor

Darrell W. Schapmire[a] and James D. St. James[b]
[a]*X-RTS Software Products, Inc., Hopedale, IL, USA*
Tel.: +1 309 449 5483; E-mail: ds@xrts.com
[b]*Millikin University, Decatur, IL, USA*

Response to Reneman and Gross Letter

Dear Editor,

Reneman and Gross, in their reply to Schapmire et al. (2010) raise the question, "Should FCE be used to identify validity of effort?". They answer their question by noting, ". . . we believe the answer. . . is clearly no." They express their doubt as to whether rehabilitation professionals can meet their ethical obligations to their patients when asked by a third-party payer to judge "the legitimacy of our patients' presenting problems for purposes of claims managements decision-making."

FCE's are, in fact, typically performed in the context of determination of disability benefits or other claims-management decision-making. The purpose of the FCE is to determine the ability of the person being tested to perform the physical work needed for a particular job. But if the person being tested is not giving a valid effort, then any measure of their functional capacity is hopelessly compromised. An FCE, therefore, must involve an assessment of whether or not the person being tested was putting forward a valid effort that reflects their actual work capacity. Unless validity of effort can be assessed with reasonable accuracy, there is no purpose in performing the FCE.

Part of Reneman and Gross's difficulty lies in their confusion of the role of a therapist treating a patient versus the role of an FCE provider assessing a person's capacity for work. While many physical therapists and other professionals may play each of these roles on occasion, they are not the same. Anyone offering their services as an FCE provider must clearly understand that an FCE is an assessment and NOT a treatment. If they are uncomfortable making assessments of validity of effort, they should inform their referral sources that they will not make such a determination, so that the referral source can decide the value of that test.

Reneman and Gross state, "it is much more constructive to conduct FCE with a neutral or therapeutic as opposed to litigious perspective, because it may then be used to assist with facilitating work participation." We believe it is precisely *because* FCEs are used in litigated cases that the issue of validity of effort *must be* addressed – and when this issue is ignored or addressed inadequately, it is utterly impossible manage cases with the expectation of optimizing outcomes.

Reneman and Gross rightly point out that a variety of factors, including social and psychological factors, might account for "excessive" variability between repeated measures. However, making the distinction between purposeful non-cooperation and various social and psychological factors is far beyond the intent or capability of any FCE. To begin with there are no gold standards for the measurement of "other factors," nor is there any universal agreement on how to address their impact. A reasonable view, though, is simply this: That which is not measured cannot be managed, and the failure to identify such behaviors squanders a unique opportunity to either address the behavior to optimize the outcome or to bring the case to closure.

The heart of the opinions expressed by Reneman and Gross appears to be this belief: "No human being can consistently behave consistently, and this holds true for people with and without pain." Not only is this statement factually untrue, but it is a misunderstanding of the validity criteria in our protocol. In fact, those criteria *do* allow for variation between sets of numbers (comparing unilateral forces to simultaneous bilateral forces) as well as variation within sets of numbers. The amount of variability was established by a controlled study. The cutoff points were determined on the ba-

sis of the maximum expected variability, based on the amount of variation observed in subjects known to be cooperative. The idea that human performance can never be "consistent" surrenders the process of evaluating insurance claimants to anyone who has an opinion – even when the opinion cannot be supported on a scientific basis. It opens wide the door for litigation and feeds the expert witness culture. Instead of assisting patients, it puts them at the mercy of a system that can be manipulated by any care provider, any guarantor – or any hired expert.

Every compensable injury case hinges on the question of "lost function" in the context of a worker's ability to perform a given job. A medical diagnosis, in and of itself, does not necessarily indicate the next logical step in case management. Thus, it is the hope of referral sources that an FCE will help physicians, case managers, guarantors and employers combine what is objectively known of an individual's medical status with what can be objectively determined about the claimant's behavior to make important case management decisions. Absent any objective information about the individual's willingness to participate fully during an FCE, cases become legal contests subject to an uncertain and perhaps unfair outcome as a result of the machinations of the legal system.

It has been proposed that FCEs would ideally transition "from experience- and expert-based towards evidence-based FCEs [1]". We agree, and we believe the transition is long overdue. We believe the expert witness culture in our field has been fed by an aversion to making judgments regarding test behaviors. This aversion sets up the possibility of abuse by the paid medical expert who may or may not have a legally-defensible opinion – and may or may not have the best interests of the patient in mind.

Reneman and Gross cite our Table 4 as evidence that our conclusion is incorrect. To accept this critique, we have to accept on blind faith the accuracy of the subjective pain reports of those persons presenting for assessment. We do not share that blind faith. We direct the reader's attention to Table 5, Category 5, identified as "low back pain or surgery, fibromyalgia and five other subjects with diagnoses not plausibly related to the upper extremities." Note that Category 5 had the highest average number of failed validity criteria. Does pain reasonably explain the results for the *low back patients* in Category 5 – or does "test behavior," as we suggest, represent a more plausible explanation for their inconsistent performances? And if "pain" causes failure of the validity criteria, why do the people who have had upper extremity fractures and surgeries (Table 5, Category 3) fail *fewer* criteria than the back pain patients?

The economic realities we now face should focus the field's attention on the issue of validity of effort testing. The cost of all torts in the United States is substantial, exceeding $245 billion in 2003 [2] Of this amount, the latest (although dated) information on workers compensation costs indicate those expenses are at least $140 billion annually [3]. The cost of all torts does not include long- and short-term disability payments, or income replacement insurance. Lastly, tort costs do not it include annual benefits for Social Security Disability and Social Security Supplemental Income, $78 billion and $37 billion, respectively, in 2004 [4]. *Indirect costs* for all compensable injuries are variously estimated to be 2x – 10x direct costs. Such costs include defensive medicine, estimated to be at least $60 billion annually, but possibly as high as $200 billion [5]. Other indirect costs include ergonomic changes, administrative costs and legal fees. Lastly, there is the incalculable effect of inflated demands for medical services on the market prices of those services. Thus, the total direct and indirect costs of all types of compensable injury and disability claims could easily total $1.0–$1.5 trillion a year. A savings of on 10% of that amount is the equivalent of a small bailout for our economy every year – *but this requires assessing validity of effort* during an FCE, not treating the process as a "neutral" or "therapeutic" process event that has implications only for the person being tested.

It is no longer acceptable to ignore the issue of validity of effort on academic or philosophical grounds. The people who make the FCE referrals and pay the bills will eventually reject testing protocols that are expensive to conduct, highly inaccurate and not legally-defensible. Persons adverse to potential involvement in litigated cases can no longer hide behind the mantle of "patient advocate" and remain a credible source of information – or a viable business entity – if they are conducting FCEs in a competitive and informed market.

We believe that the reader will find Part II of this study will put the nature of variability observed in the subjects' performance in Part I into a broader context, one that describes a pattern of behavior which extends to the assessment of lifting. Given the totality of the data which are reported in both parts of this study, we maintain our position that our tests do, in fact, accurately classify test behavior and are appropriate for use in clinical populations.

References

[1] M.F. Reneman, Introduction to the Special Issue on Functional Capacity Evaluations: From Expert Based to Evidence Based, *J Occup Rehab* **13**(4) (2003), 203–206.

[2] Towers-Perrin, 2007 Update on U.S. Tort Cost Trends, http://www.sickoflawsuits.org/pdfs/2007UpdateonUSTortCostTrends_000.pdf, (Retrieved November 30, 2010).

[3] I. Sengupta, V. Reno and J.F. Burton, Jr., *Workers' Compensation: Benefits, Coverage, and Costs 2005, with advice of the Study Panel on National Data on Workers' Compensation*, http://www.nasi.org/research/2007/report-workers-compensation-benefits-coverage-costs-2005, (Retrieved November 30, 2010).

[4] J. Christian, *Use of Functional / Vocational Expertise Project*, Social Security Administration, Webility Corporation, August 2007. http://www.webility.md/pdfs/SSA-FVE-Supplemental-Report-2007-08-27a.pdf. (Retrieved November 30, 2010).

[5] P.K. Howard, Special Health Courts: The Cure for Defensive Medicine. *The Atlantic*, February 10, 2010, http://www.theatlantic.com/national/archive/2010/02/special-health-courts-the-cure-for-defensive-medicine/36564/. (Retrieved November 30, 2010).