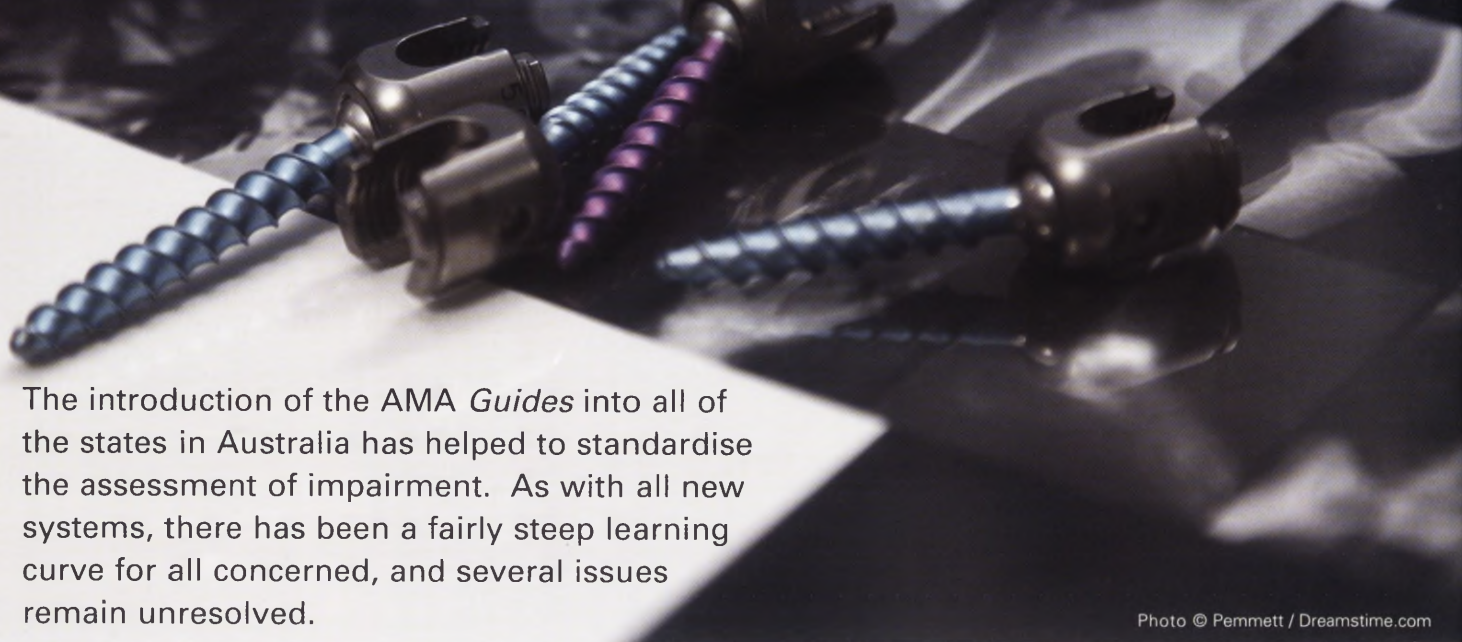


By Dr Roger Pillemer

# The application of the *AMA Guides* to workers' compensation



The introduction of the *AMA Guides* into all of the states in Australia has helped to standardise the assessment of impairment. As with all new systems, there has been a fairly steep learning curve for all concerned, and several issues remain unresolved.

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**T**his article addresses the subject under the following three headings:

- A. Assessment of impairment: past, present and future.
- B. The philosophical basis underpinning the *Guides*.
- C. Variations in the outcome of medical assessments.

## THE PAST, THE PRESENT AND THE FUTURE

Prior to the introduction of the *AMA Guides* (the *Guides*), there was no standardised basis for medical opinions, which therefore varied widely. It was very difficult to question a doctor's suggested percentage of impairment, as these were based purely on his subjective medical opinion.

The *Guides* attempt to provide objective methods of assessment that are standardised and reproducible. While all states use the *Guides* at present, different states are unfortunately using different editions, and even within states there is no conformity among different jurisdictions. For example, in NSW the Motor Accidents Authority uses *AMA Guides* edition 4, while WorkCover uses *AMA Guides* edition 5. A similar situation prevails in other states.

The *Guides* do require modification to suit local conditions,<sup>1</sup> and also to accommodate new procedures, such as disc replacements, which were not in use when the *Guides* were published. With a view to addressing issues of this type, the WorkCover *Guides* are now in their 3<sup>rd</sup> edition in NSW, and the MAA has also issued its own additional guidelines to accompany the *Guides*.

With regard to the future, as with the need to standardise

railway gauges, it seems axiomatic that there should be a national method of impairment assessment. In my opinion, this would best be achieved by using *AMA Guides* 5, modified by an 'Australian WorkCover *Guides*'.

Steps are being taken in this direction.

## THE PHILOSOPHICAL BASIS UNDERPINNING THE GUIDES

### Objective assessment

The *Guides* try and provide an objective method of impairment assessment as far as possible, using a combination of medical consensus and scientific evidence. Consider, for example, the function of a hand. The thumb, with its ability to oppose the other digits and allow grasping, is regarded as being twice as useful as the index and middle fingers, which in turn are regarded as being twice as useful as the ring and little fingers. Designating hand function as 100 per cent, it was decided to apportion 40 per cent of the function to the thumb, 20 per cent each to the index and middle fingers and 10 per cent each to the ring and little fingers. So, for example, an amputated thumb equates to a 40 per cent impairment of the hand, which (using the appropriate tables) equates to 36 per cent upper extremity impairment, which in turn equates to 22 per cent whole person impairment. Impairment assessments of other areas of the body are not as clear-cut as with the hand, but are based on similar principles.



**Impairment and disability<sup>2</sup>**

The *Guides* are concerned mainly with impairment rather than disability, and it is important to distinguish the two.

**Impairment** is the loss, loss of use, or derangement of any body part. **Disability** is the alteration of an individual's capacity to meet personal, social or occupational demands because of an impairment.

For example, the bank manager and the professional violin player who both sustain an amputation of the little finger of the non-dominant hand, will each have a 10 per cent permanent *impairment* of the hand. The *disability*, however, is vastly different. The bank manager can be back at his normal work within two weeks, whereas the violinist will never play professionally again.

**Signs and symptoms/subjective v objective**

As far as possible, the *Guides* are based on objective signs and here it is important to distinguish between signs and symptoms, and the terms 'subjective' and 'objective'.

'Symptoms' are what the patient tells the doctor, and are entirely subjective; that is, only the patient is aware of how severe the symptoms actually are. (Symptoms can usually be relied on in the usual doctor/patient relationship, but are not necessarily reliable in the compensation arena.)

'Signs' are what the doctor finds on his/her examination. Eliciting signs may or may not require the co-operation of the person being examined.

'Subjective signs' depend on the veracity/co-operation of the patient. For example, a patient may well have an ability to exert 20kg of grip strength, but may voluntarily elect to exert only 5kg of grip strength. Subjective signs can therefore be feigned.

'Objective signs', however, are the gold standard, and when present give valuable information. Examples of objective signs are depressed or absent reflexes, muscle wasting to circumferential measurement, swelling of a joint or region, and sensory or motor change in a specific distribution (spinal or peripheral nerve). Objective signs cannot be feigned and are very valuable in assessing impairment.

**Confirmation**

Assessment of impairment involves the use of various tables, figures and charts in the *Guides*. The doctor has to state very clearly how s/he has reached his or her conclusions, indicating which criteria s/he has used, as well as the basis for his or her calculations. The tables are set out in such a way that non-medical persons who are familiar with and trained in the use of the *Guides* can check the doctor's figures and conclusions: a very useful function.

**Impairment ratings not provided<sup>3</sup>**

Understandably, it is not possible for the *Guides* to cover all possible medical conditions, or combination of conditions. The *Guides* make provision for this, noting:

'In situations where impairment ratings are not provided, the *Guides* suggests that physicians use clinical judgement, comparing measurable impairment resulting from the

unlisted condition to measurable impairment resulting from similar conditions with similar impairment of function in performing activities of daily living.'

'The physician's judgement, based upon experience, training, skill, thoroughness in clinical evaluation, and ability to apply the *Guides* criteria as intended, will enable an appropriate and reproducible assessment to be made of clinical impairment.'<sup>4</sup>

**Learning curve**

Effective use of the *Guides* involves a steep learning curve, particularly with regard to some of the more uncommon sections of the *Guides*. This is one of the causes of the variation in impairment assessments, as discussed below.


**VARIATIONS IN IMPAIRMENT ASSESSMENTS**

The question I am most commonly asked by the legal profession is why impairment assessments vary so widely, despite the use of a system or method that is specifically designed to try and avoid this. There are a number of reasons, some more obvious and/or common than others.

**Demonstrable error**

This can occur simply because the medical assessor uses an inappropriate table or reads off the figures incorrectly. The solution is obviously more care and attention to detail.

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SCHOOLS

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**Patient co-operation**

It is not uncommon for claimants to exaggerate their symptoms in an effort to maximise their claimed disability.

As noted above, subjective signs can be very unreliable. For example, a claimant may actually have a range of flexion of the shoulder of 150° (normal = 180°), but may elect to actively flex the shoulder only to 120°, giving rise to a misleading assessment. This behaviour may occur for many reasons, not simply for financial gain. The factors may include the need to maintain a sick role (for whatever reason), or impress the doctor of the seriousness of the condition, etc.

**Normal variation**

Signs may well vary from day to day, especially in painful conditions, and where a condition has not yet stabilised (reached maximal medical improvement).

**Difficult assessments**

Some conditions can be particularly difficult to assess: for example, complex regional pain syndrome (CRPS).<sup>5</sup>

**Impairment ratings not provided in the Guides**

When the condition being assessed is not in the *Guides* and an analogous condition is chosen instead,<sup>6</sup> some variations will inevitably occur. These variations should ideally be fairly small.

**Different methods of assessment**

Where there are a number of different methods of assessment available, particularly in the lower limb, the *Guides* very clearly advise the use of the most suitable method for the condition being assessed. If two methods are acceptable, select the method giving the highest figure of impairment.<sup>7</sup> Errors in selecting the correct methodology may lead to differences in assessment outcomes.

**Bias**

The most important – and not openly talked about – cause of difference in the figures of assessment is ‘bias’. In my opinion, a good starting point would be to accept that we are all biased. It is not often that we are able to read a medical report and come away with the impression that the report was totally unbiased. It does happen, but not often enough.

From a medical examiner’s perspective, two kinds of bias exist – extrinsic and intrinsic.

**Extrinsic bias**

In this situation, the medical practitioner provides a medical report that favours the referrer (either the claimant or the insurance company). The bias is often blatant, but can sometimes be more subtle. The bias might not be purely for financial gain (more referrals), but can also, at times, be due to a desire to please the referrer.

The only way to really eliminate this type of bias, however, would be for the assessing doctor not to be aware of who sent the referral in the first place, or when the assessment is being carried out for a neutral body, such as in NSW where Approved Medical Specialists provide a Medical

Assessment Certificate (MAC) for the Workers’ Compensation Commission.

**Intrinsic bias**

This form of bias will manifest independently of the referrer, and I would suggest is found routinely in doctors who do assessments only for one side or the other. There are numerous possible contributing factors to this form of bias, including inherent prejudice, partiality, intolerance, etc.

**Eliminating bias**

With the introduction of the *AMA Guides*, doctors giving opinions at both extremes are gradually being pushed to the side as all parties realise that only reports giving a reasonable assessment that can stand up to scrutiny are worth obtaining. Doctors who regularly give assessments way above or below the accepted norm will now invariably have their opinions overturned in an appeal process, and the solicitors then have to deal with the understandable disappointment of their clients. In NSW, the days of widely varying figures of impairment under the old system are, arguably, almost over.

How doctors actually go about eliminating bias in their reports is the subject of another discussion, and not an easy undertaking: *‘Knowing that one may be subject to bias is one thing; being able to correct is another.’*<sup>8</sup>

**CONCLUSION**

I am optimistic that, in the future, all the states will agree on a uniform system of assessment of impairment. To date, Western Australia and South Australia have both moved to *AMA Guides 5*, and have adopted the NSW *WorkCover Guides*. Queensland is heading in this direction. It will be increasingly difficult for other states and jurisdictions not to be part of the continuing updates and improvements.

There are certainly no significant medical difficulties to achieving a uniform system for assessing impairment. I would suggest that the difficulties involved in achieving this objective are financial (in relation to threshold) issues, and other legal matters. In NSW, for example, with regard to the Motor Accidents Authority, where 10 per cent whole person impairment is the relevant threshold, there would be a significant impact in moving from *AMA 4* to *AMA 5*. I am aware that the Motor Accidents Authority has commissioned an actuarial study to assess the implications of such a move. There is also legislation present in various jurisdictions specifying which *Guides* must be used, another difficulty that must be dealt with.

I am hopeful that commonsense will eventually prevail, and we will have a national system in the not-too-distant future. ■

**Notes:** **1** NSW *WorkCover Guides* 3rd edition, p3, 1.3. **2** *AMA Guides* 5th edition, p2, 1.2. Impairment, Disability and Handicap. **3** *Ibid*, p10, 1.5. Incorporating Science with Clinical Judgement. **4** *Ibid*, p11, item 1.5. **5** *Ibid*, pp495 – 7. Complex Regional Pain Syndrome (CRPS). **6** NSW *WorkCover Guides* 3rd edition, p10, 1.59. Conditions that are not covered by the *WorkCover/AMA Guides* – Equivalent or Analogous Conditions. **7** *Ibid*, p4, 1.9. **8** Quotation from Robert K Merton, Professor of Social Sciences at Columbia University.

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