Exhibit **D**

AMA GUIDES TASK FORCE – REPORT OF MEMBER MATTHEW DAKE

INTRODUCTION

After reading the relevant portions of the 5th and 6th editions of the AMA Guides, and hearing from many of the chief authors and editors of the 6th edition of the Guides, I recommend that Iowa not adopt the 6th edition of the AMA Guides for use in Iowa. This report is not inclusive of all of my thoughts, but those that have most significantly led me to this conclusion. I have read and commend the reports of fellow task members Marlon Mormann, Saffin Parrish-Sams, and Dr. John Kuhnlein, M.D. It is not my intent to duplicate their efforts here, but hopefully add to, and continue that discussion, from my own perspective.

I must also state that I very much appreciate the time the authors and editors gave this Task Force in conducting our review. Where I attribute statements to them, I have attempted to be as accurate as possible. It is the opinion of this member that the medical professionals, authors, and editors, of the 6th edition, were well-intentioned in proposing the paradigm shift set out in the 6th edition. Despite this belief, it is the opinion of this member that the paradigm shift, and the creation of this Edition of the Guides, was flawed in both its process and result.

I. THE 6TH EDITION PARADIGM SHIFT – FLAWED PROCESS, FLAWED RESULT

The Process Was Flawed

In reviewing the 6th Edition, the editors make clear that they are involved in a significant paradigm shift (6th Edition, p. 2) between the 5th and 6th editions of the Guides. Indeed, in his statement to the Task Force, Dr. Douglas Martin, indicated that the editors knew that this paradigm shift was likely to cause controversy. Despite this understanding, neither the AMA, nor its Editors, made any significant attempts to work with members of the legal community to determine if this 'paradigm shift' was going to be workable under the various laws that utilize the Guides. In his statement to the Task Force, Dr. Rondinelli stated definitively that there was almost no consultation with the legal community. Dr. Rondinelli in turn conceded that this was probably a mistake. This member acknowledges that the AMA, and Dr. Rondinelli, are now, ex post facto, attempting consultation with some members of the legal community, particularly the ABA. This member hopes that such efforts will provide some much needed guidance in producing future Guides.

It seems to be the opinion of both Dr. Rondinelli, and the other editors of the Guides, that the 6th edition was written by doctors, solely for doctors. Failing to acknowledge that the Guides are used exclusively for litigation purposes, represents a fundamental intellectual dishonestly. The fact remains that the Guides are not used for treatment purposes. The Guides are used to assess an injured person's entitlement to compensation, most typically in state workers' compensation systems throughout the country, including Iowa. The failure to consult with the stakeholders in the system doomed the paradigm shift from its inception.

The Task Force made many attempts to get behind the reasoning and rationale for the paradigm shift. Those editors and authors that spoke to us, always made certain to specify that they were not speaking for the AMA. The AMA provided us with very little

illumination on many questions and issues that we presented directly to them. In fact, they referred us back to Dr. Rondinelli for answers to many of our questions. While this may have simply been poor communication and coordination on the part of the AMA, it at times had the appearance of stonewalling. This Task Force gave the AMA, and its editors, far more opportunity to comment and educate us on our analysis and views, than the AMA has afforded us in understanding the reasons and rationale behind its paradigm shift. This lack of transparency raises many doubts and concerns about the motives and justifications behind this shift.

This member likewise has serious questions and concerns regarding the composition of the editorial panel. At the time of his second presentation to the Task Force, Dr. Rondinelli admitted that he selected those doctors that he perceived as agreeing with him on the proposed paradigm shift. While I certainly do not fault Dr. Rondinelli for choosing doctors who agreed with his proposal, it does highlight the fact that the goal was not to create the best system, but rather to implement the paradigm shift proposed by Dr. Rondinelli. Dr. Douglas Martin confirmed that in his view, the majority of the editors and chief authors work for employers and insurance carriers. Dr. Martin honestly admitted that the composition, and the lack of diverse viewpoint, was a serious concern. This member finds this lack of perspective problematic.

It is clear that a vigorous debate about the paradigm shift did not occur, and was not welcome. It is significant that Dr. Rondinelli informed the Task Force that his was the only proposal for the 6th Edition submitted to the AMA. The AMA did not therefore choose this

paradigm shift out of a multitude of competing proposals. The AMA selected the only proposal actually tendered.

Dr. Mark Melhorn spoke to the Taskforce. He was the chief author of Chapter 15 on upper extremities. He informed the Task Force that his initial submission to Dr. Rondinelli, and the AMA, was rejected. He indicated that it had to be re-worked to conform to the generic template announced by the 6th edition editors. He further indicated that his original submission made a great deal more sense within the context of upper extremity injuries. He stated that doctors will not take the time to use the 6th edition's approach to calculate the impairment of a 'trigger finger', for example. Despite Dr. Melhorn's concerns, the 'paradigm shift' triumphed over his reasoning. This result strongly suggests that the 6th edition was not the result of a truly collaborative process, but was rather an edition driven by a few chief editors who sometimes forced square pegs into round holes.

Dr. Rondinelli, during his second visit with the Task Force, admitted that the 6th Edition was forced to publication to early. He described the actual published version of the 6th Edition as a "Beta draft". It is also troubling that the editors have already had to produce a 50-plus page errata, while the 5th edition was only subject to a 16 page errata almost two (2) years after publication. Dr. Rondinelli indicated that the 'errata' would continue to expand online in the weeks and months to follow.

The 6th edition errata makes significant changes to the upper extremity chapter, including changing the actual tables used to rate an injury. There is real concern whether doctors across Iowa will know of the 50 page errata, use it, and actually go on-line to update the same. The Errata also completely eliminates Dr. Ranavaya's "Constitution" contained in

Chapter 2. Dr. Ranavaya told the Task Force that the 'constitution' in chapter 2 is what gave the 6th Edition its 'internal consistency'. He described it as the 'anchor chapter' of the 6th Edition in that nothing was allowed to contradict Chapter 2's constitution. That 'supremacy clause' has now been eliminated. Its absence presumably results in there being little internal consistency. Dr. Rondinelli was asked to weigh in on this issue, and he demurred, noting only that he did not agree with everything in the 6th Edition.

This process and the resulting text, has been so controversial that many of the state's requiring the use of the latest edition of the Guides have refused its implementation. The process was flawed. The AMA, or its editors, used a very flawed approach in the creation and implementation of the 6th edition. Through no fault of Dr. Rondinelli, the AMA rushed to publish this "Beta draft". The results are what one might expect when a process is not allowed to reach completion.

It is the contention of this Task Force member that the resulting "paradigm shift" announced and adopted by the Editors of the 6th edition is not an improvement over the 5th edition. I believe the resulting paradigm shift would not have been an improvement even if it had been allowed to come to full fruition. It is also my view that its implementation is inconsistent with Iowa law.

The Result Of The Flawed Process = An Unworkable Text That Is Inconsistent With Iowa Law

In order to understand the reasons for the 'paradigm shift' contemplated by the 6th Edition editors, we attempted to speak to those responsible for this shift. Based on our conversation with the doctors and editors who presented to the Task Force, it seems clear

that the chief advantages behind the switch to the ICF model are obtaining funding for research, and the fact that the use of a world-wide approach may allow the AMA to sell its book overseas. That obvious cynicism notwithstanding, the editors own explanations in the sixth (6th) edition (see pp. 3-4) leave this reader quite confused.

One would suppose that the need for a paradigm shift was due to the faulty construction of the AMA's 5th edition and its predecessors. Indeed, the 6th edition notes that the earlier versions of the Guides were 'subject to criticisms" (AMA Guides, 6th, p. 2). Interestingly enough, four (4) of the eight (8) citations to these documented criticisms were made by the chief editor of the 6th edition, Dr. Robert Rondinelli (AMA Guides, 6th, pp. 16-17). Specifically, Rondinelli's criticisms seem to be that previous editions failed to:

- Provide comprehensive, valid, reliable, unbiased and evidence based ratings
- Provide ratings that accurately reflect *loss of function*
- Provide ratings that were more than the representation of legal fiction

In reviewing the 'problems' that required the paradigm shift, it is clear that the 6th edition not only fails to improve these problems, but creates many more of its own.

First, with regard to reliability and validity, the Guides own editors acknowledge, both in print, and to the Task Force, that the 6th edition is not based on <u>any</u> empirical data. How exactly does the 6th claim that it reaches more valid conclusions that the 5th? Both relied on a consensus approach. Both result in numbers that appear to be somewhat 'fictional'. Indeed, upon questioning, several of the doctors and editors who presented to the Task Force conceded that there simply is no "right" or "valid" number to be given to an injured worker for permanent impairment. This is simply a consensus approach. Again,

there is absolutely no indication that the numbers reached in the 6th are superior to those contained in the 5th.

With regard to 'reliability' the concern of the editors of the 6th is that the 5th edition did not result in good interrater reliability ("IRR"). The testimony of Dr. Rondinelli is that the 5th edition only provided ranges of impairment and gave little guidance on how to determine an impairment out of that range. The result is that different doctors produced different results. However, if there was no 'right' answer under the 5th edition, how did the editors, chiefly Dr. Christopher Brigham, conclude that the 5th edition routinely resulted in impairment ratings that were <u>too high</u>? (See 6th Edition, p. 17, endnote 18) (see, Dr. Brigham's article, AMA Guides To The Evaluation Of Permanent Impairment 'Misuse and Abuse")?

Dr. Brigham told the Task Force that he 'studied' a handful of cases, in a handful of states (largely California) and concluded that the initial ratings were 'too high'. Indeed, in an article he published, and in his statement to the Task Force, he indicated the ratings under the 5th Edition were "too high" - 89% of the time. This is a very specific number. This begs the question, if Dr. Brigham could calculate impairment ratings under the 5th edition with enough accuracy to determine that 89% of them were "too high", how exactly is it that the 5th edition, if used properly, failed to result in <u>accurate</u> ratings? Stated another way, clearly if Dr. Brigham could determine that other ratings were 'too high', than obviously he was able to find **<u>the</u>** right rating. Thus, when used properly, the 5th Edition <u>did</u> produce accurate and reproducible ratings, and good (IRR). The issue with the 5th therefore seems not to have been the methodology of the Guides themselves, but rather an issue of training the doctors in

their proper use. Indeed, since the state of California had just switched to use of the 5th edition at the time of Dr. Bringham's "study" one can presume that the doctors had little training and experience in using the Guides. If the lack of adequate training was a problem with the 5th Edition, this problem has only been made worse in the 6th edition.

Both the doctors on our Task Force, and those doctors (Drs. Martin and Melhorn specifically) agreed that the use of the 6th edition requires a great deal of training. It was the opinion of these doctors that few doctors who do not specialize in conducting IME(s) will voluntarily take such training. The medical opinions seem to suggest that the learning curve on the 6th edition is quite steep. This is a critical problem in a system such as Iowa's that depends on employer doctors, in rural areas, to provide impairment ratings. We also must remember in Iowa, employers and insurance carriers select the doctor who imposes the initial impairment ratings. This fact makes it highly unlikely that those doctors rountinely impose ratings that are too high under the AMA 5th edition. One is allowed to presume that a doctor, who gives a rating that seems too high to the insurance adjuster, may receive a phone call inquiring why his ratings are so much higher than other doctors in similar cases. Employer and insurance carriers therefore have an easy fix. They simply send workers to a different doctor who more precisely understands the Guides, or provide their doctor with more training.

Any IRR in the 6th is achieved by forcing doctors to accept a single number, unless they bother to actually go through the additional work and hurdles required to justify a higher or lower number. Under the 6th edition there is little, if any, attempt to actually 'measure' anything. The ratings are based strictly on diagnosis, with minor adjustment

possible for other factors. In short, you tell the doctor your diagnosis, and she will tell you how disabled you are. While this certainly oversimplifies the 6th edition's approach, its diagnosis driven impairment scheme undermines any notion that the 6th 'fixes' or somehow results in rating "numbers" that are more 'valid' or 'accurate'. This approach will no doubt result in some ratings being artificially higher, and some artificially lower. Neither result is acceptable.

If IRR is the true goal, the AMA could simply conclude that all impairment results in a 5% loss, and make their book ten (10) to fifteen (15) pages long, with no need for costly new editions. The IRR would be 100%. IRR is thus not the panacea that the AMA pretends. The question 'how impaired was Mr. Doe as a result of his injury?" cannot be answered without analysis. Any attempt to simplify an inherently complex issue, while laudable, is fraught with peril. This does not benefit either the employer or employees of Iowa.

Regarding bias, the 6th edition likewise misses the mark. As discussed, it used primarily the perspective of doctors and editors who make their livings working for employers and insurance carriers. Many of the tests, including the Dash and Quick Dash, were admitted by Dr. Rondinelli to be culturally insensitive, and result in biased information.

Finally, the 6th edition's new paradigm is not consistent with Iowa law. In Miller v. Lauridsen Foods, 525 N.W.2d 417, 421 (Iowa 1994), the Iowa Supreme Court, noting that we are a loss of function, or loss of use state, held:

> *The determination of functional disability is not limited to impairment ratings established by medical evidence.*

Id at 421(emphasis added).

The 6th edition, by changing its definitions and approach, invades the province of the agency under Iowa law by incorporating concepts of disability and loss of use into the ratings provided. Indeed, Dr. Mark Melhorn admitted to the Taskforce that some of the 6th analysis crosses into the area of disability and loss of use. Dr. Douglas Martin described the change from the 5th to the 6th as "monumental". Dr. Martin also indicated that the biggest change in the 6th edition was its 'focus on function'. Dr. Rondinelli, in his second presentation to the Task Force, stated that the 6th edition attempts to include an injury's impact on an injured worker's Activities of Daily Living ADL(s) in calculating impairment. This clearly steps into the legal realm regarding loss of use and function, and disability. This encroachment is not consistent with Iowa law.

The conclusion that the 6th edition encroaches on the Agency's determination of disability is supported by the fact that the 6th edition incorporates ADL(s) in calculating the underlying impairment rating. This is made more problematic by the fact that there are eight (8) different definitions of ADL(s) used throughout the Guides. Finally, the concept of using pain as a 'modifier' of an impairment rating, and suggesting that pain is already incorporated into the ratings themselves, in entirely problematic. How well is the 6th edition really measuring impact on ADL(s) when pain is largely excluded from that analysis? What the 6th edition does is place a cap on the amount of disability that can be paid for the pain and other impacts an injury has on an injured workers ADL(s). This is in clear

contravention of Iowa law. The 6th edition would be used to argue against any finding that an individual's loss of function exceeds the Guides. Employers will no doubt argue, and obtain opinions, that the impact on an injured worker's daily life, in terms of ADL and pain, has been fully considered by the 6th edition impairment rating. This is entirely inconsistent with Miller v. Lauridsen Foods, 525 N.W.2d 417, 421 (Iowa 1994) and its statement that disability includes more than the medical impairment rating. Disability, loss of function, and loss of use, are questions for the legal system, not doctors.

CONCLUSION

Dr. Alan Colledge spoke to the Task Force and indicated that Utah has created its own rating system that attempts to award "Optimum benefits in an expedient manner." This, it seems to this member, should be the goal of our system. I do not think the 6th edition of the AMA even remotely reaches that goal. I recommend the continued use of the AMA Guides, 5th edition for the time being. I recommend the Commissioner investigate the possibility of no longer relying on the AMA to dictate the nature and level of scheduled member disability under Iowa law.

At a minimum, it is the opinion of this member that the Commissioner should consider strengthening rule 2.4 to affirmatively state that while payment under the 5th is a prima facie showing of compliance, under Iowa law *The determination of functional disability is not limited to impairment ratings established by medical evidence.* The addition of this language to Rule 2.4 is simply a verbatim restatement of Iowa law first set out in Miller v. Lauridsen Foods, 525 N.W.2d 417, 421 (Iowa 1994). It is this member's

belief that the inclusion of this language will facilitate the understanding that disability, even in the scheduled member case, is not limited to medical impairment ratings.