Exhibit **G**

Report by R. Saffin Parrish-Sams, Member of the Iowa Workers' Compensation Commissioner Task Force Regarding the AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition[1]

As stated by the authors of the AMA Guides, Sixth Edition, the Sixth Edition "introduces a 'paradigm shift' to the assessment of impairment." AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition, p. 2. After reviewing the Sixth Edition of the AMA Guides, and hearing from a number of its authors and Editors, this Task Force member remains unconvinced that the "paradigm shift" is necessary, desirable, or consistent with Iowa's Workers' Compensation laws.

Why This Paradigm Shift?

The Task Force attempted to obtain concrete information concerning the identity of the members of the group who decided that a paradigm shift was necessary and desirable. The AMA was apparently unwilling or unable to provide this information, and other authors and editors interviewed appeared not to know, or to evade the question. The best information made available to the Task Force, by Medical Editor Dr. Robert Rondinelli, was that the AMA had called for proposals concerning a Sixth Edition of the AMA Guides to the Evaluation of Permanent Impairment, and Drs. Rondinelli and Katz submitted the sole proposal. The Rondinelli / Katz proposal recommended a new rating paradigm based on the ICF model, which the Sixth Edition refers to as a "comprehensive model of disablement." AMA Guides, 6th Ed., p. 3. The Rondinelli / Katz proposal was then sent to approximately 30 unnamed individuals from various specialty groups within the AMA. With about a 50% response rate from these 30 physicians, most, but not all, of those responding supported the concept of using the ICF as a model for impairment ratings. Thus, the paradigm shift found in the Sixth Edition was implemented based on the conceptual approval given by fewer than 15 unidentified individuals, none of whom were practicing attorneys or workers' compensation commissioners.

The AMA Guides is not usually used by physicians to diagnose, treat or cure any medical condition. It functions almost exclusively as a tool for physicians to use in qualifying and quantifying medical conditions for legal use. *See e.g,* AMA Guides, 6th Ed., p. 37 (acknowledging: "The *Guides* serves the societal role of providing an equitable method of compensating individuals whose ability to function has been compromised by a medical condition."); p. 20 (acknowledging: "Although doctors wrote the Guides, this book is not likely to be used in the practice of therapeutic medicine. The primary purpose of the Guides is to rate impairment to assist adjudicators and others in

[1] This document contains opinions and conclusions which are solely those of the author, based on her investigation and information studied and received to date, and should not be taken to represent the opinions of any other member of the Task Force, unless they specifically state that they concur, or those of any member of Iowa's Workers' Compensation Commission. Where references are made to statements of those who have spoken to the task force, the information presented is to the best of this author's recollection and from notes taken during the question and answer sessions. In addition, due to obvious time limitations and page constraints, this draft is by no means exhaustive in reciting the opinions and conclusions reached by its author.

determining the financial compensation to be awarded to individuals who, as a result of injury or illness, have suffered measurable physical and/or psychological loss.") As such, this Task Force member finds it bothersome that members of the legal system – the ultimate consumers – were not consulted as to whether a paradigm shift was either necessary or desirable, or *what the goals of any paradigm should be* or how it should be structured.

Portions of the introductory chapters to the Sixth Edition tout that the new paradigm is more evidence based. However, according to other portions of the Sixth Edition and its authors and editors the Task Force interviewed, the new paradigm used in the Sixth Edition is no more evidence based than the Fifth Edition or prior editions. *See e.g*, AMA Guides, 6th Ed., p. 9 (acknowledging: "Impairment and disability are complex concepts that are not yet amenable to evidence based definition"); p. 36 (conceding: "The key issue is that most of the conventional ratings in the *Guides* are not validated by empirical research."). Indeed, the Medical Editor for the Sixth Edition agreed that the only "evidence base" for all of the musculoskeletal chapters (those which are primarily used in workers' compensation cases) is level 4 evidence, which is simply a consensus based on the clinical experience / professional opinions of those consulted. Thus, the new "paradigm," and the numerical ratings it mandates, is not based on any form of systematic review, meta-analysis, randomized clinical trials, non-randomized clinical trials, or cohort studies. The new paradigm is based on the same "evidence" as prior editions of the AMA Guides, including the Fifth Edition: consensus and opinions of those consulted.

Since the Sixth Edition and each of its editors and authors interviewed agree that there is no evidence that the paradigm shift more accurately or scientifically reflects impairment or disability, then why the paradigm shift?

The consensus created by an enigmatic group, no matter how highly credentialed they may be, seems an inadequate justification for Iowa to change its current Workers' Compensation system. Despite acknowledging that the legal system is the intended end user of the AMA Guides, the Sixth Edition's Medical Editor, during his interview, and Senior Contributing Editor, in an article, both stated that legal systems are responsible for changing to accommodate the new "paradigm" contained within the Sixth Edition. *See AMA Guides Sixth Edition: Perceptions, Myths, and Insights*, C. Brigham, W.F. Uehlein, C Ujeo, L. Dilbeck, 2008 ("In interpreting reactions by different stakeholders it is important to distinguish between the criticisms of the process and the perceived impact on the stakeholders. *The more significant problems do not lie with the Guides, but rather, with how impairment ratings are used by workers compensation systems or other systems*. The AMA Guides will continue to evolve and improve. The systems that make use of the Guides must also evolve.") This is an incredibly presumptuous position, given that the "paradigm shift" was decided upon by a few individuals, whereas the workers' compensation laws of any given state, including Iowa, are the product of nearly a century of compromises by labor and employers, passed into law by elected officials.

What's Wrong With The Fifth Edition?

The Fifth Edition of the AMA Guides is by no means perfect. The Fifth Edition contains the same concerns regarding the accuracy and lack of empirical evidence

substantiating the impairment ratings as the Sixth Edition. However, Fifth Edition Editors were intellectually honest when they said:

> Most impairment percentages in this fifth edition have been retained from the fourth edition because there are limited scientific data to support specific changes. It is recognized that there are limited data to support some of the previous impairment percentages as well. However, these ratings are currently accepted and should not be changed arbitrarily.

AMA Guides, 5th Ed., p. 5. The Fifth Edition is also problematic in that it does not provide numerical ratings for certain medical conditions which are recognized by the medical community, such as epicondylitis, fibromyalgia, hernias, and mental health disorders, to name a few.

According to both the Sixth Edition and its editors, one of the big criticisms of the Fifth Edition, upon which the claimed need for a paradigm shift was based, was a "high error rate among all ratings." AMA Guides, 6th Ed. p. 2. Unfortunately, the primary study on which the claim of interrater inconsistency was based was performed by Dr. Christopher Brigham, of Brigham and Associates, Inc. at www.impairment.com. *See* AMA Guides, 6th Ed. p. 2, referencing footnote 18. Notably, Dr. Brigham has an obvious financial conflict in making such a determination. As published on Dr. Brigham's web site, his company will perform reviews of impairment ratings assigned by other physicians for a fee: the fee is $95 if he determines that the impairment rating previously assigned is correct, and $195 if he determines that the impairment rating is incorrect. Therefore, Dr. Brigham's company more than doubles its revenues by finding that other physicians provide incorrect ratings. Thus, it is not surprising that Dr. Brigham's company disagreed with 78% of the ratings done by other physicians, thereby finding a very high inter-rater inconsistency between his company's ratings and those performed by others. Nor is it surprising that his company consistently finds the average original ratings done by other physicians are too high, as it justifies the fees charged to defendants, who represent the majority of his client base. See *Erroneous Impairment Ratings*, July 25, 2008, http://www.impairment.com/ezine/ezine-07-25-08.htm; *see also* Brigham, C., *For the Defense: Misuse and Abuse, AMA Guides to the Evaluation of Permanent Impairment*, p. 32 ("The AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, are widely used and most of the impairment ratings are erroneous and higher than appropriate.").

These criticisms are not to say that the Task Force felt that there was no "interrater inconsistency" under the Fifth Edition. Interrater inconsistency does exist in Iowa under the Fifth Edition for a variety of reasons.

First and foremost, it appears we have "interrater inconsistency" because not all physicians in Iowa are using the Fifth Edition correctly. While physicians may say they are assigning an impairment rating under the Fifth Edition, this is often done without reference to a particular chapter and table used, or an explanation of why one particular rating methodology was selected over another, or a recitation of the precise diagnosis, symptoms, examination findings and measurements, and treatment results on which a rating was based.

Second, many of the ratings methods under the Fifth Edition provide a range from which the impairment number should be assigned. Different numbers within that range can be assigned for a variety or reasons. One reason may be that a treating physician is more likely to feel that they have "fixed" any problems by nature of the treatment or surgery, and therefore will assign a lower or no rating, whereas an examining physician is not "vested" in the outcome of treatment and is less likely to downplay ongoing symptoms and limitations, thereby assigning a higher rating. Another reason may be the fact that Iowa's workers compensation system is adversarial. Employer defendants deliberately select physicians to treat injured workers who are known to minimize their ultimate assessment of any permanent impairment, and therefore the legal exposure, to the party (employer / insurance carrier) who hired them. Conversely, employee claimants tend to select IME physicians who give the benefit of the doubt to the claimant who hired them.

The lack of evidence-basis for impairment ratings that is present in the Fifth Edition persists into the Sixth Edition. Similarly, the same potentials pitfalls causing inter-rater inconsistency in the Fifth Edition (improper usage, physicians vested interests in treatment outcomes, and the adversarial nature of the system) will still be present if the Sixth Edition were adopted. Instead of resolving these problems, it appears to this Task Force member that adoption of the Sixth Edition would simply bring on a whole new set of problems, some of which are discussed below, and many of which cannot be predicted.

The Goal of Any Rating Paradigm Should be Accuracy and Fairness

One of the big "selling points" by the Sixth Edition, its editors, and some of the authors interviewed, is the "interrater reliability." The goal of interrater reliability, in and of itself, is misplaced. As stated by one member of the Task Force, if interrater reliability were the goal, we could simply assign everyone a 5% rating, or some other number reached by a "consensus" of physicians. This would provide absolute interrater reliability – at the obvious expense of truth, accuracy, and validity.

The very real, and most important issue in deciding whether to adopt the Sixth Edition, is whether the Sixth Edition provides more accurate, reliable, and valid impairment ratings than the Fifth Edition: Is it more fair?

As used in the Iowa workers' compensation system, impairment ratings are meant to qualify and quantify the permanent functional impact of a medical condition <u>on the individual to whom the rating is assigned</u>. Therefore, the goal should be a rating system which <u>accurately and reliably reflects impairment of a given individual</u>. Such a system might actually and accurately have little interrater reliability for different individuals who have been given the same diagnosis. Medical science simply is not so highly developed that all persons with the same diagnosed condition will end up with the same permanent outcome. Even the Sixth Edition acknowledges that "Diagnosis should be evidence based, however, the impact of injury or illness is dependent on factors beyond physical and psychological aspects, including psychosocial, behavioral and contextual issues." <u>AMA Guides</u>, 6th Ed., p. 9.

Medicine is not so precise that all persons with the same diagnosis can receive treatment and wind up with the same result. The Sixth Edition paradigm shift seeks to make something consistent and set in stone that is widely variable from person to person

– and therefore will be inaccurate as applied to many individuals – in exchange for consistency. The Fifth Edition, in addition to providing a means for assigning diagnosis-based impairment ratings, at least enables a physician to use clinical judgment and alternatively account for actual physiological functional losses by using ROM, strength, or adding up to 3% to an impairment rating for the limitations caused by pain when warranted. This method may have made the ratings less consistent from patient to patient. However, intellectual honesty will allow for the fact that not all people are the same in terms of their capacities to endure, heal, and overcome, nor are all people provided the same level of care and treatment, nor do they all receive it timely, or under the same optimal circumstances enabling the maximal recovery.

The Negative Affects of the Complexity and High Learning Curve Associated with the Sixth Edition

The Sixth Edition of the AMA Guides is very labor intensive, according to both the physician members of the task force and Sixth Edition Editors who spoke to this panel. The minimum time to initially learn the Sixth Edition methodology is estimated to be between 25 to 30 hours if self taught, or 8 hours if learned through a training course. This does not include "practice" time in learning to draft reports under the Sixth Edition. One of the Sixth Edition Editors specifically advised against self-teaching, stating training courses are necessary to understand and use the Sixth Edition correctly. Training courses require travel, payment of fees, and time away from one's practice. In reality, very few physicians in Iowa will have the incentive to spend the 25-30 hours to self-teach, or to spend the time and money to train themselves. This is especially true of the numerous physicians in rural locations in Iowa who see workers' compensation patients as a small part of a more general practice.

As a result of the steep learning curve and initial resource investment (time and money) associated with the Sixth Edition, Iowa will either end up with very few physicians who will do ratings, or equally as problematic, very few physicians who will do them correctly. The heightened potential for incorrect ratings under the Sixth Edition is demonstrated by the fact that the Fifth Edition, despite providing an impairment rating system that is simpler than the Sixth Edition, is not always followed. This does not bode well for "interrater reliability," one of the big selling points by the Sixth Edition editors. In addition, Iowa will remain an adversarial system, and the tendencies of the respective sides to find supportive physicians will not change.

For those physicians who would undertake training and provide ratings under the Sixth Edition, their time to do ratings will increase, thus their charges to perform ratings will likely increase. In addition, if rural physicians refuse to provide ratings because of the significant time and/or monetary investment necessary to learn the Sixth Edition, travel costs associated with obtaining impairment ratings will increase. These factors will increase the cost of obtaining ratings for both employees and employers, much of which will be passed on to the insurance companies via Iowa Code § 85.39.

In addition, some sections of the Sixth Edition, such as upper extremity neuropathies, require diagnostic testing if a rating is to be given. *See* AMA Guides, 6th Ed., p. 445 ("If nerve conduction testing has not been performed or does not meet this section's diagnostic criteria, there is no ratable impairment from this section.") This

requirement will either result in increased treatment costs for employers – who will be required to pay for pre-operative nerve testing that may not have been considered diagnostically necessary in order to provide treatment before – or decreased compensation for employees – who will not be rated under the Sixth Edition with anything other than "vague wrist pain," if at all, in the absence of pre-operative EMG data. *See* AMA Guides, 6th Ed. p. 446 ("The pre-operative electrodiagnostic test should be used in the impairment rating"). In Iowa, where employers choose treating physicians, it is of great concern that the Sixth Edition enables employers to effectively deny more accurate and potentially much higher upper extremity impairment ratings by simply selecting surgeons who do not require pre-operative EMGs if clinical signs of entrapment are present. *See* AMA Guides, 6th Ed., p. 446 ("Physicians may choose to use different values when diagnosing focal nerve compromises for treating purposes."). By the time a claimant gets their single IME under 85.39, it will nearly always be too late for the claimant to get the pre-operative EMGs required for a rating under the Sixth Edition.

Values Derived by Consensus Are Influenced By Those Who Are Included In, or Excluded From, the Consensus Process

It is abundantly clear that there is nothing evidence based about impairment ratings. Both the Fifth Edition and Sixth Edition of the AMA Guides are simply different models for providing impairment ratings, with no scientific studies or evidence to prove they are accurate or reliable. Within those models, we have only consensus amongst the individuals who were asked to provide their opinion. As such, it is important to understand any biases of those who were involved in providing opinions or reaching consensus.

One of the concerns of this task force is the lack of transparency as to whose opinions were obtained. As stated above, the Task Force could not get concrete information from the AMA or otherwise as to the precise identity of the individuals who decided to adopt the new paradigm. There is no separate list identifying the authors or contributors for each of the Sixth Edition's separate chapters. When directly asked, the AMA failed to provide the Task Force with this information. It also appears that "consensus" may have been reached in the Sixth Edition, because those who were initially consulted and had differing opinions were no longer part of the "consensus" group by the time the "consensus" was reached.

Dr. Rhondinelli and others[2] provided great insight into the extreme caution that one must have in adopting a final product based on consensus, without knowing the biases of the individuals who reached the consensus, and the forces compelling the consensus. According to the individuals interviewed, the persons involved in the Sixth Edition "consensus" process were those with the interest, inclination, and resources to be involved, which resulted in an employer-oriented group of individuals without a good cross-section of the physician membership or representation by all interested parties. Dr. Rondinelli informed the Task Force that his initial belief was that, given that the editors selected for the Sixth Edition all favored the paradigm shift, the process of reaching

[2] This Task Force member would particularly like to thank Dr. Rhondinelli, Dr. Martin, Dr. Melhorn, and Dr. College, whose forthrightness in responding to pointed questions was greatly appreciated.

consensus would be easy. Instead, agendas came out, and the Sixth Edition became "a victim of the individuals who come to the table," with eleventh hour "arm twisting" of those with agendas who had not "bought into the structure of this new paradigm," in order for the editors to meet the AMA's publishing deadline.

It is also abundantly clear that a move from the Fifth Edition to the Sixth Edition will have far reaching consequences on the compensation paid to individuals under our workers' compensation system. It is true that Iowa's higher courts have specifically held that: "The determination of functional disability is not limited to impairment ratings established by medical evidence." *Miller v. Lauridsen Foods, Inc*. 525 N.W.2d 417, 421 (Iowa 1994) (finding reversible error for relying solely on an impairment rating given under the AMA Guides and failing to consider all of the evidence concerning functional disability, including lay testimony, and remanding for consideration of permanent functional impairment and penalties) *See also Christensen v. Snap-On Tools Corp.*, 554 N.W.2d 254, 257 (Iowa 1996) (stating that: "In considering the compensation due to these [scheduled member] injuries, the commissioner on remand, must consider all evidence, both medical and nonmedical. Lay witness testimony is both relevant and material upon the cause and extent of injury"); *Terwilliger v. Snap-On Tools Corp.*, 529 N.W.2d 267, 273 (Iowa 1995) (requiring consideration of both medical and non-medical evidence in determining permanent impairment).

However, in practice the overwhelming majority of attorneys, insurance adjusters, workers' compensation deputies, and judges have long used the impairment rating assigned under the Guides as the sole factor in determining the "extent of disability" to a scheduled member injury. Iowa Code §85.34(2)(a)-(t). It is the rare exception when attorneys argue, or the deputies or courts order, a disability payment for a scheduled member which goes beyond the impairment rating assigned by the Guides. This practice will not change, especially with respect to the majority of claimants in Iowa who are unrepresented by an attorney, absent a successful legal challenge to Commissioner's Rule 876-4.2, statutory changes that would be adamantly opposed by business and industry, and changes to our penalty laws. Therefore, it is difficult to recommend adoption of this consensus publication as being the measure of "fairness" or "justice" in our workers' compensation system, given the lack of transparency concerning the members of the consensus and their biases.

Iowa Should Not Attenuate Its Citizen's Rights to Guinea Pig Status

One of the big criticisms of the AMA, by contributors interviewed and articles read, was that a walk through of the Fifth Edition versus the Sixth Edition should have been done up front, before finalizing and releasing the Sixth Edition. This task force member wholeheartedly agrees. Iowa's employers and employees should not be a guinea pig for an untested, unstudied, "paradigm shift" about which Iowa's constituents were not consulted. It is an improper abrogation of the legislative and judicial power to adopt a "paradigm shift" decided upon by a small, enigmatic group of physicians, especially when that product has the potential to significantly alter the disability payments received by injured Iowans.

In Iowa, the issue of how disabled an injured worker has become has always been a legal question, not a medical question, to ultimately be decided by the workers'

compensation deputies and commissioner as the finders of fact. This has been true whether the injury is compensated based on an industrial disability, or a scheduled member disability. *See Miller*, 525 N.W.2d at 421; *Christensen*, 554 N.W.2d at 257; *Terwilliger*, 529 N.W.2d at 273. In contrast to our laws, the authors and editors interviewed, and the Guides themselves, make it abundantly clear that the paradigm shift used in the Sixth Edition "crosses the bridge into," "attempts to determine," and "is a surrogate for" legal disability. *See also* AMA Guides, 6th Ed., p. 5 (defining "impairment rating" to include the disability concept of "the degree of associated limitations in terms of ADLs.").

Very plainly, disability cannot, and should not, be a medical determination, as disability from a given diagnosis can be extremely different from person to person, and includes a plethora of non-medical factors on which medical professionals have no expertise. *See* AMA Guides, 6th Ed., p. 5 (acknowledging: "Most physicians are not trained in assessing the full array of human functional activities and participations that are required for comprehensive disability determinations."). Physicians cannot and should not be the ultimate arbiter who hears all of the evidence and determines whether a functional impairment impedes an individual's activities or participation in life situations. It has always been, and must remain, the role of Iowa's courts to ultimately determine disability, after presentation of complete and competing evidence.

Furthermore, the Sixth Edition itself concedes, "the relationship between impairment and disability remains both complex and difficult, if not impossible, to predict." AMA Guides, 6th Ed., p. 5. It therefore seems disingenuous for the editors of the Sixth Edition, with the institution of its grid and modifier paradigm which stacks the deck in favor of consistency, to purport to measure disability: "the degree of associated limitations in terms of ADLs." AMA Guides, 6th Ed., p. 5. It is even more bothersome that the Sixth Edition goes on to include numerous "disability" value judgments which substantially change the manner in which "functional impairment" has traditionally been assessed, and, as a corollary, will change how the identical condition is compensated under the Fifth Edition and Sixth Edition. For example, the Sixth Edition dictates that if you have two nerve entrapments, you rate the second entrapment at only 50% of the first, and if you have three nerves entrapped, you do not even rate the third nerve entrapment, despite the documentation of compromised physiological function of the second and third nerve. AMA Guides, 6th Ed., p. 448.

According to Dr. Rondinelli, and suggested by several others interviewed, despite this "paradigm shift" being "a major departure" from anything that had been done in the past, "we didn't have enough diligent review when done to make sure it was done correctly….. The time frame when we had to get rolling there was an overwhelming amount of work to do." Dr. Rondinelli personally expressed concern about this rush to Barry Bolus and others at the AMA, but was essentially told "too bad" because of a date the AMA had agreed upon with the publishers. Now, only eight months after publication, a 52 page errata has been published, because there was "no diligent assessment of the beta draft" and the AMA is now doing "damage control." The Task Force was also told that additional errata, or perhaps even internet-based evolving errata, were expected. This is a stark contrast to the single, 16 page errata to the Fifth Edition that was published in 2002, two years after the Fifth Edition was first published.

It came to the attention of the Task Force that Sixth Edition questionnaires, such as the Dash and Quick Dash, are not culturally sensitive, nor have they been tested to determine the reading proficiency level which a native English speaker must possess in order to be able to read, understand, and answer the questions appropriately. Lack of cultural sensitivity means that the Dash and QuickDash questionnaires may provide invalid (artificially high or low) scores for any of the numerous and diverse non-anglo cultures existing in the US, based on answers that are influenced by non-anglo cultural norms. Lack of reading level proficiency testing means these questionnaires may result in invalid (artificially high or low) scores for anglo persons with lower educational levels.

The Sixth Edition concedes that another well-known assessment, Waddell's signs, "are not valid in non-Anglo cultures, as their reliability has been tested only among English and North American patients." AMA Guides, 6th Ed., p. 27. Surprisingly, however, the Sixth Edition Editors failed to include this same caution with respect to their own untested questionnaires. Even more surprisingly, this issue / omission was not even addressed in the recently published, 52 page errata.

The lack of such sensitivity and proficiency testing for these particular questionnaires is problematic. The Dash and QuickDash scores are not only used as part of the "net adjustment formula" which can modify the normal impairment ratings, (AMA Guides, 6th Ed., p. 411); if the scores are inconsistent with other modifiers by 2 or more grades then the grade modification process is thrown out entirely, (AMA Guides, 6th Ed., pp. 406-407); and if they are simply too high (above 60) then the claimant may be classified as a symptom magnifier or in need of a psychiatric diagnosis. (AMA Guides, 6th Ed., pp. 447-448).

It was suggested to the Task Force by Dr. Rondinelli that, given the lack of cultural sensitivity in these tools, the questionnaires simply not be utilized with members of a minority population. However, a system which encourages different methodologies for assigning impairment ratings for persons of different cultures, especially one which eliminates a potential avenue for minorities to have their impairment ratings "modified" so as to provide them with the same compensation for the same injuries, is believed to be poor policy at best, and more possibly discriminatory. Such an oversight by the AMA, given the multicultural composition and divergent educational (reading) level of this nation's work force, is troubling. It is this Task Force member's firm belief that Iowa should not discriminate by using these tools only for Anglos, nor risk the potential for discrimination by using these tools when their affect on minorities and less educated individuals is unknown.

Task Force Resolutions Supported by This Task Force Member

The Sixth Edition editors have stated:

> The Guides serves the societal role of providing an equitable method of compensating individuals whose ability to function has been compromised by a medical condition. For the Guides to carry out this role, it must be perceived as fair. To be perceived as fair, the Guides must employ assessment procedures that are reliable and valid, rather than capricious ones that can be manipulated by persuasive patients.

AMA Guides, 6th Ed., p. 37. This task force member agrees that for the Sixth Edition Guides to carry out its intended role, it must be perceived as fair, and that to be perceived as fair, it "must employ assessment procedures that are reliable and valid." Unfortunately, not only does the "paradigm shift" lack an evidentiary basis to justify the shift, the Sixth Edition has valued consistency over "reliable and valid" results. It has failed to insist upon transparent drafting procedures that involve and consider the needs and opinions of the relevant end users of the Guides, and instead seeks to impose a "paradigm shift" validated only by an enigmatic consensus process that could easily "be manipulated by" a few "persuasive" physicians. As these same few stated: "doctors providing independent medical examinations and expert testimony must be aware that their opinions must be supported by scientific evidence or they lose credibility." AMA Guides, 6th Ed., p. 27-28. The Sixth Edition fails to present a credible case, supported by scientific evidence, for Iowa to adopt this new paradigm as a prominent component of our justice system.

As such, as a member of the Task Force I did not support adoption of all, or any part of, the AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition. Instead, I voted that "the emergency amendment to rule 2.4, with the substituted language the task force has recommended (discussed below), should be made permanent." My view on this matter may have been very different if there had been involvement of the legal system in formulating the Guide's goals; transparency and actual consensus with the involvement of all interested parties; greater simplicity; diligent review and resolution prior to publication of important issues including cultural sensitivity; and clear delineation between the appropriate role of the medical community and the legal community in determining disability.

I am greatly concerned about the extent to which Iowa's system for administering justice between injured workers and their employers has been historically tied, in the form of AMA Guides-based impairment ratings, to the agenda of the AMA and the physicians it unilaterally selects to put out a consensus publication, without any input from the legal community as to the identity of those involved, or the goals to be achieved. However, I voted at this time against Iowa developing its own impairment guide for either scheduled member or body as a whole conditions. I think it is a bit premature, and perhaps a bit presumptuous, for this Task Force to make this recommendation at this time. This position is, in part, based on the monumental nature of such a task. It is also based on the recent outcry by legal systems and organizations across this country that will hopefully foster greater cooperation between the medical and legal community in producing future editions of the Guides. It is also based on my agreement with the Task Force's conclusion that:

> It is premature to determine how the Sixth Edition AMA Guides will change the ultimate impairment ratings assigned across all systems. Information has been presented that some ratings, will go up, some will go down, some will stay the same. However, there is insufficient information to predict the overall change in ratings.

Instead, I strongly favor the Task Force's recommendation that "the Iowa Workers' Compensation Commissioner consider developing a rating system either by rule or legislation for recognized medical conditions that are not rated under the Fifth Edition."

Providing a uniform means for rating impairment from well-recognized medical conditions (such as mental health, tendonitis, hernias, fibromyalgia, and certain nerve entrapments, to name a few) that are not specifically addressed in the Fifth Edition of the Guides, is an essential component of a valid justice system which looks to medical Guides to establish, or as a component of establishing, compensation.

Finally, Commissioner's Rule 876-2.4, as currently drafted, is inconsistent with the Iowa Supreme Court's repeated affirmation that: "The determination of functional disability is not limited to impairment ratings established by medical evidence." *Miller v. Lauridsen Foods, Inc*. 525 N.W.2d 417, 421 (Iowa 1994) (finding reversible error for relying solely on an impairment rating given under the AMA Guides and failing to consider all of the evidence concerning functional disability, including lay testimony, and remanding for consideration of permanent functional impairment and penalties) *See also Christensen v. Snap-On Tools Corp.*, 554 N.W.2d 254, 257 (Iowa 1996) (stating that: "In considering the compensation due to these [scheduled member] injuries, the commissioner on remand, must consider all evidence, both medical and nonmedical. Lay witness testimony is both relevant and material upon the cause and extent of injury"); *Terwilliger v. Snap-On Tools Corp.*, 529 N.W.2d 267, 273 (Iowa 1995) (requiring consideration of both medical and non-medical evidence in determining permanent impairment).

In order to be consistent with Iowa Law, I agree that "the first sentence of rule 2.4 should be amended to have the word 'disability' struck, and insert in lieu of that word 'impairment or conditions compensable'." Likewise, to be consistent with Iowa Law, I agree that the Commissioner should "amend Rule 2.4 to add language consistent with *Miller v. Lauridsen Foods*, 525 N.W.2d 417, 421 (Iowa 1994), to state that 'The determination of functional disability is not limited to impairment ratings established by medical evidence'." Finally, as a pure public policy matter, I believe the Rule should be amended because it is best not to abrogate legislative and judicial power and responsibility to protect Iowa's citizens, by equating justice for injured Iowans with a number selected in accordance with any "consensus" paradigm decided upon by a small, enigmatic group of physicians who have never seen, nor treated, that injured individual.