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Assessing Impairment and Disability in the Pain Patient

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Introduction

Assessing impairment and/or disability in the pain patient is often difficult due to both administrative and clinical issues; yet this assessment is often requested. Administratively, it is complicated by numerous state, federal, and private systems and policies that have different definitions and benefit systems. Clinically, quantifying pain remains problematic as chronic pain is a subjective phenomenon, often associated with confounding behavioral, characterological, personality, and psychological issues. Additionally, the terms *impairment* and *disability* are often misunderstood. Furthermore, underlying personality structure, motivation, and psychiatric comorbidity are often determinates for disability. Chronic pain complaints may be associated with significant disability.[1] Typically, the physician does not define disability, rather the physician defines clinical issues, functional deficits, and, when requested, impairment. Disability is most often an administrative determination.

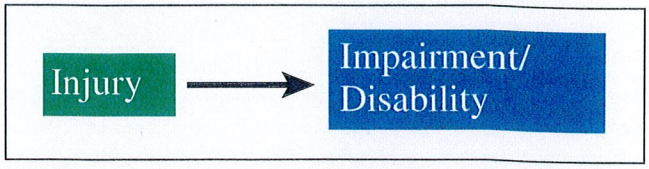
Chronic Pain is Common

Pain is the most common cause of disability, with chronic low back pain alone accounting for more disability than any other condition.[2] More than one-third of Americans in their mid-50s and older have chronic pain in their neck or back, and a similar percentage report chronic knee or leg pain.[3] Disability related to back pain has increased, although there is no significant change in back injuries or pain.[4,5] Headache disorders are frequently associated with work loss.[6] Despite advances in physiologic understanding and interventions, challenges associated with chronic pain and disability increase. The high prevalence of chronic pain in the population is often overlooked in workers' compensation and personal injury claims, where ongoing pain is often misinterpreted as not only an indication that injury or illness occurred but that it has also left permanent residuals manifested in the pain.[7]

Illness Behavior

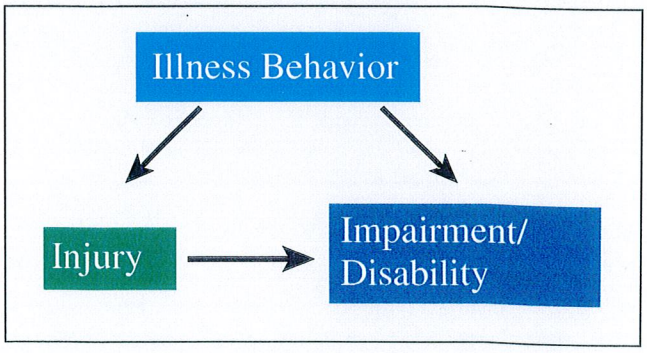
Psychogenic pain, which can be present with or without physical pathology, must be identified. Psychogenic pain is often associated with illness behavior. Illness behaviors are the observable actions and conduct that express and communicate a person's own perception of health. Illness behaviors are related to both illness and injury and to impairment and disability and may partially or completely explain the association between these states. The presumed relationship between illness or injury and impairment or disability is illustrated in Figure 1.

FIGURE 1. Presumed Relationship Between Injury and Impairment/Disability



The confounding influence of illness behavior on injury, illness, impairment, and disability is illustrated in Figure 2.

FIGURE 2. Confounding Influence of Illness Behavior on Injury, Illness, Impairment, and Disability



Failure to recognize illness behavior as a confounding influence in the relationship between illness and injury and impairment and disability explains apparently anomalous outcomes such as reports of substantial pain and incapacity that are not expected or explained on the basis of objective pathology.

Illness behaviors can be appropriate or inappropriate and occur along a continuum from unconscious and unintentional behaviors to behaviors that are conscious and intentional. In this context, unconscious refers to mental processes significant in determining behavior but of which a person is unaware. For example, a wife exhibiting a marked increase in pain behavior in the presence of an attentive and supportive husband can be unaware of the association between her behavior (which is voluntary) and the behavior of her husband (which is the motivation for her behavior). Complicating matters somewhat,

consciousness of actions (voluntariness) is not the same as consciousness of motivation (intentionality).

Illness behavior is reinforced by various secondary gain factors, including treatment by multiple medical professionals, relief from occupational responsibilities, relief from household responsibilities, attention and support of spouse and family, relief from or assistance with parenting children, and the potential for financial compensation. Inappropriate illness behavior is associated with factors such as mistaken beliefs, refusal to consider alternative explanations for symptoms, misattribution of symptoms, falsification of information, fabrication of complaints, manufactured disease, and exaggeration for profit or revenge.

Somatization

Somatization often contributes to inappropriate illness behavior. Somatization refers to a person's unconscious use of their body or bodily symptoms for psychological purposes or personal gain. In the *AMA Guides,* Sixth Edition, it is defined as "a tendency to experience and report somatic complaints (physical symptoms) in response to psychosocial stressors and seek health care services for them" (6th ed, 614). Somatizing persons report physical symptoms that lack a physical explanation, misattribute their symptoms to disease, and seek medical attention for them. Somatization occurs in 2 forms. In the first, there is no objective organic abnormality and the symptoms are literally psychogenic. In the second, an organic abnormality is present, but the patient's response to it has become exaggerated or inappropriate.

The process of somatization contributes to a number of diagnoses, including somatoform disorders as construed by the *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition, Text Revision (DSM-IV-TR)[8] and to somatic symptom disorder as construed by the DSM-5.[9] Somatoform disorders are mental disorders in which the presence of physical symptoms suggests a medical disorder, but the symptoms are not explained fully by a medical disorder. The physical symptoms of somatoform disorders are involuntary and not intentional. In contradistinction, the physical symptoms of factitious disorder and malingering are voluntary and intentional. The difference between factitious disorder and malingering is that the symptoms of factitious disorder are produced for no apparent gain, whereas the symptoms of malingering are produced for gain (eg, avoiding criminal prosecution, obtaining drugs, avoiding work, and financial compensation). Factitious disorder is a mental disorder, but the DSM does not confer disease status to malingering. Table 1 compares the essential features of these entities.

TABLE 1. Disorders and Characteristics

	Symptoms for Gain	Deceptive State of Mind	Mental Disorder
Somatoform Disorder (DSM-IV)	Yes	No	Yes
Somatic Symptom Disorder (DSM-5)	Yes	No	Yes
Factitious Disorder (DSM-IV, DSM-5)	No	Yes	Yes
Malingering	Yes	Yes	No

The essential feature of somatoform pain disorder is preoccupation with pain in the absence of physical findings that adequately account for the pain and its intensity, as well as the presence of psychological factors that are judged to have a major role. Somatization is defined as a person's conscious or unconscious use of the body or bodily symptoms for psychological purposes or psychological gain.[10, 11] Somatization is characterized by the propensity to experience and report somatic symptoms that have no pathophysiologic explanation, to misattribute them to disease, and to seek medical attention for them. Somatization can be acute or chronic and may be associated with medical comorbidity, an underlying psychiatric syndrome, a coexistent personality disorder, or a significant psychosocial stressor.[12] Somatoform disorders, factitious disorders, and malingering represent various degrees of illness behavior characterized by the process of somatization.

Somatic Symptom Related Disorders

In DSM-5, somatoform disorders are referred to as "somatic symptom and related disorders." The DSM-5 classification reduces the number of these disorders and subcategories to avoid problematic overlap. Diagnoses of somatization disorder, hypochondriasis, pain disorder, and undifferentiated somatoform disorder have been removed. DSM-5 recognizes that individuals with somatic symptoms plus abnormal thoughts, feelings, and behaviors may or may not have a diagnosed medical condition. In DSM-5, some individuals with chronic pain would be appropriately diagnosed as having somatic symptom disorder, with predominant pain. For others, psychological factors that affect other medical conditions or an adjustment disorder would be more appropriate. It is important

to recognize that in chronic pain states physical and psychological factors typically are both present and overlap and that a quality physical examination is critical before dismissing the problem as being purely psychological.

Biopsychosocial Approach

The biopsychosocial approach is currently viewed as the most appropriate perspective to the understanding, assessment, and treatment of chronic pain disorders and disability.[13, 14] Chronic pain reflects a complex and dynamic interaction among biological, psychological, and social factors.

Pain, Impairment, and Disability

Pain, impairment, and disability may coexist or be independent. Pain is a subjective experience defined by the International Association for the Study of Pain as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage."[15] Impairment is defined in the *AMA Guides* Sixth Edition[16] as "a significant deviation, loss, or loss of use of any body system or function in an individual with a health condition, disorder, or disease." Typically, the *AMA Guides* determine impairment on the basis of specific objective findings, rather than on subjective complaints. The *AMA Guides* defines disability as "an umbrella term for activity limitations and/or participation restrictions in an individual with a health condition, disorder or disease." Waddell notes that pain is a symptom, not a clinical sign, or a diagnosis, or a disease, whereas disability is restricted activity.[17] Managing pain does not guarantee that the disability will lessen or resolve. There is not a direct relationship between pain and disability.

Although it is appealing to define disability on the basis of objective as opposed to subjective factors, this is not always the case. The Institute of Medicine's Committee on Pain and Disability and Chronic Illness Behavior concluded that "the notion that all impairments should be verifiable by objective evidence is administratively necessary for an entitlement program. Yet this notion is fundamentally at odds with a realistic understanding of how disease and injury operate to incapacitate people. Except for a very few conditions, such as the loss of a limb, blindness, deafness, paralysis, or coma, most diseases and injuries do not prevent people from working by mechanical failure. Rather, people are incapacitated by a variety of unbearable sensations when they try to work."[18]

Assessing disability in the pain patient is thus a challenging endeavor. While some individuals present with a clear and direct connection between pathology and loss of function, it is problematic to measure loss of functional ability in the individual whose behavior and perception of disability and functional loss is significant, sometimes far exceeding that which would be expected from the physical pathology. Some people with chronic pain seek the designation of being "disabled" because of perceived incapacity associated with their portrayed pain and physical dysfunction. For some, seeking such designation is a logical extension of suffering a loss of capacity and utilizing an available benefit system. Others may portray being disabled as a reflection of anger, dissatisfaction, or a sense of entitlement. Individuals vary in their resiliency skills and in how they deal with subjective experiences such as pain.

For some, the designation of being disabled is more complex and may involve seeking attention and/or other benefits that for some observers may seem excessive, unreasonable, and unnecessary. The request for assistance or insurance benefits may take various forms such as a disability parking permit, avoiding waiting lines, housing assistance, help with household chores, and benefits such as monetary payments or subsidies. The individual may claim incapacity (including from work) and request disability benefits under various private, state, or federal programs.

The physician who performs a clinical evaluation that will be used to determine disability should perform a biopsychosocial assessment, recognizing the array of factors that relate to the experience of pain and disability. From a physical perspective, it is necessary to clarify the physical pathology. Some pathology cannot be directly measured (eg, headache or neuropathic pain) and other pathology may have been missed (eg, a tumor, herniated disk, or complex regional pain syndrome). There may be other problems secondary to problems with chronic pain, such as physical deconditioning and secondary psychological issues. Two individuals with similar injuries and resulting pathological changes may present with distinctly different experiences and perceptions. The first may have little or no complaints or perceived disability, while the second individual may present with significant pain behavior and dysfunction.

There may be other nonphysical (psychosocial, behavioral, and cultural) ramifications that may help explain the second individual's pain presentation and assertion of functional loss despite physical findings that do not support the reported disability. Assuming the individual is presents in an honest and credible manner, the physician then must opine on impairment or functional issues, considering physical factors as well as these other nonphysical factors. If requested, the physician may also opine on disability. Opining on disability requires an

understanding of specific definitions of disability and often specific occupational functional requirements.

Inappropriate illness behavior is common, particularly in the context of subjective experiences such as chronic pain or litigation. When the individual is not credible or there is purposeful misrepresentation such as malingering, it may not be possible to accurately define any disability.

The assessment of disability associated with chronic pain is complex, and the evaluator must approach the clinical evaluation with recognition of the many factors associated with the experience of pain and disability.

Symptom Magnification and Malingering

Symptom magnification, inappropriate illness behavior, and embellishment are not uncommon (malingering is less common but occurs and should be considered), particularly in medicolegal circumstances and entitlement programs. Therefore, evaluators need to consider whether the presenting complaints are congruent with recognized conditions and known pathophysiology and have been consistent over time. The evaluator should also determine if there is inappropriate illness behavior.

Pain behaviors (ie, facial grimacing, holding or supporting the affected body part or area, limping or having a distorted gait, shifting, exhibiting extremely slow movements, showing rigidity, moaning, or using a cane inappropriately) may indicate symptom magnification.

Nonorganic findings, that is, findings that are not explained by physical pathology, may also support a conclusion of symptom magnification. Nonorganic findings have been described dating back to the early part of the 20th century.[19] Since that time, a number of nonorganic signs have been defined.[20] In an effort to maximize information from the evaluation, physicians routinely test for nonorganic physical signs. Waddell et al. described 5 signs to assist in determining the contribution of psychological factors to patients' low back pain.[21] They were specifically interested in developing screening tests that could be used to determine the likelihood a patient would have a good outcome from surgery. The physician may perform all 5 Waddell tests—evaluation for excessive tenderness, regional weakness, overreaction, distraction, and simulation. Isolated positive signs have no clinical or predictive value, and the presence of 3 or more positive signs is considered clinically significant. These tests were not designed to detect malingering.

Malingering is defined in the DSM-IV-TR[8] as the "intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs." The DSM-IV-TR states:

> Malingering should be suspected if any combination of the following is noted:
>
> 1. Medicolegal context of presentation (eg, the person is referred by an attorney to the clinician for examination)
> 2. Marked discrepancy between the person's claimed stress or disability and the objective findings
> 3. Lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regimen
> 4. The presence of Antisocial Personality Disorder

In DSM-5, malingering receives a V code as one of the other conditions that may be a focus of clinical attention. DSM V codes identify conditions other than a disease or injury and are also used to report significant factors that may influence present or future care.

Malingering occurs at the end of a spectrum, from embellishment to symptom magnification to blatant misrepresentation. The possibility of obtaining disability benefits or financial rewards or being relieved from other responsibilities such as work increases the likelihood of malingering. Patients may unconsciously or consciously exaggerate their symptoms. With malingering, the intent is purposeful. Ill-defined complaints that occur in a circumscribed group, perhaps in a setting of poor morale or conflict, also may be viewed with suspicion. If there are suggestions of significant illness behavior or malingering, a careful investigation that includes a multidisciplinary evaluation and psychological testing may be required.[22, 23]

Treating Physician vs Independent Medical Evaluator

The treating physician who has a doctor–patient relationship with the claimant may have a different perspective than the "independent" medical evaluator (IME). The treating physician often takes a patient-advocate role and may have little desire or experience to comment on impairment or disability, nor will that physician be able to define these issues in an independent manner.[24]

Frequently, conflict and distrust develop between claimants and the independent evaluating physicians who evaluate them and the claims examiners who handle their claim. Patients often report that their problem is being discounted, while physician disability evaluators and claims representatives may express doubt and skepticism about a claimant's chronic pain complaints and reported loss of functional capacity.

The physician has the predicament of viewing the subjective reports in relationship to the objective evidence of tissue damage or organ pathology to come up with some final assessment about the extent to which the patient really is disabled from functional activities. It is not difficult to see how the treating physician who advocates for the patient will have a different perspective than the independent physician who evaluates a claimant for disability.

The independent medical evaluator is also not without his or her biases, and in some jurisdictions, only plaintiff and defense IMEs are the norm. The "true" IME is used

by both sides and in some settings is referred to as the "agreed" medical evaluator; yet this may also be problematic if the evaluator attempts to "please" each side.

When the physician provides treatment, the doctor–patient relationship is one of trust. The physician is acting as an agent for the patient. When performing a disability evaluation, the physician is acting as an agent for the state or agency that requested the evaluation. In 1992, Sullivan and Loeser recommended that physicians should ethically refuse to do disability evaluations on patients they are treating.[25] The problem with this is that adverse consequences may ensue for the patient who may be cut off from benefits absent a signed disability form.

Impairment vs Disability

The 2 main terms used when discussing disability are *impairment* and *disability.* The following definitions are from the *AMA Guides,* Sixth Edition, the World Health Organization (WHO), and various state and federal programs.

The *AMA Guides,* Sixth Edition defines disability as "an umbrella term for activity limitations and/or participation restrictions in an individual with a health condition, disorder or disease." The *AMA Guides,* Sixth Edition defines impairment as "a significant deviation, loss, or loss of use of any body system or function in an individual with a health condition, disorder, or disease." The *AMA Guides,* Sixth Edition, published in December 2007, introduced new approaches to rating impairment. The leadership for this edition was provided by Robert Rondinelli, MD, an experienced physical medicine and rehabilitation physician; this edition reflects principles of this specialty. An innovative methodology is used to enhance the relevancy of impairment ratings, improve internal consistency, promote greater precision, and simplify the rating process. The approach is based on a modification of the conceptual framework of the WHO's *International Classification of Functioning, Disability, and Health* (ICF),[27] although the fundamental principles underlying the *AMA Guides,* Sixth Edition remain unchanged.

WHO defines impairment as "any loss or abnormality of psychological, physiological or anatomical structure or function." Problems in body function or structure involve a significant deviation or loss. Impairments of structure can involve an anomaly, defect, loss, or other significant deviation in body structures. The ICF[26] changes the emphasis from the word "disability" to "activity" and "activity limitation." ICF defines activity as "something a person does, ranging from very basic elementary or simple to complex." Activity limitation is "a difficulty in the performance, accomplishment, or completion of an activity. Difficulties in performing activities occur when there is a qualitative or quantitative alteration in the way in which activities are carried out. Difficulty encompasses all the ways in which the doing of the activity may be affected."

Federal and state agencies generally use a definition that is specific to a particular program or service. To be found disabled for purposes of Social Security disability benefits, an individual must have a severe disability (or combination of disabilities) that has lasted, or is expected to last, at least 12 months or result in death and that prevents working at a "substantial gainful activity" level.[27] Impairment is described as an anatomical, physiological, or psychological abnormality that can be shown by medically acceptable clinical and laboratory diagnostic techniques.

The Americans with Disabilities Act[28] (ADA) has a 3-part definition of disability. Under ADA, an individual with a disability is a person who (1) has a physical or mental impairment that substantially limits one or more major life activities; or (2) has a record of such an impairment; or (3) is regarded as having such an impairment. A "physical impairment" is defined by ADA as "any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine."

Regardless of the system, the term "impairment" defines a measurable change (any loss or abnormality of a psychological, physiological, or anatomical structure or function) and is consistent and measurable across different systems and programs. On the other hand, disability is a social construct in that each program or system defines it differently and assigns different weights and benefits to those definitions. One can be "disabled" in one system of benefits and not in another despite the same impairment. Disability usually results from an impairment that results in a functional loss of ability to perform an activity.

It is imperative to distinguish the difference between impairment and disability. One individual can be impaired significantly and have no disability, while another individual can be quite disabled with only limited impairment. For example, a person with a below-knee amputation may be working full time quite successfully as a pianist and, therefore, would not meet the Social Security Administration's (SSA's) definition of being disabled. On the other hand, this same pianist might have a relatively minor injury to a digital nerve that severely limits his or her ability to perform basic work activities such as playing a difficult piano concerto. In some disability systems, a person in this situation might meet the definition of partial disabled, even though he or she can do other work.

Perhaps another way to distinguish the terms disability and impairment is as follows. Some diseases cause a negative change at the molecular, cellular, or tissue level that leads to a structural or functional change at the organ level; this is a measurable impairment. At the level of the person, there is a deficit in daily activities, and this is the disability.

Because of this difference between impairment and disability, and despite the fact that many disability systems are based on an individual having an injury or illness at work , the widely used *AMA Guides* have stated that impairment ratings are not intended for use as direct determinants of work disability. The impairment rating is rather based on universal factors present in all individuals, the level of impact of the condition on performance of ADLs, rather than on performance of work-related tasks. The *AMA Guides,* Sixth Edition states on page 6 that "the relationship between impairment and disability remains both complex and difficult, if not impossible, to predict."

While it is true that the *AMA Guides* is a widely used source (the vast majority of state workers' compensation systems require some use of the different editions of the *AMA Guides)* for assessing and rating an individual's permanent impairments, a number of states and the federal government's SSA disability program do not recognize the *AMA Guides* for rating impairment. In addition, the Veterans Administration has its own unique set of disability rating criteria. There is clearly no consensus on a universal system to measure impairment.

Depending on the system, impairment is necessary for disability, but other factors are considered. Different disability programs attempt to combine medical information and the associated impairment with nonmedical factors that bear on the individual's ability to compete in the open labor market. Other considerations include age, education level, and past work experience. Physicians typically provide the data regarding the medical condition and impairment, while nonmedical issues are the purview of disability adjudicators.

The *AMA Guides* and Chronic Pain

The *AMA Guides,* Sixth Edition, provides a discussion of the assessment of pain in chapter 3, Pain-Related Impairment. In that chapter it states that subjective complaints are included in the provided impairment ratings and that up to 3% whole person permanent impairment may be provided only in unusual circumstances, including when there is no other basis to evaluate impairment.

In the *AMA Guides,* Sixth Edition, the eligibility requirements for pain-related impairment (PRI) include the following:

- Pain has been determined to have a reasonable medical basis, for example, can be described by generally acknowledged medical syndromes.
- Pain has been identified by the patient as a major problem.
- The patient's condition cannot be rated according to principles described in the *AMA Guides,* Sixth Edition, chapters 4 to 17.
- The PRI rating is not specifically excluded by relevant jurisdiction. (6th ed, 40)

Some physicians may feel that the *AMA Guides'* method of impairment rating does not adequately address the "disability" and functional loss caused by some chronic pain states. The *AMA Guides* is limited, for the most part, to describing measurable objective changes or impairment; therefore, chronic pain states, despite causing significant functional losses, are not provided significant impairment ratings.

The *AMA Guides* and Maximal Medical Improvement

The A*MA Guides* states that an impairment rating can only be done when the individual has reached maximal medical improvement, that is, "the point at which a condition has stabilized and is unlikely to change (improve or worsen) substantially in the next year, with or without treatment" (6th ed, 612). It is necessary to determine that the patient is stable and that no further restoration of function is probable. If the examinee shows up and is in the middle of a flare-up or has had a new injury that interferes with the examination, it is premature to do an impairment rating. In other words, the examinee must be stabilized medically in order for the physician to fairly assess the impairment rating. If the condition is changing or likely to improve substantially with medical treatment, the impairment is not permanent and should not be rated.

The *AMA Guides* and Activities of Daily Living

The *AMA Guides* reflect the severity of the medical condition and the degree to which the impairment decreases an individual's ability to perform common ADLs, *excluding* work. Throughout the *AMA Guides,* Fifth Edition, the examiner is given the opportunity to adjust the impairment rating based on the extent of any ADL deficits (5th ed, Table 1-2, 4). ADLs are described as follows:

- Self-care and personal hygiene (urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, eating)
- Communication (writing, typing, seeing, hearing, speaking)
- Physical activity (standing, sitting, reclining, walking, climbing stairs)
- Sensory function (hearing, seeing, tactile feeling, tasting, smelling)
- Nonspecialized hand activities (grasping, lifting, tactile discrimination)
- Travel (riding, driving, flying)
- Sexual function (orgasm, ejaculation, lubrication, erection)
- Sleep (restful, nocturnal sleep pattern)

In the *AMA Guides,* Sixth Edition, distinctions are made between ADLs, basic activities (such as feeding, bathing, hygiene), and instrumented ADLs, which are complex activities such as financial management and medication use. The edition also distinguishes between activity, that is, "execution of a task or action by an individual" and participation, that is, "involvement in a life situation" and between activity limitations, that is,

"difficulties an individual may have in executing activities" and participation restrictions, that is, "problems an individual may experience in involvement in life situations."

The *AMA Guides,* Sixth Edition, Impairment Rating Percentages

A 0% whole person impairment (WPI) rating is assigned to an individual with an impairment if the impairment has no significant organ or body system functional consequences and does not limit the performance of the common ADLs. A 90%–100% WPI indicates a very severe organ or body system impairment that requires the individual to be fully dependent on others for self-care; the patient is approaching death. The *AMA Guides* impairment ratings reflect the severity and limitations of the organ/body system impairment and resulting functional limitations.

The *AMA Guides* provides weighted percentages for various body parts. However, since the total impairment cannot exceed 100%, the *AMA Guides* provides a combined values chart that enables the physician to account for the effects of multiple impairments with a summary value. Subjective concerns, including fatigue, difficulty in concentrating, and pain, when not accompanied by demonstrable clinical signs or other independent, measurable abnormalities are generally not given separate impairment ratings. Impairment ratings in the *AMA Guides* already have accounted for commonly associated pain, including that which may be experienced in areas distant to the specific site of pathology.

The *AMA Guides,* Sixth Edition, does not provide ratable impairment for somatoform disorders in Chapter 14, Mental and Behavioral Disorders. The *AMA Guides* does not deny the existence or importance of these subjective complaints to the individual or their functional impact but notes that an accepted method within the scientific literature has not yet been identified to ascertain how these concerns consistently affect organ or body system functioning. The physician is encouraged to discuss these concerns and symptoms during the impairment evaluation.

The *AMA Guides* and Work Disability

Impairment assessment is provided by the *AMA Guides;* however, the *AMA Guides* does not define disability. An individual can have a disability in performing a specific work activity but not have a disability in any other social role. An impairment evaluation by a physician is only one aspect of disability determination. A disability determination also includes information about the individual's skills, education, job history, adaptability, age, and environmental requirements and modifications. An assessment of these factors can provide a more realistic picture of the effects of the impairment on the ability to perform complex work and social activities. If adaptations can be made to the environment, the individual may not be disabled from performing a specific activity (in this scenario though, the impairment is still present).

The *AMA Guides* is not intended to be used for direct estimates of loss of work capacity (disability). Impairment percentages derived according to the *AMA Guides* criteria do not measure work disability. Therefore, it is inappropriate to use the *AMA Guides'* criteria or ratings to make direct estimates of work disability.

The *AMA Guides to the Evaluation of Work Ability and Return to Work*[19] explains that pain is a matter of an individual's tolerance. Therefore, this being subjective, it is difficult to assess disability.

Summary

The evaluation of pain and disability is complex and multifaceted. The evaluating physician must approach such an evaluation from a biopsychosocial perspective. A thoughtful and thorough evaluation is of considerable value to all involved.

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