

NO. D-4270

IN THE
SUPREME COURT OF TEXAS

TEXAS WORKERS' COMPENSATION COMMISSION, et al.

Petitioners

vs.

HECTOR GARCIA, JR., et al.

Respondents

FROM THE
FOURTH COURT OF APPEALS DISTRICT

BRIEF OF AMICI CURIAE

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BRIEF OF AMICI CURIAE

TO THE SUPREME COURT OF TEXAS:

The American Medical Association, Bruce S. Hinckley, M.D., D. A. Broudreau, D.O., and Martin Haig, M.D., as Amici Curiae, submit this brief for the consideration of the Court in connection with the application for writ of error filed in this cause.

STATEMENT OF
INTEREST OF AMICI CURIAE IN THIS LITIGATION

The American Medical Association (AMA) was founded in 1847 to promote the science and art of medicine and the betterment of the public health. It is a voluntary membership organization whose nearly 300,000 physician and medical student members practice in all specialties of medicine. The AMA is the world's largest medical publisher and

disseminates its scientific journals worldwide and publishes numerous books and other materials for the public as a means to promote health education. Among its publications is the *Guides to the Evaluation of Permanent Impairment* (3rd Edition) ("*Guides*"). The AMA seeks to further the proper use and application of the *Guides*. Similarly, the AMA has a vital interest in identifying and discouraging any improper or unauthorized use of the *Guides*, that is, any use or application of the *Guides*' evaluative standards and guidelines for a purpose or in a manner other than that for which they were intended. It is the opinion of the AMA that the Texas Workers Compensation Act ("the Act") improperly utilizes the *Guides*. Accordingly, the AMA has an interest in the outcome of this appeal, which involves the use of the *Guides* under the Act.

Drs. Hinckley, Boudreau, and Haig are physicians whose practices include the evaluation and treatment of injured workers. Each has utilized the *Guides* to conduct physical impairment evaluations. Because they disapprove of the manner in which the Act utilizes impairment evaluations, these physicians are interested in the outcome of this appeal.

ORIGIN AND SCOPE OF THE GUIDES

Development of the Guides

In 1955, a group of physicians recorded their concerns at an AMA meeting about the plethora of methods of evaluating impairments. The AMA Council on Industrial Health was authorized by the AMA Board of Trustees to establish guidelines for the medical evaluation of impairments. The goal was to develop a standard system to measure the performance deficiencies of human organ systems. Three years later, the impairment committee, with the

aid of consultants, published the first set of guidelines, "A Guide to the Evaluation of Permanent Impairment of the Extremities and Back."¹

The next set of guidelines, prepared in 1958, pertained to the visual system. Then followed guidelines for the cardiovascular system and the ear, nose, throat, and related structures. Between 1957 and 1971, the AMA committee produced a set of guidelines dealing with each of the major organ systems; each set eventually was published in the Journal of the American Medical Association. In 1971, the 13 sets were published by the AMA as the first edition of the book, *Guides to the Evaluation of Permanent Impairment*.

The Second Edition of the *Guides*, sponsored and endorsed by the AMA's Council on Scientific Affairs, appeared in 1984. The Third Edition was published in November 1988; the second printing, dated February 1989, is the edition referenced and adopted by the Act. It is currently out of print and is no longer available. Alan L. Engelberg, M.D., M.P.H., who at the time was the director of the Department of Preventative Medicine at AMA, edited the Third Edition. George M. Smith, M.D., M.P.H., authored Chapters 1 and 2 of the Third Edition, which explain the fundamental and scientific concepts which govern the formulation and use of the *Guides*, and the proper methods of reporting the evaluation and rating of impairment, respectively. Both Dr. Engelberg and Dr. Smith testified at the trial of this case. The Fourth Edition of the *Guides*, representing the most current medical knowledge and understanding, was published in 1993.

¹ Committee on Medical Rating of Physical Impairment. A guide to the evaluation of permanent impairment of the extremities and back. Journal of the American Medical Association, 1958; Special Edition, February 15, 1958.

Purpose and Proper Use

As explained in Chapter 1, the purpose of the *Guides* is to provide a framework for the evaluation and reporting of permanent medical impairment by physicians. The *Guides* apply fundamental medical and scientific concepts to provide physicians with systematic analysis and detailed medical protocols for use in the evaluation of a broad range of medial impairments. (*Guides* at 1). Through use of the *Guides*, physicians have the capability to provide thorough evaluations according to a single set of standards. (*Guides* at 7; S.F. 273 at 20). The *Guides* provide the physician with the further option to translate his or her evaluation of an impairment into an "impairment rating" and to combine multiple impairments into an overall rating through use of tables and charts. (*Guides* at 4, 9). The *Guides* are widely used in the evaluation of physical impairment.

Although they cover a broad range of physical impairments, the *Guides* are not comprehensive and do not address every impairment. Thus, for example, there is no rating system for mental trauma or chronic pain. (S.F. 241 at 20 to 242 at 25). The *Guides to the Evaluation of Permanent Impairment* were not designed as a static document—they have and will continue to evolve from edition to edition. (S.F. 228 at 9-15; 378 at 14-24).

It is critically important to the proper use of both the *Guides* and the physician reports to understand what, in fact, is being evaluated and rated. The *Guides* provide a system for evaluating or assessing *impairment* defined as the "loss of, loss of use of, or derangement of any body part, system, or function." (*Guides* at 236). Drs. Engelberg and Smith properly noted that the evaluation of impairment itself *is not* based upon specialized occupational tasks or demands, but rather upon the activities of daily living. (S.F. 232 at 21

to 233 at 4; 244 at 4-9; 381 at 3; 414 at 8-17). Further, an impairment evaluation does *not* establish, measure, or rate "disability." As explained in the *Guides*:

The accurate and proper use of medical information to assess impairment in connection with disability determinations depends on the recognition that, whereas impairment is a medical matter, disability arises out of the interaction between impairment and external demands. "Impairment" means an alteration of an individual's health status that is *assessed by medical means*; "disability," which is *assessed by nonmedical means*, means an alteration of an individual's capacity to meet personal, social, or occupational demands, or to meet statutory or regulatory requirements. Simply stated, "impairment" is what is wrong with the health of an individual; "disability" is the gap between what the individual can do and what the individual needs or wants to do.

An individual who is "impaired" is not necessarily "disabled." Impairment gives rise to disability only when the medical condition limits the individual's capacity to meet demands that pertain to nonmedical fields and activities. On the other hand, if the individual is able to meet a particular set of demands, the individual is *not* "disabled" with respect to those demands, even though a medical evaluation may reveal impairment. (*Guides* at 1-2, emphasis in original).

As noted above, the *Guides* permit physicians and others to assign an impairment rating, stated in terms of a percentage of impairment, based upon the evaluation. The assignment of an impairment rating (as opposed to the evaluation) is not a medical determination. (*Guides* at 7). As explained at trial, the impairment ratings do not have independent scientific validity -- they were not based upon epidemiological studies of large population groups and there was no reference framework within which to assign numbers. (S.F. 236 at 16 to 237 at 2; 418 at 2 to 420 at 21; 378 at 25 to 379 at 8). While the ratings provide a basis for comparison of levels of impairment, they are subordinate to the evaluation itself and should not be given a disproportionate significance. (S.F. 419 at 24 to

421 at 13). Indeed, the assignment of a rating number is optional with the physician. The limitations on the use of the rating were highlighted in the *Guides*:

A simple number, the impairment rating, although it may have been derived from a well structured complex set of thorough observations, does not convey any information about the person or the impact of the impairment on the person's capacity to meet personal, social, or occupational demands. In fact, information is lost in arriving at the number. Consequently, the strength of the medical support for a disability determination is dependent on the completeness and reliability of the medical documentation submitted. (*Guides* at 8).

THE ROLE OF THE *GUIDES* IN THE TEXAS WORKERS' COMPENSATION SYSTEM

The *Guides* play a central role in the determination of both "impairment income benefits" and "supplemental income benefits" under the Act. The Act expressly provides that:

All determinations of impairment under this Act, whether before the commission or in court, must be made in accordance with [the *Guides*] § 4.24.

The percentage impairment ratings assigned in accordance with the *Guides* dictate the duration, and therefore the overall amount, of impairment income benefits an injured worker receives. Under the Act, a worker who is impaired after achieving maximum medical improvement will receive impairment income benefits for a period equalling three weeks for each percentage point of impairment, subject to certain limitations. § 4.26(c). The greater the impairment rating, the greater the benefits; the smaller the rating, the smaller the benefits. The impairment evaluation report itself is not considered in the calculation of benefits.

Supplemental income benefits under the Act are long term benefits for injured workers whose impairment income benefits have been exhausted. Only workers whose impairment rating is 15% or greater are entitled to these benefits. Thus, the impairment rating determines an injured worker's eligibility for supplemental income benefits. Again, the substance of the impairment evaluation report itself is not considered, only the impairment rating number.

THE ACT IMPROPERLY UTILIZES THE GUIDES TO DICTATE
THE AMOUNT OF IMPAIRMENT BENEFITS AND THE
AVAILABILITY OF SUPPLEMENTAL INCOME BENEFITS
UNDER THE ACT

The authors of the *Guides* anticipated that impairment evaluations and ratings would be considered in connection with benefit determinations under worker compensation laws. It was contemplated, however, that the medical information would be *combined* with other factors to determine the extent to which the *industrial* use of the worker's body was impaired. (*Guides* at 6). Users of the *Guides* are expressly advised that a one-to-one translation of impairment to disability is a use which was not intended and, accordingly, is discouraged. (*Guides* at 6). The Act directly translates impairment ratings to impairment income benefits without consideration of the occupational demands on the worker or other factors such as the worker's age, education, training, experience, or skills. (S.F. 234 at 4-15). To the extent that the impairment income benefit is designed to compensate the injured worker for the economic consequences of impairment, the manner in which the Act uses the impairment rating to calculate that benefit is improper. The *Guides* warn against this type of use for good reason.

There is no direct relationship or correlation between physical impairment, which the *Guides* were designed to measure, and either disability, economic loss, or occupational impairment. A worker may suffer a physical impairment which will have little or no effect on that worker's ability to perform his or her job.² In that instance the worker has no disability or occupational impairment and his or her physical impairment has little or no economic consequences. Conversely, as explained by Dr. Engelberg, there are many injuries with potentially *low* overall impairment ratings which, depending on the injured worker's occupational demands, can result in a *high* level of disability.³ (S.F. 243 at 21-23). Dr. Engelberg gave numerous examples at trial of potentially low impairment high disability injuries. (S.F. 243 at 21 to 251 at 6). Thus, under the Act it is possible for two workers with very different degrees of disability (and corresponding economic loss) to receive similar overall impairment ratings and, therefore, similar benefits. If the impairment benefits scheme is intended to compensate an injured worker for an occupational impairment or for the economic loss occasioned by the worker's medical condition, then the Act's exclusive reliance on the impairment evaluation to determine the amount of benefits is neither rational nor fair. The evaluative system created by the *Guides* was not designed to be the sole determinant of the amount of compensation for a workplace injury. (S.F. 289 at 25 to 290 at 3). The *Guides* expressly warn against this type of use. (*Guides* at 6; 452 at 11-17).

² The *Guides* illustrate this point by considering the negligible effect of an injured finger on a banker's job performance. (*Guides* at 2, n. 1).

³ An impaired finger may be highly disabling to a concert pianist.

The unfairness of this approach is compounded by the Act's focus on impairment ratings. As discussed above, impairment *ratings* are subordinate to the impairment *evaluation*. While a rating may provide a useful benchmark and basis for comparison, it was by no means intended as a precise indicator of impairment. Even when two physicians agree on the extent of impairment, a three percentage point difference in the ratings would not be unexpected. (S.F. 316 at 21 to 317 at 12). Indeed, the *Guides* permit - but certainly do not require - a physician to "round" the rating number to the nearest five percent. (S.F. 278 at 18-24; 336 at 14-19). Under the Act, two workers with similar impairments may be treated differently due to the lack of precision in the rating scheme and the physician's discretion to round the rating up or down or to properly decline to do so. By focusing exclusively on the rating, the Act misuses the *Guides* and aggravates the problems created by the one-to-one translation of impairment evaluations into compensation amounts.

The impairment rating also plays an important role in the award of supplemental income benefits under the Act. These benefits compensate an injured worker for a portion of his or her wage loss, suffered as a result of the impairment. §4.28(b). However, these benefits are available only to workers who receive an impairment rating of 15 percent or greater. §4.28(b). These Amici submit that, insofar as the *Guides* are concerned, the use of *any* rating value as a threshold for workers' compensation benefits is inappropriate. (445 at 2-19). Using the ratings in this way assigns to them a function they were never intended to have. (S.F. 445 at 9-15). Since there is no direct correlation between an impairment rating and economic loss, it is neither reasonable nor fair to determine worker eligibility for supplemental income benefits solely on the basis of an impairment rating. (S.F. 219 at 21

to 220 at 4; 221 at 13). Furthermore, the *Guides* do not dictate any single impairment level which separates those workers who suffer long term economic loss and those who do not. Since workers with an impairment rating below 15 percent may, because of their occupation, suffer greater economic consequences than workers with an impairment rating above the threshold, the selection of the 15 percent level in the Act is arbitrary and unfair. (S.F. 307 at 24 to 308 at 7; 559 at 23 to 360 at 3).

The Act abuses the physician's role in the process by taking his or her medical evaluation and using it in a manner which was never intended. (S.F. 313 at 14-16; 329 at 22-24; 333 at 2-4). The *Guides* are clear: "The physician does not determine industrial loss of use or economic loss for the purpose of paying a disability benefit." (*Guides* at 2). Yet under the Act, the physician's evaluation determines the amount of impairment income benefits and the availability of supplemental income benefits. This use of the physician's evaluation is unfair to both the physician and the patient.

CONCLUSION


The *Guides* are a valuable medical tool which have served the medical community well for many years. But like any other tool, they are subject to misuse and abuse. The *Guides* describe and explain at length the concepts which underlie their proper use and warn against the improper application of impairment evaluations and ratings. Unfortunately, without consulting the AMA, the Legislature ignored those warnings and created a worker compensation system which utilizes the *Guides* in an inappropriate manner. In so doing, it has placed the *Guides* at risk of being used to generate unfair, arbitrary, and unreasonable compensation decisions, with the physician unwittingly placed in the role of decisionmaker.

(S.F. 313 at 14-16; 425 at 11 to 453 at 5). Your Amici feel compelled to call this situation to the attention of the Court.

Respectfully submitted,

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CERTIFICATE OF SERVICE

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