Functional Ability Assessment: Guidelines for the Workplace

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Short- and long-term disability certification is required in all Western countries for extended time away from work. The Americans With Disabilities Act mandates that medical providers use rational thought and justifiable criteria when evaluating an employee’s “fitness for duty.” In order to facilitate employment/disability decisions, physicians must now serve as an advisor to the employer. Both the employer and the physician are legally obligated to carefully justify any recommendations for placement or exclusion from the workplace. We propose a uniform methodology that both physicians and employers could use together to determine the performance capability of an individual with a temporary or permanent impairment or disability in terms of essential job functions as defined under the Americans With Disabilities Act.

Irrespective of medical specialty, a physician will eventually be asked to determine an employee’s temporary or permanent fitness for duty. Traditionally, employers have frequently placed medical personnel in the position of declaring whether a person was able to work. Such decisions are often made with little objective justification. Yet it has been demonstrated that predicting who will be unable to work or who will become disabled is impossible.1,2

Likewise, certifying who can work has been equally difficult.3,4 Instead of assisting in determining when a person is unable to work, the Americans With Disabilities Act (ADA) now specifically protects all individuals with “a physical or mental impairment that substantially limits one or more of the major life activities of such individuals, a record of such impairment, or being regarded as having such an impairment.”5 Under the ADA, it is no longer sufficient for a physician simply to determine when a person is unable to work. The ADA places very specific requirements on employers and their medical advisors to determine the conditions under which individuals can work. This applies not only to injured workers and those who acquire various diseases but also to those people who have lifetime handicaps and who have never worked.

Effective accomplishment of these goals will require the combined efforts of the impaired employee, health care provider, and employer to carefully consider efforts to provide reasonable accommodations for persons with impairments.5 Thus the
ADA is designed, in one respect, to assist employers in managing the effects of employees’ disabilities to facilitate their return to work (or their continued work) after an illness or injury occurs. Currently, the Equal Employment Opportunity Commission reports that 52% of cited violations relate to wrongful discharge of an employee, 27% to failure to provide reasonable accommoda-
tion, and only 10% to hiring practices.6

In the past, the medical profession bore the responsibility not only for sanctioning but also for advising patients who were in pain to stay home from work. Returning individuals to gainful employment promotes independence and is essential to a person’s self-respect and quality of life. Resumption of work has also been shown to be a significant part of the treatment for an injury, even benefit-
ing patients suffering from chronic pain.7–10 Conversely, prolonged time away from work makes recovery and return to work progressively less likely.11,12

American industry has come to appreciate W. Edwards Demming’s philosophy that the “individual worker is the company’s most important asset and respect for individuals is paramount for business success.”13 Recent estimates of direct costs for work-related injuries and illnesses are in excess of $65 billion, in addition to indirect costs of $106 billion, bringing the total estimated annual cost to US industry to $171 billion.14

The government has significant financial interests in assisting impaired individuals to obtain gainful employment. Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) are the governmental income security pro-
grams for individuals with disabili-
ties. During the 1970s, SSDI experi-
enced a doubling of enrollment to 2.9 million people, while the cost of the program increased from $2.8 to $14.9 billion per year.15 At the end of 1992, approximately 8.8 million people received SSDI and/or SSI benefits (based on their own or a family member’s disability), for a total benefit cost of $52 billion. It is now estimated that at least 43 million Americans are disabled in some way.16 Sixty percent of those not working have indicated that they would like to work if the opportunity were made available,16 and 25% of individuals who are disabled have reported some form of current job discrimination.17 Furthermore, estimates show that an employed person generates $65,000 in tax revenue, reduces the cost of social services, and generates increased business through consumer spending.18

**Fitness-for-Duty Issues**

Physicians who treat injured or ill workers are required to fill out a plethora of different and time-consuming workers’ capability state-
ments from employers, government officials, insurers, and financial ins-
titutions. All of these require basically the same information but in different formats. We realize that complex functional ability assessment pro-
grams exist which describe how to match workers to jobs.

Our interest in this subject is not new. During World War II, the Cana-
dian Army used a simple profile that originally consisted of seven cate-
gories (PULHEMS; Personality, Upper extremities, Lower extremities, Hearing, Eyesight, Mentality, Stability) with ratings of 1 through 4.

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<table>
<thead>
<tr>
<th>PHYSICAL DEMAND LEVEL</th>
<th>OCCASIONAL 0 - 33% of the workday</th>
<th>FREQUENT 34 - 66% of the workday</th>
<th>CONSTANT 67 - 100% of the workday</th>
<th>Typical energy required</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEDENTARY</td>
<td>10 lbs.</td>
<td>Negligible</td>
<td>Negligible</td>
<td>15 - 2.1 METS</td>
</tr>
<tr>
<td>LIGHT</td>
<td>20 lbs.</td>
<td>10 lbs. and/or walk/stand/push/pull of arm/leg controls</td>
<td>Negligible and/or push/pull of arm/leg controls while seated</td>
<td>2.2 - 3.5 METS</td>
</tr>
<tr>
<td>MEDIUM</td>
<td>20 to 50 lbs.</td>
<td>10 to 25 lbs.</td>
<td>10 lbs.</td>
<td>3.6 - 6.3 METS</td>
</tr>
<tr>
<td>HEAVY</td>
<td>50 to 100 lbs.</td>
<td>25 to 50 lbs.</td>
<td>10 to 20 lbs.</td>
<td>6.4 - 7.5 METS</td>
</tr>
<tr>
<td>VERY HEAVY</td>
<td>Over 100 lbs.</td>
<td>Over 50 lbs.</td>
<td>Over 20 lbs.</td>
<td>Over 7.5 METS</td>
</tr>
</tbody>
</table>

Fig. 1. United States Department of Labor Physical Demand Characteristics of Work chart.
### Workplace Functional Ability Medical Report Form

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Home Address**

I hereby authorize my physician or other health care provider to release all information about my health condition as it may relate to the appropriateness and wisdom of beginning or returning to work.

**Signature**

**To Whom It May Concern:** This report is being made to facilitate the beginning or return to modified or full-duty work by the above-named individual. I have checked any and all categories of which I am aware that may affect work status, as outlined in the Workplace Functional Ability Medical Guidelines.

**Nature of health problem(s):**

| X = Functional Ability Profile with use of personal compensating devices, such as glasses, hearing aids, braces, or prosthetics, etc. |
|---|---|---|---|---|---|---|---|---|---|---|---|
| A | A | A | A | A | A | A | A | A | A | A | A |
| A | A | A | A | A | A | A | A | A | A | A | A |
| A | A | A | A | A | A | A | A | A | A | A | A |

<table>
<thead>
<tr>
<th>Profile Category</th>
<th>Functional Ability Profile Level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

**May begin to return to work activity appropriate to the above profile:**

- [ ] as of current date, or [ ] approx.

**Hrs. of work:**

- [ ] Full time
- [ ] Less than full time - approximately ___ hrs/day, approx. ___ days/week
- [ ] Gradually increase to full time by ___
- [ ] Not fully stable. Should be reviewed in approximately ___ weeks or ___ months.

**Possible workplace accommodation(s):**

| (This section is for review by your employer, and is intended to document any reasonable accommodations that may be made within the scope of timeframes indicated by the profile.) |
| Comments/treatment recommendations/suggestions, etc.: |

**Printed name of health care provider**

**Address**

**Signature**

**Date**

**Degree/Title**

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**Fig. 2. Workplace Functional Ability Medical Report form.**

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### Medical Responsibilities

Most physicians realize that medical decisions which effect employment and earning capacity carry heavy legal and ethical responsibilities. Given the status of current employment law, any attempt to manage workers with restrictions involves a medical, legal, and ethical approach that protects not only the worker but also the employer. Generally, treating physicians cannot be sued for their opinions concerning a worker's ability to work unless a physician's statement proved false and was made with recklessness. Physicians, however, can be sued for negligent interference with the worker's contractual relationship. For these reasons, employers and patients must remember that the physician determines capability, not disability. It is the employer's administrative responsibility to determine whether "reasonable accommo-
<table>
<thead>
<tr>
<th>Category</th>
<th>Profile Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>A-U Musculoskeletal — Upper Extremity</td>
<td>Infrequent heavy lifting — affected extremity</td>
</tr>
<tr>
<td>A-H Musculoskeletal — Hand</td>
<td>Medium lifting — affected extremity</td>
</tr>
<tr>
<td>A-L Musculoskeletal — Lower Extremity</td>
<td>Light lifting — affected extremity</td>
</tr>
<tr>
<td>A-S Musculoskeletal — Spine</td>
<td>No lifting — affected extremity</td>
</tr>
<tr>
<td>B-C Neurology — General</td>
<td>No lifting — either extremity</td>
</tr>
<tr>
<td>B-E Epilepsy/Other Epileptic Disorders</td>
<td>Substitutes for all hand functions</td>
</tr>
<tr>
<td>C Pulmonary (Long)</td>
<td>Medium: May Lift — Occasional - 100 lbs.</td>
</tr>
<tr>
<td>D Cardiovascular (Heart/Blood Vessels)</td>
<td>Frequent - 50 lbs.</td>
</tr>
<tr>
<td>E Hematology/Immunology/Oncology</td>
<td>Constant - 10 lbs.</td>
</tr>
<tr>
<td>F Ophthalmology (Eye)</td>
<td>Light: May Lift — Occasional - 20 lbs.</td>
</tr>
<tr>
<td>G Otolaryngology (E.N.T.)</td>
<td>Frequent - 10 lbs.</td>
</tr>
<tr>
<td>H Gastroenterology (Digestive)</td>
<td>Constant - Negligible</td>
</tr>
<tr>
<td>I-G Genitourinary — General (M — Male or Female)</td>
<td>Limited tasks — bilateral</td>
</tr>
<tr>
<td>I-W Genitourinary — Women/Pregnancy</td>
<td>Sedentary: May Lift — Occasional - 10 lbs.</td>
</tr>
<tr>
<td>J Diabetes</td>
<td>Sedentary or substitute functions</td>
</tr>
<tr>
<td>K Dermatology (Skin)</td>
<td>Slight risk tasks — bilateral</td>
</tr>
<tr>
<td>L-M Memory/Learning/Communication</td>
<td>Slight risk tasks — bilateral</td>
</tr>
<tr>
<td>L-P Psychiatric/ Psychological/Emotional</td>
<td>Moderate risk tasks — increased supervision</td>
</tr>
<tr>
<td>L-S Substance Use Disorders</td>
<td>Heavy; may reduce hours — bilateral</td>
</tr>
<tr>
<td>M-M General Medical</td>
<td>Medium; major surgery</td>
</tr>
<tr>
<td>M-S General Surgery</td>
<td>Light; sedentary</td>
</tr>
</tbody>
</table>

### Summary of Profile Levels and Work Activity

**All work activities**

- **Allowance for access to stacks/mics and regular work schedules**
  - Heavy: Heavy with injections
  - Limit exposure to allergens/irritants
  - Learn new complex tasks
  - All — with monitoring
  - Moderately high risk tasks — normal supervision
  - Heavy; may reduce hours

**Profile Levels**

- Medium lifting — affected extremity
- Light lifting — affected extremity
- No lifting — affected extremity
- No lifting — either extremity
- Sedentary: May Lift — Occasional - 10 lbs.
- Sedentary: May Lift — Occasional - 20 lbs.
- Sedentary: May Lift — Occasional - 50 lbs.
- Sedentary: May Lift — Occasional - 100 lbs.

**Work activity appropriate**

- According to special circumstances — depends upon nature of problem
- Temporary adjustment — under evaluation — depends on situation
- No work activity appropriate

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**Fig. 3. Summary of Profile Levels and Work Activity form.**

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**Annotations** can be made. It is not the physician’s responsibility to determine the essential functions of the job, devise accommodations for the permanently disabled employee, determine the reasonableness of any accommodation proposed by the employer, or tell the employer whether the employee can do his job. Physicians should remember that estimates of patient capability must be ascertained before the employer can determine “reasonable accommodation,” “undue hardship,” or “direct threat” under the ADA and Technical Assistance Manuals. Many physicians have expressed a sense of relief in having such guidelines, which were developed by selected specialists, since most physicians have had little training in occupational medicine. Physicians should be cognizant that many companies sponsor “early return to work programs” while healing continues but before full duty can be assumed. Studies have shown that workers who return to their original employer are usually better off financially than workers who choose other options, such as alternative vocational rehabilitation plans that include retraining or new job placement.

Physicians may serve a dual role by treating an individual while also being an employee of the patient’s employer in advising how to make appropriate accommodations. Increasingly knowledgeable occupational medicine specialists may greatly enhance the ability of employers to interpret reports and recommend appropriate placements, thus not involving themselves in treating patients otherwise.

**Employer Responsibilities**

Given appropriate medical information, an employer’s administrative responsibility is to determine whether accommodations can be made. If the employer feels that accommodations represent an “undue hardship” to the company or that the employee is considered a “direct threat” to himself or others, an employability decision will have to be made. Such an action requires appropriate legal review and significant documentation, which is often dependent on the size of the employer’s
### Workplace Functional Ability Guidelines

The Workplace Functional Ability Guidelines (WFAGs)\(^{26}\) were developed by a medical task force, which consisted of 28 members of the Utah Medical Association, in consultation with other groups. The goal of the task force was to facilitate and to improve the quality and flow of information between the physician and employer in order to safely and appropriately match the worker to the workplace. The WFAGs and Medical Report Form have four purposes:

1. To assist workers who develop health problems to return to appropriate work that they can do.
2. To assist those who have health problems and who have not worked to gain employment at tasks they can accomplish effectively.
3. To help employers by providing guidelines for appropriate levels of work as determined by the employee’s health condition.
4. To offer employers suggestions as to possible accommodations to consider in determining if an employee might accomplish the essential functions of a job.

Accomplishing these purposes requires an interaction of three specific functions:

- Medical function. This includes using a standard medical evaluation by history, examination, and x-ray or other studies to establish a diagnosis and evaluate the individual’s functional ability and then generating a report based on the use of Workplace Guidelines.

Health care providers have found the report form (Fig. 2) quick and easy to use. If only a single problem is encountered, a single “x” in the appropriate category and a notation as to times and stability will suffice. The profile is based on two facing pages in the Guidelines: one a narrative and one a tabulation of profile levels. As recovery occurs, a simple change in the profile level will allow additional work activity.
The term “functional ability” is used to focus on what a person can do, not on what he cannot do. The Guidelines include 21 different categories of health concerns. The categories were selected to follow, in general, the sequence used in the 4th edition of the American Medical Association’s Guides to the Evaluation of Permanent Impairment.27 Each category has a one-page narrative and a one-page tabulation of functional levels. A profile level of one indicates no present or past limitation for that category, while level ten indicates a condition in which work of any sort does not appear to be indicated. For each level in between, levels of work, such as heavy to sedentary, or other activities, such as in vision or learning problems, are indicated. In addition, ideas for possible accommodations are shown for each level. They have no coercive or controlling effect but will be useful for employers to consider. A summary of the categories, along with the functional ability profile levels, as found on the back of the report form is shown in Fig. 3. Further detailed information on each of the 21 categories with further detailed information on each section is provided in the WFAGs booklet.* An example of a detailed report form for the Musculoskeletal-Spine section is shown in Fig. 4.

Category A-S: Musculoskeletal-Spine

Symptoms related to the spine are among the most common adult everyday health complaints and are not limited to the workplace. In most instances, individuals appear to accept or tolerate the symptoms as being an expected part of life, especially as they become older. However, when the spine is injured or in

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* Copies of the WFAGs complete booklet and Medical Report Forms may be obtained from the Utah Department of Health, Bureau of Vital Statistics, 288 North 1460 West, Salt Lake City, UT 84116-2855 at a cost of $3.00 each for the WFAG booklet and $3.00 for a pad of 10 report forms.
the case of more severe symptoms, there may be clear indication for adjustments in work expectations.

This should include not only concern for the worker’s comfort and efficiency but for the possible effects of work activities in causing increased pathology. While the details of medical history, physical examination, and special tests are essential for a correct diagnosis, clinical experience and common sense must be applied in estimating a person’s functional ability in the workplace.

The spine is divided into three segments: cervical, thoracic, and lumbar sacral. Each of the segments shares, in general, limits on weight-bearing or posture, such as lifting, carrying, bending, reaching, and standing. Problems including the pelvis should be handled as related to the lumbar sacral spine or as a special situation, depending on the circumstance. Hip problems are considered under category A-L (Musculoskeletal-Lower Extremity) (Fig. 5).

Fractures of any segment of the spine or spinal surgery will usually require a variable amount of time off work, followed by a return to work with limitations of lifting and carrying even if protected by a brace or cast. Soft tissue lesions, on the other hand, usually become stabilized to within a few weeks and generally permit a return to work with appropriate accommodations. As further healing takes place, the profile level and duration exposure may be upgraded to permit more demanding work, bearing in mind the balance between the desire to return to a previous job versus the risk of aggravating the condition. Some degree of discomfort should be expected on return to work, even with appropriate accommodations. Chronic pain that extends beyond what might be expected from the discerned pathology should be considered for its emotional overtones and may also be profiled under Category L-P (Psychiatric/Physiological/Emotional), if appropriate.

If spinal injury results in significant damage to the spinal cord, causing partial or complete paraplegia, this later condition should also be profiled under Category B-G (General Neurology). If radiculopathy results, the effect on function of the limbs may also be profiled under Category A-U (Musculoskeletal-Upper Extremity) or Category A-L (Musculoskeletal-Lower Extremity) or both. If the cauda equina is damaged, bladder symptoms may be profiled under Category I-G (Genitourinary) and bowel symptoms under Category H (Gastroenterology).

The following are some examples of suggested profile levels:

1. A 22-year-old male with symptoms of neck and shoulder pain, normal clinical findings, with full range of motion; x-rays normal; Profile Level 3 with duration specified.
2. A 30-year-old male with low back pain after a heavy load that he was helping to carry shifted; examination and x-rays negative; symptoms stabilized in 3 weeks; Profile Level 4, full-time.
3. A 55-year-old female with a long history of low back pain treatments, with radiating leg pain (radiculopathy); decreased range of spinal motion; x-rays showed moderate spondyloysis and disc herniation at L5; Profile Level 5, duration specified.
4. A 40-year-old obese male with gradual onset of mid-back pain after long hours of heavy lifting; extensive degenerative changes in the lumbar spine; Profile Level 4, duration specified.

These profiles are both dynamic and flexible. If a patient shows progressive recovery or worsening, the profile level, along with the exposure duration, can be modified as needed.

Levels of Work

While many of the functional ability categories are concerned with specialized capabilities, such as vision, hearing, learning, etc, others are related primarily to physical demands for lifting or carrying. In these categories, the DOL standards for the physical demands of different levels of work have been used. A one-page summary of level of work (Fig. 1) is included in the appendix of the guidelines.

Subjective or Intermittent Symptoms

Evaluation of subjective or intermittent symptoms is often difficult to equate to functional ability in the workplace. The description of symptom intensity and frequency (Table 1), adapted from the AMA Guides, has been helpful in using the WFAGs.
Recurrent, acute pain should be identified as primary or neurogenic and should be related to the underlying cause. Psychogenic pain or chronic pain syndromes are mental disorders and should be profiled under category L–P (Psychiatric/ Psychological/Emotional Disorders).

Use of Skill and Judgment

The following quotation from the AMA Guides represents the philosophy by which use of the WFAGs in the workplace should be governed:

“The physician’s judgment and his or her experience training, skill and thoroughness in examining the patient and applying the findings to the AMA Guides criteria will be factors in estimating the degree of the patient’s impairment. These attributes comprise part of the art of medicine, which, together with a foundation in science, constitute the essence of medical practice. The evaluator should understand that other considerations will also apply, such as the sensitivity, specificity, accuracy, reproducibility, and interpretations of laboratory tests and clinical procedures, and variability among observers’ interpretations of the test and procedures.”

Confidentiality of Information

Physicians and employers alike must remember that all medically related information must be kept confidential at the worksite and limited only to what is necessary for an appropriate job assignment or for making a reasonable job accommodation. In certain instances, an employer may have a “need to know” a medical diagnosis as described below. However, specific information about the nature of the medical condition must be kept confidential in the employee’s personal medical record. Supervisors are only entitled to know the limitations of the profile level indicated. By utilizing the WFAG form and simply noting the nature of a worker’s problem and checking the appropriate profile level, the ADA requirements for confidentiality are met and the employer is permitted to act in a prudent and reasonable fashion. Exceptions to this include the following: (1) supervisors and management must be informed about necessary work restrictions; (2) first aid and safety personnel should be informed if the disability may require emergency treatment or if any specific procedures are needed in the case of fire or other evacuations; (3) government officials can investigate compliance with ADA; (4) relevant information must be provided to state workers’ compensation offices or second injury funds; and (5) relevant information must be provided to insurance companies for cases in which the company requires a medical examination in order for health or life insurance to be provided.

Other Applications

Since a number of life activities are similar to work activities, other applications are under consideration. For example, the Utah Medical Association’s Sports Committee is considering applying the same basic approach to defining fitness for various sports activities, recognizing the difference between contact and non-contact sports, etc. The Utah Driver License Medical Advisory Board has approved, in principle, acceptance of the Workplace Functional Ability Report in lieu of the Functional Ability in Driving profile report that has been in use since 1979. Administrative law judges are using the Workplace Functional Ability Report Form in cases involving industrial injuries. Thus copies of a single simple report completed by one’s physician might facilitate a person’s working, driving, sports participation, resolving compensation, and, perhaps, personal insurance claims, etc. Changing the name of the report form to simply “Unified Fitness Report” is under consideration. After a study in one county, a one-page health questionnaire key to the 21 profile categories has been developed for use by one of the state agencies concerned with work and family support. Other studies are in progress or in the planning stages.

Summary

The WFAGs have been developed to enhance the objective flow of information between physicians and employers. Fitness for duty, functional ability determination, worker/job matching, etc. are all similar activities that the WFAGs were designed to address. We recognize that our efforts are preliminary to what could become a more refined and objective method of describing individual functional ability. The WFAGs also provide a service consistent with Principle VII of the American Medical Association’s Principles of Medical Ethics, which states that, “a physician shall recognize a responsibility to participate in activities contributing to and improving the community.”

Acknowledgment

Special acknowledgment is given to the 28 members of the Utah Medical Association who contributed to the WFAGs.

References


We solicit suggestions and comments for improving the WFAGs. Please address these to the Utah Medical Association, 540 East 500 South, Salt Lake City, UT 84102, or to the corresponding author of this article.
1996. Data compiled by the Office of Program Operations from the EEOC's Charge Data System's National Data Base.

Not So Haute Couture

"I can see no advantage to the Queen or the public if the Lord Chancellor removes his tights."—Lord Waddington, objecting to Britain's top judge's proposal to replace his 17th-century outfit with modern attire.