The Well-Designed Functional Capacity Evaluation: 
Application in Disability Determination

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Estimates derived from 2006 Census report suggest 18.6 percent of the US population have a disability lasting some length of time and 6.0 percent for disability have a disability lasting 6 months or longer. Data from the CDC indicates that $397.9 billion was spent on health services for disabled individuals in 2006. This figure represents 26.7 percent of all U.S. adult 2006 health care costs.

In these times of unprecedented disability costs, our society has a pressing need to make appropriate disability decisions for those who are unable to return to work. Disability claims professionals play an extremely important role in this process. The Functional Capacity Evaluation (FCE) can provide important information regarding an individual’s ability to safely perform the physical demands of work (Lechner, Jackson, Roth, & Stratton, 1994, Lechner, Roth, & Stratton, 1991) and thus can provide valuable information in the disability determination process.

Disability adjudicators often receive extensive information regarding the client’s medical condition and impairments. Without FCEs, the client’s functional physical abilities are often determined through client self-report or physical examination, medical diagnosis or informal observation within an exam room. Client perception may be clouded by motivation to return to employment. The accuracy of intuitive clinical determinations of function varies greatly among clinicians (Sokolow, Silson & Taylor, 1958). Diagnosis and impairment have been shown to be unrelated to function (Lankorst, Van de Stadt & Van der Korst, 1985). Alternatively, a well-designed FCE can provide objective information on a wide range of functional activities for clinical decision-making (Lechner et al 1994, Lechner et al 1991, Isernhagen 1988).

Despite the importance of the FCE to disability determination, a wide variety of evaluation approaches exists with very little research to define the optimal FCE (King, Tuckwell & Barrett, 1998, Reneman, 2003). There are several commercially available FCE systems with proprietary procedure manuals and thousands of FCEs that have been developed by individual clinicians. A wide variety of clinical opinions and largely undocumented controversy regarding the components of a well-designed FCE abound.

The purpose of this paper is to discuss the key features of well-designed FCEs and to provide guidelines and suggestions to the disability adjudicator regarding the factors to consider when selecting an FCE or FCE provider. Topics addressed will include the scope of testing and features of the FCE protocol, including: test length, types of reports, qualifications for test administrators, equipment and space requirements, objectivity, reliability, and validity, training requirements, and use of normative data. Considerable attention will be paid to the FCE approaches to consistency and sincerity of effort as this is such an important aspect of the FCE. Application of FCE to the field of disability determination also will be addressed. It is important for the reader to recognize that for many aspects of FCE, there is little to no research support the various approaches to a testing issue.

Scope of Testing. The disability insurance industry typically differentiates between three different types of FCEs: 1) “Own job,” 2) Own occupation, 3) Any occupation. For an “own-job” FCE, the evaluator tests
only those tasks directly related to the job and the client’s abilities are compared to former or current job demands. For an “own-occupation” FCE, client abilities are compared to a generic type of work typically as it’s described in the US Department of Labor’s Dictionary of Occupational Titles (DOT). For an “Any-occupation” FCE, most evaluators use a complete battery of tasks that cover all physical demands listed in the DOT and no comparisons to job or occupations are made (King et al, 1998). Advantages and disadvantages can be identified for all three approaches.

Job-specific FCEs may be more cost effective if the test is tailored to address only the specific job demands. However, if the client cannot return to the former job and requires placement in alternative work, further testing may be needed. This approach might involve the client returning to the clinic and repeating parts of a former test. In such cases the job-specific test may not be cost effective. On the other hand, in disability determinations, alternative placement is not an issue and job-specific testing is frequently desired. In occupation-specific testing, DOT descriptions can be outdated and new occupations may not be described since the DOT has not been fully updated in many years. Careful communication between the evaluator and the referral source(s) prior to the testing provides invaluable insight into the purpose of the test and the nature of the questions that need to be answered. Such communication can provide the basis for a consensus regarding the type of testing most appropriate for an individual client.

**Test length.** The length of FCEs varies from one hour to several weeks (Frings-Dresen et al, 2003; King et al 1998, Lechner et al 1998). The clinician’s goal should be to perform no more testing than is necessary to provide accurate results. Studies reported by Lechner et al support the conclusion that a reliable, valid determination can be made using the ErgoScience PWPE in a one-day, three to four-hour format (Lechner et al, 1994, Lechner et al, 1996). Can comparable results be achieved in a shorter period of time? At the time of this writing, there is no peer-reviewed research that addresses this issue. Do other FCE protocols require longer testing over multiple days? Recent studies suggest that 2-day testing does not enhance test reliability or validity (Reneman, Dijkstra, Westmass, & Goeken, 2002).

**Report Format.** FCE reports vary in length from one page to thirty-five or more pages. While some referral sources prefer a concise report, others prefer a lengthier one. Some disability carrier referral sources want the client’s abilities classified according to a safe level of overall exertion ranging from Sedentary to Very Heavy. However, it must be remembered that these generic categories represent a range. Both client and job demands may be in the same general exertion category and yet specific physical abilities on individual job tasks do not match individual job demands. For example, the client may be at the bottom of the sedentary range while the job demands can be near the top of the sedentary level. Due to these classification issues, some carriers do not want the client classified according to overall level of exertion as they feel it boxes the client into a category that may not be appropriate. Regardless of whether an overall level of work is provided, it is important to document the specific abilities associated with each task of the test within the overall level of work.

The tolerance for an 8-hour day, self-limiting behavior, function-to-function inconsistencies, and a comparison of the client’s abilities to the job or occupation demands (if desired) should also be reported. A conclusion/summary/recommendations section at the end of the report is helpful to interpret the results but may not be desired by all referral sources.

**Equipment and space.** Space requirements for an FCE will vary according to the FCE protocol and the tasks evaluated. In general, a dedicated private area for evaluation is optimal but not required. Lifting and position tolerance tasks generally require at least a 10’ X 10’ area to allow the evaluator to
adequately visualize the client’s entire body. To achieve an accurate and clear view of any deviations present, the evaluator must view the client from a specific perspective (typically perpendicular to the plane of movement). Therefore, having an uncluttered evaluation area is helpful. For carrying, pushing, pulling, walking and crawling, a 25 - 30 foot walkway with the ability to step back 8 - 10 feet from the client in both the sagittal and frontal planes is optimal. More short or narrow walkways make visual observation difficult and may reduce reliability and validity. Access to stairs and adequate ceiling height for ladder climbing is important when assessing clients with these job requirements.

Testing may be done at the work-site, provided that testing equipment is available. Some FCE systems have portable equipment for work-site assessment. These systems typically require approximately 30 minutes to set up and 30 minutes to breakdown the portable equipment.

Some of the FCEs utilize generic lift boxes, push-pull sleds, ladders, tool boxes, and adjustable height shelving and rely primarily on clinical observation. Others require equipment that has been developed especially for their protocol. Does using additional technology enhance reliability and validity? Studies have yet to be conducted that establish appropriate guidelines for use of existing or new technology.

**Administrator qualifications.** FCE systems differ as to the disciplines considered qualified to perform the assessment. Some systems train only occupational and physical therapists, others include exercise physiologists, athletic trainers, vocational evaluators, nurses, physical therapists and occupational therapy assistants.

Occupational therapists were the first to perform FCEs, (Lechner, Daly, McKelvy, & Fadel, 2004) soon to be followed by physical therapists. Some insurance carriers restrict those who can be reimbursed for performing FCEs, allowing payment only for FCEs performed by physical or occupational therapists. To circumvent this issue and continue to utilize professionals other than physical or occupational therapists, some clinics have two individuals perform the FCE. Often the therapist, who can be reimbursed, performs only the musculoskeletal component of the evaluation while the majority of the test is performed by the paraprofessional or technician. On occasion, the therapist performs no part of the testing and merely co-signs the report. If the carrier has professional requirements for performing FCEs, discussions regarding the use of alternate personnel with the clinic are important.


Given the lack of consensus on FCE protocols, (Reneman, 2003) achieving universal criteria and competencies would be difficult. In this author’s opinion, certification should require knowledge of test
administration, scoring, appropriate musculoskeletal screening and the contraindications/precautions for performing the FCE.

In this author’s opinion, two evaluator issues are paramount for safe and accurate test administration and scoring. Firstly, the FCE evaluator must be able to recognize and evaluate medical conditions that are contraindications or pre-cautions for performing FCE. Secondly, the evaluator must have adequate background in the normal and pathological biomechanics associated with injury and illness. This knowledge of biomechanics enables the evaluator to recognize a maximal response to load and to recognize deviations in posture and movement patterns that limit non-materials handling aspects of work.

**Training requirements.** The training requirements for those administering a FCE vary among protocols, ranging from 0 to 5 days (Table 1). Most commercially available systems require some training. Some FCE systems require that participants pass a competency requirement to be certified. Those performing a self-developed test often have no formal training and instead, learn on the job. This lack of formal training is of concern since physical and occupational therapy programs do not typically include FCE training as part of the curriculum. However, there is no peer-reviewed, published evidence regarding the extent of training necessary to achieve a reliable, valid, FCE. Unpublished pilot studies conducted by this author, suggested that for one FCE protocol, the ErgoScience FCE, three days of training was needed to achieve adequate levels of reliability (unpublished pilot studies conducted at UAB, 1988-89).

**Safety precautions.** Injury during a FCE can occur as a result of exceeding the client’s musculoskeletal, cardiovascular, or neurological system tolerances. Stopping tasks when the activity begins to appear unsafe minimizes the chance of musculoskeletal injuries. The determination of a consistent stopping point requires clear operational definitions and specific decision-making criteria help to standardized the decision-making process and protect the client from overexertion.

Some FCE experts advocate teaching proper lifting techniques prior to the testing while others feel that it will bias test results. In this author’s opinion, the welfare of the client far outweighs any potential for bias. No studies exist that address this issue. The examiner cannot expect clients to permanently change their lifting technique or to apply the newly learned technique in the work setting after one instruction section. After a brief instruction, however, clients typically begin the task using somewhat better body mechanics and are less vulnerable to injury during the evaluation. If the client requires instruction in body mechanics prior to the evaluation, the need for further instruction should be documented in the final report so that additional assistance can be provided prior to return to work.

Controversy exists surrounding the safety of isometric lift testing. Some commercial FCE systems utilize isometric lifting. This author has heard multiple anecdotal complaints of injury that occurred during isometric lift testing. One possible explanation for the reported injuries with isometric lifting is that the client can build up a significant amount of force with little accompanying observable biomechanical evidence of effort. This lack of visual feedback limits the examiner’s ability to stop the client before a safe maximum is exceeded.

There are countless medical conditions that may require physical examination prior to an FCE. For example, if the client relates symptoms associated with nerve root compression or vertebral artery compromise, examiners are advised to perform a brief screening exam prior to the FCE testing. If this screen is positive, any FCE tasks that increase symptoms related to nerve root irritation/compression or vertebral artery compromise should be stopped immediately.
Blood pressure should be monitored prior to initiating an FCE. If the blood pressure significantly exceeds safety guidelines, the client should be advised that the FCE cannot be performed and that medical follow-up is recommended. Contacting the referring physician to describe the problem and suggesting that an FCE could be performed as soon as the blood pressure is brought under control will help to ensure that this problem is addressed. Follow up with written documentation is recommended. Some clients have borderline hypertension that is exacerbated by caffeine, nicotine, and/or stress involved in reaching the clinic. Therefore if the client’s blood pressure only slightly exceeds the cutoff point, the therapist may decide to proceed with caution monitoring the blood pressure after each task, and watching the patient closely for symptoms of distress. If the blood pressure stabilizes or decreases, proceeding with the FCE is most likely safe. If the blood pressure continues to rise, the test should be discontinued.

Monitoring the client’s heart rate with a device that has an upper-limit alarm helps to prevent clients from performing tasks that exceed their cardiovascular capabilities. When clients are taking heart rate suppressing drugs such as beta or calcium channel blockers, however, heart rate can no longer be used as an indicator of overexertion. Instead, the clinician must rely on the client’s perceived exertion level or upon clinical signs of overexertion including respiratory rate, color etc. to determine safe exertion levels. The evaluation and monitoring of neuromusculoskeletal and cardiovascular signs and symptoms discussed above make it a difficult for non-medical personnel to perform the test safely.

**Level of objectivity.** Some clinicians associate objectivity exclusively with interval or ratio scales such as inches, foot-pounds of force, joules, degrees, etc. Objective means that a measure is as free as possible from observer bias (Rothstein & Echternach, 1993). Observation of movement, a method often used in FCEs, also can be objective if the procedures, parameters of observation and the scoring system are operationally defined. Reliability and validity research establishes the objectivity, consistency and accuracy of the scoring system (Lechner et al 1994).

**Generalizing Performance.** During most FCEs, each physical demand of work is typically assessed for a brief period of time, usually no more than 5 to 10 minutes. The examiner must then decide, based on performance during this brief period of time, the duration of day this demand could be performed by the worker. For example, if the examiner observes a client perform the “stooping” task of an FCE, he/she must then determine whether the client can perform stooping “Constantly,” “Frequently,” “Occasionally,” or “Never” as defined by the US Department of Labor in the Dictionary of Occupational Titles (1991). These projections are often done using clinical intuitive guesswork. In unpublished pilot studies, this author has found this intuitive approach for projecting to the 8-hour day to be very unreliable from therapist to therapist. Utilization of a standardized scoring system, a systematic data collection process, and rating performance according to operational definitions and algorithms minimized much of this variability (Lechner et al, 1994 and Lechner et al, 1996).

**Sincerity of Effort.** One of the most challenging and controversial aspects of FCE involves determining the client’s sincerity of effort (Geisser, Robinson, Miller, & Badde, 2003; Lechner, Bradbury, Bradley, 1998; King et al, 1998; Robinson, Macmillan, & O’Connor, 1991).

Clients who perceive secondary financial gain through the workers’ compensation system may exaggerate their dysfunction. As a result, many methods for detecting these clients have evolved (Table 2). A thorough discussion of these approaches and the literature supporting them is beyond the scope of this manuscript and is the subject of a critical review (Lechner et al, 1998) and another manuscript in
this publication. However, a brief review of the issues surrounding assessing sincerity of effort in FCE seems warranted.

Despite their widely accepted use, some of the methods were not developed for the purpose of detecting sincerity of effort. Waddell’s non-organic signs (NOS) are a classic example of this type of misapplication (Waddell, McCulloch, Kummel, & Venner, 1980). Waddell developed 8 clinical signs or tests that should be negative when administered to low back clients. If the client experiences scores positively on 3 out of the 8 signs, he/she is considered to be withholding effort in a FCE. Waddell developed the NOS “to help identify clients who require more detailed psychological assessment” (Waddell et al, 1980). This explicitly stated purpose does not suggest that scoring positively on the NOS means that the client is withholding full effort (Scalzitti, 1997). Yet, unfortunately, the NOS have been equated with an insincere effort and outright malingering in clinical practice and, even in the peer-reviewed literature (Lehman, Russell, & Spratt 1983; Spratt, Lehman, Weinstein, & Sayre, 1990).

Many of the tests used to detect sincerity of effort are not being scored using their original methods, usually because the methods are too complex or cumbersome for the clinical setting. The bell-shaped curve, for example, involves testing isometric grip strength at 5 different handle positions (Stokes, 1983). A plot of the force at the 5 different positions is expected to produce a bell-shaped curve. As originally developed by the investigators, a computerized curve analysis procedure was used to analyze the curve (Robinson Macmillan, & O’Connor, 1993; Simonsen, 1995) and when used in this manner is a very reliable protocol. However, most clinicians use visual inspection of the curve, which has been shown to be less reliable and valid (Robinson et al).

The standardization, reliability, and validity of some of the methods used to determine sincerity of effort are questionable. For example, test administration of Waddell’s non-organic signs was described in a manner that has resulted in wide variability in test administration. This lack of standardization may contribute to findings that some of the signs are unreliable (Korbon, DeGood, & Schroeder, 1987) found axial loading, trunk rotation, and overreaction to have poor reliability. Other studies that demonstrated higher reliability of Waddell’s non-organic signs involved considerable training of the examiners by Dr. Waddell (Waddell et al, 1980; Waddell, Main, & Morris, 1982).

Measuring the coefficient of variation (CV) typically involves having the client perform 3 maximum repetitions of an isometric contraction. The CV is calculated by dividing the standard deviation by the mean of the three measures. The underlying assumption is that sub-maximal efforts will produce greater variability or a higher CV. Poor reliability and a high incidence of false negatives, however, have been reported for this approach in isometric testing (Lin et al, 1996, Robinson et al, 1993). Robinson et al. (Robinson et al, 1993) reported interclass correlation coefficients for maximal and sub-maximal efforts of isometric grip strength as .036 to .025, indicating very poor reliability for the CV. These investigators also found a high percent of false negatives with this approach (Simonsen, 1995) and examined CVs for eight isometric strength tasks tested using the ERGOS Work Simulator. They found poor correlation between the CVs of the various tests and concluded that there was no evidence to suggest that CV can be used independently to determine sincerity of effort.

These are but a few examples of a growing body of evidence in the peer-reviewed literature suggesting that many of the methods widely used to evaluate sincerity of effort in clients who are undergoing a FCE are not adequately supported by research. Disability insurance carriers are encouraged to be educated consumers when it comes to utilizing test results from these protocols.
In addition to formal consistency of effort testing, clinicians can document whether a client is performing to a maximum effort by comparing visual observations of signs of effort to the client’s willingness to perform. If the client stops himself/herself prior to reaching a maximum effort, however, the therapist cannot determine the reason(s) underlying this self-limiting behavior. The client may be terminating the task because of pain, fear of re-injury, anxiety, depression, poor understanding of instructions, or a conscious or unconscious attempt to manipulate the results of the test.

If obvious function-to-function discrepancies, gross inconsistencies in functional performance, or attempts to feign maximal effort are observed during an FCE, the clinician should report such behavior. Inconsistencies observed and measured provide evidence in support of non-compliance. However, clients should be confronted respectfully, and these findings should be interpreted within the context of performance on the test as a whole.

Another method used by some payers for addressing sincerity of effort is client surveillance. However, interpretation of the surveillance tape can be challenging. The FCE examiner can play an important role by reviewing surveillance videos and making function to function comparisons to FCE performance.

**Normative data.** Since the passage of the Americans with Disabilities Act (ADA) (ADA Technical Assistance Manual, 1992) comparing the client’s abilities to the job demands has become the basis for return-to-work and pre-employment/post-offer testing. If abilities meet job demands, then the client can return to work or the job applicant can be hired. Whether the individual’s abilities are in the 5th or 95th percentile has little bearing on whether the individual can return to work or perform the physical abilities of the job. Even in “Any Occupation” FCEs the client’s abilities are compared to any presence of any occupation that does not exceed the client’s abilities. The one exception lies in the area of manual and finger dexterity testing where test results must first be translated into a percentile score and then into an aptitude score for comparison to Department of Labor classifications of the dexterity demands. The DOL dexterity demands are classified according to normative function (Dictionary of Occupational Titles, 1991).

**Indications for FCE.** In this author’s opinion, FCEs are grossly underutilized. Most return to work decisions and many disability determinations are made based on clinical intuitions with no functional observation-based measurements performed. They are typically reserved for those cases where treatment has failed, poor motivation is suspected, return-to-work attempts have not been successful, or the client is in the chronic phases of impairment. These are all appropriate times to perform a comprehensive FCE. However, if FCE components were used at the conclusion of acute care when the initial return to work decision is being made, fewer cases might become chronic and efficient and effective return to work could be facilitated.

Consider this example. A client with a diagnosis of lumbar strain is completing 4-6 weeks of acute care physical therapy. Three of the most demanding aspects of the client’s job require him to lift 56 pounds from floor to waist and stoop and kneel occasionally. During the final acute care physical therapy visit, the therapist administers these three functional tasks as part of the discharge evaluation. The client was able to successfully complete the kneeling and lifting but had difficulty tolerating the stooping.

The client was returned to work with the restriction of avoiding stooping for 2 weeks and to continue physical therapy to improve stooping tolerance. After two weeks of continued treatment and modified work, the stooping task was re-administered and the client now demonstrated improved tolerance to stooping at the occasional level. The client was released to work full duty and therapy was
discontinued. The FCE tasks helped set realistic return to work parameters and gradually return the client to work full duty.

**Implications of FCEs for treatment.** If clients are to begin a program of work simulation and conditioning after acute care treatment, FCEs (combined with job demands information) can be used to help establish the focus and goals of the program. There are many work-related functions that the client might perform as part of an industrial rehabilitation program. For example, why should a client work on ladder climbing if this task is not part of his job or if his performance on that task already meets his job requirement? Using FCEs can make the program more focused, more efficient and more cost-effective.

Weekly progress on functional activities can be monitored using selected tasks of the FCE that relate to the tasks and goals of the work simulation program. For example, a client may need to lift 42 pounds from the floor to a waist height table for her/his job. On the initial FCE she/he was only able to lift 26 pounds. In the work simulation program, she/he would likely be working on improving floor-to-waist lifting and could be re-tested weekly on this task until the work-related goal of 42 pounds is met. Having this functional data makes the return to work decision much more objective and comfortable for all involved.

**Isolation of body parts.** Some referral sources will request an FCE on a single body part in isolation. Such requests typically are made because the client has a pre-existing condition involving another body part and the payer does not want be responsible for this pre-existing component of the dysfunction. This request may be impossible to fulfill, however, especially in the lower extremity, due to the complexity of biomechanical function. Most lower extremity function occurs with the foot planted on an immovable surface while bearing a portion of body weight. Movement in one of the lower extremity joints creates movement in all other joints in the chain (Norkin & Levange, 1992).

Therefore, if the ankle does not have full motion, the hip and knee joints will not be able to move through full range of motion when the client is performing a weight-bearing task. For example, if the task is walking and the ankle cannot plantarflex fully at the end of the stance phase of gait, the hip and knee will not be able to extend fully. As a result, stride length will be shortened. The resulting shorter stride will require faster cadence and higher energy consumption to maintain a functional walking speed and may limit the client’s tolerance to walking over an 8-hour day.

If the client with the ankle restriction described above has only an ankle injury, then resulting deviations and functional restrictions obviously are due to that injury. The picture becomes more complicated, however, if the client has had a previous knee injury in addition to the ankle injury. When the shortened stride length and functional limitations are observed, the relative contribution of the recent ankle injury is difficult to discern. The only way to determine the percent additional dysfunction due to the ankle injury is to compare FCE test results after the knee injury to those after the ankle injury. Such sequential testing is not possible post hoc and sequential test results are seldom available.

In the upper extremity the relative contribution of two injuries to the same limb may be somewhat easier to determine. However, the picture may still be clouded. For example, a hand injury should not affect the ability to reach. However, some hand injuries may cause pain and swelling in certain positions of reaching. Thus, hand injuries can contribute to a reaching dysfunction.
Application of FCEs in Private Sector Disability Determination. FCEs are seldom used to determine whether a client receives short term disability (personal communication). Most short term disability decisions are based on medical information or treatment guidelines. Even when clients transition from the short term to the long term phase of disability compensation, FCEs are seldom utilized. This author feels however, that functional testing could be very valuable for making short term disability determinations and in the transition decision. In short term disability and in the transition from short term to long term disability, the FCE could be customized to test the most demanding aspects of the job or occupation.

In the long term private disability insurance arena, FCEs are more widely used. For policies where the client is insured relative to their specific job, the client’s abilities are compared to job demands and claimants receive benefits if abilities do not match job demands. In these cases, a detailed job description for comparison to the client’s abilities in the FCE is essential. Own job policies are rare in today’s environment. The “own occupation” long term disability policy is much more common. In the “own occupation” determination, client abilities are compared to the generic demands of an occupation as defined by the Dictionary of Occupational Titles (DOT) (Ref). In some policies, the own occupation phase lasts for a two-year period and after that time; claimants must be unable to perform any occupation in order to continue receiving benefits. At that point in time, when the policy converts to any occupation, carriers use an FCE to test clients’ abilities without comparison to job or occupation.

Summary and Conclusions. Successful disability determination requires the use of medical, functional, and vocational data (Toppino & Boyd, 1994). The disability adjudicator must provide a comprehensive assessment of all these areas and needs objective, accurate information regarding the physical functional abilities of their clients. The FCE can be a valuable source of this information. However, little consensus exists regarding the optimal FCE testing protocol. Universal standards for FCEs are lacking. Research has emerged to support the reliability and validity of some aspects of some of the commercially available FCE systems. However, most commercial FCEs lack supporting research for the entire tests and those developed by individual clinics also are lacking in this regard.

There are many considerations for disability adjudicators who are selecting a FCE provider or a testing protocol for their own use: test length, type of protocol, equipment and space requirements, training requirements, safety precautions, test validation, and sincerity/consistency of effort protocols are all important consideration. The type of test selected may also vary depending on the purpose of testing. A variety of approaches are commercially available and even greater variety exists in FCEs developed by individual clinicians.

Because of the lack of definitive research, disability adjudicators should select the protocol that they understand, can easily interpret and explain, and that has research that will help the expert to withstand a legal challenge. Protocols lacking peer-reviewed research are the most vulnerable in this regard.
References


