

U.S. Department of Labor

Office of Workers' Compensation Programs
Division of Energy Employees Occupational
Illness Compensation
Washington, DC 20210



November 3, 2020

Dr. Steven Markowitz, Chair
Advisory Board on Toxic Substances and
Worker Health
Queens College, Remsen Hall
65-30 Kissena Boulevard
Flushing, NY 11367

Dear Dr. Markowitz:

I am writing to you regarding concerns that program stakeholders have directed to the Advisory Board on Toxic Substances and Worker Health about our efforts to evaluate impairments ratings for appropriate application of the *AMA Guides™ to the Evaluation of Permanent Impairment, Fifth Edition*.

Over the past year, the Division of Energy Employees Occupational Illness Compensation (DEEOIC) has seen a substantial increase in respiratory impairment ratings from physicians applying different methodologies to assign whole person impairments. In some instances, these methods have given rise to questions as to whether the *Guides* provide sufficient instruction to permit or prohibit certain methodologies. As with most questions of medical sufficiency, the DEEOIC has had to rely on the input of qualified physicians to address questions relating to proper application of the *Guides* in the claim process.

From the assessment of the information received so far, DEEOIC has received conflicting medical input on whether certain functional measurements are an acceptable basis for assigning respiratory impairment. Based on the concerns communicated to the Board, DEEOIC acknowledges that there are competing interpretations of the *Guides* when it comes to how to use patient data in assigning a whole person impairment. The *Guides* oftentimes communicates broad discretion to physicians in how to reasonably calculate ratings based on the totality of available data. In other situations, the *Guides* are more prescriptive.

The most common example DEEOIC has encountered regarding an interpretive disagreement relates to the assignment of the VO₂max calculation to Table 5-12 (Pg. 107 of the *Guides*) derived from a Six-Minute Walk Test (6MWT). From the distance walked during the test, physicians are assigning a VO₂max using a formula described in a BMC Pulmonary Medicine article from May 26, 2010¹:

$$\text{Mean Peak VO}_2 \text{ (ml / kg / min)} = 4.948 + 0.023 * \text{Mean 6 MWD (meters)}$$

(SEE 1.1 ml / kg / min)

¹ <https://bmcpulmed.biomedcentral.com/articles/10.1186/1471-2466-10-31>

Some rating physicians have been using this calculation in lieu of respiratory data provided in a Pulmonary Function Test (PFT). In instances where both PFT and VO₂max calculations exist, physicians are relying on the worst of the two scores to assign an impairment. This can lead to a common situation encountered by DEEOIC where a PFT result equals a Class 1 rating under Table 5-12, while the VO₂max corresponds with a Class 4 rating. While the *Guides* allows a physician to use any one of the criteria (including the application of the VO₂max) in Table 5-12 to place an employee in a Class 1 - 4 impairment, it provides no clear guidance on the appropriateness of the testing used in support of the calculation of VO₂max itself.

In a different methodology, a physician is applying a conversion table from ACSM's Guideline for Exercise Testing and Prescription, 9th edition, Philadelphia, PA: Wolters Kluwer Lippincott Williams & Wilkins, 2014, page 173. I have attached a copy of the relevant conversion table (Exhibit 1). This suggests that anyone walking less than approximately 2300 feet in 6 minutes is potentially ratable as a Class 4 impairment according to Table 5-12 in the *Guides* (VO₂max <15 mL/(kg·min)).

The counter argument to the application of the 6MWT in assigning VO₂max is that the test itself is a very poor indicator of respiratory functionality. Any number of non-respiratory factors can influence the test outcome. A more reliable methodology for arriving at the VO₂max is through a cardiopulmonary exercise gas-exchange measurement.

DEEOIC has also received input that any physician that does rely on a 6MWT to gauge impairment should ensure that the conduct of the test meets specific qualitative standards. To this end, DEEOIC received a reference to an American Thoracic Society publication, *ATS Statement: Guidelines for the Six Minute Walk Test* (Attached as Exhibit 2).

After evaluating the matter, DEEOIC has recently determined that the *Guides* does not provide clear, prescriptive instruction on the calculation of the VO₂max, nor does it prohibit the use of the 6MWT to assign the VO₂max. It also provides no qualitative standards for performing the test. As the *Guides* serve as the singular basis for assigning whole person impairment, DEEOIC currently has no documented reason to conclude that the 6MWT is an inappropriate method for assigning the VO₂max.

Until DEEOIC receives input that warrants a change, DEEOIC will evaluate submitted impairment ratings based on the technical guidance provided in the *Guides*. In the absence of specific prescriptive or prohibited practices within the text of the *Guides*, DEEOIC will defer to the judgment of a qualified rating physician in the application of particular measures to assign whole person impairment. However, as is the case for all adjudications, the totality of all the evidence submitted is considered by a claims examiner. Accordingly, this does not preclude DEEOIC from seeking clarification from a physician on the proper calculation of combined ratings or clarifying how reported effects of an accepted illness on activity of daily living correspond to a particular rating percentage.

DEEOIC is systematically reviewing several pending cases where this problem has arisen. My hope is that we can quickly address many impairment claims that this issue delayed.

Concurrently, I am seeking the Board's input on this topic. Specifically, I am asking that the Board's consider and respond to the following questions:

1. What are the permissible testing methodologies that a physician may use in assigning a VO₂max for application in Table 5-12 of the *Guides*?
2. If the 6MWT is a valid methodology for assigning a VO₂max for application in Table 5-12, should the evidence document that the test conforms with any particular medical standard in validating the test outcome, and what are acceptable methods for calculating the VO₂max from a validated 6MWT result?

I look forward to working with the Board to obtain clarification on this very challenging issue.

Sincerely,

RACHEL POND Digitally signed by RACHEL POND
Date: 2020.11.03 13:24:23 -05'00'

Rachel D. Pond
Director,
Division of Energy Employees
Occupational Illness Compensation

Exhibit 1 – Six Minute Walk Test Conversion Table

Table 2

6 Minute Walk Test Distance Conversion Table

Standard estimates from 6MWD (feet walked) to METs

Based on ACSM metabolic prediction equation formula for horizontal walking.*

Distance in feet	Distance in meters	MPH	Meters·min ⁻¹	VO ₂ (ml·kg ⁻¹ ·min ⁻¹)	METs
500	152	.94	25	6.04	1.73
510	155	.96	26	6.09	1.74
520	159	.98	26	6.14	1.75
530	162	1.00	27	6.19	1.77
540	165	1.02	27	6.24	1.78
550	168	1.04	28	6.29	1.80
560	171	1.06	28	6.35	1.81
570	174	1.08	29	6.39	1.83
580	177	1.10	29	6.45	1.84
590	180	1.11	30	6.50	1.86
600	183	1.13	30	6.55	1.87
610	186	1.15	31	6.59	1.89
620	189	1.17	32	6.65	1.90
630	192	1.19	32	6.70	1.91
640	195	1.21	33	6.75	1.93
650	198	1.23	33	6.80	1.94
660	201	1.25	34	6.85	1.96
670	204	1.27	34	6.90	1.97
680	207	1.28	35	6.95	1.99
690	210	1.30	35	7.00	2.00
700	213	1.32	36	7.06	2.02
710	216	1.34	36	7.11	2.03
720	219	1.36	37	7.16	2.05
730	223	1.38	37	7.21	2.06
740	226	1.40	38	7.26	2.07
750	229	1.42	38	7.31	2.09
760	232	1.44	39	7.36	2.10
770	235	1.45	39	7.41	2.12
780	238	1.47	40	7.46	2.13
790	241	1.49	40	7.51	2.15
800	244	1.51	41	7.56	2.16
810	247	1.53	41	7.62	2.18
820	250	1.55	42	7.67	2.19
830	253	1.57	42	7.72	2.20
840	256	1.59	43	7.77	2.22
850	259	1.61	43	7.82	2.23
860	262	1.62	44	7.87	2.25
870	265	1.64	44	7.92	2.26
880	268	1.66	45	7.97	2.28
890	271	1.68	45	8.02	2.29
900	274	1.7	46	8.07	2.31

Distance in feet	Distance in meters	MPH	Meters·min ⁻¹	VO2(ml·kg ⁻¹ ·min ⁻¹)	METs
910	277	1.72	46	8.12	2.32
920	280	1.74	47	8.17	2.34
930	283	1.76	47	8.22	2.35
940	287	1.78	48	8.28	2.36
950	290	1.79	48	8.33	2.38
960	293	1.81	49	8.38	2.39
970	296	1.83	49	8.43	2.41
980	299	1.85	50	8.47	2.42
990	302	1.87	50	8.52	2.44
1000	305	1.89	51	8.58	2.45
1100	335	2.08	56	9.08	2.60
1200	366	2.26	61	9.59	2.74
1300	396	2.45	66	10.10	2.89
1400	427	2.64	71	10.61	3.03
1500	457	2.83	76	11.12	3.18
1600	488	3.02	81	11.62	3.32
1700	518	3.21	86	12.13	3.47
1800	549	3.40	91	12.64	3.61
1900	579	3.59	97	13.15	3.76
2000	610	3.70	102	13.66	3.90
2100	640	3.97	107	14.16	4.05
2200	671	4.16	112	14.67	4.19
2300	701	4.34	117	15.18	4.34
2400	732	4.53	122	15.69	4.48
2500	762	4.72	127	16.20	4.63
2600	792	4.91	132	16.70	4.77
2700	823	5.10	137	17.22	4.92
2800	853	5.29	142	17.72	5.06
2900	884	5.48	147	18.23	5.21
3000	914	5.67	152	18.74	5.35

Formula is most accurate for estimating MET levels for horizontal walking speeds between 1.9 to 3.7 mph (50-100 m·min⁻¹).

$$*VO_2 \text{ (METs)} = [0.1 \times \text{speed (m·min}^{-1}\text{)} + 3.5\text{mLO}_2\cdot\text{kg}^{-1}\cdot\text{min}^{-1}] + 3.5\text{mLO}_2\cdot\text{kg}^{-1}\cdot\text{min}^{-1}$$

ACSM's Guidelines for Exercise Testing and Prescription, 9th ed. Philadelphia, PA: Wolters Kluwer Lippincott Williams & Wilkins. 2014, p 173

American Thoracic Society

ATS Statement: Guidelines for the Six-Minute Walk Test

THIS OFFICIAL STATEMENT OF THE AMERICAN THORACIC SOCIETY WAS APPROVED BY THE ATS BOARD OF DIRECTORS
MARCH 2002

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PURPOSE AND SCOPE

This statement provides practical guidelines for the 6-minute walk test (6MWT). Specifically, it reviews indications, details factors that influence results, presents a brief step-by-step protocol, outlines safety measures, describes proper patient preparation and procedures, and offers guidelines for clinical interpretation of results. These recommendations are not intended to limit the use of alternative protocols for research studies. We do not discuss the general topic of clinical exercise testing.

As with other American Thoracic Society statements on pulmonary function testing, these guidelines come out of a consensus conference. Drafts were prepared by two members (P.L.E. and R.J.Z.) and were based on a comprehensive Medline literature search from 1970 through 2001, augmented by suggestions from other committee members. Each draft responded to comments from the working committee. The guidelines follow previously published methods as closely as possible and provide a rationale for each specific recommendation. The final recommendations represent a consensus of the committee. The committee recommends that these guidelines be reviewed in five years and in the meantime encourages further research in areas of controversy.

BACKGROUND

There are several modalities available for the objective evaluation of functional exercise capacity. Some provide a very complete assessment of all systems involved in exercise performance (high tech), whereas others provide basic information but are low tech and are simpler to perform. The modality used should be chosen based on the clinical question to be addressed and on available resources. The most popular clinical exercise tests in order of increasing complexity are stair climbing, a 6MWT, a shuttle-walk test, detection of exercise-induced asthma, a cardiac stress test (e.g., Bruce protocol), and a cardio-

pulmonary exercise test (1, 2). Other professional organizations have published standards for cardiac stress testing (3, 4).

Assessment of functional capacity has traditionally been done by merely asking patients the following: "How many flights of stairs can you climb or how many blocks can you walk?" However, patients vary in their recollection and may report overestimations or underestimations of their true functional capacity. Objective measurements are usually better than self-reports. In the early 1960s, Balke developed a simple test to evaluate the functional capacity by measuring the distance walked during a defined period of time (5). A 12-minute field performance test was then developed to evaluate the level of physical fitness of healthy individuals (6). The walking test was also adapted to assess disability in patients with chronic bronchitis (7). In an attempt to accommodate patients with respiratory disease for whom walking 12 minutes was too exhausting, a 6-minute walk was found to perform as well as the 12-minute walk (8). A recent review of functional walking tests concluded that "the 6MWT is easy to administer, better tolerated, and more reflective of activities of daily living than the other walk tests" (9).

The 6MWT is a practical simple test that requires a 100-ft hallway but no exercise equipment or advanced training for technicians. Walking is an activity performed daily by all but the most severely impaired patients. This test measures the distance that a patient can quickly walk on a flat, hard surface in a period of 6 minutes (the 6MWD). It evaluates the global and integrated responses of all the systems involved during exercise, including the pulmonary and cardiovascular systems, systemic circulation, peripheral circulation, blood, neuromuscular units, and muscle metabolism. It does not provide specific information on the function of each of the different organs and systems involved in exercise or the mechanism of exercise limitation, as is possible with maximal cardiopulmonary exercise testing. The self-paced 6MWT assesses the submaximal level of functional capacity. Most patients do not achieve maximal exercise capacity during the 6MWT; instead, they choose their own intensity of exercise and are allowed to stop and rest during the test. However, because most activities of daily living are performed at submaximal levels of exertion, the 6MWD may better reflect the functional exercise level for daily physical activities.

INDICATIONS AND LIMITATIONS

The strongest indication for the 6MWT is for measuring the response to medical interventions in patients with moderate to severe heart or lung disease. The 6MWT has also been used as a one time measure of functional status of patients, as well as a predictor of morbidity and mortality (see Table 1 for a list of these indications). The fact that investigators have used the 6MWT in these settings does not prove that the test is clinically useful (or the best test) for determining functional capacity or changes in functional capacity due to an intervention in patients with these diseases. Further studies are necessary to determine the utility of the 6MWT in various clinical situations.

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Internet address: www.atsjournals.org

Formal cardiopulmonary exercise testing provides a global assessment of the exercise response, an objective determination of functional capacity and impairment, determination of the appropriate intensity needed to perform prolonged exercise, quantification of factors limiting exercise, and a definition of the underlying pathophysiologic mechanisms such as the contribution of different organ systems involved in exercise. The 6MWT does not determine peak oxygen uptake, diagnose the cause of dyspnea on exertion, or evaluate the causes or mechanisms of exercise limitation (1, 2). The information provided by a 6MWT should be considered complementary to cardiopulmonary exercise testing, not a replacement for it. Despite the difference between these two functional tests, some good correlations between them have been reported. For example, a significant correlation ($r = 0.73$) between 6MWD and peak oxygen uptake has been reported for patients with end-stage lung diseases (36).

In some clinical situations, the 6MWT provides information that may be a better index of the patient's ability to perform daily activities than is peak oxygen uptake; for example, 6MWD correlates better with formal measures of quality of life (37). Changes in 6MWD after therapeutic interventions correlate with subjective improvement in dyspnea (38, 39). The reproducibility of the 6MWD (with a coefficient of variation of approximately 8%) appears to be better than the reproducibility of 1-second forced expiratory volume in patients with chronic obstructive pulmonary disease (COPD) (8, 39–42). Questionnaire indices of functional status have a larger short-term variability (22–33%) than does the 6MWD (37).

The shuttle-walking test is similar to the 6MWT, but it uses an audio signal from a tape cassette to direct the walking pace of the patient back and forth on a 10-m course (43–45). The walking speed is increased every minute, and the test ends when the patient cannot reach the turnaround point within the required time. The exercise performed is similar to a symptom-limited, maximal, incremental treadmill test. An advantage of the shuttle walking test is that it has a better correlation with peak oxygen uptake than the 6MWD (46, 47). Disadvantages include less validation, less widespread use, and more potential for cardiovascular problems.

CONTRAINDICATIONS

Absolute contraindications for the 6MWT include the following: unstable angina during the previous month and myocar-

dial infarction during the previous month. Relative contraindications include a resting heart rate of more than 120, a systolic blood pressure of more than 180 mm Hg, and a diastolic blood pressure of more than 100 mm Hg.

Patients with any of these findings should be referred to the physician ordering or supervising the test for individual clinical assessment and a decision about the conduct of the test. The results from a resting electrocardiogram done during the previous 6 months should also be reviewed before testing. Stable exertional angina is not an absolute contraindication for a 6MWT, but patients with these symptoms should perform the test after using their antiangina medication, and rescue nitrate medication should be readily available.

Rationale

Patients with the previously mentioned risk factors may be at increased risk for arrhythmias or cardiovascular collapse during testing. However, each patient determines the intensity of their exercise, and the test (without electrocardiogram monitoring) has been performed in thousands of older persons (31, 48) and thousands of patients with heart failure or cardiomyopathy (32, 49, 50) without serious adverse events. The contraindications listed previously here were used by study investigators based on their impressions of the general safety of the 6MWT and their desire to be prudent, but it is unknown whether adverse events would occur if such patients performed a 6MWT; they are, therefore, listed as relative contraindications.

SAFETY ISSUES

1. Testing should be performed in a location where a rapid, appropriate response to an emergency is possible. The appropriate location of a crash cart should be determined by the physician supervising the facility.
2. Supplies that must be available include oxygen, sublingual nitroglycerine, aspirin, and albuterol (metered dose inhaler or nebulizer). A telephone or other means should be in place to enable a call for help.
3. The technician should be certified in cardiopulmonary resuscitation with a minimum of Basic Life Support by an American Health Association–approved cardiopulmonary resuscitation course. Advanced cardiac life support certification is desirable. Training, experience, and certification in related health care fields (registered nurse, registered respiratory therapist, certified pulmonary function technician, etc.) are also desirable. A certified individual should be readily available to respond if needed.
4. Physicians are not required to be present during all tests. The physician ordering the test or a supervising laboratory physician may decide whether physician attendance at a specific test is required.
5. If a patient is on chronic oxygen therapy, oxygen should be given at their standard rate or as directed by a physician or a protocol.

Reasons for immediately stopping a 6MWT include the following: (1) chest pain, (2) intolerable dyspnea, (3) leg cramps, (4) staggering, (5) diaphoresis, and (6) pale or ashen appearance.

Technicians must be trained to recognize these problems and the appropriate responses. If a test is stopped for any of these reasons, the patient should sit or lie supine as appropriate depending on the severity of the event and the technician's assessment of the severity of the event and the risk of syncope. The following should be obtained based on the judgment of the technician: blood pressure, pulse rate, oxygen saturation, and a physician evaluation. Oxygen should be administered as appropriate.

TABLE 1. INDICATIONS FOR THE SIX-MINUTE WALK TEST

Pretreatment and posttreatment comparisons
Lung transplantation (9, 10)
Lung resection (11)
Lung volume reduction surgery (12, 13)
Pulmonary rehabilitation (14, 15)
COPD (16–18)
Pulmonary hypertension
Heart failure (19, 20)
Functional status (single measurement)
COPD (21, 22)
Cystic fibrosis (23, 24)
Heart failure (25–27)
Peripheral vascular disease (28, 29)
Fibromyalgia (30)
Older patients (31)
Predictor of morbidity and mortality
Heart failure (32, 33)
COPD (34, 35)
Primary pulmonary hypertension (10, 36)

Definition of abbreviation: COPD = chronic obstructive pulmonary disease.

TECHNICAL ASPECTS OF THE 6MWT

Location

The 6MWT should be performed indoors, along a long, flat, straight, enclosed corridor with a hard surface that is seldom traveled. If the weather is comfortable, the test may be performed outdoors. The walking course must be 30 m in length. A 100-ft hallway is, therefore, required. The length of the corridor should be marked every 3 m. The turnaround points should be marked with a cone (such as an orange traffic cone). A starting line, which marks the beginning and end of each 60-m lap, should be marked on the floor using brightly colored tape.

Rationale. A shorter corridor requires patients to take more time to reverse directions more often, reducing the 6MWD. Most studies have used a 30-m corridor (51), but some have used 20- or 50-m corridors (52, 53). A recent multicenter study found no significant effect of the length of straight courses ranging from 50 to 164 ft, but patients walked farther on continuous (oval) tracks (mean 92 ft farther) (54).

The use of a treadmill to determine the 6MWD might save space and allow constant monitoring during the exercise, but the use of a treadmill for 6-minute walk testing is not recommended. Patients are unable to pace themselves on a treadmill. In one study of patients with severe lung disease, the mean distance walked on the treadmill during 6 minutes (with the speed adjusted by the patients) was shorter by a mean of 14% when compared with the standard 6MWD using a 100-ft hallway (55). The range of differences was wide, with patients walking between 400–1,300 ft on the treadmill who walked 1,200 ft in the hallway. Treadmill test results, therefore, are not interchangeable with corridor tests.

REQUIRED EQUIPMENT

1. Countdown timer (or stopwatch)
2. Mechanical lap counter
3. Two small cones to mark the turnaround points
4. A chair that can be easily moved along the walking course
5. Worksheets on a clipboard
6. A source of oxygen
7. Sphygmomanometer
8. Telephone
9. Automated electronic defibrillator

PATIENT PREPARATION

1. Comfortable clothing should be worn.
2. Appropriate shoes for walking should be worn.
3. Patients should use their usual walking aids during the test (cane, walker, etc.).
4. The patient's usual medical regimen should be continued.
5. A light meal is acceptable before early morning or early afternoon tests.
6. Patients should not have exercised vigorously within 2 hours of beginning the test.

MEASUREMENTS

1. Repeat testing should be performed about the same time of day to minimize intraday variability.
2. A "warm-up" period before the test should not be performed.
3. The patient should sit at rest in a chair, located near the starting position, for at least 10 minutes before the test starts. During this time, check for contraindications, measure pulse and blood pressure, and make sure that clothing and shoes are appropriate. Complete the first portion of the worksheet (see the APPENDIX).

4. Pulse oximetry is optional. If it is performed, measure and record baseline heart rate and oxygen saturation (SpO₂) and follow manufacturer's instructions to maximize the signal and to minimize motion artifact (56). Make sure the readings are stable before recording. Note pulse regularity and whether the oximeter signal quality is acceptable.

The rationale for measuring oxygen saturation is that although the distance is the primary outcome measure, improvement during serial evaluations may be manifest either by an increased distance or by reduced symptoms with the same distance walked (38). The SpO₂ should not be used for constant monitoring during the exercise. The technician must not walk with the patient to observe the SpO₂. If worn during the walk, the pulse oximeter must be lightweight (less than 2 pounds), battery powered, and held in place (perhaps by a "fanny pack") so that the patient does not have to hold or stabilize it and so that stride is not affected. Many pulse oximeters have considerable motion artifact that prevents accurate readings during the walk (57).

5. Have the patient stand and rate their baseline dyspnea and overall fatigue using the Borg scale (see Table 2 for the Borg scale and instructions [58]).
6. Set the lap counter to zero and the timer to 6 minutes. Assemble all necessary equipment (lap counter, timer, clipboard, Borg Scale, worksheet) and move to the starting point.
7. Instruct the patient as follows:

"The object of this test is to walk as far as possible for 6 minutes. You will walk back and forth in this hallway. Six minutes is a long time to walk, so you will be exerting yourself. You will probably get out of breath or become exhausted. You are permitted to slow down, to stop, and to rest as necessary. You may lean against the wall while resting, but resume walking as soon as you are able.

You will be walking back and forth around the cones. You should pivot briskly around the cones and continue back the other way without hesitation. Now I'm going to show you. Please watch the way I turn without hesitation."

Demonstrate by walking one lap yourself. Walk and pivot around a cone briskly.

"Are you ready to do that? I am going to use this counter to keep track of the number of laps you complete. I will click it each time you turn around at this starting line. Remember that the object is to walk AS FAR AS POSSIBLE for 6 minutes, but don't run or jog.

Start now, or whenever you are ready."

TABLE 2. THE BORG SCALE

0	Nothing at all
0.5	Very, very slight (just noticeable)
1	Very slight
2	Slight (light)
3	Moderate
4	Somewhat severe
5	Severe (heavy)
6	
7	Very severe
8	
9	
10	Very, very severe (maximal)

This Borg scale should be printed on heavy paper (11 inches high and perhaps laminated) in 20-point type size. At the beginning of the 6-minute exercise, show the scale to the patient and ask the patient this: "Please grade your level of shortness of breath using this scale." Then ask this: "Please grade your level of fatigue using this scale."

At the end of the exercise, remind the patient of the breathing number that they chose before the exercise and ask the patient to grade their breathing level again. Then ask the patient to grade their level of fatigue, after reminding them of their grade before the exercise.

8. Position the patient at the starting line. You should also stand near the starting line during the test. Do not walk with the patient. As soon as the patient starts to walk, start the timer.
9. **Do not talk to anyone during the walk.** Use an even tone of voice when using the standard phrases of encouragement. Watch the patient. Do not get distracted and lose count of the laps. Each time the participant returns to the starting line, click the lap counter once (or mark the lap on the worksheet). Let the participant see you do it. Exaggerate the click using body language, like using a stopwatch at a race.

After the first minute, tell the patient the following (in even tones): "You are doing well. You have 5 minutes to go."

When the timer shows 4 minutes remaining, tell the patient the following: "Keep up the good work. You have 4 minutes to go."

When the timer shows 3 minutes remaining, tell the patient the following: "You are doing well. You are halfway done."

When the timer shows 2 minutes remaining, tell the patient the following: "Keep up the good work. You have only 2 minutes left."

When the timer shows only 1 minute remaining, tell the patient: "You are doing well. You have only 1 minute to go."

Do not use other words of encouragement (or body language to speed up).

If the patient stops walking during the test and needs a rest, say this: "You can lean against the wall if you would like; then continue walking whenever you feel able." Do not stop the timer. If the patient stops before the 6 minutes are up and refuses to continue (or you decide that they should not continue), wheel the chair over for the patient to sit on, discontinue the walk, and note on the worksheet the distance, the time stopped, and the reason for stopping prematurely.

When the timer is 15 seconds from completion, say this: "In a moment I'm going to tell you to stop. When I do, just stop right where you are and I will come to you."

When the timer rings (or buzzes), say this: "Stop!" Walk over to the patient. Consider taking the chair if they look exhausted. Mark the spot where they stopped by placing a bean bag or a piece of tape on the floor.

10. Post-test: Record the postwalk Borg dyspnea and fatigue levels and ask this: "What, if anything, kept you from walking farther?"
11. If using a pulse oximeter, measure SpO₂ and pulse rate from the oximeter and then remove the sensor.
12. Record the number of laps from the counter (or tick marks on the worksheet).
13. Record the additional distance covered (the number of meters in the final partial lap) using the markers on the wall as distance guides. Calculate the total distance walked, rounding to the nearest meter, and record it on the worksheet.
14. Congratulate the patient on good effort and offer a drink of water.

QUALITY ASSURANCE

Sources of Variability

There are many sources of 6MWD variability (see Table 3). The sources of variability caused by the test procedure itself should be controlled as much as possible. This is done by fol-

lowing the standards found in this document and by using a quality-assurance program.

Practice Tests

A practice test is not needed in most clinical settings but should be considered. If a practice test is done, wait for at least 1 hour before the second test and report the highest 6MWD as the patient's 6MWD baseline.

Rationale. The 6MWD is only slightly higher for a second 6MWT performed a day later. The mean reported increase ranges from 0 to 17% (23, 27, 40, 41, 54, 59). A multicenter study of 470 highly motivated patients with severe COPD performed two 6MWTs 1 day apart, and on average, the 6MWD was only 66 ft (5.8%) higher on the second day (54).

Performance (without an intervention) usually reaches a plateau after two tests done within a week (8, 60). The training effect may be due to improved coordination, finding optimal stride length, and overcoming anxiety. The possibility of a practice or training effect from tests repeated after more than a month has not been studied or reported; however, it is likely that the effect of training wears off (does not persist) after a few weeks.

Technician Training and Experience

Technicians who perform 6MWTs should be trained using the standard protocol and then supervised for several tests before performing them alone. They should also have completed cardiopulmonary resuscitation training.

Rationale. One multicenter study of older people found that after correction for many other factors, two of the technicians had mean 6MWDs that were approximately 7% lower than the other two sites (31).

Encouragement

Only the standardized phrases for encouragement (as specified previously here) must be used during the test.

Rationale. Encouragement significantly increases the distance walked (42). Reproducibility for tests with and without encouragement is similar. Some studies have used encouragement every 30 seconds, every minute, or every 2 minutes. We have chosen every minute and standard phrases. Some studies (53) have instructed patients to walk as fast as possible. Although larger mean 6MWDs may be obtained thereby, we recommend that such phrases not be used, as they emphasize initial speed at the expense of earlier fatigue and possible excessive cardiac stress in some patients with heart disease.

TABLE 3. 6MWD SOURCES OF VARIABILITY

Factors reducing the 6MWD	
Shorter height	
Older age	
Higher body weight	
Female sex	
Impaired cognition	
A shorter corridor (more turns)	
Pulmonary disease (COPD, asthma, cystic fibrosis, interstitial lung disease)	
Cardiovascular disease (angina, MI, CHF, stroke, TIA, PVD, AAI)	
Musculoskeletal disorders (arthritis, ankle, knee, or hip injuries, muscle wasting, etc.)	
Factors increasing the 6MWD	
Taller height (longer legs)	
Male sex	
High motivation	
A patient who has previously performed the test	
Medication for a disabling disease taken just before the test	
Oxygen supplementation in patients with exercise-induced hypoxemia	

Definition of abbreviations: COPD = chronic obstructive pulmonary disease; 6MWD = 6-minute walking distance.

Supplemental Oxygen

If oxygen supplementation is needed during the walks and serial tests are planned (after an intervention other than oxygen therapy), then during all walks by that patient oxygen should be delivered in the same way with the same flow. If the flow must be increased during subsequent visits due to worsening gas exchange, this should be noted on the worksheet and considered during interpretation of the change noted in 6MWD. The type of oxygen delivery device should also be noted on the report: for instance, the patient carried liquid oxygen or pushed or pulled an oxygen tank, the delivery was pulsed or continuous, or a technician walked behind the patient with the oxygen source (not recommended). Measurements of pulse and SpO₂ should be made after waiting at least 10 minutes after any change in oxygen delivery.

Rationale. For patients with COPD or interstitial lung disease, oxygen supplementation increases the 6MWD (17, 59, 61). Carrying a portable gas container (but not using it for supplemental oxygen) reduced the mean 6MWD by 14% in one study of patients with severe respiratory disability, but using the container to deliver supplemental oxygen during the exercise increased the mean 6MWD by 20–36% (59).

Medications

The type of medication, dose, and number of hours taken before the test should be noted.

Rationale. Significant improvement in the distance walked, or the dyspnea scale, after administration of bronchodilators has been demonstrated in patients with COPD (62, 63), as well as cardiovascular medications in patients with heart failure (19).

INTERPRETATION

Most 6MWTs will be done before and after intervention, and the primary question to be answered after both tests have been completed is whether the patient has experienced a clinically significant improvement. With a good quality-assurance program, with patients tested by the same technician, and after one or two practice tests, short-term reproducibility of the 6MWD is excellent (36). It is not known whether it is best for clinical purposes to express change in 6MWD as (1) an absolute value, (2) a percentage change, or (3) a change in the percentage of predicted value. Until further research is available, we recommend that change in 6MWD be expressed as an absolute value (e.g., the patient walked 50 m farther).

A statistically significant mean increase in 6MWD in a group of study participants is often much less than a clinically significant increase in an individual patient. In one study of 112 patients (half of them women) with stable, severe COPD, the smallest difference in 6MWD that was associated with a noticeable clinical difference in the patients' perception of exercise performance was a mean of 54 m (95% confidence interval, 37–71 m) (64). This study suggests that for individual patients with COPD, an improvement of more than 70 m in the 6MWD after an intervention is necessary to be 95% confident that the improvement was significant. In an observational study of 45 older patients with heart failure, the smallest difference in 6MWD that was associated with a noticeable difference in their global rating of worsening was a mean of 43 m (20). The 6MWD was more responsive to deterioration than to improvement in heart failure symptoms.

Reported Mean Changes in 6MWD After Interventions

Supplemental oxygen (6 L/min) during exercise in patients with COPD or interstitial lung disease increased mean 6MWD by approximately 83 m (36%) in one study (59). Patients taking

an inhaled corticosteroid experienced a mean 33 m (8%) increase in 6MWD in an international COPD study (16). Patients with COPD in a study of the effects of exercise and diaphragmatic strength training experienced a mean increase in 6MWD of 50 m (20%) (65). Lung volume reduction surgery in patients with very severe COPD has been reported to increase 6MWD by a mean of 55 m (20%) (13).

Cardiac rehabilitation in patients referred with various heart diseases increased 6MWD by a mean of 170 m (15%) in a recent study (66). In 25 older patients with heart failure, an angiotensin-converting enzyme inhibitor medication (50 mg captopril per day) improved 6MWD a mean of 64 m (39%) compared with a mean increase of only 8% in those receiving a placebo (19).

Interpreting Single Measurements of Functional Status

Optimal reference equations from healthy population-based samples using standardized 6MWT methods are not yet available. In one study, the median 6MWD was approximately 580 m for 117 healthy men and 500 m for 173 healthy women (48). A mean 6MWD of 630 m was reported by another study of 51 healthy older adults (53). Differences in the population sampled, type and frequency of encouragement, corridor length, and number of practice tests may account for reported differences in mean 6MWD in healthy persons. Age, height, weight, and sex independently affect the 6MWD in healthy adults; therefore, these factors should be taken into consideration when interpreting the results of single measurements made to determine functional status. We encourage investigators to publish reference equations for healthy persons using the previously mentioned standardized procedures.

A low 6MWD is nonspecific and nondiagnostic. When the 6MWD is reduced, a thorough search for the cause of the impairment is warranted. The following tests may then be helpful: pulmonary function, cardiac function, ankle-arm index, muscle strength, nutritional status, orthopedic function, and cognitive function.

Conclusions

The 6MWT is a useful measure of functional capacity targeted at people with at least moderately severe impairment. The test has been widely used for preoperative and postoperative evaluation and for measuring the response to therapeutic interventions for pulmonary and cardiac disease. These guidelines provide a standardized approach to performing the 6MWT. The committee hopes that these guidelines will encourage further research into the 6MWT and allow direct comparisons among different studies.

This statement was developed by the ATS Committee on Proficiency Standards for Clinical Pulmonary Function Laboratories.

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APPENDIX

The following elements should be present on the 6MWT worksheet and report:

Lap counter: _____

Patient name: _____ Patient ID# _____

Walk # _____ Tech ID: _____ Date: _____

Gender: M F Age: _____ Race: _____ Height: _____ft _____in, _____ meters

Weight: _____ lbs, _____ kg Blood pressure: _____ / _____

Medications taken before the test (dose and time): _____

Supplemental oxygen during the test: No Yes, flow _____ L/min, type _____

	Baseline	End of Test
Time	____:____	____:____
Heart Rate	_____	_____
Dyspnea	_____	_____ (Borg scale)
Fatigue	_____	_____ (Borg scale)
SpO ₂	_____ %	_____ %

Stopped or paused before 6 minutes? No Yes, reason: _____

Other symptoms at end of exercise: angina dizziness hip, leg, or calf pain

Number of laps: _____ (×60 meters) + final partial lap: _____ meters =

Total distance walked in 6 minutes: _____ meters

Predicted distance: _____ meters Percent predicted: _____ %

Tech comments:

Interpretation (including comparison with a preintervention 6MWD):