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A Role for the Courts: Treating Physician Evidence in Social Security Disability Determinations

RACHEL SCHNEIDER

In assessing the Disability Insurance program, the Social Security Administration ("SSA") has recognized that "[t]he steps in the current disability process have not changed in any important way since the beginning of the ... program in the late 1950s", yet at the same time, the SSA has acknowledged that "case loads, types of disabilities, and the demographic characteristics of individuals with disabilities who are potentially eligible for benefits have changed radically." 1

With these changes has come increasing discord about how the SSA should make disability determinations. One point of contention has been the treating physician rule. The treating physician rule governs the weight that SSA adjudicators give to the opinions and evidence provided by the disability benefit claimant's treating physician. The argument about what weight is given to treating source evidence is a proxy for a deeper argument about what disability is, who should define it, and how disability determinations should be made.

Two themes emerge from this argument. First, creating a strong treating physician rule has been one way for courts to introduce judicial discretion into their review of the disability determinations made by the SSA's Administrative Law Judges ("ALJs"). Insofar as federal courts apply a deferential substantial evidence review to ALJ decisions, they have only a limited ability to attack ALJ disability determinations directly. Moreover, because social security decisions have been publicly perceived as politically motivated, or at least tainted by an SSA bias against expanding disability benefits, 2 courts have tried to shift

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2. The dramatic cuts in the disability rolls during the Reagan administration have been well documented. See, for example, Paul Light, Artful Work: The Politics of Social Security Reform 117-28 (Random House, 1985); Robert Pear, Conferees Agree on Bill to
more responsibility for disability determinations onto doctors. In this way, courts can implicitly shape ALJ procedures and influence the probative value given to medical evidence, even when they are powerless to reverse a decision outright. Meanwhile, the SSA has struggled against judicial intervention to maintain its control over the disability determination process, partly to reduce costs, but partly to protect its jurisdiction.

Second, attempts by Congress and the SSA to objectively define disability in these programs belies medical reality and reveals the second theme in this debate over disability. The SSA has aimed for an objective definition of disability in order to bureaucratize and generalize disability determinations. However, this admirable attempt to treat all applicants equally has lead to overgeneralization since individualized determinations would be more consistent with medical definitions of disability. Furthermore, admitting that context is important and that medical determinations are partly subjective will not harm the framework of objective decision-making envisioned by Congress and the SSA.

Section I of this Comment will address the disagreement between the courts and the SSA over the treating physician rule. It will suggest that the regulations promulgated by the SSA in 1991 did not resolve the dispute over the appropriate weight to be given to treating physician evidence. Section II will discuss the differences between medical and legal definitions of disability and the resulting differences in identifying disability. Section II will then make brief recommendations about how to better integrate medical and legal conceptions of disability within the Social Security disability programs, suggesting that medical definitions cannot be directly incorporated into the SSA’s fundamentally legal disability decision. Instead, a strong treating physician rule should be used to give a large amount of actual discretion over the decision to doctors, while maintaining the SSA’s formal authority. This solution acknowledges the institutional needs of both doctors and lawyers and supports voluntary acquiescence by Social Security adjudicators to the opinions of treating physicians.

I. Evidentiary Standards for Social Security Disability Programs

A. SEEKING DISABILITY BENEFITS

In Fiscal Year 1995, an estimated 2.9 million initial disability claims (a 69 percent increase over Fiscal Year 1990 levels) will be forwarded by the Social Security

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3. 59 Fed Reg 47887 (cited in note 1).
Security Administration to the state agencies that make initial disability determinations. Congress has decreed that "[a]n individual . . . shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such vacancy exists for him, or whether he would be hired if he applied for work." Furthermore, the "inability to engage in any substantial gainful activity" must be caused by a "medically determinable physical or mental impairment. . . ."

From these broad statutory guidelines, the SSA has developed a five-step sequential evaluation procedure to determine which claimants are disabled for purposes of Disability Insurance, and are therefore entitled to benefits. This procedure is intended to lead to uniform, equitable decisions. Step One asks if the claimant is currently engaged in "substantial gainful activity." If so, the claimant is denied without further inquiry. If the claimant, however, is not engaged in substantial gainful activity, the adjudicator moves on to Step Two, which calls for an evaluation of whether an "impairment or combination of impairments . . . significantly limits [the claimant's] physical or mental ability to do basic work activities." At this stage, the claimant's age, education, and work experience are not considered. If no medically severe impairment is found at Step Two, the claim is denied.

If an impairment limiting ability to do basic work activities does exist at Step Two, the adjudicator in Step Three compares the impairment to the "listings" of medical conditions which establish a conclusive presumption of disability. Meeting the listings ends the inquiry here, and the claimant receives benefits. But if the claimant's impairment is not included within the listings, then the evaluation continues. In Step Four, the claimant must prove that the impairment prevents the performance of past work. If it does, under Step Five, the SSA investigates whether the claimant is able to perform other work in the national economy, taking into consideration age, education, and work experience. At Step Five, the SSA uses a matrix of the relevant factors ("the grids") to determine whether work exists in the national economy that the claimant is capable of doing. If, according to the grids, the claimant can work, the request for benefits is denied. If, either according to the grids or because of the existence of impair-

ments not considered in the grids, the claimant cannot work, the request for benefits is approved.13

The Supreme Court has looked carefully at this process in two decisions. In *Bowen v Yuckert*, the Supreme Court upheld the analysis of Step Two, which calls for a judgment as to the medical severity of the claimed disability, and by implication condoned the sequential evaluation process of Steps One through Five.14 Though the *Yuckert* Court discussed abuse of the Step Two severity regulation in which 40 percent of applicants were denied without considering their age, education, or work experience, it still allowed the use of Step Two, despite the statutory requirement seemingly to the contrary.15 During the extended *Yuckert* litigation, the SSA and the appellate courts hearing *Yuckert*-like claims limited the use of the severity regulation, and thereby lowering the number of claimants that were denied.16 Therefore, although the acontextuality of Step Two determinations does not render them illegal, the agency and federal courts have found that this acontextuality does necessitate limiting usage of the regulation.

The Supreme Court also upheld the use of medical vocational guidelines at Step Five in *Heckler v Campbell*.17 The grids, matrices of the four factors Congress identified as relevant to disability—physical ability, age, education, and work experience—were adopted through rulemaking. The Court found that the rulemaking procedures provided the protection against arbitrary decision-making required by due process and that claimants have the opportunity to prove that the grids do not apply to them.18 In addition, case-by-case consideration of this issue would overburden the agency with unnecessary litigation.19

In both *Campbell* and *Yuckert*, the Supreme Court addressed a recurring

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15. Id at 157-59 (O'Connor and Stevens concurring).
16. Social Security Ruling 85-28, Program Policy Statement, *Titles II and XVI: Medical Impairments That Are Not Severe* (1995). Before the severity regulation was promulgated, 8% of all claimants were denied benefits at this stage; but after the regulations, approximately 40% were denied. As the lower courts enjoined use of Step Two or imposed narrowing constructions, the Step Two denial rate dropped to 25%. *Yuckert*, 482 US at 157-58 (O'Connor and Stevens concurring).
17. 461 US 458 (1983). Separate opinions by Brennan and Marshall question whether the ALJ fulfilled his "basic obligation" to develop a full and fair record and explore all relevant facts. Id at 470-71 (Brennan concurring); id at 473 (Marshall concurring in part, dissenting in part). Numerous lower court opinions have been decided on this basis as well, suggesting that distrust of ALJs may drive judicial doctrine. Some of the appellate courts seem to worry that there is a lack of adequate representation and protection for the claimant in the adversarial, legalistic, bureaucratic disability decision-making process. See, for example, *Cruz v Sullivan*, 912 F2d 8, 11-12 (2d Cir 1990); *Lashley v Health and Human Services*, 708 F2d 1048, 1051-52 (6th Cir 1983) for the requirement that ALJs have a heightened duty to protect the interests of claimants lacking legal representation.
19. Id at 467-68.
problem within the SSA: how to balance the need for administrative efficiency and consistent, standardized decisions against the need for individualized assessments. In both cases, the Court acquiesced to the SSA’s general, bureaucratic solutions instead of insisting on individualized judgments. The Court’s view of disability determinations may be incomplete, however. As Justice Blackmun pointed out in his Yuckert dissent, the statute defining disability and eligibility for disability benefits demands contextual determinations in recognition of the fact that the same medical condition is, for example, disabling for a seventy year-old but not for a twenty year-old. Context is provided by the sequential evaluation process as a whole, but is missing at each stage viewed alone. As a result, because a claimant can be denied at any of the Steps, that claimant may be denied benefits before her claim is contextualized.

Still, the Five Step evaluation does not exhaust claimants’ avenues of recourse. If the claimant is denied benefits through the Five Step evaluation, he can initiate the three-stage administrative appeal process. The claimant can first request reconsideration of the application, de novo, by the state agency administering the disability program on behalf of the federal government. If denied again (as the overwhelming majority of claimants requesting reconsideration are), the claimant has access to an administrative hearing before an Administrative Law Judge within the SSA Bureau of Hearings and Appeals. The SSA expects to receive 590,000 requests for ALJ hearings in Fiscal Year 1995; this figure represents more than a 75 percent increase over Fiscal Year 1990. Third, the claimant can appeal an adverse ALJ decision to the Appeals Council. Finally, after exhausting the three-tiered administrative appeal process, the claimant can appeal the decision to federal district court.

Throughout the lengthy application and appeal process, medical evidence is crucial to the correct identification of disability. The SSA relies on medical

21. 20 CFR §§ 404.909 (a), 416.1409 (a) (1995). See also Smith v Schweiker, 709 F2d 777, 779 (2d Cir 1983) (“Disability determinations are governed by procedures coordinated by the state and federal governments.”).
22. In Fiscal Year 1991, 83% of those appealing to the reconsideration level were denied. Staff of House Committee on Ways and Means, 102d Cong, 2d Sess, The Green Book: Overview of Entitlement Programs 60-61 (Comm Print, 1992). In Fiscal Year 1993, 48% of denied applicants requested reconsideration; of these 86% were denied again. 59 Fed Reg at 47902 (cited in note 1). After reconsideration denial, 75% of the applicants (75% of whom are represented by an attorney or other advocate by this point) requested an ALJ hearing. Id.
25. 59 Fed Reg at 47887 (cited in note 1).
27. 42 USC § 405 (g) (1988).
evidence in four of the five steps of the initial evaluation process (all except Step One which looks at “substantial gainful activity”). When a claimant appeals a negative initial decision, the medical evidence is scrutinized again by the SSA, and then by an ALJ, the Appeals Court, and finally by the federal courts. Medical evidence from three different sources, the treating physician, a consulting examiner, and a medical advisor, may be considered at each stage of the decision-making process. Consequently, the weight given to treating physician evidence relative to the opinions rendered by other medical and vocational experts may often decide the outcome of the case. The treating physician rule, which gives a degree of increased deference to the evidence provided by the claimant’s doctor, appeared at least by 1977 and has been consistently used by all circuits in some form since then.

B. THE PRE-1991 TREATING PHYSICIAN RULE

Before 1991 the SSA regulations did not provide a uniform statement of the scope of the treating physician rule. Instead, the rule only existed at common law. Federal circuit courts had articulated the treating physician rule in several different forms, complicating SSA compliance nationwide. Moreover, because the circuit courts had created the treating physician rule and imposed it upon SSA ALJs, the rule’s authority and legitimacy were unclear.

The articulations of the treating physician rule varied among the circuits in several ways. Circuit courts demanded different degrees of deference to the opinions of the treating physician. In the Tenth Circuit, the “well-established rule... [was] that the Secretary [of the SSA] must give substantial weight to the testimony of a claimant’s treating physician, unless good cause is shown to the contrary.” In the Eighth and Eleventh Circuits, a similar rule, giving considerable weight to treating physician evidence, was followed. The Second and

30. “Administrative law judges are responsible for reviewing the evidence and making findings of fact and conclusions of law. Administrative Law Judges are not bound by any findings made by State agency medical or psychological consultants. However, these findings are considered at the hearing level and should be evaluated according to the factors applied to other medical opinions.” ALJs can also ask for and consider the opinions of medical advisors on the nature and severity of impairment(s) and whether they meet the listings. 20 CFR §§ 404.1527 (f)(2), 416.927 (f)(2) (1995). The Appeals Council follows the same rules as ALJs. 20 CFR §§ 404.1527 (f)(3), 416.927 (f)(3) (1995).
31. Allen v Weinberger, 552 F2d 781 (7th Cir 1977) (stating that if an impairment exists, the opinion of the treating physician is entitled to substantially greater weight than that of a doctor who sees the claimant only once).
32. Frey v Bowen, 816 F2d 508, 513 (10th Cir 1987).
Fourth Circuits used a slightly different formulation, holding that the treating physician's findings created a rebuttable presumption of disability status.34

The circuit courts also assigned a different relative weight to the opinions of treating physicians depending on the circumstances. For example, in the Ninth Circuit, the treating physician's opinion constituted substantial evidence only if it rested on objective evidence; but if the treating physician's medical reports were brief, inconclusive, unsupported, or contradictory, they could be disregarded.35 Also, under the Ninth Circuit's rule, questions of credibility were deferred to the SSA.36 Still, when the ALJ disregarded the findings of a treating physician, the ALJ was required to make findings explaining why the treating physician’s opinion was not followed.37

Courts have also considered the opinions given by non-treating physicians. Two other types of medical opinions, those from consultative examiners and those from medical consultants, may be requested by the SSA when it is evaluating a claim of disability.38 Therefore, when the SSA or courts define the treating physician rule, they must define the weight to be given to treating physician testimony relative to the testimony of these two other types of medical examiners, both of whom receive compensation from the SSA. Consultative examiners meet with the claimant only once if the SSA feels that the initial application does not provide enough information on which to base a disability decision.39 Medical consultants participate in the initial disability decision. In the appeal process, their opinions are considered part of the evidentiary record.

In several circuits, including the Second, Sixth, Eighth, and Tenth, the opinions of consultative examiners were given only “limited weight” and could not constitute the “substantial evidence” necessary to override the treating physician.40 The Tenth Circuit expressed outright suspicion of SSA-paid doctors, holding that “the reports of [treating] physicians ... are given greater weight than are reports of physicians employed and paid by the government for the purpose of defending against a disability claim.”41

34. Schisler v Bowen, 851 F2d 43 (2d Cir 1988); Coffman v Bowen, 829 F2d 514, 517 (4th Cir 1987) (“[I]n the Fourth Circuit ... [t]he rule requires that the opinion of a claimant's treating physician be given great weight and may be disregarded only if there is persuasive contradicting evidence.”); Mitchell v Schweiker, 699 F2d 185, 187 (4th Cir 1983). See also Zelenske, 27 Clearinghouse Rev at 34 (cited in note 33).
35. Magallanes v Bowen, 881 F2d 747, 751 (9th Cir 1989).
36. Id.
37. Id. This rule was followed in many other circuits as well. Floyd v Bowen, 833 F2d 529, 532 (5th Cir 1987).
40. See, for example, Frey, 816 F2d at 515; Cruz v Sullivan, 912 F2d 8, 13 (2d Cir 1990); Turpin v Bowen, 813 F2d 165, 170 (8th Cir 1987); Lashley v Health and Human Services, 708 F2d 1048, 1054 (6th Cir 1983).
41. Turner v Heckler, 754 F2d 326, 329 (10th Cir 1985), quoting Broadbent v Harris, 698 F2d 407, 412 (10th Cir 1983).
The most controversial court formulation of the treating physician rule was the Second Circuit’s, which engendered a decade-long confrontation between the courts and the SSA in *Schisler I*, *II*, and *III*.\(^\text{42}\) The Second Circuit’s rule declared that the “treating source’s opinion on the subject of medical disability—i.e., diagnosis and nature and degree of impairment—is (1) binding on the fact-finder unless contradicted by substantial evidence and (2) entitled to some extra weight, even if contradicted by substantial evidence, because the treating source is inherently more familiar with a claimant’s medical condition than are other sources.”\(^\text{43}\) Most notably, the Second Circuit found that the “opinions of non-examining medical personnel cannot, in themselves and in most situations, constitute substantial evidence to override the opinion of a treating source.”\(^\text{44}\) Stated this strongly, the treating physician rule effectively mandated ALJ deference to the treating physician.

According to the Second Circuit, *Schisler I* “confronted chronic problems with the [the SSA’s] compliance with the so-called treating physician rule.”\(^\text{45}\) The Second Circuit found that, regardless of the Secretary’s claim that the SSA was following the rule, “the volume of appeals from the Secretary[’s decisions] implicating the rule raised a serious question as to whether the Secretary was actually following the rule.”\(^\text{46}\) The judgment directed the SSA to draft a Social Security Ruling (“SSR”) embodying the treating physician’s rule so that the ALJs

42. *Schisler v Heckler*, 787 F2d 76 (2d Cir 1986) (“*Schisler I*”); *Schisler v Bowen*, 851 F2d 43 (2d Cir 1988) (“*Schisler II*”); *Schisler v Sullivan*, 3 F3d 563 (2d Cir 1993) (“*Schisler III*”). *Schisler I* was brought in 1980 to determine whether the Secretary of Health and Human Services was acquiescing in the treating physician rule. The Secretary represented to the court that the agency followed the court’s version of the treating physician rule. The court directed the Secretary to inform its adjudicators of the stated policy regarding the treating physician rule. The Secretary proposed a Social Secretary Ruling (“SSR”) that would bring it into conformity with the *Schisler I* court’s ruling. *Schisler I*, 787 F2d at 84-85. However, the SSR was modified by the district court, and the Secretary brought an appeal in *Schisler II* claiming that the ordered revisions exceeded the district court’s authority. The appellate court upheld the district court’s revision of the SSR, with minor revisions of its own. *Schisler II*, 851 F2d at 44-45. In 1991, after notice and comment rulemaking, new regulations were issued that differed from the Second Circuit’s version of the treating physician rule. The district courts that confronted the issue held that the new regulations were binding in administrative proceedings but stated that the judge-made treating physician rule would govern disability rulings on appeal in federal court. *Schisler v Sullivan*, 1992 WL 170736 (W D NY 1992). In *Schisler III*, the Secretary challenged the ruling that the judge-made treating physician rule governs federal court appeals. The court there held that (1) the Secretary had the authority to issue regulations concerning the treating physician rule; (2) the new regulations were valid, even though they differed from the Second Circuit’s prior version of the rule; and (3) the regulations were binding both in administrative and federal courts of appeals. *Schisler III*, 3 F3d at 567-68.

44. Id at 47 (citations omitted).
45. Id at 44.
46. Id.
would know and follow the rule. Presumably, the Second Circuit intended that the rule drafted by the SSA would be consistent with the treating physician rule that the court had articulated previously.

In Schisler II, the court considered the validity of the SSR drafted by the SSA without notice and comment rulemaking. The SSR, in the words of the district court in Schisler II, "fails to reflect, in significant respects, the treating physician rule recognized and effective here and to be in place nationwide" and "is rambling and ambiguous, and not to a small degree unedifying to those in the field who must make the important decisions delegated to the Secretary." The district court and then the appellate court modified the SSR so that it paralleled the Second Circuit's rule.

The Second Circuit's interaction with the SSA in the Schisler cases demonstrates most dramatically a phenomenon observable in all of the circuits that articulated some form of the treating physician rule: the introduction of judicial discretion into the constitutionally-required substantial evidence standard applied to SSA determinations. Under this standard, a determination made by the SSA according to appropriate procedures and "supported by substantial evidence . . . is conclusive and must be affirmed." Substantial evidence is defined as "more than a mere scintilla and less than a preponderance," but it is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Ultimately, the substantial evidence standard dramatically curtails the discretion of federal courts to overrule SSA decisions.

However, it is possible that "[t]he rules on medical testimony are another example of the flexibility with which courts employ the 'reasonable mind' standard of judicial review." As a result, "[b]y enforcing various rules of evidence upon the administrative law judges, the courts are free to look at the record as a whole and correct (through reversal or remand) what they regard as unreasonable findings." In this way, courts introduce flexibility into the substantial evidence standard by using the treating physician rule to define the relevant evidence that a reasonable mind would accept as sufficient, and by doing so, it may be "possible for the court to engage in an almost de novo review." Some commentators disapprove of this introduction of judicial discre-

47. Schisler I, 787 F2d at 84.
48. Schisler II, 851 F2d at 44-45 (quoting the district court order).
49. Id at 44, 46.
51. Richardson, 402 US at 401, quoting Consolidated Edison Co. v NLRB, 305 US 197, 229 (1938). See also Muse v Sullivan, 925 F2d 785, 789 (5th Cir 1991); Schisler II, 851 F2d at 47 (As stated in the SSR required by the Second Circuit: "Substantial evidence is such relevant evidence as a reasonable mind would accept as adequate to support a conclusion.").
53. Id.
54. Id.
tion and propose avoiding it by “affirming the Secretary in ‘close cases’” and “leaving issues such as credibility up to the administrative law judge (provided the record contains specific findings).” This Comment argues instead that the introduction of judicial discretion into review of Social Security disability determinations is a positive development. Judicial review provides a necessary check on evidentiary standards that would otherwise go unmonitored.

Thus, Schisler II can be partially understood as the court refusing to allow the SSA to promulgate rules without rulemaking proceedings. It can also be understood as the federal court staking out its territory. The tone of the Schisler I and II opinions indicates frustration with the SSA’s policy of non-acquiescence, which the court reads as an insulting refusal to follow the law of the Second Circuit.

C. THE SSA'S 1991 TREATING PHYSICIAN RULE

In 1991, after undergoing formal notice and comment rulemaking, the SSA promulgated regulations standardizing the level of deference to be given treating physician evidence. In its notice of final rulemaking, the SSA explained that its clarification of the evidentiary weight to be accorded to medical evidence was precipitated by “judicial decisions in several circuits point[ing] to a need for a clear policy statement” that would encourage uniformity of adjudication and eliminate uncertainty. The SSA asserted that a majority of the circuit courts agree that: (1) “treating source evidence tends to have a special intrinsic value” because of the treating source’s relationship with the claimant, and (2) “if the Secretary decides to reject such an opinion, he should provide the claimant with good reasons for doing so.” In addition, the notice affirms that the SSA has the authority to issue the rules because “[n]one of the circuit courts of appeals has held that its treating physician rule is required by the [Social Security] Act or the Constitution.”

Importantly, the regulations state clearly that medical opinions are not dispositive as to a finding of disability. Instead, medical assessments are part of the evidentiary record. The opinions of physicians and psychologists “reflect judgments about the nature and severity of [a patient’s] impairment(s), including [the patient’s] symptoms, diagnosis and prognosis, what [the patient] can still do despite impairment(s), and [the patient’s] physical or mental restrictions,” but they cannot be directly translated into a legally relevant finding of

55. Id at 29.
57. Id at 36934.
58. Id.
59. Id.
disability.62

Under the 1991 regulations, the SSA reserved for itself each of the following responsibilities: (1) the finding of an inability to work,63 (2) the decision of whether an impairment meets or equals any Listing at Step Three, (3) the evaluation of functional capacity, and (4) the application of vocational factors.64 With respect to treating physician testimony, the regulations established that the treating source’s opinion should be accorded “controlling weight” if it is “well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence.”65 If the SSA does not assign controlling weight to the treating source’s opinion when making a disability determination, the SSA must give good reason for the weight given to the treating physician’s opinion and must consider the treating source evidence as it would any other medical opinion.66

More generally, medical opinions, other than controlling treating source opinions, must be accorded evidentiary weight by considering several factors.67 If a treatment relationship exists, the adjudicator must consider its length and the frequency of examination,68 as well as the nature and extent of the treatment relationship.69 Source opinions supported by relevant evidence and explanation are accorded more weight than those that are not,70 and the more consistent the opinion is with the record as a whole, the more weight will be given to that source’s opinion.71 Moreover, additional weight will be given to the opinion of a specialist about things related to that specialty than to non-specialist sources.72 Lastly, “other factors” that support or contradict the opinion may be considered for nontreating sources.73

The regulations also declare that every medical opinion received will be evaluated, regardless of its source,74 and that generally, more weight will be given to the opinions of sources who have examined the claimant than to those who have only examined the medical record.75 Even where treating sources are not controlling, the SSA promises to give them more weight “since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of [the claimant’s] medical impairment(s) and may bring a

74. 20 CFR §§ 404.1527 (d), 416.927 (d) (1995).
unique perspective to the medical evidence that cannot be obtained from objective medical findings alone. . . .”76 The SSA further claims that its “policy . . . takes into account and, in large measure, was shaped by, the kinds of concerns raised by the circuit courts.”77

This policy statement by the SSA acknowledges that “because opinions always have a subjective component, because the effects of medical conditions on individuals vary so widely, and because no two cases are ever exactly alike, it is not possible to create rules that prescribe the weight to be given to each piece of evidence that [may be taken] into consideration in every case.”78 The Social Security regulations thereby reveal a basic tension in that they strive for objective identification of disability while acknowledging that the decision-making procedure includes a certain amount of subjectivity and individualization.

D. CASE LAW INTERPRETATION OF THE POST-1991 TREATING PHYSICIAN RULE

Since the promulgation of the 1991 regulations, an interesting phenomenon has occurred. Only the Second Circuit has acknowledged a change in its treating physician rule. The other circuits have either claimed that the 1991 regulations codified their circuit’s law79 or have continued to follow their pre-1991 precedent, implying that they perceive no change in their circuit’s law based on the regulations.80

The Second Circuit, confronted with the regulations in Schisler III, found both similarities and differences between the SSA’s new regulations and the Circuit’s previous rule. The court noted that both “examine the treating physician’s relationship with the claimant and generally defer to the treating source because of that relationship,” and both “require the Secretary to provide a claimant reasons when rejecting a treating source’s opinion.”81 However, the regulations “permit the opinions of nonexamining sources to override treating sources’ opinions, provided they are supported by evidence in the record,”82 while the Second Circuit had held that they could not.83 Also, the “regulations accord less deference to unsupported treating physician’s opinions than do our
decisions.\footnote{84}

These two differences constitute major substantive changes to the Second Circuit's treating physician rule, but the \textit{Schisler III} court held that "because the Secretary has complied with the applicable rule-making procedures, [the courts] must give the new regulations 'the deference traditionally shown' to the Secretary's regulations."\footnote{85} The court reasoned that "the emerging law thus appears to give courts more leeway in establishing rules governing agency proceedings in areas where there are no comprehensive regulations than where such regulations exist."\footnote{86} This reasoning suggests that the agency has primary authority for establishing evidentiary rules, but that some check on agency discretion needs to exist. When the agency has gone through notice and comment rule-making, as with the 1991 regulations, then the courts should defer to the substantive rules of the agency because appropriate checks are in place.

In contrast to the Second Circuit's response, other circuits have merged the common law with the 1991 SSA regulations. But there remains disagreement over the roles to be played by the court and the SSA as well as confusion over the scope of the post-1991 treating physician rule. For example, the Tenth Circuit has stated that "in contrast to the situation in the Second Circuit . . . in this circuit the regulations have merely codified existing law."\footnote{87} The Tenth Circuit's pre-1991 rule according "substantial weight" to the opinion of the treating physician comports with the proscriptions of the 1991 regulations.\footnote{88}

The Tenth Circuit, however, did not formerly allow the SSA to rule against the opinion of the treating physician based on the opinion of the consultative examiner,\footnote{89} yet the post-1991 SSA regulations, as interpreted by the Second Circuit, allow the SSA to do so.\footnote{90} The Tenth Circuit seems to say that because it has always recognized the SSA as having final authority for the disability decision, its treating physician rule need not be as strong as the Second Circuit's rule, which makes the treating physician's conclusions binding on the ALJ.

In a since-vacated opinion, \textit{Morse v Shalala}, the Eighth Circuit exhibited disagreement, and at least momentary confusion, over the weight to be given to legal as opposed to medical conclusions under the 1991 regulations.\footnote{91} In over-

\begin{itemize}
  \item \footnote{84}{Id at 567.}
  \item \footnote{85}{Id at 569.}
  \item \footnote{86}{Id at 568.}
  \item \footnote{87}{Castellano v Health and Human Services, 26 F3d 1027, 1029 (10th Cir 1994). See also Nelson v Sullivan, 966 F2d 363, 367-68 (8th Cir 1992) ("[T]he new regulations merely codify existing law.").}
  \item \footnote{88}{See text accompanying notes 56-78.}
  \item \footnote{89}{Frey v Bowen, 816 F2d 508, 515 (10th Cir 1987).}
  \item \footnote{90}{See text accompanying notes 85-86.}
  \item \footnote{91}{Morse v Shalala, 16 F3d 865, 875 (8th Cir 1994) (Upon review of denial of disability benefits, the court must determine whether "substantial evidence on the record as a whole . . . support[s] the Secretary's determination . . . ."), vacated by 32 F3d 1228, 1229 (8th Cir 1994) (Review may not look only at evidence supporting the Secretary's decision because the "substantial evidence test requires that . . . evidence [is also taken . . .]".)} 
\end{itemize}
turning the ALJ's decision, the court stated that "[u]nless there is medical evidence that contradicts or refutes the physician's medical conclusion, the Secretary is bound to treat the treating physician's diagnosis and conclusion as substantial evidence."92

Writing in dissent, Judge Magill, however, argued convincingly that the treating physician's opinion was conclusory and legal, not medical.93 According to Judge Magill, if the majority allows the treating physician to decide whether the claimant's disability satisfies the SSA's legal criterion, then the decision contradicts the regulations' reservation of this decision to the agency, as well as the majority's claim that the regulations merely codified Eighth Circuit precedent.94 Judge Magill distinguished between medical opinions such as "[the patient] must avoid fumes" and "avoid lifting more than 20 pounds" and legal conclusions such as "[the patient] is disabled under the Social Security Act."95 He particularly objected to the doctor's ability to override any Step Five decision by the SSA.96 Vocational experts, not doctors, should determine if there is work in the national economy which the claimant could theoretically do.97

Recent Fifth, Sixth, and Ninth Circuit cases do not mention the 1991 regulations, citing confidently to pre-1991 precedent for the treating physician rule.98 These three circuits defer to the treating physician's opinion if it is supported by objective medical evidence, yet in cases of conflicting medical evidence they defer to the credibility determination made by the ALJ.99 The Sixth Circuit, for example, held in 1994 that the SSA "is not bound by treating physicians' opinions, especially when there is substantial medical evidence to the contrary" and that "[s]uch opinions are only accorded great weight when they are support-

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93. Morse, 16 F3d at 876 (Magill dissenting).
94. Id.
95. Id at 876 n 1.
96. Id at 877.
97. Id ("Regardless of the label, a physician's statement on the ultimate issue of disability is not binding on the Secretary. . . . Dr. Davis' 'findings' to which the majority refers are neither medical findings, nor medical conclusions. Dr. Davis made a broad conclusory statement that Ms. Morse 'is disabled as far as regular work is concerned.').
98. Matney v Sullivan, 981 F2d 1016, 1019 (9th Cir 1992), citing to Magallanes v Bowen, 881 F2d 747, 751 (9th Cir 1989); Cutlip v Health and Human Services, 25 F3d 284, 286-87 (6th Cir 1994), citing to Young v Health and Human Services, 925 F2d 146, 151 (6th Cir 1990); Paul v Shalala, 29 F3d 208, 211 (5th Cir 1994), citing to Scott v Heckler, 770 F2d 482, 485 (5th Cir 1985).
99. See, for example, Magallanes, 881 F2d at 751 (Where treating physician's opinion rests on objective evidence, it is substantial evidence. But when medical reports are inconclusive or contradictory, questions of credibility are left to the SSA. The treating physician's opinion is not conclusive and can be disregarded if it is brief, unsupported, or contradicted. The ALJ must make findings explaining why the treating physician's opinion is not followed.); Cutlip, 25 F3d at 286-87.
ed by sufficient clinical findings and are consistent with the evidence.\textsuperscript{99}\textsuperscript{100} This statement suggests that when substantial evidence exists to both support and refute the claimant’s position, the court should defer to the SSA’s decision.

The Fifth Circuit had taken a similar position in the 1987 case of \textit{Floyd v Bowen}, finding that “credibility choices must often be made between conflicting medical evidence” and that “[s]uch choices are within the discretion of the administrative agency administering the social security benefits program.”\textsuperscript{101} In 1994, the Fifth Circuit still cited to this case as authority for the strength of the treating physician rule.\textsuperscript{102} In its explanatory responses to comments published with the 1991 regulations, the SSA, however, stated that when conflicting substantial evidence exists, it would follow the treating physician rule.\textsuperscript{103} Therefore, if an ALJ decision were to contradict the determination of the treating physician, it is unclear whether the Fifth Circuit would defer to the ALJ’s decision, as \textit{Floyd} seemingly suggests, or whether the Fifth Circuit would hold the SSA to its stated purpose of deferring to the treating physician’s opinion where conflicting substantial evidence exists.

The majority of the circuits thus acknowledge no change in the treating physician rule after the 1991 regulations. This response reveals something of the underlying dynamic among the courts, the SSA, and the treating physician rule. First, courts ordinarily create slow, evolutionary change through subtle manipulation of statutes and regulations. In this instance, circuit courts have nudged the regulations towards their own rules. Second, some courts have attempted to resolve the inherent tension in disability determinations between subjective, individualized assessments on the one hand and objective and generalized decisions on the other by deferring to ALJs, while others have deferred to the treating physician. Third, the evidentiary weight given to treating physician evidence encompasses two separate arguments: (1) a disagreement about the evidentiary standards used by ALJs and (2) a dispute about who will establish those standards. Neither the SSA nor the federal courts have been willing to acquiesce to the other’s articulation of the rule. Therefore, an institutional analysis of the relationship between the SSA and the judicial system will not necessarily resolve this dispute. Instead, a comparison of medical and legal approaches to disability reveals the appropriate weight to give to treating physician evidence.

\section*{II. Medical Versus Legal Definitions: When Is Impairment Disability?}

\subsection*{A. Definitions and Their Significance}

The legal and medical definitions of disability differ substantially. The legal definition varies according to legal context. For instance, workers’ compensation

\textsuperscript{100} \textit{Cutlip}, 25 F3d at 286-87 (citations omitted).
\textsuperscript{101} \textit{Floyd v Bowen}, 833 F2d 529, 532 (5th Cir 1987).
\textsuperscript{102} \textit{Paul v Shalala}, 29 F3d 208, 211 (5th Cir 1994).
\textsuperscript{103} See text accompanying note 76.
programs, the Veterans' Administration,\textsuperscript{104} tort liability standards, and private insurance companies each use slightly different criterion to establish disability. In Social Security disability programs, the definition of disability depends primarily on the claimant's inability to work.\textsuperscript{105} The definition allows for limited contextual evidence, acknowledging that similar impairments affect individuals differently. Thus, the age, education, and work experience of the claimant are considered.\textsuperscript{106} Emphasis is placed, however, on the existence of an objectively proven medical impairment.\textsuperscript{107} Furthermore, the existence of work that the claimant is capable of doing is proven generally, through the use of listings categorizing medical conditions at Step Three and grids based on the national economy at Step Five.\textsuperscript{108} If the claimant does not fit into any of the categories established by the listings and the grids, he or she bears the burden of proving that his or her individual condition merits a disability finding.\textsuperscript{109}

The definition of disability proposed by the American Medical Association ("AMA"), in contrast, depends more on determinations about individual capacity and context. According to the \textit{AMA Guides to the Evaluation of Permanent Impairment} (the "AMA Guides" or "Guides"), "disability arises out of the interaction between impairment and external requirements, especially those of a person's occupation" and reflects "the gap between what a person \textit{can} do and what the person \textit{needs} or \textit{wants} to do."\textsuperscript{110} A disability is "an alteration of an individual's capacity to meet personal, social, or occupational demands, or statutory or regulatory requirements, because of an impairment."\textsuperscript{111} The incorporation of a person's inability to meet statutory requirements into the AMA's definition of disability, however, does not merge the SSA and the AMA's definitions of disability. The AMA's definition generally includes those determined to be disabled by SSA standards, but may also include additional people that do not meet the more rigid statutory requirements.\textsuperscript{112} The AMA's definition admits variation in degrees of disability, while the SSA's only recognizes two positions, disabled and not disabled.\textsuperscript{113}

Both the SSA and the AMA definitions include the idea that the inability to

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\textsuperscript{104} "A disability determination by the Veterans Administration is non-binding on the Secretary, however, because the criteria applied by the two agencies vary." \textit{Floyd v Bowen}, 833 F2d 529, 534 (5th Cir 1987).

\textsuperscript{105} 42 USC § 423 (d)(2)(A) (1988).

\textsuperscript{106} Id.

\textsuperscript{107} 42 USC § 423 (d)(1)(A) (1988).

\textsuperscript{108} See text accompanying notes 10-13.

\textsuperscript{109} See text accompanying notes 21-27.

\textsuperscript{110} \textit{American Medical Association, Guides to the Evaluation of Permanent Impairment} 2 (AMA, 4th ed 1993).

\textsuperscript{111} Id.

\textsuperscript{112} One might go further and say that the SSA definitions create the disability, and that the medical definition acknowledges that the SSA definitions do so. See Claire H. Liachowitz, \textit{Disability as a Social Construct: Legislative Roots} 12 (Penn, 1988).

\textsuperscript{113} \textit{AMA, Guides} at 4-5 (cited in note 110).
function is caused by a medical impairment. According to the AMA, a “permanent impairment” is a “deviation from normal in a body part or organ system and its functioning . . . that has become static or stabilized during a period of time sufficient to allow optimal tissue repair, . . . that is unlikely to change in spite of further medical or surgical therapy [and] that interfere[s] with an individual’s ‘activities of daily living.’”\(^{114}\) Furthermore, as an “alteration of an individual’s health status,” an impairment is a “medical issue” to be “assessed by medical means.”\(^{115}\) The *AMA Guides* declares that the relationship between impairment and disability is entirely contextual and offer the example of a surgeon who has lost a hand. The doctor certainly has an impairment and is disabled in terms of the ability to be a surgeon, but not in terms of the ability to be the chief of a hospital medical staff.\(^{116}\)

The AMA definitions are closely related to those formulated by the World Health Organization ("WHO"). According to WHO, “any loss or abnormality of psychological, physiological, or anatomical structure or function” is an impairment.\(^{117}\) Disability, however, is the social result of the impairment, or “any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.”\(^{118}\) Impairment, defined as loss of function, is independent of context. Disability, defined as the inability to meet the expectations of a certain role, is context-dependent, but since the definition of disability incorporates the definition of impairment, certain elements of its proof remain context-independent.\(^{119}\)

The expertise of physicians is in the identification of impairment, not disability.\(^{120}\) The identification of disability therefore calls for the translation of a medical concept into legally relevant terms, and is best completed by those with an understanding of the legal standard.\(^{121}\) Under this view, the definitions of disability in the medical and legal communities differ because they serve different purposes. The medical definition is directed towards treatment, while the legal definition focuses on compensability.\(^{122}\)

Notwithstanding this difference, accurate translation from medical to legal concepts requires an understanding of both the relevant legal and medical concepts. The legal community would therefore benefit greatly from more fully incorporating medical views of disability into the legal definitions and thereby more fully incorporating medical views into the process of translating medical

\(^{114}\) Id at 1.
\(^{115}\) Id.
\(^{116}\) Id at 2.
\(^{118}\) Id at 143.
\(^{120}\) Id.
\(^{121}\) Id.
\(^{122}\) Id.
conditions into a legal status. To say that ALJs are qualified to complete the translation alone assumes that the process is entirely legal and bureaucratic and that disability is determined by assigning individuals to general categories. Instead, the treating physician rule mitigates the over-legalization of disability standards and responds more fully to the individualized, contextual nature of disability. Also, insofar as the goal is to compensate only those with medically-documented disabilities, doctors are in the best position to accurately identify those people.

B. SOME EXAMPLES: PSYCHOLOGISTS AND RHEUMATOLOGISTS

In order to evaluate whether physicians or SSA bureaucrats identify disability more accurately and efficiently, it is important to compare how the two standards operate in practice. Ideally, the process of translating a medical condition—impairment—into a legal status—disability—should not result in systematic differences that depend on whether physicians or the SSA makes the determination.

To test this theory, two recent studies have explored the relationship between physician and SSA determinations of disability. The first study examined the faithfulness with which the SSA regulations operationalize the statute's definition of disability, and suggests that the SSA successfully incorporated current psychiatric understandings (or medical definitions of disability) into the regulations (legal definitions of disability). The second investigated the degree of agreement between doctors' and SSA's decisions when evaluating rheumatic impairments, and found that that agreement was no more than that which would be expected by chance. While only providing an initial estimate of the agreement between SSA and medical definitions in practice, these two studies suggest that if there is a problem with SSA disability regulations, it is not inherent in the regulations themselves. Instead, any problems result from the potential for wrong or incomplete implementation of the legal standards.

In 1991, the American Psychiatric Association ("APA") attempted to determine "how well the standards and guidelines [used by the SSA] operationalize the statutory definition of disability in a manner consistent with current psychiatric practice." The APA study instructed two groups of psy-

126. The SSA has not responded to concerns about the implementation of its 1991 regulations: "Some of the comments raised details about how the regulations would be implemented. We believe these comments are not substantive public comments that must be addressed in the regulations." 56 Fed Reg at 36937-38 (cited in note 56).
chiatrists to evaluate disability claimants’ case histories. One group used only the statute, understood through current psychiatric practice, and the other used the SSA guidelines.\textsuperscript{128} The APA found a high rate of agreement between the disability determinations of the two groups.\textsuperscript{129} This result indicates that the regulations adequately interpret the statute and accommodate current psychiatric understandings.

This study is encouraging, insofar as it indicates that the SSA successfully incorporates medical definitions of mental disability in the actual regulations. Nevertheless, the APA’s findings are not generalizable to an assessment of the entire SSA disability evaluation process for several reasons. First, the APA used panels of physicians, rather than individual doctors, to make decisions in order “to increase reliability and reduce idiosyncratic judgments.”\textsuperscript{130} Second, the APA used actual psychiatrists instead of Social Security employees.\textsuperscript{131} Since neither panels nor doctors make disability determinations in the SSA, this study does not indicate how well the SSA implements the regulations in practice. Furthermore, when the two groups of psychiatrists disagreed on the outcome of a particular case, they usually indicated that it was a hard or less well-documented case.\textsuperscript{132} But it is exactly such a case that is likely to be appealed to an ALJ, the Appeals Council, or a federal court; therefore, confidence in more mundane SSA decisions does not justify deferring to SSA judgment at these levels of review.

A 1993 study focused directly on some of these concerns in evaluating the work capacity of claimants suffering from musculoskeletal impairments.\textsuperscript{133} This study compared the SSA’s assessment of a claimant’s disability with rheumatologists’ evaluations of the same individual’s ability to work.\textsuperscript{134} Since fifteen percent of the one million new claimants each year allege musculoskeletal impairment,\textsuperscript{135} the operation of the Five Step disability evaluation process when applied to this type of impairment may be generally instructive.

The study found that agreement between the SSA and the rheumatologists regarding the claimants’ ability to work was no more than would be expected by chance.\textsuperscript{136} The rheumatologists and SSA decision-makers agreed on the disability status of thirty-five of the fifty-two claimants (sixty-seven percent).\textsuperscript{137} This thirty-five included all eleven claimants who met the SSA medical evaluation criteria to be judged disabled.\textsuperscript{138} The “complete agreement [between the

\textsuperscript{128} Id at 1039.
\textsuperscript{129} Id at 1040.
\textsuperscript{130} Id at 1039.
\textsuperscript{131} Id at 1041.
\textsuperscript{132} Id (Physicians’ confidence in their decisions was quantified and correlated well with agreement between the groups.).
\textsuperscript{134} Id.
\textsuperscript{135} Id.
\textsuperscript{136} Id at 29-30.
\textsuperscript{137} Id at 28-29.
\textsuperscript{138} Id at 30.
rheumatologists and the SSA] for claimants who met the listed medical criteria" (listings) is unsurprising because "those who met the criteria had the greatest observed joint swelling, pain and limitation in range of motion." Of twenty-seven judged able to work by the SSA, however, the rheumatologists judged eleven to be unable. Thus, as in the APA study, the rheumatologists and the SSA tended to disagree about the hard or less well-documented cases.

The report suggests several causes for the discrepancies between the rheumatologists and the SSA. The discrepancies may have been caused by the complexity of the work capacity concept itself. Work capacity is partially "determined by factors such as personal motivation, work requirements, and control over pace, which cannot reliably be deduced from review of the medical record." In addition, the study acknowledged that objective criteria for determining disability have limitations, particularly when applied to diseases that are not diagnosed well with laboratory tests. More subjective factors, such as lack of endurance and fatigue, are not addressed at all in the SSA's criteria for determining disability, but do form a significant limitation to ability to work under the medical definition of disability. Finally, the study faults the SSA for relying too heavily on paper record reviews, rather than actual examinations.

The study concludes with the suggestion that "claimants who fail to meet the listings could have a standardized performance-based evaluation like the work capacity evaluation instead of a record review" in order to allow for consideration of factors that can only be weighed through direct examinations. This evaluation must be completed "on a pro forma basis by impartial physicians with expertise in the evaluation of the specific organ system or systems involved." This individualized assessment by a physician would be more accurate than current consultative exams. Consultative examiners, by their own admission, often know very little about the rheumatic disease they are responsible for evaluating, and often conduct so many exams each year that careful, individualized assessments become impossible.

Analysis of the two studies indicates that medical and Social Security definitions of disability differ in important ways: the medical identification of disability is more individualized, incorporates motivation level as part of the disability evaluation, and acknowledges that certain impairments (pulmonary or cardiovascular, for example) are more conducive to objective proof than others.

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139. Id at 26, 30.
140. Id at 26.
141. Id.
142. Id.
143. Id.
144. Id.
145. Id.
146. Id at 30.
147. Id at 30-31.
148. Id at 28 (Consultative examinations are conducted by various physicians, only some of whom have training in rheumatology.).
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(musculoskeletal).

The SSA should adjust to minimize these differences. The SSA's self-identified responsibilities when deciding claims for disability benefits include the duty: "(1) to be impartial; (2) to provide each claimant with the fairest possible assessment of the evidence, and even to assist each claimant in developing the evidence when necessary; and (3) to protect the public interest by providing benefits only to those claimants who are truly disabled." The "fairest possible assessment of the evidence" arguably requires incorporation of current medical definitions into the disability evaluation. Yet, SSA control over the evaluation procedure is also required by the SSA's duty to control costs and provide benefits only to the "truly disabled." A strong treating physician rule provides a compromise between these two demands. It would individualize disability determinations by giving substantial weight to the treating physician's testimony, the source most capable of producing an individualized assessment; yet, the treating physician rule would also fit within a generalized evaluation process.

C. TURNING THE DISABILITY DECISION OVER TO DOCTORS

Institutional elements of the disability determination also support the use of a strong treating physician rule. Lawyers, administrators, and doctors have consistently rejected other responses to the inconsistency between legal and medical definitions of disability, such as delegating the responsibility for the disability determination directly to the medical community or adopting the AMA definition of disability within the legal determination. These two potential solutions would ameliorate the problems that arise from the current use of non-medically trained decision-makers and medical consultants who examine the claimant only once or who merely review the paper file. They also would allow for change in the legal definition of disability as the medical definition changes and would mitigate against overgeneralization or agency bias. However, neither proposal really works, primarily because these ideas do not respond to the institutional needs and biases of the medical and legal communities. Examining the approach to medical evidence in workers' compensation systems and the objections of some members of the medical community helps to explain why.

Workers' compensation commissions and Social Security disability adjudicators both struggle to translate medical issues into legal concepts. Therefore, the use of medical panels in workers' compensation cases provides a direct means of analyzing how medical decision-makers would function in the SSA. The type of medical advisor used varies widely by state; twelve states utilize some form of medical panel and many others use impartial medical examiners. When panels are used, they vary in size and authority. Usually, they give an opinion about the diagnosis and causation of disease; but sometimes they also consider the

149. 56 Fed Reg at 36950 (cited in note 56).
150. Peter S. Barth, Resolving Occupational Disease Claims: The Use of Medical Panels ix-xi (Workers Compensation Research Institute, 1985).
extent of disability. A recent study of these medical panels, conducted by the Workers Compensation Research Institute, indicates that they have met with some success.

However, the panels appear to be successful only when they play an advisory role. The Workers' Compensation Research Institute study found a "fundamental difference between states where panels serve in quasi-judicial roles (Georgia and formerly Maryland) and those where one or more doctors conduct examinations of claimants." The study found that "[t]he adjudicatory role changes the focus of the panel system, and the change is not a good one."

This is because, "[w]here [panel decisions] are binding, [there is] a marked reluctance to use the system." The panelists are more effective if they operate "less as jurists and more as qualified medical specialists." The "few panels that sit as 'medical courts' have not been as well accepted as those that do what doctors typically do" and they "face the resistance of attorneys and administrators, who see them as usurping their role without having legitimate expertise in legal process or principles."

In particular, the study found that "if there is one group that consistently finds fault with the program it is attorneys" who tend to be "deeply suspicious of medical panels." Lawyers frequently question the doctors' objectivity and impartiality, and view medical courts as incompatible with the adversarial system. Similarly, agency officials often resent the roles that doctors play.

At the same time, many doctors object to giving physicians the ultimate responsibility for disability determinations. For example, in 1989, the Washington State Department of Labor and Industries suggested requiring treating physicians in pain clinics to perform disability ratings. The ratings are necessary before the department can end its obligation to replace wages and provide health care to the injured worker. The proposal engendered "substantial resistance" among the attending physician staff of the University of Washington Pain Clinic, and it was not continued after its pilot program. Apparently the medical

151. Id at xi.
152. Id at xv ("In most states actively using panels, there is a high degree of satisfaction among administrators and attorneys for both sides. They feel that panels are a source of consistent decisions based on objective evidence. Panel findings are routinely adopted by the adjudicators . . . and frequently stimulate the parties to settle.").
153. Id at 42.
154. Id.
155. Id at 37.
156. Id.
157. Id at xvii-xviii.
158. Id at 47.
159. Id.
160. Id at 47-48.
162. Id at 1829.
163. Id.
staff felt that performing disability ratings would negatively impact doctor-patient relationships within the clinic, impeding the clinic's ability to provide quality medical care.164

As described in a paper motivated by this experiment, "encounters between physician and patient for the purposes of treating and rating disability create fundamentally different relationships."165 When medical diagnosis focuses on effective treatment for the patient’s pain, the physician “acts as agent for the patient,” but when diagnosis focuses on rating the patient’s disability, the physician “acts as agent for the state.”166 The paper asserts that “[t]herapeutic success depends in many ways on trust between physician and patient, especially in a rehabilitation setting, in which patient values and motivation play such a central role.”167

Because “[t]he difference between compensable and noncompensable disability is not a medical difference,” but a legal difference, the purpose of the evaluation drives the formulation of the definition of disability.168 Disability rating is largely medical in technique, but not in purpose. Where “ratings exist to sort those who, in whole or in part, cannot work from those who will not work,”169 the determination is a legal one. In contrast, when doctors examine physically or mentally impaired patients for purposes of treatment, they focus on the disability only insofar as doing so will aid them in making the proper diagnosis and prescribing an appropriate treatment. The unwillingness of a patient to work will typically play a much smaller role in a purely medical analysis.

The controversy between the medical and legal communities about how to define disability, and over who should define it, has raged since the creation of the Social Security Disability Insurance Program. The program was enacted by Congress in spite of physician protestations that “disability cannot [be] determined ... on a purely ‘medical’ basis” and in spite of “the destructive contradiction of a medical system that simultaneously certifies people as totally disabled and seeks to rehabilitate them.”170 According to the legislative history, “Congress pressed ahead with the Social Security Disability Insurance program based on a model of disease in which ‘disease always has an underlying or anatomical basis, and real disease can be reliably identified by physicians through clinical techniques.’”171 Initially, because of these complaints, the AMA op-

164. Id.
165. Id at 1830.
166. Id.
167. Id.
168. Id.
169. Id.
posed the creation of publicly funded disability insurance.\textsuperscript{172}

In response to these problems, a solution could be to adopt purely medical definitions for use within the legal system. Again, workers' compensation commissions provide an example of this practice, since they are more closely guided by the AMA definition and standards of disability than Social Security adjudicators are. In "40 of 53 jurisdictions (38 states and 2 territories), use of the \textit{Guides is mandated or recommended} by law in workers' compensation cases, or the book is frequently used in such cases."\textsuperscript{173} However, simply incorporating the medical definitions into the legal system may not work for the SSA for several reasons.

First, the \textit{AMA Guides} acknowledges that "no formula is known by which knowledge about a medical condition can be combined with knowledge about other factors to calculate the percentage by which the industrial use of the body is impaired."\textsuperscript{174} As a result, the \textit{Guides} writes in bold that "[i]t must be emphasized and clearly understood that impairment percentages derived according to \textit{Guides} criteria should not be used to make direct financial awards or direct estimates of disabilities."\textsuperscript{175} The AMA rejects responsibility for defining disability for workers' compensation or Social Security Disability, and recognizes that there is a translation into legal standards that must occur about which it may have no expertise.\textsuperscript{176}

In addition, significant differences between workers' compensation and the SSA programs are relevant to the choice of definitions. Although the issue in both types of proceedings is whether or not the claimant suffers from a compensable disability, the programs and their use of medical evidence are significantly different. Workers' compensation programs acknowledge that degrees of disability exist, while SSA programs do not.\textsuperscript{177} Workers' compensation commissions have established standards to assess partial disability and need to rely more heavily on medical opinions to use these standards.\textsuperscript{178} Furthermore, workers' compensation claims are often made through an adversarial proceeding, while

\begin{itemize}
    \item \textsuperscript{172} Osterweis, Kleinman, and Mechanic, \textit{Pain and Disability} at 24 (cited in note 170).
    \item \textsuperscript{173} AMA, \textit{Guides} at 3-4 (cited in note 110) (In 1991, 19 jurisdictions mandated the use of the \textit{Guides} by law, 10 recommended them by law, 11 used the \textit{Guides} frequently, though gave them no legal mention, and 13 did not use the Guides. In Texas, mandatory use of the Guides was being litigated in 1991.).
    \item \textsuperscript{174} Id at 4.
    \item \textsuperscript{175} Id at 5.
    \item \textsuperscript{176} Id at 4-5. The \textit{Guides} helps to resolve this problem, without purporting to reach a perfect solution: "Each administrative or legal system that uses permanent impairment as a basis for disability ratings should define its own means for translating knowledge about an impairment into an estimate of the degree to which the impairment limits the individual's capacity to meet personal, social, occupational, and other demands or to meet statutory requirements."
    \item \textsuperscript{177} Barth, \textit{Resolving Occupational Disease Claims} at xi (cited in note 150).
    \item \textsuperscript{178} Id.
\end{itemize}
disability hearings are not.\textsuperscript{179} In Social Security disability determinations, the SSA is not directly represented; instead, the ALJ is supposed to develop the case fully, taking into account the needs of both the SSA and the claimant, and make an impartial decision.\textsuperscript{180} Therefore, one important element of SSA procedures must be the provision of a reasonable substitute for the scrutiny engendered by an adversarial proceeding,\textsuperscript{181} without the transformation of the process into an adversarial one. And most importantly, the Guides is directed to doctors, not lawyers or bureaucrats. If the SSA is going to emulate workers' compensation determinations by utilizing medical definitions of disability, it must do so through greater deference to medical advisors, not through wholesale adoption of medical definitions.

III. Conclusion

This Comment has examined institutional constraints on attempts by different organizations in society to define disability. The SSA, federal courts, and the medical community each use slightly different definitions, and slightly different methods of evaluation of disability. These differences result in different identifications of who is disabled, or at least whose disabilities are compensable. Moving the legal definition towards the medical will resolve some of these differences by integrating the two conflicting goals of the Social Security Administration: objective, general, and consistent determinations combined with individualized assessments. The best way to integrate the legal and medical definitions is through the use of a strong, though not binding, treating physician rule.

This result satisfies a need for more subjectivity and acknowledges that disability is context-driven, rather than simply and mechanically structural and medical. This solution also fills a need for less bureaucratization, and less generalized decisions—without destroying the legal distinction between those who "cannot" and "will not" work. This solution will not negatively impact the doctor-patient relationship and will preserve the difference between medical and legal perspectives and institutional roles. In essence, treating physicians, because of their unique position, will define those claimants who are impaired and who should be declared disabled, but the SSA will retain the authority and responsibility for reaching the legal conclusion of who is disabled. This result can be, and in some circuits is already, achieved through the courts. Even though the 1991 SSA regulations initially implied that the federal courts lost the battle with SSA about who should define disability, courts still use the treating physician rule to monitor SSA decisions. Ultimately, they should continue to do so because the

\textsuperscript{179} Id at 42; 56 Fed Reg at 36935 (cited in note 56).
\textsuperscript{181} 56 Fed Reg at 36935 (cited in note 56) (The SSA asserts that its current procedure does effectively mimic the safeguards of the adversarial process.).
courts can thereby insure that the SSA's disability determinations incorporate a sufficient degree of individualized and contextualized assessment of the claimants' physical or mental impairments.