

2015

Medical-Legal Partnerships: Origins and Ethical Lessons

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Recommended Citation

Cathryn Miller-Wilson, *Medical-Legal Partnerships: Origins and Ethical Lessons*, 93 Neb. L. Rev. 636 (2014)

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Medical–Legal Partnerships: Origins and Ethical Lessons

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* Cathryn Miller-Wilson is currently Deputy Director of HIAS Pennsylvania and was a Visiting Assistant Professor of Law at Villanova University School of Law at the time this Article was written. Thank you to Michelle Dempsey, Michael Campbell, Beth Lyon, Dveera Segal, and Amy Spare for your comments and helpful thoughts on early drafts of this Article. Thank you also to Leah Hill, Wendy Bach, Binny Miller, Fatma Marouf, Natalie Chin, and Flora Didonato for your insightful ideas, leads, comments, and inspiring support. This Article would not exist without the early work and inspiration from Karam Mounzer, MD, Danielle Travagline, Esquire, and my former clients at the AIDS Law Project of Pennsylvania. Thanks also goes to Maggie Eisen, Director of the Philadelphia Legal Assistance Medical–Legal Partnership for her supportive comments. For your tireless research, thoughtful discussions, and exacting editing, thanks go to my research assistant, Susan Stanton. Finally, thanks also goes to Drexel Law Student Anthony Magdalinski for picking up so quickly and filling in last minute gaps.

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I. INTRODUCTION

The medical–legal partnership movement was born from recognition of the complexity that poverty imposes on health.¹ While health conditions do not generally discriminate based on economic status, remedies certainly do. For example, wealthy children can and do suffer from asthma, but unlike a poor child with asthma, a wealthy child’s family has the means to eliminate environmental factors that may be aggravating it. A poor child’s family, without a lawyer, may have no ability to force the landlord to remove the mold, insects, or rodents that may be aggravating the child’s condition and no ability to simply move to better housing.

Dr. Barry Zuckerman, Chief of Pediatrics at Boston Medical Center, is credited with recognizing this and creating a model medical–legal partnership in 1993 that has since been replicated in more than twenty states across the country.² The partnerships are loosely defined, some consisting of simply generating legal referral resources for doctors to refer their patients. However, in its most effective form, medical–legal partnerships are formal partnerships between a doctor’s office and a lawyer’s office wherein the partners train each other regularly about medical and legal definitions, medical and legal obligations, medical and legal issues that are interconnected, and work together to solve their patients’/clients’ medical/legal problems. Attorneys, doctors, educators, and policymakers have lauded these innovative interdisciplinary partnerships created to serve low-income communities.³ Commentators have written articles enthusiastically

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1. ELIZABETH TOBIN TYLER ET AL., *POVERTY, HEALTH AND LAW: READINGS AND CASES FOR MEDICAL-LEGAL PARTNERSHIP* (Carolina Academic Press 2011); *see also* THE NAT’L CTR. FOR MED. LEGAL P’SHIP, www.medical-legalpartnership.org (last visited March 6, 2014), *archived at* <http://perma.unl.edu/G66R-GLAW> (providing general information regarding the medical-legal partnership movement).
 2. *See* Randye Retkin, Esq. et al., *Lawyers and Doctors Working Together—A Formidable Team*, *HEALTH LAW.*, Oct. 2007, at 33, 34; Elizabeth Tobin-Tyler, Esq., *Holistic and Collaborative Approaches to Practicing Law and Medicine*, *R.I. BUS. J.*, May–June 2009, at 37 (referring to Dr. Zuckerman as having had the “novel” idea of creating a medical–legal partnership that launched a national movement); Sylvia Pagan Westphal, *Lawyers Help Patients Solve Problems: National Network Connects Medical-Legal Programs Aiding Low Income Families*, *WALL ST. J.*, April 11, 2006, at D3.
 3. *See* Amy Kilelea, *Collaborative Lawyering Meets Collaborative Doctoring: How a Multidisciplinary Partnership for HIV/AIDS Services Can Improve Outcomes for the Marginalized Sick*, 16 *GEO. J. ON POVERTY L. & POL’Y* 413 (2009); Charity Scott, *Doctors as Advocates, Lawyers as Healers*, 29 *HAMLIN J. PUB. L. & POL’Y*

endorsing these partnerships, sharing success stories and urging the continued creation of many more.⁴

This Article joins this chorus in favor of the creation of medical–legal partnerships, focusing on one particular population, the low-income disabled.⁵ An examination of this population’s treatment within the disability income system⁶ reveals, however, a startling discovery. Medical–legal partnerships, in the effective form described above, were utilized by government and private industry in their review and adjudication of claims decades before Dr. Zuckerman’s actions became a movement.⁷ Government and private industry have created medical–legal partnerships to process claims and those part-

331 (2008); Elizabeth Tobin-Tyler, *Allies Not Adversaries: Teaching Collaboration to the Next Generation of Advocates, Doctors and Lawyers to Address Social Inequality*, 11 J. HEALTH CARE L. & POL’Y 331 (2008); Westphal, *supra* note 2 (“It’s very exciting. Dr. Zuckerman has really been a visionary,” says Eileen Ouellette, president of the American Academy of Pediatrics. The medical-aid programs have helped fill a gap created by the stagnation of federal funding for low-income legal aid, says Don Saunders, director of civil legal services at the National Legal Aid & Defender Association in Washington.”).

4. See Stacy L. Brustin, *Legal Services Provision Through Multidisciplinary Practice—Encouraging Holistic Advocacy While Protecting Ethical Interests*, 73 U. COLO. L. REV. 787 (2002); Kilela, *supra* note 3; Tina Rosenberg, Op-Ed, *When Poverty Makes You Sick, A Lawyer Can be the Cure*, N.Y. TIMES, July 17, 2014, <http://nyti.ms/1nCBPjh>, archived at <http://perma.unl.edu/FU8A-2667>.
5. “Low-income” is a term that often has very specific definitions. However, for purposes of this Article, I am speaking more generally of those persons who, whether they might have once worked and been well above any kind of federal poverty guideline definition, are, upon becoming disabled and unable to work, without any other source of income or support and therefore in need of some kind of disability income benefit to survive. In addition, of course, I am including in my discussion those persons who have never worked and always lived at or below the federal poverty level.
6. There are a variety of benefits that a disabled person can claim, ranging from social security disability income benefits, to short- and long-term disability income benefits available through a disability insurance policy, to worker’s compensation benefits, and other debt-relief benefits available for student loans or through mortgage insurance policies, credit card insurance policies, etc. All of these benefits require medical documentation to verify that the claimant meets the definition of disability proscribed either by law or regulation or by a particular insurance policy. Medical–legal partnerships on behalf of disabled indigent persons who are applying for any of these benefits are critical. However, this paper will only focus on the need for medical–legal partnerships within the context of social security disability income benefits and long-term disability income benefits provided through employer benefit plans.
7. See Vernellia R. Randall, *Managed Care, Utilization Review, and Financial Risk Shifting: Compensating Patients for Health Care Cost Containment Injuries*, 17 U. PUGET SOUND L. REV. 1, 27–28 (1993) (discussing Congress’s development of Peer Review Organizations in the 1970s and 80s, composed of physicians, responsible for conducting utilization review for services provided under the Medicare Program, which took many forms, such as preadmission review for scheduled hospitalizations, retrospective claims review, and admissions review for unscheduled hospitalizations).

nerships have exploited the differences in definition and perspective between the medical and legal professionals involved in assisting the disabled.⁸ Therefore, as this Article argues, medical–legal partnerships on behalf of the low-income disabled are not only beneficial but are, in fact, ethically required.

Lawyers and doctors for impoverished communities struggle not only with the complexity that poverty imposes on their clients'/patients' lives but also with their own resource limitations which make effectively managing their practices extremely difficult. Lawyers or doctors for the poor will have to forgo hiring investigators, ordering multiple diagnostic tests, filing multiple claims, or prescribing multiple treatments unless they can find creative ways to fund those activities. While it is perfectly understandable, even expected, that such "luxuries" will indeed be absent from a poverty lawyer or doctor's representation/treatment, there is a legitimate question whether these same lawyers and doctors are acting ethically when they "represent" or "treat" their clients/patients without these tools. It becomes a question, of course, of what is minimally necessary for ethical representation/treatment.⁹ This question is answered, in part, by the literature regarding the boundaries of ethical representation/treatment.

With respect to lawyers, some argue that "zealousness" on the part of the lawyer requires unlimited advocacy, regardless of ability to pay,¹⁰ and some attempt to impose a boundary on the ethical representation of poor people by seeking to add considerations of the community to the calculus.¹¹ Others argue the opposite, that poverty lawyering is absolutely limited by the resources of the lawyer and the

8. *Id.*

9. Note that "medical ethics" or the "ethical obligations" of a doctor have been said to encompass three separable, though overlapping concepts. These have been referred to as "decorum," or more simply the virtues of a doctor as a moral being; the deontological aspects of ethical medical practice consisting more of rules to be followed; and what at least one author has described as "politic ethic"—those practices that recognize that a doctor's care occurs in and has ramifications for a community. See ALBERT R. JONSEN, *A SHORT HISTORY OF MEDICAL ETHICS* (2000), for a lengthier and more detailed discussion. As I am addressing the practical constraints of ethical medical practice, I will be referring primarily to the deontological concept of medical ethics. As Jonsen suggests, however, the concepts are not mutually exclusive and moral conceptions of ethical practice, even when considered more broadly, support rather than undermine the contention that resource limitations do not excuse interdisciplinary incompetence.

10. Gary Bellow & Jeanne Kettleon, *From Ethics to Politics: Confronting Scarcity and Fairness in Public Interest Practice*, 58 B.U. L. REV. 337, 355–56 (1978); Michelle S. Jacobs, *Legal Professionalism: Do Ethical Rules Require Zealous Representation for Poor People?*, 8 ST. THOMAS L. REV. 97, 110 (1995).

11. Paul R. Tremblay, *Toward a Community-Based Ethic for Legal Services Practice*, 37 UCLA L. REV. 1101, 1136 (1990).

client, and that this is ethical.¹² With respect to doctors, the debate is substantially similar, focusing on the fiduciary duties of the doctor and when and how that relationship requires “advocacy.”¹³

Part II of this Article will provide an ethical analysis of the doctor and lawyer role. Specifically examining the boundaries of the fiduciary obligations of the doctor and the zealous advocacy obligations of the lawyer, it is clear that effective fulfillment of these obligations requires interdisciplinary partnership¹⁴ work when seeking to treat and represent the low-income disabled. Claims of inability to do so for those that cannot pay only exacerbate the very problems that adequate fulfillment of these obligations is meant to ameliorate: poverty, poor health, and dependence.

In addition to examining the literature regarding the roles and ethical obligations of lawyers and doctors, the question of the boundaries of those roles and obligations is also answered by looking at the specific context of the litigation in question. When attempting to assist a disabled person who has no source of income (and little financial support from loved ones), it is important to understand the practical realities faced by that person upon applying for a benefit to which she is lawfully entitled.

Part III will bolster the argument that ethical fulfillment of the obligations discussed in Part I requires interdisciplinary partnership work by providing a brief historical analysis of disability claims adjudication. As disability claims have risen in both the government and private sectors, courts and legislatures have struggled to find ways to fairly adjudicate these claims without bankrupting either the government or the disability insurance companies involved. This struggle gave rise to a number of rules, some judicially created and some legis-

12. Bellow & Kettleson, *supra* note 10, at 354. Bellow and Kettleson refer to an ABA Opinion that said many lawyers believe that due to resource constraints failure to advocate completely zealously is an understandable and perhaps even justifiable lapse of the poverty lawyer. However, note that the committee then went on to state that lack of resources on the part of the lawyer is not a justification for failing to fulfill ethical obligations and representation that is not sufficiently zealous or diligent violates Canon 6 of the ABA model rules. ABA Comm. on Ethics & Prof'l Responsibility, Informal Op. 1359 (1976).

13. See LAURENCE B. McCULLOUGH, JOHN GREGORY AND THE INVENTION OF PROFESSIONAL MEDICAL ETHICS AND THE PROFESSION OF MEDICINE 3 (1998); L. Schwartz, *Is There an Advocate in the House? The Role of Health Care Professionals in Patient Advocacy*, 28 J. MED. ETHICS 37 (2002).

14. I use the term, “interdisciplinary partnership” to encompass partnerships that are much deeper than simply acting as a mutual referral resource. I refer to a partnership where both partners understand and educate one another about their respective roles and role conflicts, how those roles impact obligations to patients/clients, as well as their use of language, terms, and perspective. Additionally, the partners should understand and educate one another about barriers to patient/client service and whether these can be overcome with a review of the patient/client’s problem through the other profession’s lens.

latively created, which were meant to aid in this process but ultimately only served to heighten the inability of physicians to provide effective medical opinion evidence without enlisting the interdisciplinary support of their lawyer colleagues.

The courts, as the final arbiters of disability-related claims decisions, have unwittingly supported and widened the gap between medical opinion and legal definition. They have done so by making repeated pronouncements that nontreating physicians, often paid by the very persons making the legal decisions regarding disability, can provide evidence as worthy of weight as that of treating physicians. This judicial recognition of insurer or government-created defense mechanisms has resulted in the increasing institutionalization of insurer or government medical–legal partnerships. As these partnerships have become more sophisticated and entrenched, a disabled patient’s application, resting solely on the isolated treating physician’s record, is doomed to fail.

In Part IV we will see precisely why an isolated treating physician’s record is doomed to fail. I will analyze the legal requirements for most disability-related benefits and distinguish those requirements from doctor goals in creating treatment records. Specifically, I will examine the traditional role expectations of doctors and how current legal expectations are in conflict with more traditional views of the role of doctors.

In Part V, I will return to our discussion of lawyer and doctor ethics. Recognizing the origins of the interdisciplinary partnership ultimately supports the current medical–legal partnership movement but requires a stronger ethical response from doctors and lawyers. The disabled must have access to doctors and lawyers who work as full interdisciplinary partners on behalf of their low-income disabled patients/clients. This necessity is starkly revealed when the tools that have been used to deny claims are acknowledged.

II. ETHICAL OBLIGATIONS BEYOND RESOURCE LIMITATIONS

While we are all familiar with the Hippocratic admonition to “do no harm,” it is less clear how far this obligation extends. The literature surrounding ethical obligations of doctors helpfully delineates the ethical obligations as fiduciary in nature.¹⁵ A fiduciary has been defined as “someone who is required to act for the benefit of another person Generally, one person stands in a fiduciary role to another when that person, due to special training, expertise, or other qualifica-

15. Scott, *supra* note 3, at 331. See also Tyler, *supra* note 2, n.4 (citing Tracy v. Merrell Dow Pharmaceuticals, Inc., 569 N.E.2d 875, 879 (Ohio 1991)).

tion, holds potential power and influence over the other.”¹⁶ It is precisely this power imbalance that ethics seeks to address by “imposing duties of care and loyalty on the fiduciary.”¹⁷

Laurence McCullough traces this concept to one first introduced by John Gregory in the late 18th Century.¹⁸ Gregory, through his teachings and writings, developed a defined physician–patient relationship, with associated morally-based behaviors, in response to a list of problems relating to the commercial manner in which medicine was then practiced.¹⁹ As described in great detail by McCullough, the relationship and practice of medicine at the time was primarily driven by the patient and her purse rather than by a sense of independent professional duty.²⁰ Gregory sought to solve this problem by highlighting for his students the importance of creating a relationship governed by a patient’s needs but bounded by a physician’s judgment.²¹ Meeting patient demands, regardless of how medically sound such demands were, most often resulted in danger to the patient.²² Similarly, however, dictating treatment plans without regard to the patient’s express or implied concerns also resulted in danger to the patient.²³ Gregory wrote extensively about the importance of sympathy as a virtue for the physician—sympathy that required the physician to put his patient’s needs before his own by listening, expressing curiosity about the patient’s life, seriously considering patient suggestions and patient capabilities, and taking all of this into account when prescribing treatment.²⁴ The imposition of Humean concepts of sympathy, trustworthiness and compassion forged a physician–patient relationship where before there was merely a push and pull between patient and physician.²⁵ This relationship, and its moral boundaries, are what Gregory created and what became, in a modern articulation, the basis for what we call the fiduciary relationship between physician and patient.²⁶

This understanding is helpful to determining a kind of floor for medical ethics but not a ceiling. Why this is important is aptly illustrated in Charity Scott’s article, *Doctors as Advocates, Lawyers as Healers*.²⁷ Professor Scott begins the article by recounting her health-

16. Scott, *supra* note 3, at 334.

17. *Id.* at 334.

18. McCULLOUGH, *supra* note 13.

19. *Id.* at 4–5.

20. *Id.* at 58–67.

21. *Id.* at 173–266.

22. *Id.* at 220–52.

23. *Id.*

24. *Id.* at 190–200, 213–19.

25. *Id.* at 220–52.

26. *Id.* at 5.

27. Scott, *supra* note 3, at 331.

care-professional audience's unanticipated reaction to her pronouncement regarding the physician's fiduciary duty to their patients at a conference on conflict resolution in healthcare.²⁸ As she tells it, audience members reacted angrily, complaining about the "burdening" of doctors with "more duties," exclaiming that "the doctor-patient relationship is therapeutic."²⁹ In other words, as Professor Scott determined through greater discussion and thought both during and after the conference, doctors saw themselves as healers and saw healing as an obligation that was not necessarily connected to advocacy.³⁰ The concept of fiduciary, however, is broad enough to encompass both roles. As Professor Scott concludes, taking the concept of fiduciary "seriously may unsettle our conventional views of doctors as healers and lawyers as advocates."³¹

As McCullough has described, there are three key components to how a physician's fiduciary obligations have been defined: "(1) [the physician] must be in a position to know reliably the patient's interest, (2) should be concerned primarily with protecting and promoting the interests of the patient, and (3) should be concerned only secondarily with protecting and promoting the physician's own interests."³² The development of these concepts has been pivotal to the physician's understanding that her commitment to her patients renders her commitment to her own interests, whether for "income, job security and advancement, prestige, fame and power," secondary.³³ This subordination of personal interests in favor of the interests of the person being served has been articulated as an element of the "ideal' conception of a profession."³⁴

In the case of the indigent disabled claimant's physician, her power, and by extension her obligation, encompasses not only the treatment of the claimant's physical or mental ills (healing), but also effective participation in the disability claims process itself (advocacy). This is true for three reasons: the specific nature of the process for obtaining disability benefits, which silences the patient's voice in favor of the physician's; the fact that the process is part of a larger legal adversarial context that presumes formalized argument and counterargument; and finally, the fact that, for this particular population, income supports are an inseparable part of treatment. Income supports

28. *Id.* at 331-32.

29. *Id.*

30. *Id.*

31. *Id.* at 333.

32. McCULLOUGH, *supra* note 13, at 5 (citing L.B. McCULLOUGH & F.A. CHERVENAK, *ETHICS IN OBSTETRICS AND GYNECOLOGY* 12 (1994)).

33. *Id.* at 2.

34. *Id.* at 3 (citing Allen Buchanan, *Is There a Medical Profession in the House?*, in *CONFLICTS OF INTEREST IN CLINICAL PRACTICE AND RESEARCH* 105, 107 (Roy G. Spece et al. eds., 1996)).

for this population are a social determinant of health and therefore a factor to be treated in order to effectively heal.³⁵

Regarding patient voice, it is important to note that within the context of the disability claims process, it is the physician who is given the voice to provide witness to the claimant's disability.³⁶ While the claimant is asked to describe her impairments, her voice is not given the same weight as that of the physician either in the examining room or throughout the disability claims process.³⁷ It is the claimant's physician who has the power to be heard when she articulates the nature and extent of the claimant's impairments, not the claimant.³⁸

One can certainly argue that within the legal process for obtaining disability benefits, perhaps it is this precise procedural requirement that a claimant provide physician documentation of her own ailment that is the problem, and not the physician's failure to effectively document the claimant's ailment. Lucie White, in her famous story regarding her client, Mrs. G, discusses a "humanist vision," wherein "procedural justice is a normative *horizon* rather than a technical problem."³⁹ In other words, achieving procedural justice generally requires us to expand our understanding beyond merely permitting access to ensuring meaningful participation that allows for and comprehends subordinated voices. What passes for procedural justice—providing an opportunity for the subordinated to speak—fails to account for the constructs that render "the subjectivity and speech of

35. The social determinants of health, such as substandard housing and food scarcity, are precisely what Dr. Zuckerman realized were preventing his patients from healing despite their compliance with his treatment recommendations. The problem, he realized, was the limits of his prescriptions. Medicine alone could not cure his patients' ills. In some circumstances, the toll that poor nutrition and shelter had on his patients was so great that his prescriptions had virtually no impact on their illness. It was this realization that led the doctor to conclude that social determinants, as well as physical and psychological ones, must be addressed as part of the healing process. See THE NAT'L CTR. FOR MED. LEGAL P'SHIP, *supra* note 1.

36. See 20 C.F.R. § 404.1512(a) (2014) (claimants must "furnish *medical* and other evidence that we can use to reach conclusions about your medical impairment(s)" (emphasis added)); See also *id.* § 404.1513(a) ("Sources who can provide evidence to establish an impairment. We *need* evidence from *acceptable medical sources* to establish whether you have a medically determinable impairment(s). Acceptable medical sources are: (1) licensed physician . . . (2) licensed or certified psychologists . . . (3) licensed optometrists" (emphasis added)).

37. See *id.* § 404.1513(b)(6) ("Medical reports should include . . . [a] statement about what you can still do despite your impairment(s) based on the acceptable medical source's findings on the factors under paragraphs (b)(1) through (b)(5) of this section")

38. See *id.* § 404.1527(c)(2) (requires that reviewing courts "give more weight to the opinions" of the claimants' treating physicians).

39. Lucie White, *Subordination, Rhetorical Survival Skills, and Sunday Shoes: Notes on the Hearings of Mrs. G.*, 38 BUFF. L. REV. 1, 3 (1990).

socially subordinated persons as inherently inferior to the speech and personhood of dominant groups.”⁴⁰

Within the context of the current procedural processes that exist for indigent disabled claimants, a legal definition of “objective medical evidence of disability”—a requirement for both social security disability benefits and most private disability income benefits⁴¹—includes evidence provided by an outsider, a third party, a person with relevant medical expertise who has a professional obligation to provide medical facts and truthful medical opinion regarding a claimant’s ability to work.⁴² As the physician provides these medical facts and opinion, the facts and opinion provided by the claimant get pushed aside. The claimant’s descriptions, opinions, and answers to questions are reviewed only with respect to whether they are consistent with the physician’s statements.⁴³ Those claimant statements that contradict the physicians’ are discounted, deemed “not credible.”⁴⁴ In this manner, the claimant’s procedural protection is almost entirely eliminated. How can one claim “meaningful participation” if one’s testimony is

40. *Id.* at 4.

41. Mary Crossley, *The Disability Kaleidoscope*, 74 NOTRE DAME L. REV. 621, 629 (1999) (citing 42 U.S.C. § 423(d)(1)(A) (1995)); Mala M. Rafik, *Objective Evidence in Disability Claims*, 20 PRAC. LITIGATOR 31 (2009).

42. 20 C.F.R. §§ 416.920, 416.927 (2014). With respect to private long-term disability insurance, requirements differ from policy to policy. However, many long-term disability insurance policies require “objective evidence” of disability. See Aaron Hotfelder, *Appealing a Denial of Long-Term Disability Insurance*, NOLO, <http://www.nolo.com/legal-encyclopedia/appealing-denial-long-term-disability-insurance.html> (last visited May 8, 2014), archived at <http://perma.unl.edu/AC32-WBF6>; Insurance Companies, MYDISABILITYAPPEAL.COM, <http://www.mydisability-appeal.com/insurance-companies.php> (last visited May 8, 2014), archived at <http://perma.unl.edu/W86T-KHE4>; Long-Term Disability: What Reasons are Given by Insurance Companies to Deny a Claim?, ALLAN W. BEN, PC, <http://www.allanwbenpc.com/blog/erisa/long-term-disability-what-reasons-are-given-by-insurance-companies-to-deny-a-claim> (last visited May 8, 2014), archived at <http://perma.unl.edu/9KSN-VF6W>; OBJECTIVE EVIDENCE, <http://getmyltdbenefits.com/practice-areas/objective-evidence> (last visited May 8, 2014), archived at <http://perma.unl.edu/R7KY-YYHQ>.

43. See *Lingenfelter v. Astrue*, 504 F.3d 1028, 1035–36 (9th Cir. 2007) (“To determine whether a claimant’s testimony regarding subjective pain or symptoms is credible, an ALJ must engage in a two-step analysis. First, the ALJ must determine whether the claimant has presented objective medical evidence of an underlying impairment”); see also 20 CFR § 404.1513(a) (requiring claimant to provide evidence from “acceptable medical sources,” which include licensed physicians, psychologists, and optometrists).

44. See *Vasquez v. Astrue*, 572 F.3d 586, 591–92 (9th Cir. 2008)(discussing ALJ’s decision to reject claimant’s subjective testimony of her chronic pain due to discrepancies between those statements and the information contained in the reports from the treating and examining physicians); see also *Similia v. Astrue*, 573 F.3d 503, 518 (7th Cir. 2009) (upholding ALJ’s rejection of claimant’s credibility due to the contradictory nature of his testimony when compared to several of his doctors’ reports).

constantly erased, minimized, or deemed not worthy of credulity by the testimony of the witness recognized by the justice system as the "true" voice of the patient?

Subsuming the client's voice into that of the physician's requires physicians to truly hear their patients so as to effectively communicate the patient's position rather than undermine it. Given the physician's power to act as the claimant's voice, the physician has the corresponding responsibility to ensure that her articulation is appropriately supportive of her disabled patient's claims.⁴⁵ Doctors who are not legally trained but who nevertheless attempt to advocate on behalf of their patients often end up undermining, rather than supporting,

45. Note that the term "appropriately supportive" is meant to include only those actions or words that the physician believes, in her medical judgment, to be true. When referring to indigent disabled patients, I am referring to those patients who the physician believes to be disabled in the colloquial sense of the term. In other words, I am referring to those patients who, given what the physician knows of her patients' past work history or education levels, as well as the patients' physical and mental limitations, are unable to work, in the physician's opinion. I am not referring to those patients who the physician does not believe are disabled, nor am I advocating any compromise of the physician's independent medical judgment. Where a physician does not believe that a patient is disabled, her obligation is to ensure that her patient understands this, as well as the reasons for that belief. Additionally, a dialogue regarding the patient's capabilities, symptoms, potential treatments, and potential referrals for assistance in addressing the problems that drove the patient to believe she was eligible for disability in the first place should ensue. In this manner, rather than simply amplifying or drowning her patient's voice, a physician can return the patient's voice to the patient by working with the patient to achieve benefits (income support or work-related) that are consistent with their collaborative assessment of the patient's capabilities and needs.

While honest discussions of a patient's capabilities may seem beyond what is required ethically, and often raise legitimate concerns that a physician has regarding the patient's willingness to trust her physician, such discussions are consistent with modern conceptions of medical ethics that include moral responsibility for the patients' rights of self-determination. See Tom L. Beauchamp, *Emerging Paradigms in Bioethics: Principles and Other Emerging Paradigms in Bioethics*, 69 *Ind. L. J.* 955, 958-59 (1994). Pretending to support a patient's self-conception that she is disabled for fear that failure to do so will result in a breach of trust ultimately and ironically will do more damage to the physician/patient relationship than honest discussions and appropriate referrals would. This is precisely because a physician who does not believe that her patient is disabled, but fails to convey this to the patient, will complete medical documentation requests in a manner that reflects her skepticism and, consequently, benefits will be denied. Certainly, upon receipt of the denial the physician can continue the pretense, expressing outrage on the patient's behalf, but this does nothing to ensure that the patient has a sustainable income, health insurance, or any ability to comply with treatment recommendations. Note that Beauchamp's discussion of a patient's autonomy and right of self-determination is as a contrast to or outgrowth from traditional medical ethical conceptions which focus on patient welfare. In the context of the low-income disabled patient, however, interdisciplinary competence as physician responsibility is supported by both traditional and modern conceptions.

their patients' claims. Worse, doctors who don't view their role as advocacy at all fail to understand how their "objective" reporting of a patient's condition will doom an application to fail. Undermining a patient application for disability benefits can result in serious harm to the patient, both in terms of her welfare and her autonomy. Consequently, failing to advocate or failing to learn what effective advocacy requires when a patient is disabled is unethical. Ethical obligations relating to both patient welfare and autonomy cannot be derived without consideration of the adversarial context. A physician that says, "I must be objective, I will only report what I see and let those in authority make the ultimate decision as it is not my place to determine whether a patient is legally eligible for benefits," fails to acknowledge that the process for obtaining benefits is, necessarily, a process wherein a claimant must prove disability to those who presume capability. In other words, there is no magical, objective, unbiased decision maker in the sky. Decisions regarding eligibility for benefits are made, in the first instance, by the doctors and lawyers who are paid by the decision makers. They are trained and paid to interpret their own definitions of disability narrowly. To pretend that the decision makers "know" who is "truly" disabled and who is not is to pretend that the truth will be made apparent without benefit of the normal back-and-forth required by our adversary system. It is contrary to the very cornerstone of our adversarial process to assume that some objective truth can be determined without the benefit of counterargument. Because the claimant's physician plays a vital role in the disability claims process, which is adversarial in nature, it is unethical for a physician to claim that he or she has no opinion and is merely reporting "the medical facts."⁴⁶

Finally, because disability income benefits for the indigent disabled are the sole source of income and financial support for those patients, accessing food, shelter, clothing and health care are impossible without them. In other words, income benefits for persons with no other source of income or financial support are directly connected to treatment. If treatment is defined not only as analyzing, diagnosing, prescribing and providing a treatment plan, but also as the actual follow-up to that plan, then there is no treatment without the income to

46. As alluded to above, perhaps there is an argument that a claimant's physician should not have this role, that this is overly burdensome on the physician who, after all, wants solely to treat her patient. Certainly, many physicians believe that the myriad requests for documentation thrust upon them by their patients are not why they went to medical school. Whether the role that our legal system, built as it is on the participants' ability to prove their claims, is unreasonable and should be abolished, is beyond the scope of this paper. My argument is simply a call for recognition that our legal system, such as it is, does impose this role on the claimant's physician and that the ethical requirements of fulfilling this role therefore include interdisciplinary education.

make it happen. Even a doctor willing to visit an indigent disabled patient at a shelter—providing her time and expertise for free—cannot then ensure that the medicinal, nutritional, and minimum environmental needs of her patient are met absent actually physically providing the medicine, food, and shelter herself. Arguably the physician's obligation is to provide the recommendation, the plan of action, rather than fulfill the physical need. But where a patient's lack of income makes following the treatment plan an actual impossibility, whose responsibility is it? Put another way, where even minimal recommendations cannot be followed, what is the meaning of health care access? When furnishing what is necessary in terms of effective advocacy will provide the income that provides that ability to pursue the treatment plan, it is clear that advocacy for the indigent disabled is merely an extension of the doctor's clear obligation to provide the diagnosis and treatment plan. It is not a separable task that is recommended but not obligatory.

It is important to note here that despite the reluctance of some who continue to believe that healing does not encompass advocacy, based on my own experiences with my clients' doctors, most doctors for the indigent disabled intuitively understand the importance that advocacy has in their patient's lives. The problem is a failure to understand that effective advocacy is not only beyond their skill and training but often counterintuitive to their own understanding of what questions are being asked and why. The failure to fully appreciate the gaps between their own perspectives and those of the legal arena in which their patients must fight can result in ineffective, time-consuming advocacy efforts and a life-threatening (for their patient) denial of benefits.

As stated above, there are three essential "components" to a physician's ethical obligation as fiduciary, the first of which is competence.⁴⁷ A physician who is unaware of the nature and extent of the review facing her disabled patient's records or how to effectively present the evidence in support of her patient's claim, is arguably not competent. Again, we are faced with the question of whether competence encompasses merely knowing which drug or treatment to prescribe, or whether it includes ensuring that the prescription can be filled. In light of the American Medical Association's articulation of the physician's obligation "to advocate for the patient's welfare," the answer must be the latter, broader conception of competence.⁴⁸ As already stated, an indigent disabled patient has no source of income

47. Scott, *supra* note 3, at 336, 337. See McCULLOUGH, *supra* note 13, at 5 (citing L.B. McCULLOUGH & F.A. CHERVENAK, *ETHICS IN OBSTETRICS AND GYNECOLOGY* 12 (1994)).

48. AM. MED. ASS'N., *CODE OF MEDICAL ETHICS OPINION E-10.015* (2001), archived at <http://perma.unl.edu/NFN6-M5KM>.

other than her potential disability benefits. Therefore, a physician's failure to work with her patient's attorney not only by responding to requests but also by learning how to characterize the medical evidence in the light most favorable to her patient is a failure to advocate for her patient's welfare that will result in a failure to help her patient heal. It is not merely an unfortunate error. It is an ethical violation. It is the ethical obligation to understand the importance of crossdisciplinary work on behalf of indigent disabled patients that is critical to the successful fulfillment of a physician's advocacy and healing obligations.⁴⁹

Similarly, a lawyer's duty to "zealously advocate" on behalf of her client encompasses her need to ensure that she has marshaled the evidence in the light most favorable to her client. This means that merely seeking medical records and submitting them is not sufficient. As will be discussed in more detail below, medical records are kept by the physician for the physician. They are often, at best, unhelpful with regard to the legal question of whether the client is disabled and at worst they unintentionally undermine the client's application. It is the lawyer's job to anticipate and address these issues through active interdisciplinary involvement with her client's doctor.

Interestingly, most of the literature regarding the discussion of a lawyer's obligation of zealousness is about discomfort with overzealous lawyers who take this obligation too far. The literature, with a few notable exceptions,⁵⁰ is silent regarding resource limitations and consequent underzealous lawyering. Nevertheless, it is clear, as already stated, that there is no written exemption for the poverty lawyer.⁵¹ Zealousness is justified in the name of adversary advocacy.

49. Trudy Lieberman, *This Doctor Treats Poverty Like a Disease*, CTR. FOR ADVANCING HEALTH (Nov. 6, 2013), <http://www.cfah.org/blog/2013/this-doctor-treats-poverty-like-a-disease>, archived at <http://perma.unl.edu/Q5B-GC8Z>. In characterizing poverty in this manner, Dr. Bloch suggests that "treating" lack of income supports as part of the disease or health condition suffered by the patient is integral to providing treatment. Therefore, he "prescribes" financial plans for his patients such as following up on tax refunds or applying for social security benefits and subsidies that could assist his patients with food or medicine. What I argue here is not only that providing such "prescriptions" should be a regular part of the practice for any doctor of low-income disabled patients but that the prescriptions need to be completed with the care that comes from interdisciplinary learning and training, since these prescriptions cannot be filled by mere delivery to a pharmacy. They can only be filled after an adjudicator has been legally persuaded of the patient's eligibility for the prescription.

50. For the exceptions see Bellow & Kettleison, *supra* note 10; Jacobs, *supra* note 10; Tremblay, *supra* note 11.

51. See Jacobs, *supra* note 10, at 101 (citing Tremblay, *supra* note 11, at 1136). See also ABA COMM. ON LEGAL AID AND INDIGENT DEFENDANTS, STANDARDS FOR THE PROVISION OF CIVIL LEGAL AID ii–iii (2006) (These Standards are presented as aspirational guidelines The Standards do not create any mandatory requirements[,] . . . do not expand, add or change any ethical responsibilities with which

The problem, however, is deciding what constitutes zealous advocacy and how it is to be determined.

Zealousness is not defined by the Model Code of Professional Responsibility.⁵² Michelle Jacobs raises, as an example of the vagueness of the term, the question of whether going to an indigent client's home for an interview is required when the client is unable to present herself to the lawyer's office but the lawyer believes that an in-person interview would be more effective for the representation.⁵³

Where a client can pay for a home visit, the question of whether it is ethically required to do so in the above-described circumstance is not reached. Certainly, the paid lawyer who engages in a home visit is as unavailable to her other clients while engaged in the home visit as a poverty lawyer would be. However, where payment replaces the inquiry regarding zealousness, lawyers with resources can simply resolve any potential conflicts. A lawyer with resources can have another lawyer, most likely from within her own office, take over the matter that would otherwise be sacrificed while the lawyer went on the home visit. She can do so, in part, because she can charge the client that needs the home visit for her time.⁵⁴

As poverty lawyers don't have associates to assign things to, every home visit on behalf of one client means the inability to serve the im-

a legal aid provider or practitioner must comply[,] and all lawyers are bound by the ethical rules that apply in the jurisdiction in which they practice." Note, as well, that in the introduction to the ABA Standards, beneath the heading "Underlying Principles of the Standards" is the following: "*Zealous representation of client interests*. All lawyers should pursue their clients' interests with zeal consistent with the law and applicable standards of professional conduct." *Id.* at iv.

52. MODEL CODE OF PROF'L RESPONSIBILITY EC 7-2 (1980) (stating that "[t]he bounds of the law in a given case are often difficult to ascertain" and citing Justice Holmes in *Superior Oil Co. v. Mississippi*, 280 U.S. 390, 395-96 (1930) ("[T]he very meaning of a line in the law is that you intentionally may go as close to it as you can if you do not pass it. . . . It is a matter of proximity and degree as to which minds will differ . . .")).

53. Jacobs, *supra* note 10, at 101.

54. It should be noted that lawyers who charge disabled clients extra monies for services rendered specifically because of the client's disability could run afoul of the Americans with Disabilities Act. See 28 C.F.R. § 36 (1991) (governing obligations of public service providers in rendering their services accessible and ensuring communication abilities of these services providers to all users). Assuming, however, that a wealthy disabled client—or simply a wealthy client who prefers the convenience of a home visit—can pay for a home visit and is given the option of doing so, a lawyer for such a client can choose to do so without needing to ask oneself whether such a visit is ethically necessary for the representation. Once the home visit is characterized as a necessity by the indigent client—or rather the indigent client makes a claim that she is unable to travel—the lawyer who has other indigent clients to attend to is now faced with determining whether a home visit is a legal necessity, a requirement for zealous and effective representation.

mediate needs of one or more other clients. If zealousness requires the lawyer in Ms. Jacobs's hypothetical to visit her client, then what becomes of the lawyer's ethical obligations towards the second client who the lawyer will not be able to assist the afternoon of the home visit because the lawyer is busy assisting the first client? Because the poverty lawyer does not have the ability to simply assign another associate to the second client, does the poverty lawyer end up convincing herself that zealousness doesn't require the home visit and therefore decide simply to conduct the interview over the phone? And whether or not this is the outcome, does the fact that the second client's needs are being considered by the poverty lawyer turn the question of what zealousness requires into a question that is improperly answered in part by expediency, creating a conflict of interest between two otherwise wholly unconflicting client matters?

Paul Tremblay addresses these concerns in directly suggesting that, of course, the situation in legal services offices or in any limited resource office creates a conflict between clients.⁵⁵ Time is finite and cannot be "grown" through the addition of another lawyer to add her time to the pool of resources to be spent on clients. Therefore, time spent on one client matter necessarily detracts from time with another.⁵⁶ These arguments were raised by Tremblay largely in direct response to the seminal article on legal-services lawyering by Gary Bellow and Jeanne Kettleson, who argued vociferously that the only ethical way to limit legal services to the poor is to limit the number of persons served but not the actual service provided.⁵⁷ While Tremblay notes that more recent conversations with Bellow and Kettleson reveal that their stance has evolved in recognition of the costs and benefits of high-volume practice, he nevertheless acknowledges that their original position is one that, at the time of his writing, continued as the majority viewpoint of the profession.⁵⁸ For this reason, as he explains, it is this viewpoint that he challenges.⁵⁹

Tremblay argues primarily that "conventional notions of informed consent and zeal" are different in the legal-services context than they are in the private lawyering context.⁶⁰ Because of a lack of resources, Tremblay argues, a poverty lawyer must provide less client-centered and more lawyer-directed representation than the private lawyer is able to provide.⁶¹ By way of example he suggests that poverty lawyers may simply not be able to afford to bring to trial a case where a good

55. Tremblay, *supra* note 11.

56. *Id.*

57. Bellow & Kettleson, *supra* note 10.

58. Tremblay, *supra* note 11, at 1102 n.5.

59. *Id.*

60. *Id.* at 1102.

61. *Id.* at 1102–03.

settlement offer is made, despite a client's insistence that she wants her "day in court."⁶² Similarly, experts may not be called and discovery may be minimal, all because the lawyer's office cannot afford to provide these services (and the clients cannot afford to pay for them) rather than because the client agrees that these things are unnecessary.⁶³

While Tremblay's arguments seem reasonable and logical, they fail to account for the realities of any law office, even one that is well-resourced, and the constraints placed on the lawyer by the ethical rules. It is certainly possible that a lawyer who can freely charge her client for the privilege of having her day in court (if that is what the client wants to do) is able to reject a good settlement offer and, while tending to her client's trial, put another associate on her other client matters. However, whether that lawyer will do so when faced with a good settlement offer depends very much on the lawyer's assessment of the merits of a trial.⁶⁴ If the lawyer can present several valid reasons for not going to trial, she is obligated to do so.⁶⁵ If the client persists in desiring to go to trial, the lawyer is still obligated to consider whether the client's goals are, as a threshold matter, meritorious and not frivolous.⁶⁶ If the assessment is that going to trial is ethically permissible, the lawyer can and should still counsel the client against this plan if the lawyer believes that the client will fare better by accepting the settlement offer.⁶⁷ Finally, if, after all of this, the client remains steadfast in her desire to go to trial, the lawyer can still (provided it is not the eve of trial and would not unduly prejudice the client) withdraw, refer the client to another lawyer, or both.⁶⁸ Ultimately, even for a wealthy client, the lawyer who is given a good settlement offer will not go to trial unless she believes that doing so would advance the client's interests. The fact that the lawyer for the wealthy client will get paid to go to trial certainly makes it easier for the lawyer to do so but it does not make the decision less lawyer directed. Lawyers for wealthy clients have more time than poverty lawyers but not an infinite amount. They therefore have the same need to make cost-effective decisions.

The same arguments can be made when considering which witnesses to call or what discovery to be made. Certainly a poor client is severely constrained by her lack of a litigation budget. However, a lawyer for a wealthy client who calls and deposes unnecessary wit-

62. *Id.* at 1123.

63. *Id.* at 1118.

64. *See* MODEL CODE OF PROF'L RESPONSIBILITY EC 7-5, 7-7, 7-8, DR 7-101 (1980).

65. *Id.* EC 7-8, DR 7-101.

66. *Id.* EC 7-5, DR 7-101.

67. *Id.*

68. *Id.* EC 7-8, DR 7-101.

nesses engages in endless and frivolous discovery and otherwise conducts a “no holds barred” approach to a client matter is more likely to be sanctioned than victorious.⁶⁹ At a minimum, a wealthy client is likely to realize at some point that the enormous litigation expenses do not seem justified by the result and could therefore refuse to pay, terminate the relationship with the lawyer or law firm, or both. Again, as with the decision whether to accept an offer or go to trial, the decisions regarding litigation-related expenses are expected, by both the courts and the clients, to be cost-effectively made. In addition, the decision about whether a particular expense is necessary to advance the client’s interests is generally one to be made by the lawyer or with the lawyer’s counsel. Even wealthy clients cannot insist that a particular person be deposed or hired as an expert if doing so, in the lawyer’s assessment, would not advance the client’s interests.⁷⁰

Of course there can be a wide gap between minimally necessary and frivolous. This is not to suggest that there are not a great deal of advantages that a wealthy client has in litigation that a poor client simply does not. However, viewing the ethical rules as a floor, rather than a ceiling, it is not fair to suggest, as Tremblay does, that lawyers for poor people simply are not able to be as client centered as lawyers for wealthy people because their time as well as money resources are limited. It is possible, as is proven by legal-services attorneys across the country every day, to provide superb, client-centered lawyering on behalf of multiple poor clients. The lawyers who do this are able to do so in part by working long hours (some longer than their private lawyer counterparts), literally “growing” their time resource by being willing to conduct business at all hours, and in part by being experts at conducting low-cost but high-yield litigation.

While Tremblay’s bleak description of the rationing of legal services that legal-services lawyers are forced to provide due to a lack of resources is not entirely incorrect, the fault lies with suggesting that the real limitations that resources impose make comparison to private-practice professionalism impossible. To be sure, greater resourced law firm clients have more choices. But the choices are not limitless nor are the resources of the law firms. Where funding constrains the choices of legal-services attorneys, the demand for cost-effective results, the constraints of market-place competition, the personal goals of the law firm managing partners and of the law firm lawyers themselves, as well as the professional rules of conduct all place boundaries on the practice of law for any lawyer and create similar kinds of conflicts for resources among private clients. The difference is a matter of degree rather than of kind. Further, the

69. *Id.* EC 7-4, 7-5, 7-9, 7-10, DR 7-101 .

70. *Id.* EC 7-7, 7-8, 7-9, DR 7-101; see E. Wayne Thode, *The Ethical Standard of the Advocate*, 39 TEX. L. REV. 575, 582 (1961).

differences, because they are a matter of degree, result in practices on the legal-services side that compensate for their client's resource constraints.

Legal-services lawyers, as already stated, are experts at conducting low-cost but high-yield litigation. In fact, arguably, it is precisely because of this expertise, resulting in an extremely high success rate on behalf of their impoverished clients, that legal services have come under attack politically.⁷¹ Legal-services lawyers cost government and business substantial amounts—not in funding but in the development of legal entitlements from children's SSI to due process hearings for welfare benefits to due process rights for juveniles. These entitlements exist because of the lawsuits that nonprofit legal-services offices have brought on behalf of their clients and litigated and won or settled favorably.⁷² Consequently, every year since 1995 (ironically five years *after* Tremblay's article was published) Congress has voted to reduce legal-services funding or keep it well below prior funding-year highs, and has even imposed specific restrictions on the work that those offices can do, while need and eligibility for legal services has increased.⁷³ The legal-services resource landscape is therefore far more dire and restricted than it was when Tremblay wrote. And yet, legal-services lawyers continue to find ways to provide fully zealous representation to their clients and, as this Article argues, must continue to do so.

The fundamental problem with conceding that lack of resources necessarily constrains poverty lawyering to the point of necessitating ethical exceptions is of course the quality of justice that results from

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71. Kat Aaron, *The GOP Plot to Destroy Legal Aid: Behind the Conservative Effort to Gut a Crucial Anti-Poverty Lifeline*, MOTHER JONES, Feb. 14, 2011, <http://www.motherjones.com/politics/2011/02/gop-slashes-legal-aid-funds>, archived at <http://perma.unl.edu/ZEM3-LWHG>.
 72. Carrie Menkel-Meadow, *Legal Aid in the United States: The Professionalization and Politicization of Legal Services in the 1980's*, 22 OSGOODE HALL L. J. 29, 42–43 (1984). See also *Sullivan v. Zebley*, 493 U.S. 521 (1990) (establishing disabled children's right to SSDI and brought by Philadelphia Community Legal Services, Inc.); *Goldberg v. Kelly*, 397 U.S. 254 (1970) (holding that procedural due process requires that pretermination evidentiary hearing be held when public assistance payments to welfare recipients are discontinued and brought by Mobilization for Youth (MFY) Legal Unit, a legal aid program funded by the Office of Economic Opportunity); *Application of Gault*, 387 U.S. 1 (1967) (holding that a juvenile has right to notice of charges, to counsel, to confrontation and cross-examination of witnesses, and to privilege against self-incrimination and brought by the nonprofit American Civil Liberties Union).
 73. CARMEN SOLOMON-FEARS, CONG. RESEARCH SERV., RL34016, LEGAL SERVICES CORPORATION: BACKGROUND AND FUNDING 3, 5 (2013) (discussing restrictions on the work legal services organizations do and discussing the legal need not being met by legal services organizations); *Funding History*, LEGAL SERVS. CORP., <http://www.lsc.gov/congress/funding/funding-history> (last viewed Apr. 15, 2014), archived at <http://perma.unl.edu/S29Z-CRPJ>.

such a concession. Lawyers and clients, just like doctors and patients, have a fiduciary relationship. The ethical rules that govern lawyer behavior form the boundary of obligations that a lawyer owes to her client and to the public. They are minimums, designed to redress the imbalance, in knowledge and expertise (and consequently power) between lawyer and client. The relationship between a poor client's lawyer and her client is not less imbalanced than the relationship between a wealthy client's lawyer and her client. If anything, the imbalance is greater between the impoverished client, who is disempowered precisely because of her poverty as well as her lack of legal expertise, and her lawyer. The potential for abuse of the fiduciary relationship is therefore greater as is, consequently, the need for insistence on application of all of the ethical rules, without exception. And again, to argue, as Tremblay does, that expectations of zealotry and client-centered lawyering for legal-services lawyers are simply unrealistic given the conflicts of interest between clients that limited resources creates, fails to account for the effective management of those conflicts that both public-sector lawyers and private attorneys are forced to engage in every day.⁷⁴ Accepting that differences be-

74. That private lawyers manage these conflicts as well can be clearly seen by implication in a conversation between author and attorney Bryan Garner and U.S. Supreme Court Chief Justice Roberts regarding this exact question: how to balance costs with quality. Chief Justice Roberts emphatically states that ultimately, because of the lawyer's professional obligations and her reputation as a professional, quality cannot be sacrificed. The discussion does not revolve around poverty lawyers but rather, lawyering as a general matter. See *Judges, Lawyers, and Writers on Writing*, LAWPROSE, [https://www.lawprose.org/interviews/judges-lawyers-writers-on-writing.php?vid=roberts_balance&vidtitle=Hon. John Roberts_On_Balancing_Quality_and_Cost](https://www.lawprose.org/interviews/judges-lawyers-writers-on-writing.php?vid=roberts_balance&vidtitle=Hon._John_Roberts_On_Balancing_Quality_and_Cost) (last visited 4/3/2014), archived at <http://perma.unl.edu/GHY3-257S>.

Interestingly, Chief Justice Roberts emphasizes professionalism rather than ethical obligations, which is something that Michelle Jacobs discusses in analyzing the ethical dilemma that limited resources causes for poverty lawyers. See Jacobs, *supra* note 10, at 107–08. Jacobs cites the work of JACK SAMMONS, *LAWYER PROFESSIONALISM* 63 (1988), for an alternative definition of professionalism as “a way for people to participate in a meaningful fashion in the resolution of their social disputes,” and suggests that employment of this definition would result in greater zealous advocacy on the part of legal services lawyers. *Id.* at 111.

While I do not disagree that this definition is helpful to our understanding of professional obligations, I do not see it as changing or enhancing the poverty lawyer's ability to fulfill her ethical obligations. Those obligations exist regardless of how we define the term professional. An attorney providing minimally adequate services is only sufficiently zealous if in providing those services she has succeeded in meeting her client's goals for the representation. If she cannot meet her client's goals then the services she has provided are not only insufficiently zealous but also not even minimally adequate. The difficulty, as Ms. Jacobs pointed out in the beginning of her article, comes back to the lack of definition for zealous. While I believe most would instinctively agree that minimally adequate does not equal zealous the difficulty is in determining precisely where the difference lies. For my purposes, however, this difference does not have to be fully

tween private- and public-sector lawyers is one of degree rather than kind reveals that these conflicts exist on the private side as well. The fact that legal-services lawyers must prioritize client matters is not different in the private sector, it simply occurs more often in the public sector.

Additionally, to the extent that the resource constraints truly do make it impossible in particular individual cases for the poverty lawyer to render sufficiently zealous representation, the responsibility for that failure stems from, as already stated, the lack of resources, not the attorney. Consequently the remedy should involve looking at those that provide the insufficient resources, not at rendering the attorney's professional obligations less important or unenforceable. In other words, where there is an ethical violation, the solution cannot be to ignore or abandon the ethical rule that was violated, even where the attorney's violation was through no fault of her own.

Finally, as Tremblay himself ultimately points out, not every choice is a kind of zero sum game.⁷⁵ For example, a poverty lawyer who chooses to do more in-depth research regarding an issue about which she has some knowledge and therefore did not necessarily have to do, can now use whatever she has found to benefit future clients whose matters involve the same legal issues.⁷⁶ Similarly, a poverty lawyer who, after consultation with a client, turns down a settlement offer and proceeds to trial, will, as a result of trying that case, have the benefit of her experience in trying the case.⁷⁷ This will render her future litigation-related representation more effective for clients

defined before we can determine that representation of an indigent disabled person in the disability income context without the benefit of an interdisciplinary partnership is neither minimally adequate nor sufficiently zealous to withstand ethical challenge precisely because of the adversary's use of interdisciplinary partnerships to determine and then defend against the claim.

75. See Tremblay, *supra* note 11, at 1120–22 (discussing the need for legal services lawyers, due to resource constraints, to make decisions about the most efficient ways to allocate those resources). Resources such as attorney time are allocated not only based on what allocation will ensure success of an individual client's case but also based on what allocation will most likely benefit all impoverished clients and potential clients. Tremblay is here recognizing that the legal-services corporation itself, which funds legal services across the country, was created as part of President Johnson's "War on Poverty" effort. As a result, legal services are not only about the provision of individual representation but also about the provision of individual representation in a manner that is most likely to aid the indigent, as a group, in climbing out of poverty. This was all well and good in the abstract but in reality potentially creates a conflict between an individual client's legal needs and the legal needs of her community who were also potential clients. See *History: The Founding of LSC*, LEGAL SERVS. CORP., <http://www.lsc.gov/about/what-is-lsc/history> (last visited Nov. 3, 2014), archived at <http://perma.unl.edu/P6AH-ZKXE>.

76. See Tremblay, *supra* note 11 at 1120–22.

77. *Id.*

whose cases involve the same litigation forum or whose cases are before the same judge.⁷⁸

Tremblay argues that, in addition to limiting what cases to take in a poverty practice, the issue of whether to undertake a particular action in a case should be determined, in part, by whether the contemplated action will have beneficial impacts or ramifications for the community that is being served by the poverty law practice.⁷⁹ In other words, as he proposes it, legal-services lawyers should be “governed within professional ethics contexts by a vision that explicitly includes community norms.”⁸⁰

Including community norms is a way in which Tremblay envisions resolving some of the conflict of interest dilemmas that poverty lawyers face due to resource constraints.⁸¹ By way of example, Tremblay discusses a common dilemma faced by legal-services housing lawyers.⁸² These lawyers often find themselves representing tenants accused of crimes and facing eviction from public housing as a result, while most of the other tenants at the housing project where that tenant/client lives (many of whom may also be clients) feel that it would be beneficial to evict all criminally involved tenants.⁸³ Taking the conflict even further, Tremblay also points out that the same lawyer undertaking representation of the criminally charged tenant may also represent clients who are on public housing waiting lists and in desperate need of housing that cannot be obtained as long as all public housing units remain occupied.⁸⁴

Whether to devote lawyer resources to assisting the criminally charged tenant with remaining in public housing rather than, for example, assisting her in finding alternate housing or combatting the criminal charges is a question that can be ethically resolved, suggests Tremblay, by considering the community’s concerns as well as the client’s.⁸⁵ In this manner, taking the latter course of action rather than the former would be ethically sound.⁸⁶ The client would not be abandoned and the assistance provided would be zealous, but the goals of the zealous representation would not be determined solely by the cli-

78. *Id.*

79. *Id.* at 1130.

80. *Id.*

81. *Id.* at 1131.

82. *Id.* at 1126–28.

83. *Id.*

84. *Id.*

85. *See id.* at 1130, 1134, 1139-40 (advocating that legal services lawyers be governed within professional ethics context that takes into account the interests of the community these lawyers serve, balanced along with the interests of the individual client).

86. *See id.*

ent without regard to the community in which the client lives and the lawyer practices.⁸⁷

The problem with this proposal, however, is that Tremblay is merely switching one ethical problem for another. If the client's clear goals are to remain in public housing and there is a legally defensible way to argue that she should be able to do this, ignoring these goals because of community concerns presents a problem of divided loyalty that is not permissible.⁸⁸ Certainly, it is ethical to counsel your client about many considerations, including those of the community in which she lives, but if, after counseling, the client persists in seeking the vindication of her right to remain in public housing, she has the right to an attorney who will assist her, zealously, in obtaining this goal. That poor clients' everyday choices are severely constrained by their poverty—even to the point in many instances of removing choice altogether—is not a reason to superimpose further limitations on their already limited options by requiring indigent clients to put their individual needs aside in favor of the community's. Our system of justice is built around the belief that individual rights, not community, government, or privately held group rights are paramount. That poverty makes enforcement of those rights more difficult is unquestionable. But declaring that poor persons simply cannot expect to have their rights enforced does not ease this difficulty, it merely pretends that the difficulty is not worthy of consideration.

So where does this bring us in terms of the lawyer's ethical obligations toward the indigent disabled client? Even if one is not persuaded that zealous representation on behalf of indigent clients is a realistic standard and believes that Tremblay's proposed compromise involving community is closer to the mark, the particular advocacy tool that I am proposing meets both standards. A medical-legal partnership is one that expands the capacity of both the law office and medical office to serve the community as it enhances the quality of legal and medical services provided. The professional's competence and resulting ability to handle future client/patient needs with greater efficiency as well as more effectively is expanded a great deal. The context of the dispute makes the formation of medical-legal partnerships more than a great idea, however. As discussed in greater detail below, the adversaries in a disability-benefit matter utilize medical-legal partnerships to support their position. Therefore, effectively representing a disabled claimant in this context renders the employment of a medical-legal partnership on the claimant's behalf an ethical necessity.

87. *See id.*

88. MODEL RULES OF PROF'L CONDUCT r. 1.15 (1983) ("Loyalty and independent judgment are essential elements in the lawyer's relationship to a client.").

I started the discussion of the lawyer's ethical obligation of zealousness by acknowledging that the rules do not make it clear how that term is defined. However, it is clear that if a particular advocacy tool, such as the formation of an interdisciplinary partnership, is not used and this particular decision to forgo use of that tool results in a devastating loss for the client, it is questionable whether the lawyer fulfilled her ethical obligations.

III. THE MEDICAL–LEGAL GAP: HISTORY OF DISABILITY CLAIMS ADJUDICATION

I referred earlier to the importance of the legal context in determining the ethical underpinning of the obligation to form interdisciplinary partnerships on behalf of the indigent disabled.⁸⁹ Disability claims are made within an adversarial system that is meant to deliver fair adjudications based on the premise that each party has the opportunity to present evidence in support of the claims being made. While the indigent disabled have the opportunity to submit their medical records for review just like any other claimant, the way in which this evidence became insufficient is starkly demonstrated in the evolution of claims decisions.

The goal of the Social Security Disability Income program is to provide income support to disabled workers;⁹⁰ however, ensuring that social security monies only go to truly disabled claimants is an implied foundational part of this goal. As claims have steadily increased,⁹¹ along with negative press attention,⁹² Social Security's attempts to ensure accurate and consistent results have driven both regulatory amendments and court decisions.⁹³ As claim payments have increased,⁹⁴ the need to ensure on-going profitability as well as accuracy and consistency has motivated the private sector to amend their policy

89. *Supra* Part II.

90. *Benefits for People with Disabilities*, SOC. SEC. ADMIN., <http://www.ssa.gov/disability> (last visited May 8, 2014), *archived at* <http://perma.unl.edu/VP4V-K6MZ>.

91. *Selected Data from Social Security's Disability Program*, SOC. SEC. ADMIN., <http://www.ssa.gov/oact/STATS/dibStat.html> (last visited Oct. 15, 2014), *archived at* <http://perma.unl.edu/WQG2-HS9B>.

92. *House Probe Cries Foul on Social Security Disability Claims*, CBSNEWS.COM (June 24, 2013, 4:45 PM), <http://www.cbsnews.com/news/house-probe-cries-foul-on-social-security-disability-claims/>, *archived at* <http://perma.unl.edu/J2KU-APWL>.

93. *See Heckler v. Day*, 467 U.S. 104, 112–19 (1984) (citing legislative history to hold that Congress has made clear that it rejects mandatory deadlines, which would expedite disputed SSA claims adjudications, to ensure that quality and uniformity in adjudicatory decision-making are maintained).

94. *Long Term Disability Claim Payments Increase while the Number of Covered Workers Rises*, PR NEWSWIRE, <http://www.prnewswire.com/news-releases/long-term-disability-claim-payments-increase-while-the-number-of-covered-workers-rises-211974611.html> (last visited May 8, 2014), *archived at* <http://perma.unl.edu/VP4V-K6MZ>.

language and the public sector to create legislation and interpret that policy language narrowly.⁹⁵ It is this need for accuracy and consistency that exists in both the public and private sectors that has driven

.edu/68P8-USTU (pointing to a multi-year upward trend despite a slight decrease in 2012).

95. The rationale for the wide variation in defining disability and its subsequent narrowing over time on the private disability insurance side is hard to find or nonexistent because of the protections provided to private insurers in disclosing such information. For example, a model regulation from the National Association of Insurance Commissioners, labeled, rather appropriately, the Corporate Governance Annual Disclosure Act, provides for the “confidential treatment of the corporate governance annual disclosure and related information that will contain confidential and sensitive information related to an insurer or insurance group’s internal operations and proprietary and trade secret information which, if made public, could potentially cause the insurer or insurance group competitive harm or disadvantage.” *Corporate Governance Annual Disclosure Model Act*, NAT’L ASS’N OF INS. COMM’RS, http://www.naic.org/documents/committees_e_isftf_corp_governance_model_act.pdf (last visited Nov. 3, 2014), archived at <http://perma.unl.edu/93V4-BSXG>.

Thus, similar acts adopted by the states may provide an explanation for the lack of available information regarding private insurance policies and procedures surrounding disability claims administration. What is publicly known is that private disability insurance is a for-profit industry, and, as a general matter, there is regulation of the industry meant to ensure that insurance contracts entered into are fairly enforced, that there has been a relatively steady increase in claims—either made or paid—over the last several decades and that during this same time period the industry has presented an ever-narrowing definition of disability. See Ashlea Ebling, *Disability Insurance: The Overlooked Employee Benefit*, FORBES, June 19, 2014, <http://www.forbes.com/sites/ashleaebling/2014/06/19/disability-insurance-the-overlooked-employee-benefit/>, archived at <http://perma.unl.edu/9TVT-B5MK> (discussing 2014 annual disability claims report by the COUNCIL FOR DISABILITY AWARENESS, a group which represents and collects claims data from 19 private insurance companies, highlighting a trend of increasing disability claims payments for private insurance providers); see also Izabela Z. Schultz, *Impairment and Occupational Disability in Research and Practice*, in HANDBOOK OF COMPLEX OCCUPATIONAL DISABILITY CLAIMS: EARLY RISK IDENTIFICATION, INTERVENTION, AND PREVENTIONS 27 (Izabela Z. Schultz & Robert J. Gathcel eds., 2006) (“Disability compensation systems, however, including workers compensation and long term disability insurance companies, have historically preferred more narrow and specifically functionally focused definitions . . . to make compensability objectively verifiable and financially viable for the institutions granting disability status . . .”). Given these facts, it is not unreasonable to infer that the motivation for the narrowing of the disability definitions has been to ensure profitability as well as accuracy and consistency in determining eligibility.

As for the public side of disability definitions, see *Third in a Hearing Series on Securing the Future of the Social Security Disability Insurance Program: Hearing Before the Subcomm. on Soc. Sec. of the H. Comm. Of Ways & Means*, 112th Cong. 6–41 (2012) (Statement of Michael J. Astrue, Comm’r of the Social Security Administration), archived at <http://perma.unl.edu/622A-JGPG> (describing the legislative history of narrowing and restricting the definition of “disability” in the Social Security program over the years due to increases in claims for benefits).

the above-mentioned evolution in claims decisions and, consequently, claims-defense strategies.⁹⁶

A. The Rise and Fall of the Treating Physician Rule

In 1962 the Fourth Circuit, in *Underwood v. Ribicoff*,⁹⁷ provided an early iteration of what would later come to be known as “the treating physician rule” in the social security disability income benefit context. The court provided a template for later attempts to legally organize the medical evidence presented by claimants seeking social security disability benefits.

In *Underwood*, the claimant’s treating physician provided evidence of several serious medical conditions and his opinion that these prevented the claimant from working.⁹⁸ The claimant was then sent to two Social Security consultative examiners who provided their own reports regarding the claimant’s condition.⁹⁹ The consultative examiners’ reports only differed from the treating physician’s with regard to the severity of the claimant’s ailments, not with regard to their existence.¹⁰⁰ The objective medical facts, according to the court, therefore, supported a finding that the claimant was medically impaired.¹⁰¹ Whether the impairment was sufficiently severe to prevent the claimant from engaging in substantial gainful activity¹⁰² was a matter of subjective evidence.¹⁰³ Ruling in favor of the claimant, the court stated, “[c]onsideration here should be given to the fact that Howard

96. Utilizing unconventional strategies to collect evidence and dispute a disability claimant’s petition for benefits, such as video surveillance of an individual performing everyday activities, can provide convincing arguments for denying benefits. See *Finley v. Hartford Life & Acc. Ins. Co.*, 400 Fed. Appx. 198, 199–201 (9th Cir. 2010) (discrediting claimant Finley’s testimony of disability due to video surveillance of the claimant doing yard work and household chores); see also Robert R. Pohls, *Litigating Disability Insurance Claims Involving Post-Traumatic Stress Disorder: Defense Strategies and Techniques*, JD SUPRA, <http://documents.jdsupra.com/69c3e704-7bbe-4751-84c2-caa3d35ec94a.pdf> (last visited Nov. 4, 2014), archived at <http://perma.unl.edu/K8G8-HQSB> (discussing the use of videotape surveillance to solicit damaging testimony of the absence or presence of diagnostic criteria).

97. 298 F.2d 850 (4th Cir. 1962).

98. *Id.* at 852.

99. *Id.*

100. *Id.* at 852–53.

101. *Id.*

102. “Substantial gainful activity” (“SGA”) is a terms of art, defined in the Social Security Act and regulations as

work activity that is both substantial and gainful[.] . . . Substantial work activity is work activity that involves doing significant physical or mental activities. . . . Gainful work activity is work activity that you do for pay or profit. Work activity is gainful if it is the kind of work usually done for pay or profit, whether or not a profit is realized.

20 C.F.R. § 404.1572 (2014).

103. *Underwood*, 298 F.2d at 852.

was Claimant's treating physician, whereas Reeves saw him only once for a routine examination."¹⁰⁴ It was clear with this decision that treating physicians needed to ensure that they could provide sufficient evidence of severity, not simply of impairment. However, assuming that they did so, with this decision, at least, such evidence would be given more weight than contrary evidence provided by a government physician who had minimal contact with the claimant.

In addition to severity of symptoms, another challenge giving rise to battles between treating and government physician evidence were those diseases, recognized as early as 1967 by the Sixth Circuit Court of Appeals,¹⁰⁵ whose diagnoses rested on purely subjective symptoms. In considering evidence regarding a psychiatric impairment, the court in *Branham v. Gardner* stated unequivocally that "purely subjective symptoms may sustain a finding of disability."¹⁰⁶ But in getting to this point, the court quite tellingly states,

It used to be that, unless impairment or disabilities could be substantiated by objective symptoms, they were not considered, as, in any way, established. "But modern medicine is neither so scientific nor so helpless today that it either does, or must, evaluate only objective factors."¹⁰⁷

The court both acknowledged that past practices were based solely on objective evidence and that there had been an evolution that led to the understanding that "modern medicine" includes consideration of both objective and subjective factors. From here, it is easy to see how Social Security's desire for consistency and accuracy was truly challenged.

Over the next thirty years, it became clear that differences in the severity of impairments as well as the existence of impairments, proven through subjective testimony and medical opinion, would be the battleground in disability determinations. The circuit courts, to varying degrees and in slightly different forms, articulated the need to give increased deference to the evidence provided by treating physicians.¹⁰⁸ However, while there appeared to be relative consensus among the circuit courts that some kind of deference should be pro-

104. *Id.* at 853.

105. *Branham v. Gardner*, 383 F.2d 614 (6th Cir. 1967).

106. *Branham*, 383 F.2d at 618 (citations omitted).

107. *Id.* (quoting *Hayes v. Celebrezze*, 311 F.2d 648, 654 (5th Cir. 1963) ("[T]he statute does not require that disability or its cause be substantiated objectively.")).

108. Rachel Schneider, *A Role for the Courts: Treating Physician Evidence in Social Security Disability Determinations*, 3 U. CHI. L. SCH. ROUNDTABLE 391, 396 (1996). See also Barbara A. Sheehy, *An Analysis of the Honorable Richard A. Posner's Social Security Law*, 7 CONN. INS. L. J. 103, 127-28 (2001) ("the [treating physician rule] is a 'judicially created presumption designed to aid disabled Americans in proving disability to the SSA' (quoting George Szary, Note, *The Treating Physician Rule: Morgan Presumption in Social Security Disability Insurance and Supplemental Security Income Cases*, 17 N.Y.U. L. REV. & SOC. CHANGE 303, 304 (1989-1990)).

vided, precisely how much and when differed.¹⁰⁹ Therefore, the Social Security Administration's (SSA) ability to comply with a consistent standard across the circuits was difficult if not impossible.¹¹⁰ For these reasons, as well as reasons related to SSA's on-going effort to improve the efficiency, consistency, and accuracy of disability determinations in the Social Security context, SSA promulgated regulations that codified a treating physician rule in 1991.¹¹¹

This rule, while clearly articulating a preference for treating physician evidence (and therefore opinion), simultaneously proscribed this preference with limitations. As stated in a 1999 Second Circuit case, “[a] treating physician’s statement that the claimant is disabled cannot itself be determinative.”¹¹² In other words, what had long been gaining momentum in several circuits as a simple evidentiary preference for treating physician evidence became yet another complicated regulation that contained several subparts and caveats,¹¹³ making it somewhat less than the simple, early admonition that “consideration . . . should be given to the . . . treating physician.”¹¹⁴

Meanwhile, on the private side, disability claims were litigated in federal courts after the 1974 enactment of the Employee Retirement Income Security Act (ERISA).¹¹⁵ The definitions of disability in those cases are governed by insurance contracts, not the federal statute. Nevertheless, in those cases, disability claimants—faced with similar conflicts between their own doctors and industry doctors—began to argue that a treating physician rule, analogous to Social Security’s, should be imported into the consideration of these private claims.¹¹⁶

In *Black & Decker v. Nord*,¹¹⁷ the Supreme Court considered, but dismissed, this argument stating, “if a consultant engaged by a plan may have an ‘incentive’ to make a finding of ‘not disabled,’ so a treating physician, in a close case, may favor a finding of ‘disabled.’”¹¹⁸

109. *Id.*

110. *Id.*

111. See 20 C.F.R. § 404.1519h (2014).

112. *Snell v. Apfel*, 177 F.3d 128, 133 (2d Cir. 1999); see also *Sheehy*, *supra* note 108, at 132 (citing Posner’s skepticism of treating physician evidence in *Cummins v. Schweiker*, 670 F.2d 81, 84 (7th Cir. 1982), and then characterizing the 1991 amendments as “essentially [codifying] Judge Posner’s skepticism of treating physician evidence”).

113. See 20 C.F.R. § 404.1527 (2014) (dividing “Evaluating opinion evidence” into five subsections and dividing subsection (c) of that section, “How we weigh medical opinions,” into six sub-sections, one of which contains two further subsections describing in great detail the factors to be considered regarding the treatment relationship between the claimant and the medical opinion provider).

114. *Underwood v. Ribicoff*, 298 F.2d 850, 853 (4th Cir. 1962).

115. Pub. L. No. 93-406, 88 Stat. 829 (1974).

116. See, e.g., *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 829 (2003).

117. *Id.*

118. *Id.* at 832; see also Roy F. Harmon, III & A.G. Harmon, *Weighing Medical Judgments: Explaining Evidentiary Preferences for Treating Physician Opinions in*

The statement, made twelve years after passage of the 1991 rule by the SSA, echoes the much earlier statement by Judge Posner that “as [the claimant’s] personal physician he might have been leaning over backwards to support the application for disability benefits” and that for this reason the opinion of personal physicians should not be given controlling weight.¹¹⁹

While the Court in *Nord* additionally stated the SSA rule could not be judicially imported into the federal law and therefore was not applicable, it is interesting that in support of this contention, it articulated its concerns about the subjectivity of medical opinion evidence. In other words, just as the SSA has and continues to struggle with the subjectivity of medical opinion evidence, the Court also acknowledged that judicial disability determinations are fraught with the uncertainty and inconsistency that comes from reliance on medical opinion.

The notion that a decision regarding disability benefits is “accurate” necessarily rests on an assumption that there is some objective truth about a claimant that could be discovered through appropriate review and investigation. But if subjective “truths”—level of pain, level of confusion, disorientation, fatigue, etc.—are recognized as legitimate considerations, then whether a claimant’s application for benefits was accurately awarded or denied highly depends not only on the objective medical evidence, but also whether the subjective evidence provided was deemed credible and persuasive. Learning how to present the subjective evidence in a manner that leads to a specific, objectively reasonable conclusion then becomes the work of the claims examiner and the claimant. In other words, having access to a legally trained advocate who has access to a legally trained doctor is critical to obtaining the desired outcome in a case where the claimed disability is difficult to determine objectively.

B. The Search for Accuracy and Consistency: Regulatory and Contractual Amendments

The economic downturn of the 1970s led to a substantial increase in social security disability claims.¹²⁰ While the increase in claims

ERISA Cases After Black & Decker Disability Plan v. Nord, 13 MICH. ST. U.J. MED. & L. 157 (2009) (explaining how *Nord* affects the evidentiary weight of treating physician opinions).

119. *Cummins v. Schweiker*, 670 F.2d 81, 84 (7th Cir. 1982).

120. David H. Autor & Mark G. Duggan, *The Growth in the Social Security Disability Rolls: A Fiscal Crisis Unfolding*, 20 J. ECON. PERSP. 71, 72, 89 (2006). From 1978, as Autor and Duggan point out, it is clear that disability claims increase simultaneously with unemployment rate increases. *Id.* at 89 fig.4. Perhaps ironically, in the early seventies the disability income program expanded which resulted in a great deal more claims being granted. *Id.* at 77–78. The increase in disability income awards, which occurred alongside the increase in disability income claims, contributed to a public sense that the program had become fiscally much

alone—without regard to the merits of those claims—caused its own problems for the SSA, the substantial number of court reversals of SSA hearing examiner decisions became newsworthy.¹²¹ During this period, judges, congressional representatives, and the press constantly criticized the SSA for getting it wrong.¹²² Tales of claimants who died before the courts could reverse their wrongful denials were told along with tales of ne'er-do-wells who were claiming disability rather than working because they could.¹²³ Such tales led to Congressional hearings and redoubling of agency efforts to come up with regulations that would produce more consistent and accurate outcomes.¹²⁴ The result, however, was to decontextualize the criteria needed to prove disability and to create a definition that was increasingly legally rather than medically based.¹²⁵

too expensive to maintain and an urgency that it be scaled back. *Id.*; see generally Patricia P. Martin & David A. Weaver, *Social Security: A Program and Policy History*, 66 SOC. SEC. BULL. 1 (2005), archived at <http://perma.unl.edu/X6JR-FH9U>; *Program Cost and Size*, SOC. SEC. ADMIN, http://www.ssa.gov/policy/docs/chartbooks/disability_trends/sect01.pdf (last visited Aug. 18, 2014), archived at <http://perma.unl.edu/X6JR-FH9U>.

121. See Cathryn Miller-Wilson, *Becoming Poor: Stories of the Real “Safety Net” and the Consequences for Middle America*, 13 QUINNIPIAC U. HEALTH L.J. 1, 35–36 (2009) (“[A] substantial number of initial denials are reversed; two thirds of the cases appealed result in eventual distribution of benefits.” (citing Erik Eckholm, *Disability Cases Last Longer as Backlog Rises*, N.Y. TIMES, Dec. 13, 2007, <http://www.nytimes.com/2007/12/10/us/10disability.html>, archived at <http://perma.unl.edu/FJM-9BQH>)).
122. FRANK S. BLOCH, *DISABILITY DETERMINATION: THE ADMINISTRATIVE PROCESS AND THE ROLE OF MEDICAL PERSONNEL* 101–02 (1992). As a result of a number of reports and studies done by the General Accounting Office in the early 1980s, SSA determined that as many as 18% of disability beneficiaries were not in fact “disabled according to the statutory standard” and as many as “33 percent of disability beneficiaries might no longer be disabled.” *Id.* at 100.
123. *Id.*
124. See S. REP. NO. 94-550, at 4 (1975), reprinted in 1975 U.S.C.A.N.N. 2347, 2350 (discussing the need to improve the “validity” of SSI hearings by modifying evidentiary requirements); see also S. REP. NO. 96-408, at 30, 52, 55 (1980), reprinted in 1980 U.S.C.A.N.N. 1277, 1308, 1330, 1333 (discussing balance between decision making quality and timeliness, recommending new policies to improve the quality of disability–adjudicatory decision making).
125. See Brian C. Murchison, *Treating Physicians as Expert Witnesses in Compensation Systems: The Public Health Connection*, 90 KY. L.J. 891, 917 (2002) (“[T]he genesis of the SSA’s five-step sequential framework for determinations of disability, [is] a controlled analytic process designed to ‘allow the most straightforward cases to be decided quickly and efficiently on medical grounds alone’ and intended overall to produce ‘consistent, standardized decisions.’” (footnotes omitted) (quoting FRANK S. BLOCH, *DISABILITY DETERMINATION: THE ADMINISTRATIVE PROCESS AND THE ROLE OF MEDICAL PERSONNEL* 7 (1992); Rachel Schneider, Comment, *A Role for the Courts: Treating Physician Evidence in Social Security Determinations*, 3 U. CHI. L. SCH. ROUNDTABLE 391, 395 (1996))).

While creating a definition that ensures determinations are based on “medical grounds alone” seems intuitively correct, the five-step sequential framework and

As disability claims increased on the private side just as rapidly as they had in the public sector,¹²⁶ insurance companies—facing large payouts—also struggled with the accuracy of determinations. Because their motives were profit driven, they, of course, sought to lessen their liability through any legal means. Recognizing that mental illness was usually diagnosed through subjective observations and assessments, private disability insurance companies issued policies that created a cap on how long claimants could receive disability insurance for mental impairments.¹²⁷ Although the claimant is required, under the terms of most policies, to provide medical evidence of mental illness just like he or she would have to for a physical impairment, the policy usually clearly indicates that if the impairment is due to a mental illness, then the most the claimant could collect under the policy are one or two years of benefits. For physical ailments, however, most policies provide benefits for as long as the claimant can show that he or she is physically disabled and unable to work or at least until retirement age, whichever is sooner. For the long term benefits most claimants seek, the claimants have to prove, through the provision of objective medical evidence, that they are physically disabled in accordance with the terms of the policy.¹²⁸

The five-step sequential process of determining disability in the public context¹²⁹ and the objective-evidence criteria required in the

its controlled analytic process causes determinations to be based on legal grounds, not medical. The medical evidence that has been gathered is fitted into this legal definition. However, the legal definition does not contain room for medical opinion, only medical fact evidence. Therefore, medical opinion evidence is given little if any weight in the determination process. But medical opinion is part and parcel of a doctor's process in determining whether a patient is medically disabled. Separating doctors' opinion from the "medical facts" they submit is not something practicing physicians normally or comfortably do. Thus, while the motivation for the creation of the five-step process was most certainly an attempt to be more medically based, in practice, it is much more reliant on the legal organization of medical facts—divorced from medical opinion—than on pure medical grounds.

126. *2013 Long Term Disability Claims Review*, COUNCIL FOR DISABILITY AWARENESS, http://www.disabilitycanhappen.org/research/CDA_LTD_Claims_Survey_2013.pdf (last visited Aug. 18, 2014), *archived at* <http://perma.unl.edu/R5K-TBDE>; *2010 Long-Term Disability Claims Review*, COUNCIL FOR DISABILITY AWARENESS, http://www.disabilitycanhappen.org/pdfs/research/CDA_LTD_Claims_Survey_2010.pdf (last visited Aug. 18, 2014), *archived at* <http://perma.unl.edu/UG5P-WSYJ>.
127. Miller-Wilson, *supra* 121, at 11 (citing Frank N. Darras, *Cause or Symptom? Two Key Court Decisions Define the Limitations of Mental Illness Insurance Claims*, BEST'S REVIEW, Mar. 1, 2006, <http://www.thefreelibrary.com/Cause+or+symptom+%3F+Two+key+court+decisions+define+the+limitations+of+...-a0143437062>, *archived at* <http://perma.unl.edu/82QG-W4L9>).
128. *Id.* at 11–12, nn. 35–36.
129. 20 C.F.R. § 404.1520 (2014). These are the steps Social Security uses to decide if a claimant is eligible for benefits. At any stage, if the claimant does not meet the

private context make it clear that consulting physicians for both government and industry need legal training. Rather than approach the question of whether a particular claimant is medically disabled—a question that any qualified doctor should be able to answer given his or her training and expertise—doctors are asked to answer the question of whether a particular claimant’s medical facts meet certain narrowly proscribed legal criteria. That question is not a medical one, it is a legal one. Therefore, consulting doctors need to be trained and educated about the law and legal requirements such as: When and how do certain criteria have to be applied? How should the evidence provided be evaluated in light of the legal criteria (rather than in light of the doctor’s opinion about whether the claimant is disabled)? Effectively, medical–legal partnerships between consulting physicians and the lawyers and legal advocates representing the government and industry’s interests, who were involved in the claims review process, had to be created in order for the consulting doctors to be able to do their jobs.¹³⁰

Courts, meanwhile, watched this unfold and realized that physicians’ sworn statements—viewed as sacrosanct because of their reliability—were in fact neither more nor less reliable than any other type of opinion evidence. Industry- and government-created medical–legal partnerships revealed that medical opinion evidence is not a house built on a firm foundation of objective evidence, but is instead a house of cards built on physicians’ subjective judgments. This revelation, in turn, has contributed to the urgency felt by the courts and Congress to continue to seek greater and better ways to make more accurate, consistent and efficient determinations.¹³¹

criteria, Social Security will reject the claim. The first step considers work activity, steps two and three consider medical severity of the disability in accordance with the preapproved list of a disabilities, step four considers a claimant’s residual functional capacity and past work history, and step five considers the residual functional capacity in relation to age, education, and work experience. *Id.*

130. B.P. Wolff & William G. Hamm, *What about the Social Security Medical Consultant*, 76 J. MED. ASS’N GA. 515, 517 (1987) (stating that the State requires an intensive two week training for Social Security medical reviewers); Winston Chung, *Doctors Trade Integrity for Insurance Company Profit*, SFGATE (May 10, 2013, 6:45 AM), <http://blog.sfgate.com/wchung/2011/05/10/doctors-trade-integrity-for-insurance-company-profits/>, archived at <http://perma.unl.edu/UX3X-X8UE> (discussing how health insurance companies create formulas that they teach to medical reviewers to aid in rejecting claims); Evan George, *Doctors Paid to Aid in Disability Denials*, DAILY J. (Oct. 13, 2009), <http://www.disabilityrights-legalcenter.org/sites/disabilityrightslegalcenter.org/files/about/documents/DoctorsPaidtoAidinDisabilityDenials-DJ10-13-09.pdf>, archived at <http://perma.unl.edu/395P-MN4J> (describing how private firms that review claims for private insurance companies coach their physician reviewers).
131. Since the passage of the Social Security Act in 1935, there have been over 15 major legislative initiatives to amend the Act, such as the 1965 Amendments im-

This quest, however, has severely inhibited indigent claimants' ability to support their claims. The regular standards employed in analyzing whether a person is disabled for purposes of receiving a particular benefit are generated and applied by lawyers to physician-created records. This results, inevitably, in a large gap between what is required and what is provided. Claimants with resources can pay doctors to review the necessary information for effective compliance with the disability-application requirements and to consult with an attorney regarding those requirements. Indigent claimants, however, have no ability to reimburse their doctor for taking this extra time. Consequently and unsurprisingly, little more than a photocopy of incomplete medical records is what is provided on behalf of indigent disabled claimants. The medical records are often incomplete because medical professionals create them for the purposes of providing treatment, not for purposes of bolstering a disability claim.¹³²

While perhaps it is appropriate to leave the question of actual disability to the fact-finder, the fact-finder in a disability claim proceeding must rely on the "facts" provided by both sides in order to make his or her determination. Where a medical-legal team develops the "facts" supporting the insurer, it is unsurprising that these would be deemed more creditable than the "facts" developed by a lone physician. Physicians for indigent claimants have not had the same access to training and education that would assist them in providing information responsive to the regulations or contract definitions as their social security or private-insurance-company physician counterparts. The narrowly drawn questions of the regulation or contract are confusing and misleading to doctors who are used to providing a fuller, more nuanced picture of their patient's health when asked for information. So, where the agency and industry doctors have access to legal information and legal advice about the meanings of the questions and how to answer them, indigent claimants' doctors do not. In short, the agency and industry doctors have access to and are part of an interdisciplinary medical-legal partnership.

In addition to recognizing how the quest for more accurate, consistent and efficient claims has resulted in effective medical-legal partnerships on the part of government and private industry, it is important to recognize that despite the seeming objectivity of an in-

plementing the Medicare Program and the 1984 Disability Amendments which reorganized the Continuing Disability Reviews program. See *Legislative History*, SOC. SEC. ADMIN., <http://www.ssa.gov/history/law.html> (last visited Nov. 4, 2014), archived at <http://perma.unl.edu/L7UM-UAVM>; see also *History of the SSI Program*, SOC. SEC. ADMIN (2000), <http://www.ssa.gov/history/pdf/ssi.pdf>, archived at <http://perma.unl.edu/AHZ6-66KL> (providing a detailed report of the legislative changes made to the program between 1972-1999). For changes in the private sector, see Goodley, *infra* note 172; Harmon, *supra* note 118.

132. These differences are discussed in greater depth *infra* Part IV.

creased focus on “medical fact” rather than medical opinion, subjectivity still plays an enormous role in disability decisions.¹³³ The increased complexity of legal definitions has merely changed the focus from unfettered medical evidence to carefully legally organized evidence. Government and industry physicians are trained to provide information that is responsive to the regulation, but the very parties trying to reduce costs provide the training.¹³⁴ Therefore, it is easy to see how emphasis regarding the meanings and process of applying the legal definitions comes from the agency or industry perspective, not the perspective of the claimants. But, while a process that involves greater clarity and specificity of a legal definition is presumptively more efficient, there is little evidence to suggest that this results in more consistent or more accurate decisions.¹³⁵

These private and government medical–legal partnerships have highlighted the gap between the requirements and the evidence, the general effectiveness of medical–legal partnerships and the need for

133. Frank S. Bloch, *Medical Proof, Social Policy, and Social Security's Medically Centered Definition of Disability*, 92 CORNELL L. REV. 189, 231 (2007); Lars Noah, *Pigeonholing Illness: Medical Diagnosis As A Legal Construct*, 50 HASTINGS L.J. 241, 246–47 (1999); Margaret C. Rodgers, *Subjective Pain Testimony in Disability Determination Proceedings: Can Pain Alone Be Disabling?*, 28 CAL. W. L. REV. 173 (1992); Schneider, *supra* note 108, at 402.

134. Bernard P. Wolff & William G. Hamm, “*What About the Social Security Medical Consultant?*,” 76 J. MED. ASS’N GA. 515, 517 (1987) (“[T]he Social Security physician mainly bases his assessment on existing rules and regulations.”). BLOCH, *supra* note 122, at 101, discusses this as well: “[A]s Martha Derthick has noted, [d]isability decisions, because of their inherent subjectivity, were highly susceptible to changes in the political context—and “crackdown” was in the air.” *Id.* (quoting MARTHA DERTHICK, AGENCY UNDER STRESS: THE SOCIAL SECURITY ADMINISTRATION IN AMERICAN GOVERNMENT 44 (1990)).

There is similar evidence of the training and motivations on the private side. See Chung, *supra* note 130 (“I have seen documents that require nurses and doctors to adhere rigidly to the guidelines and they are penalized for introducing any element of clinical judgment that varies from the strict criteria that is to be applied.”); George, *supra* note 130 (“These firms coach their doctors . . . to use strict medical definitions they provide to determine a person’s ability to work.”).

135. See Bloch, *supra* note 133 (outlining the definition of disability and its application); John J. Capowski, *Accuracy and Consistency in Categorical Decision-Making: A Study of Social Security's Medical-Vocational Guidelines—Two Birds with One Stone or Pigeon-Holing Claimants?*, 42 MD. L. REV. 329 (1983) (criticizing the guidelines for failing to achieve their major goals of accuracy and consistency); see generally JERRY L. MASHAW ET AL., SOCIAL SECURITY HEARINGS AND APPEALS: A STUDY OF THE SOCIAL SECURITY HEARING SYSTEM (1978). In the private context, see *Do Private Long-Term Disability Policies Provide the Protection They Promise?: Hearing before the S. Comm. on Fin.*, 111th Cong. 96 (2010) (statement of Mark D. DeBofsky, Att’y at Law, Adjunct Professor of Law John Marshall Law School) (discussing “arbitrary and capricious” standard of review employed in ERISA disability insurance cases and stating that this has “elevated” the concept of deference to the insurance companies’ determination “above the goal of assuring an accurate claim decision”).

the advocacy community to respond in kind by forming medical–legal partnerships on behalf of the indigent disabled.

IV. THE MEDICAL–LEGAL GAP: PHYSICIAN PERSPECTIVES VS. LEGAL REQUIREMENTS

Before moving forward in the analysis of the tension between legal and medical definitions of disability, it is important to highlight the myriad ways in which physician and lawyer roles and actions differ. Doctors' perceptions, training, and demands on their time are completely different from and counterproductive to—from an advocacy perspective—those of a lawyer. When faced with a request for information regarding a claimant's ability to work, doctors incorrectly draft responses under the assumption that they know the training and background of those who will be reading their responses and how those readers will respond. There are four specific ways in which doctor and lawyer differences overburden physicians and doom disability claims to fail: (1) with respect to legal definitions; (2) with respect to medical records—methodology and goals; (3) with respect to evidentiary standards; and (4) with respect to the purposes of reviews.

A. Medical Definitions vs. Legal Definitions

Social Security's definition of disability is not the same as the definition of disability provided in a private disability insurance policy.¹³⁶ Furthermore, Social Security's definition is a matter of federal law and regulation, as well as years of interpretive case law.¹³⁷ The definitions provided in a private insurance policy differ from policy to policy and are interpreted as a term of the contract—the actual insurance policy itself.¹³⁸

These differences in the legal definition of disability do not rest with disability income claims. The disabled are also eligible for stu-

136. See *Part I – General Information*, SOC. SEC. ADMIN, <http://www.ssa.gov/disability/professionals/bluebook/general-info.htm> (last visited Aug. 18, 2014), archived at <http://perma.unl.edu/L6FY-EZ8H> (describing “disability” as “the inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months”); see also *Private Disability Benefits*, GLAD 2–3 (March 2014), <http://www.glad.org/uploads/docs/publications/disability-benefits.pdf>, archived at <http://perma.unl.edu/8DVP-6D2T> (noting that most private disability insurance policies define disability as either (1) being unable to complete material job tasks of the *current* job, or (2) having trouble performing *any* job tasks).

137. See, e.g., *Barnhart v. Walton*, 535 U.S. 212 (2002) (upholding the Social Security Administration's construction of the Social Security Act as requiring the claimant to demonstrate that she cannot perform any gainful act of employment for at least one year in order to qualify as disabled under the Act).

138. See *Private Disability Benefits*, *supra* note 136.

dent loan assistance and can purchase disability insurance to cover mortgage or credit card payments. Despite the fact that federal student loan discharges are also governed by federal law, the Department of Education has created its own separate definition of “total and permanent disability” which is different than the SSA’s.¹³⁹ And of course, the disability insurance policies that cover mortgage payments, credit card payments, and private student loans, all contain their own definitions of disability.¹⁴⁰ The definitions of disability also differ widely on premium-waiver applications for life insurance.¹⁴¹ In the employment context, the definitions for being disabled, and therefore needing an accommodation under the Americans with Disabilities Act, are different than the definitions for qualifying for family medical leave under the Family Medical Leave Act.¹⁴² To claim any or all of these benefits, disabled claimants must provide evidence from their physician, which is then subject to different legal standards depending on the claim being made.

Doctors, however, define disability medically. That is to say, what they deem to be disabling, debilitating, or incapacitating is based on their scientific knowledge, their experience with the patient, and their own experience and personal biases about what a patient should or should not be able to do given their illness(es), the course of treat-

139. 34 C.F.R. § 674.51(aa)(1) (2014).

140. See *Explaining Ways the Social Security Administration Can Improve the Disability Review Process: Hearing Before the Subcomm. on Energy Policy, Health Care & Entitlements of the H. Comm. on Oversight & Gov’t Reform*, 113th Cong. 36–47 (2014) (STATEMENT OF MARIANNA LACANFORA, ACTING DEPUTY COMM’R FOR RETIREMENT AND DISABILITY POLICY, SOCIAL SECURITY ADMINISTRATION), archived at <http://perma.unl.edu/7RHY-DQVH>; A Workers’ Most Valuable Asset: *Protecting Your Financial Future with Disability Insurance*, NAT’L ASSOC. OF INS. COMM’RS (November 2011), http://www.naic.org/documents/consumer_alert_protecting_financial_future_disability_insurance.htm, archived at <http://perma.unl.edu/H5Z9-2CSX> (confirming the proposition that the definition of disability will vary by policy offered).

141. *CIGNA’s Waiver of Premium with Extended Death Benefit*, CITY OF KETTERING, <http://www.ketteringoh.org/wp-content/uploads/2013/04/Waiver-of-Premiu-FAQ.pdf> (last visited Nov. 1, 2014), archived at <http://perma.unl.edu/TXB4-XNLF> (“Disabled employees must meet the definition of disability that applies during the waiver waiting period – they must be disabled from their regular occupation or receiving disability benefits under the employer’s plan.”); Sun Life Financial, *Group Life Waiver of Premium Frequently Asked Questions*, KADEC, http://www.kadec.org/uploads/employee_section/SunLife_Group_Life_Waiver_of_Premium_1.pdf (last visited Nov. 1, 2014), archived at <http://perma.unl.edu/JDP2-WB4Z> (“[A] person is considered totally disabled if he or she is unable to perform the material and substantial duties of any occupation for which he or she is qualified (or becomes reasonably qualified) due to education, training, or experience. The disability must be caused by an injury or sickness.”)

142. See 42 U.S.C. § 12102 (2012); 29 C.F.R. § 1630.2(g) (2014) (ADA definition of “disability”); *Id.* § 825.113 (stating the Family and Medical Leave Act of 1993 definition of “serious health condition”).

ment, and compliance with that treatment.¹⁴³ Lawyer Rachel Schneider puts it most succinctly:

The expertise of physicians is in the identification of impairment, not disability. 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. 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.¹⁴⁴

All of these differences have important implications for a patient who is seeking benefits.

B. Medical Records: Doctor Goals vs. Legal Documentation Requirements

A doctor's goals when creating medical records often conflict with the goals of a patient who needs those medical records to prove disability. Doctors record patient complaints to the extent that they are a necessary consideration for a doctor when contemplating treatment.¹⁴⁵ A doctor, whose every effort is bent on medical success, generally only notes signs of progress in a patient's record. Doctors have no reason to document medical failures unless it is to provide themselves a record that a particular course of treatment had already been tried and therefore new or different courses of treatment are necessary.

When all treatment options available have been tried and have failed, however, repetitive statements documenting the patient's lack of responsiveness are not part of what a doctor needs to verify in writing.¹⁴⁶ Once a doctor has reached the end of the treatment road, regu-

143. See Schneider, *supra* note 108, at 392 (“[A]ttempts 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 led to overgeneralization since individualized determinations would be more consistent with medical definitions of disability.”).

144. *Id.* at 407 (footnotes omitted).

145. See Serguei Pakhomov et al., *Agreement Between Patient-reported Symptoms and Their Documentation in the Medical Record*, 14 AM. J. MANAGING CARE 530 (2008); Jan-Joost Rethans et al., *To What Extent do Clinical Notes by General Practitioners Reflect Actual Medical Performance? A Study Using Simulated Patients*, 44 BRIT. J. GEN. PRAC. 153, 154 (1994); Annette S. Strömrgren et al., *Does the Medical Record Cover the Symptoms Experienced by Cancer Patients Receiving Palliative Care? A Comparison of Record and Patient Self-Rating*, 21 J. OF PAIN & SYMPTOM MGMT. 189 (2001).

146. See Rethans *supra* note 145. This article records the results of an examination of “the extent to which clinical notes in medical records of general practice consultations reflected doctors’ actual performance during consultations.” *Id.* at 153. The findings generally suggest, “clinical notes inadequately reflected the actual con-

lar check-ups are not meant to redocument what is already known. They are meant merely to determine if there are other, heretofore unknown and undocumented symptoms that have cropped up. If things remain the same, that is, the patient's disease is progressing as expected and no new medical issues have arisen, doctors will frequently record positive remarks such as, "patient doing well," "patient stable," "patient has no new complaints."¹⁴⁷ These remarks are not intended by the physician as evidence of the patient's ability to work or function—as the law defines those terms. They are merely evidence that nothing medically new has happened to the patient.

Additionally, while any good doctor will be responsive to patient complaints, especially repeated ones that the patient claims are debilitating, doctors also know and understand the limits of science. Therefore, while responsiveness will often take the form of various diagnostic tests in an effort to rule out certain conditions, the limits of the tests are well known and accepted. A patient whose symptoms remain undiagnosed but, despite on-going complaints manages to have some good days, will eventually be told that nothing further can be done. Medicines and referrals to mental-health professionals, or both, prescribed to help a patient cope with debilitating symptoms which do not appear to be treatable will be provided, but the chart will focus on the medical successes in the patient—a decreasing viral load, a healed bone fracture, even a cured cancer—rather than on the tiresome symptoms that can neither be explained nor treated.¹⁴⁸

sultation and thus were insufficiently valid" and further that "doctors perform differently when patients present with chronic disease compared with acute problems." *Id.* at 154. Specifically, the records of those doctors whose patients presented with a chronic disease contained even less information than those whose patients presented with acute pain. *See also* Herbert A. Simon, *Artificial-Intelligence Approaches to Problem Solving and Clinical Diagnosis, in* *Logic of Discovery and Diagnosis in Medicine* 87 (Kenneth F. Schaffner ed., 1985) ("From the therapeutic or 'troubleshooting' standpoint we want to follow the causal stream up to a point where intervention is possible"). When the diagnosis of an illness is clear and all available treatments have been tried, there is little more to record unless a change in symptoms is significant enough to convince the doctor that perhaps there is an additional diagnosis and course of treatment. *See* Noah, *supra* note 133, at 246–47.

147. *See* Cathryn Miller-Wilson, Karam Mounzer, & Danielle Mourar, *Medical-Legal Collaboration—Beyond Partnerships—The Cornerstone Of Effective Advocacy For The Disabled In The Modern World* (March 1, 2012) (unpublished manuscript) (on file with author).

148. *Id.*; *see also* Noah *supra* note 133, at 247 ("Physicians view patient care as an iterative process designed to treat a condition to the best extent possible. They do not care much about the disease's etiology—the theory of its origin or cause—unless understanding causation would assist in diagnosis and treatment.").

However, an insurer or other arbiter of patient claims usually uses the recorded medical successes as evidence of ability to work.¹⁴⁹ But conversations with the treating professionals upon news of the patient's claim denial will almost always reveal surprise and consternation on the part of the doctor who never intended his personal checklist of accomplishments on the patient's behalf to be used to deny an extremely disabled patient a source of income.

C. Evidentiary Standards: The Legal Myth of Medically Objective Evidence

The disconnect between what medical records actually document and what insurers and government officials use them to prove is highlighted by the oft-repeated legal requirement of "objective evidence."¹⁵⁰ Most legal definitions of disability require the claimant to

149. See *McLaughlin v. Prudential Life Ins. Co. of Am.*, 319 F. Supp. 2d 115, 127 (D. Mass. 2004) (holding that Prudential's Medical Director's findings were credibly supported by the record even though, admittedly they focused on "cited notations culled from successive visits stating that McLaughlin, 'has done quite nicely . . . starting to regain her strength,' 'doing well . . . pleased with her progress,' and 'continues to show marked improvement . . . normal strength both proximally and distally (in the [lower extremities])'" and ignored "adverse aspects of the record on which the Medical Director could have relied in reaching a different conclusion").

It should be noted that a major factor in the court's upholding of the insurance company's decision in *McLaughlin* was their earlier determination that application of the "arbitrary and capricious" review standard was appropriate. *Id.* at 125. As the court ultimately stated, "if reviewed *de novo* [the case] might be decided differently." *Id.* at 127. The significance of the legal standard of review is yet another aspect of disability determinations that is far beyond the training, understanding and experience of most doctors. While insurance industry doctors receive training that enables them to ensure that their opinions are in keeping with the legal standards that will be applied, no such training, outside of a deliberately created interdisciplinary partnership between claimant's doctors and their lawyers, exists for claimants' doctors.

For another example, see *Skretvedt v. E.I. Dupont De Nemours & Co.*, 268 F.3d 167 (3d Cir. 2001), *abrogated by Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008). In that case, long-term employee Skretvedt brought an ERISA action against his former employer in order to challenge its denial of his claim for long-term disability benefits. In reviewing the evidence, the court remarked on a particular set of handwritten notes, written by Skretvedt's two physician's, Dr. Schiff and Dr. Binhammer, and submitted by Dupont as evidence that the plaintiff was not disabled. *Id.* at 181. The notes revealed that the plaintiff was "much improved on Paxil" and that the plaintiff's "[d]epressive Medical [sic] illness [had] improved." *Id.* at 182 (alteration in original). Dupont argued that these comments indicated that plaintiff's condition was not permanent and therefore, the plaintiff did not meet their definition of disabled. The circuit court understood this was not the case, stating the notes made it clear that the doctors believed the plaintiff's condition had improved, "not that it had improved to a point where he was capable of performing his previous job at Dupont." *Id.*

150. See *Huffaker v. Metropolitan Life Ins. Co.*, 271 Fed. Appx. 493, 500 (6th Cir. 2008) (upholding the rule that an ERISA disability benefits plan can require a

provide objective evidence, in the form of diagnostic tests, of disability.¹⁵¹ However, doctors know and understand that a disabled individual will not always have irrefutable diagnostic proofs and unequivocal answers to all their disabling complaints. First, diagnostic tools, regardless of their sophistication, do not always reveal the existence or severity level of a patient's disabling condition.¹⁵² Second, patients often do not have access to the diagnostic tools that might provide this information precisely because their disabling condition has prevented them from working and obtaining adequate health insurance.¹⁵³ Thus, even where diagnostic tools would actually

claimant provide objective medical evidence of disability); *see also* Johnson v. Metropolitan Life Ins. Co., 437 F.3d 809, 814 (8th Cir. 2006) (holding that an ERISA plan administrator can require “objective evidence” of a claimant's disability in deciding whether to deny or approve a claim for long-term disability under the plan).

151. The social security disability statute requires a claimant to have a “medically determinable physical or mental impairment” evidenced by measurable outward signs of disability; patient reports of symptoms and pain will not suffice unless supported by and consistent with objective evidence.” Crossley, *supra* note 41, at 629 (quoting 42 U.S.C. § 423(d)(1)(A) (1995)). In the private disability income context, *see* Rafik, *supra* note 41.
152. *See, e.g.*, George R. Parkerson Jr. et al., *Classification of Severity of Health Problems in Family/General Practice: An International Field Trial*, 13 FAM. PRAC. 303, 303–04 (1996) (noting the difficulty in assessing severity of symptoms and recognizing the importance in adequate diagnostic tools).
153. *See Skredvedt*, 268 F.3d at 182 (noting that “Skretvedt had no health insurance during much of the period from 1995 to 1997 and was unable to pay for treatments”).

The Patient Protection and Affordable Care Act (PPAC), Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified in scattered sections of 42 and 26 U.S.C.), does provide some premium assistance to employers to assist their early retiring former employees with premiums or health care costs and provides some tax credits to assist families needing assistance in purchasing health insurance. *See id.* §§ 1102, 1401, 1402. Additionally, there are a variety of provisions in the PPAC that affect premium costs and health care costs, generally, in an attempt to make health care more affordable. *See id.* §§ 1003, 1311, 1401–1563. However, while PPAC provides states with funding to expand their Medicaid program, not all states have agreed to take this money. Therefore, the problem of the indigent disabled falling into a health insurance gap at a time when coverage for treatments and medical support for disability-related benefits is most crucial remains. *See* 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2012); Amy Lischko & Beth Waldman, *Understanding State Resistance to the Patient Protection and Affordable Care Act: Is it Really Just Politics as Usual?*, 9 J. HEALTH & BIOMEDICAL L. 27 (2013); Robert Pear & Michael Cooper, *Reluctance in Some States Over Medicaid Expansion*, N.Y. TIMES, June 29, 2012, <http://www.nytimes.com/2012/06/30/us/politics/some-states-reluctant-over-medicaid-expansion.html?pagewanted=all>, archived at <http://perma.unl.edu/E3PR-QH35>.

Additionally, while the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. No 99-272, 100 Stat. 82 (1986), provides most former employees with the ability to retain their health insurance, they can only do so by paying the premiums. *See* 29 U.S.C. §§1001–03 (2012). Clearly, a person who is no longer working and who is in the process of applying for disability-related in-

provide the necessary objective evidence to confirm disability, many patients do not have access to these tools because they simply cannot afford them.

Whether through a simple in-office test or through costly, sophisticated technology, the patient must have the income to get to the doctor's office and the health insurance to be seen by the doctor in order to provide results that verify the existence of disabling conditions. Without these, the tests cannot be performed and the objective evidence required cannot be provided.¹⁵⁴

In any event, as already stated, clinicians will not always be able to corroborate a patient's claimed inability to work with a specific test or diagnosis. Medical science recognizes its limitation in understanding the underlying physiopathology of several distinct clinical entities and in identifying the appropriate diagnostic tools.¹⁵⁵ The world of claims processing, governed by legal definitions and requirements, however, does not. A doctor's claim that a patient is too fatigued to work, without lab tests to substantiate their complaint—low testosterone, anemia, low thyroid hormone level, low cortisol level, or the presence of a superimposed disease accounting for their fatigue—will be trivialized and likely ultimately ignored by an insurer, employer, or creditor.¹⁵⁶

come benefits does not, in fact, have any income at the moment of application. Therefore, absent having savings or a source of income from another family member, the "right" to continue employer-provided health insurance does not actually result in disabled persons having health insurance.

154. Note that many private insurers will follow up with a claimant's scant records and pay for various diagnostic tests and examinations in an effort to assist a claimant in making their claim. However, the tests themselves often give results that need to be interpreted rather than clear-cut, unbiased, and objective conclusions. For those tests open to interpretation, the insurance industry doctor will find that the results are "inconclusive" or "not supportive of claimant's claimed level of severity." See George, *supra* note 130. Additionally, doctors often treat sick patients without giving a formal diagnosis. Without this formal diagnosis, however, disability insurance companies will reject them. *Id.*; see also Noah, *supra* note 133, at 246–47 (stating that physicians do not focus on the accuracy of the diagnosis but rather the treatment).
155. See Miller-Wilson et al., *supra* note 147 (citing Lesley M. Arnold et al., *Evaluating and Diagnosing Fibromyalgia and Comorbid Psychiatric Disorders*, 69 J. CLIN. PSYCHIATRY e28 (2008); Lorenzo Lorusso et al., *Immunological Aspects of Chronic Fatigue Syndrome*, 8 AUTOIMMUNITY REVIEWS 287 (2009)).
156. See Miller-Wilson et al., *supra* note 147. In discussing the theoretical medical model of disability, Professor Mary Crossley points out that, "because [medical professionals] focus on classifying the nature and causes of impairment, medical professionals may have a tendency both to falsely universalize the impact of a particular impairment and to fail to recognize that a given impairment may produce varying degrees of limitation in different people." Crossley, *supra* note 41, at 650–51 (footnote omitted). It is precisely this problem of universalization that undercuts government and industry attempts to render more accurate decisions.

D. Medical Records Revisited: Medical Follow-up vs. Legal Reviews

The final gap between the legal standard that must be proved in a disability income matter and what actually medically occurs during the life of a disabled patient is with respect to determinations that occur after an initial finding of disability. Both the public and private systems require periodic reviews of a person's "on-going disability" even after determining that a patient meets the definition of disability and is eligible for benefits.¹⁵⁷ In some contexts, these periodic reviews can occur as often as every three months.¹⁵⁸

For any chronic sufferer of disease, a doctor will ensure that periodic appointments are made. However, the frequency of these appointments very much depends on the nature of the disease and the likelihood that the appointments will yield a medically important development. If there is little expectation that the patient will have medical needs at frequent intervals, appointments will not be scheduled at frequent intervals. Doctors will not schedule more frequent appointments to deal with the patient's legal need for updated paperwork, nor is it likely that doctors will even calendar the deadline for completion of the patient's legal paperwork. Doctors' calendars generally include only those appointments and obligations that are related to their patients' medical issues and needs. Thus, what appears to be a simple legal burden—the timely provision of medical evidence in support of a client's claim—is in fact a frequent cause of disallowance of a client's claim.

The difficulty filling out paperwork in a timely fashion also stems from the differences in training between lawyers and physicians.

157. See 20 C.F.R. § 404.1594 (2014); *Palmer v. Metro. Life Ins. Co.*, 415 F. App'x 913, 915–16 (10th Cir. 2011) (describing private insurance disability review).

158. See 20 C.F.R. § 404.1590(d)–(i) (2014); see also *Program Operations Manual System*, SOC. SEC. ADMIN., <https://secure.ssa.gov/poms.nsf/lnx/0428001020> (last updated Sept. 24, 2013), archived at <http://perma.unl.edu/76BP-VFGP> (discussing the different time frames for Continuing Disability Reviews; for example, for individuals with an impairment expected to improve receive scheduled reviews every 6-18 months). When Social Security Disability applications are approved, the medical updates are generally requested every three or even seven years. *What You Need to Know: Reviewing Your Disability*, SOC. SEC. ADMIN. 1 (January 2005), <http://www.ssa.gov/pubs/EN-05-10068.pdf>, archived at <http://perma.unl.edu/9CQF-6GFQ>. However, sometimes an application will be approved for only one year, in which case an update is requested annually until and unless the benefit is fully awarded and the update moves to a less frequent timetable. See *id.* (providing for earlier review every six to 18 months if improvement is expected). Private insurance carriers, however, ask for medical updates at least annually and more often than not, even more frequently than this. LA. DEP'T OF INS., CONSUMER'S GUIDE TO INDIVIDUAL HEALTH INSURANCE 22 (2004) ("The frequency . . . depends upon the particular policy. For example, a given insurance company may require such medical updates every month.").

From the first day of law school, lawyers are taught that keeping deadlines—set by courts and legislators—is a critical part of effective ethical representation. This is not the case for medical treatment, which is based on making people healthy, not on filling out paperwork in a timely manner.

For fairly obvious reasons, however, all requests for documentation have deadlines. In an effort to ensure a patient's application for some kind of benefit does not languish, providers are asked to complete detailed forms within anywhere from two weeks to thirty days of a request.¹⁵⁹ While most benefit grantors will grant extensions of time if asked, many patients and providers do not know they can make this request. Often, because providers are busy providing medical care to their patients, deadlines that a patient believes the providers are adhering to pass without the timely completion of the forms.¹⁶⁰

Whether a failure occurs because there was no effort to seek more time or simply because of a memory lapse, if the forms are not timely provided, the benefits can be terminated, ending what is the only source of income for the disabled patient. There are often appeal rights, but while appeals are pending the benefit is not forthcoming.¹⁶¹ Appeals can take anywhere from thirty days to two years to be decided.¹⁶² While the patient is waiting for the appeal to be decided, their access to health care is diminished or terminated altogether.

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159. Div. of Temp. Disability Ins., *Claim for Disability Benefits*, STATE OF N.J. DEPT OF LABOR & WORKFORCE DEV., http://lwd.dol.state.nj.us/labor/forms_pdfs/tdi/WDS1.pdf (last visited Nov. 1, 2014), archived at <http://perma.unl.edu/QN7C-TYE8> (disability application from New Jersey Department of Labor stating applicant has 30 days to file application; includes section of application to be filled out by physician); Labor and Workforce Dev. Agency, *Physician/Practitioner's Guide to Disability Insurance*, STATE OF CAL. EMP'T DEV. DEPT 2, http://www.edd.ca.gov/pdf_pub_ctr/de2548.pdf (last visited Nov. 1, 2014), archived at <http://perma.unl.edu/L4XL-GT2B> (describing the need for claimants to file physicians' medical extension forms within 20 days of issuance of the notice given to the claimant that their benefits are about to expire).
160. Richard J. Baron, *What's Keeping Us So Busy in Primary Care? A Snapshot from One Practice*, 362 N. ENGL. J. MED. 1632 (2010) (describing the responsibilities primary care physicians have outside of the many patients they see); Amy S. Oxentenko et al., *Time Spent on Clinical Documentation: A Survey of Internal Medicine Residents and Program Directors*, 170 ARCHIVES INTERNAL MED. 377 (2010) (stating that medical internal medicine residents spend almost as much time on paperwork as seeing patients because they have so much paperwork to complete); Pauline W. Chen, *Doctors and Patients, Lost in Paperwork*, N.Y. TIMES, Apr. 8, 2010, http://www.nytimes.com/2010/04/08/health/08chen.html?_r=0 (describing the vast amounts of paperwork that doctors must complete), archived at <http://perma.unl.edu/J3X2-CHW5>.
161. *The Appeals Process*, SOC. SEC. ADMIN. 2 (Jan. 2008), <http://www.ssa.gov/pubs/EN-05-10041.pdf>, archived at <http://perma.unl.edu/9XV-2W8H>.
162. *Plan to Reduce the Hearings Backlog and Improve Public Service at the Social Security Administration*, SOC. SEC. ADMIN. 3 (Sept. 13, 2007), <http://www.ssa.gov/hearingsbacklog.pdf> (showing Chart 2: The Number of Days It Takes to Process a

V. THE GAP WIDENS: THE RISE IN JUDICIAL SUPPORT OF NONTREATING PHYSICIAN EVIDENCE

The distinctions between medical and legal perspectives regarding disability in general are neither new nor particularly surprising, so why is such acknowledging and addressing these differences in perspectives of such great importance now? The SSA has been making disability determinations since 1956.¹⁶³ Insurance companies have been in the disability business, off and on, since the early 1900s.¹⁶⁴ An analysis of the case law trends over several decades during the twentieth century, however, shows a gradual but alarming trend: while the treating physician rule was being debated and narrowed and legal definitions of disability were rendered more complex, as discussed in Part III, above, the courts began acknowledging and respecting government and industry medical opinion evidence.

As discussed above, the 1970s brought recession and economic downturn. Joblessness rose and so did disability claims.¹⁶⁵ As a result, congressional hearings about the ballooning costs of the disability program were held, amendments to the SSD and SSI programs were passed, and the SSA underwent several monumental changes in order to try to rein in the costs. There is little discussion in the historical literature about what all of these changes meant for the SSA's relationship with doctors.¹⁶⁶ However, a glance at Social Security Disability decisions from the mid-1970s through the mid-1980s clearly shows a growing deference towards agency physician reports. And embedded in that deference are statements that imply the agency physician reports are more thorough, more detailed, and therefore much more worthy of credence than previously given.¹⁶⁷

Hearing Has Grown over the Years), *archived at* <http://perma.unl.edu/73TH-U72B>.

163. John R. Kearney, *Social Security and the "D" in OASDI: The History of a Federal Program Insuring Earners Against Disability*, 66 SOC. SEC. BULL. 1, 10 (2006).
164. William J. Baker, *Disability Income Insurance: An Odyssey*, 24 DISABILITY INCOME INS. 278 (1992) (citing CHARLES E. SOULE, *DISABILITY INCOME INSURANCE: THE UNIQUE RISK* (Jane Lightell ed., 2d ed. 1989)).
165. The rise in disability claims and consequent concern about maintaining the financial health of the social security trust is attributed to a number of factors: slow economic growth, high unemployment, the creation of the SSI program, and an increase in appeals by denied claimants. *See* Kearney, *supra* note 163.
166. *But see* BLOCH, *supra* note 122, at 100–01 (responding to reports of large percentages of erroneous disability claims decisions, the administration initiated an accelerated review process and an "immediate need for a dramatically increased amount of medical evidence at the state Disability Determination Services" which resulted in a huge rise in the use of independent contractor doctors by the SSA).
167. *See* Gilliam v. Califano, 472 F. Supp. 598, 602 (E.D. Mo. 1979) (holding in favor of the Secretary, the court stated, "Plaintiff's treating physician" delivered "a four sentence report" whereas "the Secretary's two examiners . . . filed thorough and complete physical examination reports. . . . [T]he Secretary's decision here is

The move away from treating physician deference on the private side begins more convolutedly than on the public side. The Supreme Court's case of *Firestone Tire & Rubber Co. v. Bruch*¹⁶⁸ in 1989 is seminal, though it is not about a disability claim. The plaintiffs in that case were seeking benefits under a termination plan that was created and administered by their former employer, Firestone Tire and Rubber Co.¹⁶⁹ The Court engaged in a lengthy analysis in order to determine what standard of review to employ in reviewing the former employees' claims under ERISA.¹⁷⁰ They held that the standard should be de novo, "unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan."¹⁷¹ While the decision purports to create greater accountability for plan administrators, in actual effect, employer-created plans were suddenly revised after this decision to ensure that the administrators were given discretionary author-

grounded upon the testimony of two competent physicians who have submitted in-depth medical reports, which were visibly adequate to support his findings that the claimant was not under a disability as defined by the Social Security Act"). Note that in this case, as in the private disability decision noted in *McLaughlin v. Prudential Life Ins. Co. of Am.*, 319 F. Supp. 2d 115 (D. Mass. 2004), the court admits that there was enough evidence to support an opposite finding but that they are constrained to hold in favor of the Secretary as the "[c]ourt is not empowered to consider this case De [sic] novo." *Gilliam*, 472 F. Supp. at 602. Again, social security doctors, just like insurance doctors, presumably must receive information and training about the legal standard of review, as well as the legal requirements to prove disability. See also *Ward v. Heckler*, 786 F.2d 844, 846 (8th Cir. 1986) (holding in favor of the Secretary and stating, "In the present case, although some medical evidence indicates that Ward suffers from physical impairments, only rather conclusory statements of one treating physician indicate that Ward's impairments are substantial or disabling. Dr. Reynolds[, the consultative examiner,] expressed this conclusion . . ."); *Mongeur v. Heckler*, 722 F.2d 1033, 1039 (2d Cir. 1983) (holding that Social Security's consultative examiner's report "constitutes evidence substantial and sufficient to contradict the opinion" of claimant's treating physician and treating nurse); *Rutherford v. Schweiker*, 685 F.2d 60 (2d Cir. 1982) (affirming the ALJ's denial of disability benefits); *Bolton v. Sec'y of Health and Human Servs.*, 504 F. Supp. 288, 290 (E.D.N.Y. 1980) (holding that there was substantial evidence to support the Secretary's denial of disability, and considering "reports of two consultative medical experts who had examined plaintiff in connection with her application for disability benefits"). In *Rutherford*, 685 F.2d at 61, the court took notice of two Psychiatric Consultative Evaluation reports which were provided in support of the disability examiner's denial of benefits. Specifically referring to the more recent report, the ALJ "found that plaintiff had no significant secondary damage because of alcoholism." *Id.* at 62. In dissent, Circuit Judge Timbers pointed out, however, that the ALJ's reliance on the reports mistakenly failed to evaluate "appellant's alcoholism according to his voluntary ability to control its use." *Id.* at 65.

168. 489 U.S. 101 (1989).

169. *Id.* at 105-06.

170. *Id.* at 108-15.

171. *Id.* at 115.

ity.¹⁷² With those revisions, the standard of review for benefits claims under employer-provided plans became “arbitrary and capricious.”¹⁷³

Once the legal standard is thus lowered, it is easy to see how the Court has laid the groundwork for rejecting treating-physician evidence. In fact, after *Bruch*, an administrator who uses his or her own qualified physician to make a determination cannot be required to, instead, give extra weight to the treating physician unless the claimant can show that doing so is arbitrary and capricious. It is clear that it would be exceedingly difficult to meet this standard if the plan administrator had access to qualified physicians to make their own determinations about the claimants. Thus, while employers and administrators always utilized medical consults, *Bruch* created an industry incentive to increase that usage and streamline the partnership between doctors and industry claims reviewers and lawyers.

In reviewing the increasingly detailed reports of insurers as well as plaintiffs’ arguments about conflict of interest, the courts have realized that while plaintiffs may have a valid argument that the insurer’s doctors are merely “physician advocates” for the insurer, this only highlights the fact that the plaintiffs, for their part, have “physician advocates” who are equally biased.¹⁷⁴ However, at least one author

172. James Goodley, *The Effect of Metro. Life v. Glenn on ERISA Benefit Denials: Time for the “Treating Physician Rule,”* 26 J. CONTEMP. HEALTH L. & POL’Y 403, 407 (2010) (“Employers and unions administering ERISA plans wanted more control of, and deference to, their decision making. Consequently, and in response to *Bruch*, many plans provided provisions including the abuse of discretion standard of review in controlling plan documents.” (citing Roy F. Harmon III, *The Debate Over Deference in the ERISA Setting—Judicial Review of Decisions by Conflicted Fiduciaries*, 54 S.D. L. REV. 1, 11 (2009)).

173. *Davis v. Unum Life Ins. Co. of Am.*, 444 F.3d 569, 575 (7th Cir. 2006) (“When, as here, the terms of an employee benefit plan afford the plan administrator broad discretion to interpret the plan and determine benefit eligibility, judicial review of the administrator’s decision to deny benefits is limited to the arbitrary-and-capricious standard.”). And in the lower court’s opinion in *Davis*, the court cites to the decision in *Herzberger v. Standard Ins. Co.*, 205 F.3d 327 (7th Cir. 2000), for the holding that a “plan administrator’s benefit determinations will be largely insulated from judicial review by reason of being discretionary.” *Davis v. Unum Life Ins. Co. of Am.*, No. 03 C 6362, 2005 U.S. Dist. LEXIS 7211, at *34 (N.D. Ill. 2005) (citing *Herzberger v. Standard Ins. Co.*, 205 F.3d 327, 332 (7th Cir. 2000)), *rev’d*, 444 F.3d 569 (7th Cir. 2006). See also Ann K. Wooster, Annotation, *Judicial Review of Denial of Disability Benefits Under Employee Benefit Plan Governed by Employee Retirement Income Security Act (ERISA)*, 29 U.S.C.A. § 1132(a)(1)(b)—*Selection and Scope of Particular Standards of Review—Post-Firestone Cases*, 12 A.L.R. FED. 2d 1 (2006) (“The Supreme Court’s decision in *Firestone Tire & Rubber Co. v. Bruch* . . . established with respect to employee benefit plans generally that courts are to review denials of benefits under a de novo standard of review, unless the plan grants discretionary authority to the plan administrator to make decisions concerning eligibility and benefits.” (citation omitted)).

174. See *Blakley v. Comm’r of Social Sec.*, 581 F.3d 399, 408 (6th Cir. 2009) (discussing ALJ’s decision to reject treating physician’s assessment of claimant because “the

has pointed out that the bias of an industry doctor is in no way equivalent to the bias of a treating physician: the “inherent incentives and payment designs” are different for a treating physician versus an industry physician.¹⁷⁵

Whether one agrees with this distinction, however, is not necessary to conclude that as a general matter, physicians, like any other person, are subject to biases—personal, professional, financial and political. Judicial excoriation of “physician advocates”¹⁷⁶ is therefore

possibility always exists that a doctor may express an opinion in an effort to assist a patient with whom he or she sympathizes for one reason or another . . . [or] provide such a note in order to satisfy their patient’s requests and avoid unnecessary doctor/patient tension.”); *see also* *Yates v. Colvin*, 940 F.Supp 664, 676 (S.D. Ohio 2013) (citing the language of the *Blakley* case and describing it as “boilerplate” language utilized by ALJs in the Circuit); *Wojna v. CIGNA Group Ins.*, No. CV 10-07238-JAK (JEMx), 2011 WL 3236025, at *1-3 (C.D. Cal. July 21, 2011) (granting plaintiffs request for the discovery of information to prove bias based on the amount CIGNA paid to the company that supplied it with medical professionals for claims determinations); *McGahey v. Harvard University Flexible Benefits Plan*, 685 F.Supp.2d 168, 178-80 (D. Mass. 2009)(questioning the impartiality of the doctors used by Harvard in the “independent medical examination” of the claimant).

175. *See* Goodley, *supra* note 172, at 432. Goodley states, “The insurer’s goal is profit maximization, despite that [sic] fact that under ERISA, it is supposed to act ‘solely in the interest of the participants and beneficiaries.’ . . . Though physicians are no doubt subject to pressures from those that are paying them (notwithstanding their ethical and legal obligations), it would seem the pressures on a plaintiff’s treating physician would be less serious than on an IME or IEP, because the IME or IEP is likely to have more repeat business with the insurer. NELA has noted that although there is some concern about the trustworthiness of a treating physician, the more pressing issue is the problem of insured plans hiring repeat IMEs and IEPs who are thus incentivized against the truly independent practice of medicine . . .” *Id.* at 432–33 (footnotes omitted).

Of course, this defense does not wholly work because presumably what makes one the treating physician is the fact that he or she can rely on the “repeat business” of the patient. So the real issue is not repeat business, it is repeat lucrative business. Although it is generally understood that doctors are well paid, insurance doctors are paid several times more by their insurer clients than they would be by individual patients and their individual health insurance companies. *See* Chung, *supra* note 130; George, *supra* note 130; Parija Kavilanz, *Doctors: Why We Can’t Stay Afloat*, CNN MONEY, <http://money.cnn.com/galleries/2012/smallbusiness/1201/gallery.doctors-broke/index.html> (last updated Jan. 10, 2012), *archived at* <http://perma.unl.edu/SFNG-D3HU>. Additionally, the process of being paid by an insurance company for work performed rather than by a patient’s insurance company in accordance with the individual idiosyncrasies of the patient’s policy is presumably more efficient and less of a hassle.

176. *See* Kevin F. Foley, “Physician Advocacy and Doctor Deception A Doubled-Edged Attack on Due Process,” *FED. LAW.*, July 2001, at 24; *see also* *Davis*, 444 F.3d at 578 (referring with incredulity to several of the treating physician’s statements, and stating, “these examples and others in the record show Dr. Raymond more as an advocate than as a doctor rendering objective opinions”). As with Judge Foley, however, this court confuses dishonesty and significant exaggeration with advocacy. The examples provided did reasonably raise an inference that the treating

misplaced—as is the expectation that any person who is asked to provide a professional opinion is completely neutral. Professional opinion is based on training and experience among other things. Experiences are necessarily personal to the professional that had them. It is therefore nonsense to exclaim that physician advocates are biased and therefore unethical and untrustworthy. Physician advocates are precisely what the industry realized they could cultivate and, in so doing, their reliance on their own physicians became more credible.

The case of *Davis v. Unum Life Insurance Co. of America*¹⁷⁷ is a prime example of how the court is so blinded by their concerns about a less-than-credible treating physician that they give no acknowledgment whatsoever to the role that the insurance company's physicians played in the claims decision. In that case, the plaintiff, William Davis, applied for long-term disability benefits after his employer fired him.¹⁷⁸ The benefits were awarded for a mental disability but not a physical one—the difference between two years of disability income and income until retirement age.¹⁷⁹ Davis argued that he had severe pain, diabetes, and heart trouble and therefore, for physical reasons, was unable to work.¹⁸⁰ Unum had an in-house psychiatrist, orthopedic surgeon, internist, a doctor of physical medicine and rehabilitation, a clinical psychologist, and an M.Ed.—a vocational rehabilitation specialist—examine Davis's file.¹⁸¹ All of these members of the Unum team concluded Davis was capable of working at a sedentary job and had no physical ailments sufficiently severe enough to meet Unum's definition of disability.¹⁸²

On appeal, Davis argued the standard of review should be *de novo* rather than the arbitrary and capricious standard usually employed because Unum's doctors were biased against him and had a conflict of interest.¹⁸³ In response, the court said tellingly,

We presume neutrality “unless a claimant shows by providing specific evidence of actual bias that there is a significant conflict.” . . . [W]hether a doctor

physician's records and statements were not credible. That the physician's motive for behaving badly was likely from a desire to help his patient is not in question. But to frame the problem as one of advocacy implies that all physicians who wish to advocate on behalf of their patients are “not objective,” which overstates the matter and reinforces the assumption that there are some doctors who are “neutral or objective.” All doctors have opinions. Whether they are effective advocates in advancing those opinions or ineffective liars and exaggerators largely depends on their innate abilities, their sense of personal integrity, and their training and educative contact with lawyers.

177. 444 F.3d 569.

178. *Id.* at 571.

179. *Id.* at 571–72.

180. *Id.* at 573.

181. *Id.* at 572–73.

182. *Id.* at 573.

183. *Id.* at 575.

is in-house or not is an irrelevant distinction in this context. To start, plan administrators have a duty to all plan participants and beneficiaries to investigate claims and make sure to avoid paying benefits to claimants who are not entitled to receive them.”¹⁸⁴

Absent from their discussion was the plan administrator’s duty to plan participants and beneficiaries to investigate claims and make sure to pay claimants who are entitled to receive them. To prioritize the duty to deny false claims over the duty to award true ones is reflecting a bias against the individual claimant.¹⁸⁵ Notwithstanding this bias, that the court presumes neutrality of in-house insurance doctors—who are paid by the insurer and have access to the insurer’s lawyers for consultation when needed—simply reflects how deep and effective the partnership is. The issue, therefore, is not how to eliminate physician advocates but rather how to ensure that disabled claimants have as much access to physician advocates as insurers do.¹⁸⁶

It should be noted that references to physician advocates mean: a licensed professional who is capable of organizing the medical facts in the light most favorable to his or her patient. I do not conflate, as Mr. Foley does, a physician advocate with a physician who lies or exagger-

184. *Id.* (quoting *Kobs v. United Wis. Ins. Co.*, 400 F.3d 1036, 1039 (7th Cir. 2005)).

185. Note that I am not suggesting here that this bias—the bias in favor of the group over the individual—is incorrect. The point is merely that it is a bias and should therefore be acknowledged. The court’s failure to acknowledge the bias inherent in their own reasoning contributes to their failure to acknowledge that Unum’s full-time staff necessarily worked to support Unum’s mission, which is biased in favor of the group and against the claimant. Ultimately, it painted Unum’s elaborate medical–legal partnership as some kind of neutral, objective, and trustworthy source of information. That Unum’s medical team was ultimately more credible in its findings than Davis’s is not something that I would necessarily disagree with. But to find that they are more credible because they are less biased is unsupportable. Arguably, if Davis had the resources available to Unum, to assemble a treatment team that included a lawyer, it is entirely possible that he could have amounted a more effective and credible case. Or, alternatively, if there was no credible case to be made, he could have saved himself the aggravation and mental and physical costs of litigation.

186. In a prior article I advocated for regulatory change that would eliminate government and private insurer’s ability to extensively review claimant physician records absent a determination that the provided records were somehow inherently unreliable because of evidence that the submitting physician was not qualified or had been convicted of perjury, or both. I noted at the time the suggestion was radical and not necessarily realistic but was proposed primarily to highlight how far the disability determination system had drifted from its goal of providing an income safety net for those who were too sick or incapacitated to work. See Miller-Wilson, *supra* note 121, at 35–36. Recognizing that creating medical–legal partnerships is how government and private industry have succeeded in persuading the judiciary that a particular claim should be denied, an alternative and less radical solution to the problem of improperly denied claims is to ensure that claimants have access to the same tools.

ates the medical facts to such an extent that they are untrue.¹⁸⁷ There is a clear distinction between false or significantly exaggerated medical records or testimony and records or testimony that are accurate in accordance with the physician's best professional judgment. The key is acknowledging that only a small amount of medical information is "objective": blood tests, MRIs, CT scans, and X-rays reveal important information. But they do not, in many instances, tell the entire story of a patient's capabilities. A treating physician, who has watched and examined a patient over time, is capable of delivering an opinion based on both the test results and his or her observations about what those capabilities are. That a different physician is capable of giving a different opinion despite the same facts is neither unusual nor a reason to assume that patients' physicians are simply not as credible as they used to be.

The key issue is that with the growth of disability claims has come a burgeoning industry response to those claims: develop medical–legal partnerships to review and respond to the claims so that denials will have a stronger legal foundation. Legally defining disability more clearly is a natural way to try to gain greater accuracy and consistency in determinations. It is no surprise, therefore, that the courts have been persuaded more often that the "accurate" determination is the one that was presented by the medical–legal team rather than the one presented by the lone doctor whose notes and test results undermine his patient's claim for all the reasons discussed in Part IV.

VI. CLOSING THE GAP: SEEING THE CREATION OF INTERDISCIPLINARY PARTNERSHIPS ON BEHALF OF THE DISABLED AS AN ETHICAL OBLIGATION

Recall the overarching quest for both public- and private-sector disability income claims adjudication has been to achieve greater accuracy, consistency, and efficiency in claims processing. These goals are intuitively important for achieving balance and fairness. Analyzing the legislative and judicial history of disability claims, however, reveals that if anything, both the public and private sectors have fallen farther behind in achieving these goals rather than gained progress. Increasingly complex legal standards have rendered the ability of the SSA and private insurers to process initial claims internally more efficient.¹⁸⁸ But the resulting decisions are much less often accurate or consistent, and, ironically, cause an increase in the numbers

187. FOLEY, *supra* note 176.

188. See Martin & Weaver, *supra* note 120 (stating the influx of new claims in the 1970s led to reforms in the 1980s in order to reduce the number of claims granted and lower the costs of administering the program). But see Terry A. Low, *Eleven Ways to Assure the Success of a Disability Claim*, LAW OFFICES OF TERRENCE A. LOW AND ANTHONY J. CANTA 1, <http://www.lowandcanata.com/CM/Articles/Elev>

of appeals, which renders the entire claims decision process inefficient.¹⁸⁹

While courts and legislators recognize that the difficulty lies in the gap between medical and legal definitions and constructs, their failure to recognize how the SSA and the insurance industry have tried to narrow this gap through the creation of medical–legal partnerships has added to the muddle. If we can recognize the effective response to the increased regulation disability examiners have developed, we can begin to advocate for similar responses on the claimant’s side. Once claimants also have access to interdisciplinary advocacy teams, there is hope for more accurate and consistent results.

Furthermore, while many lawyers and doctors, as already indicated in the introduction to this piece, have realized the benefits of interdisciplinary work, such recognition is far from universal. In large part this is due to a lack of resources. Re-framing legal representation on behalf of the indigent disabled as a health-care issue rather than a legal issue can result in greater funding for legal services.¹⁹⁰ But this is not always the case as funding for health-care initiatives has been dwindling as a result of the current economic crisis.¹⁹¹

Medical–legal partnerships have not gained universal recognition in the communities that serve low-income disabled populations because both doctors and lawyers continue to see these partnerships as a luxury or an interesting innovation rather than as an ethical obligation. Examining each professions’ articulation of ethical obligations, and the specific legal context of disability claims, however, reveals that this is not an accurate conclusion for the indigent disabled population.

en-Ways.pdf (last visited Aug. 19, 2014), *archived at* <http://perma.unl.edu/9FB9-HCV9>.

189. See Capowski, *supra* note 135, at 342–43 (describing the inaccuracy of the Social Security process); Low, *supra* note 188, at 1 n.1.

190. Killelea, *supra* note 3, at 455.

191. Killelea, *supra* note 3, at 446–47; Lisa Girion & Mark Medina, *Hospitals Feel Ill Effects of Recession*, L.A. TIMES, Jan. 14, 2009, <http://articles.latimes.com/2009/jan/14/business/fi-hospitals14>, *archived at* <http://perma.unl.edu/Q26A-YZYH>; Stephanie Kirchgaessner, *US Hospitals Face Financial Problems*, FIN. TIMES, Jul. 10, 2012, <http://www.ft.com/cms/s/0/15a0ac02-caa2-11e1-8872-00144feabdc0.html#axzz2dJLBkYbC>, *archived at* <http://perma.unl.edu/FEW9-G6AX>; see also *Investing in America’s Health: A State-by-State Look at Public Health Funding and Key Health Facts*, TRUST FOR AMERICA’S HEALTH (April 2013), <http://healthyamericans.org/assets/files/TFAH2013InvstgAmrcsHlth05%20FINAL.pdf>, *archived at* <http://perma.unl.edu/5X6S-R6BC> (discussing decreasing federal and state funding for public health issues).

VII. CONCLUSION

In a hearing held on September 28, 2010 in the U.S. Senate titled *Do Private Long-Term Disability Policies Provide the Protection They Promise?*, Senator Max Baucus, in his opening statement, made clear what should have been obvious to the courts:

Abusive insurance company tactics start with having doctors with conflicts of interest review claims. Many of these doctors are employed either by the insurance company or by the companies that do a lot of business with the insurance company. These arrangements make it far too easy for the doctors to deny claims, terminate claims, or reject appeals.¹⁹²

So why is the fact that the insurance company pays their doctors for their opinion not considered a conflict of interest for the courts? It is likely because this arrangement is, in fact, a medical–legal partnership. The medical–legal partnership on behalf of the insurance company is no more or less a conflict than that posed for the doctor who is “paid” for his opinion by his patient. So what’s the problem? Not the pay but the unlevel playing field created when an insurance company can and does create medical–legal partnerships while the claimant has no financial ability to create a similar advocacy team on his or her own behalf.

One answer might be to ban or significantly disrupt such partnerships. Whether this is advisable or feasible is beyond the scope of this Article. Instead, I argue for the formation of medical–legal partnerships, modeled after the in-house partnerships that exist on the government or insurance company’s side, but created to serve the interests of the low-income disabled claimant. This population, in particular, needs this attention precisely because of its lack of resources.

Much has been written about the lack of a true safety net for the low-income disabled.¹⁹³ This is in part due to the large denial rate of

192. *Do Private Long-Term Disability Policies Provide the Protection They Promise?*, *supra* note 135, at 1.

193. See Robert J. Landry, III & Amy K. Yarbrough, *Global Lessons from Consumer Bankruptcy and Healthcare Reforms in the United States: A Struggling Social Safety Net*, 16 MICH. ST. J. INT’L L. 343, 347 (2007); Miller-Wilson, *supra* note 184; Thomas Bartlett Wilinsky, *Mending the Safety Net’s Safety Net: The Federal Courts Study Committee’s Proposals for Reforming the Social Security Disability Benefits Review Process*, 18 N.Y.U. REV. L. & SOC. CHANGE 1079, 1080 (1991); Julie Turkewitz & Juliet Linderman, *The Disability Trap*, N.Y. TIMES, Oct. 20, 2012, http://www.nytimes.com/2012/10/21/sunday-review/the-trap-of-supplemental-security-income.html?_r=0, archived at <http://perma.unl.edu/Q3PJ-ENXR>; David Wittenberg, *A Health-Conscious Safety Net? Health Problems and Program Use Among Low-Income Adults with Disabilities*, URBAN INSTITUTE 1 (Sept. 2004), http://www.urban.org/UploadedPDF/311065_B-62.pdf, archived at <http://perma.unl.edu/3L6H-VKT5>.

disability income applications.¹⁹⁴ When a low-income disabled person is denied social security or private disability benefits, or both, there is an appeals process, but the process is long and there is generally no income available while the appeal is pending. The fact that the disabled claimant must wait months, sometimes years, without any source of income has a direct impact on that claimant's health and welfare. Given this, it is easy to see how physicians' professional obligations towards their patients should extend to ensuring that their evidence in support of their patients' disability application is effective. Likewise, an attorney representing a disabled claimant in a disability income proceeding has an obligation to ensure that the evidence gathered is effective.

Despite this, most of the literature surrounding medical-legal partnerships uses language that implies these partnerships are innovative solutions to the complex problems presented by the intersections of poverty, health, and law.¹⁹⁵ These same articles argue that doctors should learn advocacy skills and lawyers should learn healing skills as a more effective way of advancing their patient or client's overall health and well-being.¹⁹⁶ While I do not disagree with any of these statements, they fail to acknowledge that these partnerships are not new and, when enlisted by government and private industry claims reviewers, have increased the denial rate.

Analysis of the case law regarding disability income claims adjudication reveals that there is a gap between the medical evidence and the legal requirements. Such analysis further reveals that government and industry have tried to close this gap by utilizing medical-legal partnerships that work to show why the evidence submitted does not meet the legal standard. Examination of ethical definitions of lawyer and doctor roles show that both are required to competently serve and advocate for the welfare of their clients or patients. Competence, in relation to service of the indigent disabled, requires knowledge of the disability claims adjudication process, including how the medical evidence provided will be examined by the disability claims reviewer and the fact that the claims reviewer is, most often, an interdisciplinary treatment team. In light of this knowledge, competence also requires the corresponding knowledge of how legal definitions should be applied to the medical evidence. This, in turn, can only be learned through interdisciplinary education, training, and cooperation.

194. *Annual Statistical Report on Social Security Disability Insurance Program, 2012*, SOC. SEC. ADMIN., (Nov. 2013), http://www.ssa.gov/policy/docs/statcomps/di_asr/2012/di_asr12.pdf, archived at <http://perma.unl.edu/R4X8-64HT>. Unfortunately, private denial rates do not appear to have been recorded.

195. See, e.g., Killelea, *supra* note 3; Scott, *supra* note 3; Tyler, *supra* note 3.

196. See, e.g., Scott, *supra* note 3.

Acknowledging the existence of these government and private medical–legal partnerships is important to understanding why creating these on behalf of the low income disabled is not only a good idea but necessary for effective treatment and representation. It is this narrow but critical obligation—the parameters of ethical advocacy on the part of both the doctor and the lawyer who serve the low income disabled—that has been the focus, therefore, of this Article.

While the limited services provided to low-income communities are understandable, they are not, as I argue, ethically justifiable. Ethical obligations of doctors and lawyers do not include caveats that exempt these professionals when there are not sufficient resources for them to be able to maintain their ethical obligations.