

Mandate for a Uniform and Affective Justice

The underlying assumption of the Social Security disability programs is that they can be administered fairly and equitably. Fairness and equity are arrived at through a uniformity in disability decision making, which is further enhanced by a series of doctrinal protections, all of which are also designed to protect the federal coffers from illegitimate claims. Often, as the evidence of prejudice in the system will reveal in subsequent chapters, these goals conflict as judges scramble to compromise these objectives through the decision-making process.

To ensure that the disability programs are fair in allocating benefits, Social Security devised several substantive and procedural mechanisms to adjudicate the claims of each American who applies. Of these mechanisms, the following five are considered essential to ensuring uniformity: (a) the listings of impairments that form a standard measure of disabilities; (b) a requirement that disabling conditions be verified by objective medical evidence; (c) the medical-vocational guidelines, or “Grid,” that consider vocational factors; (d) a five-step sequential evaluation process that dictates the order in which decisions are made; and (e) an appeals procedure that grants dissatisfied applicants a hearing before an impartial administrative law judge.

In this chapter, I describe how these mechanisms form a part of Social Security’s commitment to impartiality and to distinguishing the deserving from the undeserving. More importantly, however, this chapter provides necessary background for my developing thesis that Social Security’s attempts to make decision making impartial through the use of these mechanisms has failed because these rules not only are themselves biased but also are often disregarded by the adjudicators mandated to adhere to them. Moreover, in practice, these rules all too often conflict with those

mandates that direct judges to affirmatively accommodate and engage claimants in the hearing process. This conflict manifests most dramatically in the narratives of the denied cases presented in chapters 4, 5, and 6, which document the ALJs' consistent predilection to criticize claimants or be biased and never or rarely to positively accommodate or engage the claimants who appear before them.

The Listings of Impairments

The listings of impairments (the "listings") are lists of medical criteria against which every applicant's medical condition is compared (20 C.F.R. 404, subpt. P, app. 1). The listings describe more than 100 medical conditions by their symptoms, signs, and laboratory findings. For each condition, the listings also establish levels of severity that can usually be presumed to result in an inability to work.

The listings attempt to standardize the disability application process because they measure each recognized condition by the same criteria. In two very straightforward examples, applicants who are mentally retarded will be judged "disabled" according to the listings if their IQ is 59 or less (20 C.F.R. 404, subpt. P, app. 1, 12.05 B), and claimants who have one foot and one hand amputated will also be judged "disabled" under the listings (20 C.F.R. 404, subpt. P, app. 1, 1.09 C).

Symptoms reflecting the applicants' own perceptions of their impairment carry little or no weight unless supported by visible signs or laboratory findings that are considered "objective medical evidence" (42 U.S.C. § 423 (d) (5) (A)). If the claimant's medical condition is the same, similar to, or worse than the description in the listings, the claimant automatically is determined to be disabled.

The requirement that adjudicators make disability decisions based on "objective medical evidence" is among the most important safeguards afforded to disability claimants. Underlying this requirement is the assumption that if disability decisions are based on objective medical evidence, the adjudicator's possible biases with regard to issues such as a claimant's illness, race, or gender will be prevented from penetrating the process.

If claimants' conditions do not meet the listings, they are judged on additional criteria, including age, education, and previous work experience, as described in detail later in this chapter.

The Requirement That Disabling Conditions Be Verified by Objective Medical Evidence

To recognize a condition as disabling, the Social Security system requires that the symptoms be verified by “objective medical evidence”—that is, by visible signs or laboratory findings made by physicians (42 U.S.C. 423 (d) (5) (A)). This requirement is considered central to ensuring that the application process is fair and unbiased and that it disqualifies all but the truly deserving. The objectivity of medical evidence, however, naturally depends on the physicians who generate, interpret, and explain it.

Four types of physicians play critical roles in the disability decision-making process: the applicant’s treating physician, consultative examiners (CEs), disability determination services (DDS) physicians, and medical experts (MEs). The applicants’ own physicians are the most influential of these groups because Social Security regulations grant controlling weight to the opinions of treating physicians as long as they are well supported by clinical and laboratory findings and not inconsistent with other evidence in the record (Social Security Rulings 1996 96-2P). Treating physicians, or personal physicians, provide disability adjudicators such as judges with clinical impressions and diagnoses in the form of photocopied medical records and specially prepared medical reports.

CEs are paid by a state agency to examine an applicant (usually only once) and to provide medical findings and reports only when applicants cannot afford a treating physician or when treating physicians refuse to cooperate or are deemed unqualified (20 C.F.R. 404.1517). When a claimant is required to visit a CE, the doctor will both examine and interview the applicant and give a medical impression according to that single meeting.

In every case, at least one physician from the DDS, a state agency that helps make disability determinations for the federal government, evaluates the applicant’s medical file at the first two stages of the application process to make findings of fact about the medical evidence and what additional tests are needed (20 C.F.R. 404.1527 (f) (1)). The DDS assesses the medical records and reports to determine the eligibility of the claimant for benefits. Unlike CEs, DDS physicians have no direct contact with the applicant.

Finally, MEs advise ALJs in cases where judges require assistance in

interpreting medical evidence at the hearing. The MEs never examine the claimant but make their assessments based on their review of the medical records and their impressions of the claimant's testimony at the hearing. Typically, MEs attend claimants' hearings and decide whether applicants meet or equal a listing and how their medical impairment limits their ability to perform job-related activities (20 C.F.R. 404.1527 (f) (2)).

In sum, physicians help satisfy the requirement that disabling conditions be verified by "objective" medical evidence. This mechanism, therefore, assumes both that medical evidence is objective and that the people generating that evidence are unbiased in the methods applied when ordering and evaluating clinical tests.

The "Grid"

The medical-vocational guidelines, commonly referred to as the "Grid," are a standardized set of rules from the Code of Federal Regulations that are laid out in grid format. These factors become relevant in a disability claim when an applicant's condition does not meet or equal the listings. Adjudicators are required to render disability decisions based on the Grid's recommendation (20 C.F.R. 404, subpt. P, app. 2). In cases in which an impairment restricts an applicant's physical capabilities, disability adjudicators rely on the Grid roughly as follows. Adjudicators take into account the applicants' remaining physical capabilities—that is, their "residual functional capacity," along with other factors including age, education, and previous work experience—and refer to the Grid for a standardized determination of what employment possibilities still exist. For example, according to the Grid, a physically disabled 55-year-old woman with an eleventh-grade education and previous experience as a retail salesperson would be found "not disabled" if she had residual functional capacity—that is, she still retained the ability to perform telephone sales sitting at a desk (20 C.F.R. 404, subpt. P, app. 2, 201.03). The Grid is therefore facially neutral and hence objective insofar as it standardizes decision making by plugging applicants into a predetermined decision-making formula.

The Five-Step Sequential Evaluation Process

The five-step sequential evaluation process, the fourth mechanism designed to increase objectivity and promote uniformity in disability deci-

sion making, requires adjudicators to evaluate each disability claim in a prescribed order. Adjudicators must follow the five-step sequence throughout the application and appeals process.

The process for determining each disability claim begins with the DDS, the state agency hired by the federal government to evaluate the medical grounds of the claim and to supplement them as needed. The federal government contracts this function out to state agencies so that initial and reconsideration-stage medical workups and evaluations are made in the claimant's home state. This delegation makes sense because state-run agencies have stronger institutional ties to the professionals and local agencies needed to process and adjudicate claims.

A DDS evaluation is carried out by a team of examiners that includes a physician who is well-versed in the rules (20 C.F.R. 404.1527 (f) (1)). As noted, DDS evaluators base their decisions exclusively on medical and related records and reports; they have no face-to-face interviews with applicants. As the first step of the sequential evaluation process, DDS adjudicators establish whether applicants are working. Work is defined as involving "significant physical or mental activities" and is done "for pay or profit" (20 C.F.R. 404.1572 (a), (b)). If claimants are working, benefits are denied. If claimants are not working, their cases proceed to step two in the sequential evaluation process.

In step two, evaluators determine whether the claimants' impairments are "severe." An impairment is considered severe when it significantly affects a person's ability to work. If the claimants' impairments are considered nonsevere, the claim is denied; if they are found to be severe, the claims proceed to step three.

In step three, evaluators consider whether the applicants' medical problems meet or equal the conditions defined in the listings of impairments. If the condition matches or exceeds the listings requirement, the claimant automatically qualifies for benefits. If the condition is closely related but not identical to the definition in the listings, the DDS adjudicators determine whether the impairment is "close enough" to the listings. If they assess the documented condition as "close enough," the claimants are found disabled on the theory that their conditions "equal" the description in the listings (Social Security Rulings 1986, 86-8). If the applicants' conditions are assessed as less severe or are not included in the listings, evaluators proceed to step four.

At step four, a claim is denied if evaluators conclude that the appli-

cants' conditions do not prevent them from doing work they did in the past. If the applicants are found incapable of performing their past work, evaluators move to step five.

In this final step, adjudicators assess the claimant's "residual functional capacity"—that is, whether the alleged medical condition affects the claimant's ability to perform activities common to many kinds of work, including sitting, standing, walking, lifting, carrying, pushing, and pulling (Social Security Rulings 1983, 83-10). To make this assessment, adjudicators also consider the applicant's age, education, and work experience (Social Security Rulings 1983, 83-10). Taking all these factors into account, evaluators decide whether the applicant is physically or mentally capable of doing any full-time work in the national economy. If the impairment is physical, the Grid is applied to make that final decision; otherwise, the adjudicator evaluates the claim in light of the physical and mental impairments alleged. If claimants are found capable of working, their disability claims are denied. If they are found incapable, their claims are approved.

In sum, this five step-process further standardizes decision making by ensuring that each applicant's case is given the same procedural and substantive treatment.

The Appeals Process

The final mechanism designed to ensure applicants a fair and uniform determination is an appeals procedure that grants dissatisfied applicants a hearing before an ALJ. It is useful to characterize the hearing process in the context of the overall application procedure.

Eligibility for disability benefits begins with an application that is initially processed by a claims representative at a Social Security district office. Social Security claims representatives do not themselves make substantive disability determinations. Rather, they help applicants fill out necessary forms, forward all the relevant paperwork to the DDS for a decision, and process approved claims.

If the application is denied, the applicant has recourse to various levels of appeal. The first of these, called a reconsideration, allows the applicant to submit additional medical or other related evidence to a team of DDS examiners but does not usually include a face-to-face interview (20 C.F.R. 404.913).¹ The chances of a favorable decision at the reconsideration stage are relatively low. Of the 2.5 million Americans whose initial

applications were reviewed in 1993, approximately 60 percent were denied benefits (U.S. House 1994, 57). That same year, only 48 percent of those whose initial applications were denied applied for a reconsideration, and 86 percent of them were again denied benefits (U.S. House 1994, 57).

More recently, Social Security has attempted to improve and streamline the application process. The SSA's "Reengineering" or "Disability Redesign" Plan proposes to reduce the length of the application procedure in half and to make decisions between adjudicators more consistent (GAO 1997; NOSSCR 1998). Although this plan is moving forward, it will be several more years before it can be fully implemented and the benefits, whatever they will actually be, can be realized.² Some minor changes, however, have already been detected. In 1996, 2.4 million applications were received, with a denial rate of 69 percent, compared to the 60 percent rate 3 years earlier. Fifty percent of denied applicants requested a reconsideration, and 87 percent of them were denied reconsideration (GAO 1997). If these numbers suggest a trend, Social Security's reengineering effort should render fewer applicants eligible for benefits overall. As discussed later, those that are eligible are more likely to be found disabled at the initial or reconsideration stages.

At the second appeal, applicants are guaranteed a face-to-face hearing before an ALJ. Indeed, the hearing transcripts and decisions that form the basis of my work are taken from this stage of the decision-making process. As federal adjudicators, judges are explicitly directed by the U.S. Code to be fair and impartial, and they are required to comply with the listings, to base decisions on objective medical evidence, to employ the Grid, and to follow the five-step sequential evaluation process (42 U.S.C. § 405 (b) (1)). The ALJs are also mandated to serve not only as judges but also as "prosecutors" for Social Security (no agency representative, other than the judge, who is supposedly "independent," is present at the hearing). If the claimant is unrepresented, the judge is also charged with helping the claimant manage the hearing or otherwise to act as a kind of "defense" counsel.

In addition to these safeguards, ALJs are required to follow a number of other procedural and substantive rules and regulations. This second stage is probably the system's most important protection for applicants (Taibi 1990). In fact, as detailed later, ALJs award benefits to more applicants than do initial and reconsideration evaluators.

Among the several important procedures judges are bound to follow is the hearing notification process, which is regulated by *Hallex: Hearings*,

Appeals and Litigation Law Manual. Hearing notices inform claimants of the time and place of the hearing and whether an expert will be present. The notice, which is usually in English but is also available in Spanish, informs applicants that the hearing is informal and that they have a right to representation.³ Usually, the notice includes a list of legal-services agencies and other organizations available to represent claimants on their cases. In the first quarter of 1997, 58.9 percent of claimants appearing before Social Security ALJs were represented by an attorney (SSA 1996–97). Of the favorable decisions awarded in 1997, 58.6 percent of claimants were represented, while 39.3 percent of the favorable decisions were issued to claimants who were unrepresented (SSA 1998).

Hearing conduct and procedure are also regulated by *Hallex*. In general, claimants arrive at the OHA with their attorneys or representatives half an hour before the scheduled hearing time. This period enables claimants to review, usually for the first time, their medical records, which have now been placed in a folder called an exhibit file.

When the hearing is about to begin, a hearing assistant (someone who helps the ALJ with the hearing proceedings) calls claimants and their attorneys (if applicable) into the hearing room. When claimants enter the hearing room, most judges are already seated. Judges sit at a large, raised, wooden desk and generally wear a judge's robe (although *Hallex* does not require judges to do so).

Once the proceedings begin, *Hallex* requires judges to introduce themselves to claimants and to present an opening statement that explains the following: (a) the manner in which the hearing will proceed, (b) the procedural history of the case (that the case was previously processed by DDS adjudicators and when), and (c) the issues that the judge will resolve (i.e., a claim for DI or SSI) (SSA 1992, I-2-650; I-2-652). Usually within the opening statement, judges describe how the hearing process will proceed—that is, that they will take the claimants' testimony by asking questions and by providing the attorneys the opportunity to ask questions.

If the claimant is not represented by an attorney, the judge "must secure on the record an unrepresented claimant's acknowledgment of the right to representation and affirmation of the claimant's decision to proceed without a representative" (SSA 1992, I-2-652). Although Social Security judges are not mandated to provide representation, as in criminal cases, obtaining what is called the "acknowledgment and waiver" of the Social Security claimant's right to an attorney is still key given its practical significance. This mandate extends even further. Should the claimant not

be represented, the judge has an affirmative duty, described more fully in chapters 4 and 5, to assist the claimant through the hearing process. This constitutes the second instance, in addition to the opening statement, in which judges are affirmatively mandated to make the claimant's journey through the hearing process as emotionally hospitable as possible.

Next, the ALJ administers an oath to the claimant and any witnesses present at the hearing, including vocational and/or medical experts (SSA 1992, I-2-654). Following the oath, the judge must determine from the attorney or claimant whether the exhibits have been examined and whether there are any objections to the records contained in the exhibit folder (SSA 1992, I-2-658). When such objections are raised, they are usually against a particular medical report or record prepared by a physician who never or only briefly examined the claimant.

The primary purpose of the hearing is to give claimants an opportunity to present their cases before an ALJ and to prove that they suffer from physical or mental impairments that are severe enough to prevent them from working. In addition, the hearing gives the judge an opportunity to evaluate claimants face to face, to question claimants about their impairments, to resolve ambiguities between the medical evidence and the claimants' complaints, and most importantly to evaluate the claimants' credibility with regard to symptoms that are hard to verify with objective evidence, such as pain and fatigue (Social Security Rulings 1996, 96-7p). These credibility determinations are regulated both by agency policy in the form of rulings and by federal common law, which has evolved to help standardize the way judges evaluate subjective concerns, such as: Is the applicant's pain disabling? Do the applicants' impairments really prevent them from working six to eight hours a day? Finally, ALJs are in many cases mandated to use the hearing to determine whether they should order further medical examinations or tests to consider impairments not fully developed in the record. For example, it is not uncommon for a mental impairment to go undeveloped in the record until an ALJ meets the claimant and orders an evaluation or for a claimant's heart condition to be considered nonsevere until testimony reveals otherwise. This too represents the judge's affirmative duty to develop the claimants' cases and to ensure that the evidence in the exhibit files adequately reflects the extent and nature of the impairments.

There is no standardized length of time for a hearing, although they usually last from 30 to 45 minutes. Some are as short as 10 minutes, and some last as long as 90 minutes. Sometimes a hearing takes longer because

judges have medical or vocational experts who assist them with the cases' technical aspects.

Following the hearing, judges wait for any additional evidence to be submitted and then write decisions, supporting their findings with "their reasons for the decision," "based on evidence offered at the hearing or otherwise included in the record" (20 C.F.R. 404.953). *Hallex* rules explicitly govern how a decision should be prepared: they direct the ALJ to "avoid using emotionally charged words, pejorative terms, and personal judgments or opinions, even if the harmful language appears in evidence or testimony" (SSA 1992, I-2-835A1). In essence, *Hallex* mandates that judges respect claimants and balance the interests of eliciting testimony against the aggression that all too often manifests in judicial proceedings involving people who are distinctly less advantaged than the adjudicators hearing their claims.

ALJs grant the highest rate of awards of any adjudicators in the Social Security disability system. Of the applicants denied benefits at reconsideration in 1993, 54 percent requested a hearing. Of the more than 240,000 cases heard by ALJs that year, 68 percent were ruled eligible for disability benefits (U.S. House 1994, 57). One of the most dramatic changes detected from SSA's efforts to redesign the decision-making process has been in ALJ award rates. Studies reveal that since redesign was implemented, OHA allowance rates have dropped 11 percent (NOSSCR 1998).⁴

If denied benefits at the hearing stage, claimants may appeal their cases at four more levels: the Appeals Council, an administrative appeals branch of the SSA located in Washington, D.C.; U.S. District Court; U.S. Circuit Court; and finally the U.S. Supreme Court. Approximately 60,000 cases are considered by the Appeals Council each year. In 1993, the majority of these appeals—70 percent—resulted in a denial of benefits. Of the cases denied at the Appeals Council, 10 percent were appealed to U.S. District Court (U.S. House 1994, 57). At district court, judges review cases to be sure the ALJ had substantial evidence on which to deny the claim. District courts can deny or grant cases or order remands—that is, send cases back to ALJs either for further evidentiary development or for additional hearing proceedings. If a case is denied at district court, an applicant can appeal to U.S. Circuit Court. Approximately 8 percent of cases are appealed to circuit court. Very few cases are appealed to the Supreme Court.

Although, in theory, these substantive and procedural mechanisms are designed to ensure that DDS adjudicators and ALJs are bound by sim-

ilar rules and procedures, there is evidence presented in the next chapter and in several studies described therein that suggests both that the mechanisms themselves may be inherently biased and that disability decision makers are often inconsistent, inaccurate, and even prejudicial in their practices. It is important first to describe what other procedures accompany and complement these uniform measures to better understand how the disability decision-making process has become riddled with contradictory and conflicting mandates.

Mandate for an Affective Justice

The adjudication of disability claims, like most judicial procedures in the United States, addresses the ultimate goal of making fair and impartial decisions by using two principal, often conflicting, approaches: on the one hand, it employs techniques such as objectivity or emotional distance, cross-examination, and uniformity; on the other hand, it mandates that judges accommodate and engage claimants, identify and distinguish differences, and ensure that all participants receive the individual treatment they deserve. In this regard, the process is simultaneously withholding and giving, rule bound and engaging, preoccupied with treating everyone the same yet recognizing and treating differences as the circumstances might demand.

Whereas the first section of this chapter focused almost exclusively on procedural and substantive mechanisms that make the disability decision-making process uniform, this section describes those rules and procedures that mandate that judges tailor their proceedings to claimants' particular needs, needs that often require judges to identify special traits of claimants needing individualized treatment. The conflict lies in the fact that the uniformity rules dictate that judges apply the rules similarly to similar applicants (to put aside biases), whereas the rules described in this section specifically require judges to distinguish claimants according to certain unique traits and to provide a hearing process that takes those differences into account.

As chapter 3 will demonstrate and the evidence already presented has intimated, the Social Security system as a whole and ALJs in particular have a well-documented history of identifying particular characteristics of claimants to disadvantage them—that is, to bias the decision-making process against them. Chapter 5 will show that in the denied cases reviewed, judges were resistant to using identifying characteristics in any

positive sense, to accommodate the special needs of less advantaged claimants or to engage them in the otherwise uniform and bureaucratized process of disability decision making.

Before describing in some detail the mechanisms of accommodation and engagement, it is important to note that these procedures, all embedded in doctrine in one form or another, are no less important than the so-called uniform mechanisms described in the previous section.⁵ The only difference is that these mechanisms require judges to affirmatively accommodate or engage claimants and/or their evidence. Painfully, the judges in my small sample fail on all scores—they are capable neither of uniformly applying rules to render fair decisions (of putting aside their biases) or of meeting their affirmative duty to accommodate or engage claimants through the hearing process (of using the differences deemed relevant in the decision-making process to protect those claimants who by law are entitled to that protection).

Doctrinal Foundation for an Affective Justice

The U.S. Supreme Court has held that an ALJ has the ultimate responsibility for ensuring that every claimant has a full and fair hearing (*Richardson v. Perales*, 402 U.S. 389 (1971)). Social Security case law likewise requires the ALJ to “scrupulously and conscientiously probe into, inquire of, and explore for all the relevant facts . . .” (*Hennig v. Gardner* 276 F. Supp. 622, 624 (N.D. Tex. 1967); *Gold v. Secretary of Health, Education and Welfare*, 463 F.2d 38, 43 (2d Cir. 1972)).⁶ This mandate holds whether or not a claimant is represented by counsel but particularly if a claimant has “ill health” or an “inability to speak English well” (*Gold v. Secretary of Health, Education and Welfare*, 463 F.2d 38, 43 (2d Cir. 1972)).⁷

To develop their records fully, all Social Security disability applicants require some accommodation or assistance because they are all either physically or mentally ill. However, several claimants have needs that case law identifies as requiring special accommodation or that other research strongly suggests requires such accommodation.⁸ In this regard, unrepresented claimants, people who are illiterate, applicants with a limited education, applicants with mental impairments (including addictions), and applicants who do not speak English well have all been legally recognized as requiring special accommodation.

Under certain circumstances, socioeconomic status also presents needs that require special accommodation. For example, when claimants

cannot afford to obtain medical records or reports needed to validate their claims, an ALJ has an affirmative duty to obtain relevant records and reports (20 C.F.R. 404.950(d); 20 C.F.R. 416.1450(d)).

The mandate to accommodate claimants with special needs is derived from the broad requirement that judges “scrupulously” and “conscientiously” probe the issues, ensuring a full development of the record.⁹ Accommodation requires judges to make an affirmative effort to ensure that claimants’ special needs are addressed. Such accommodation differs depending on the special need of the claimant. Briefly, minimum accommodation for people who are unrepresented and illiterate, lack an education, or have difficulty reading English requires judges to inquire whether the claimants can read or comprehend the exhibit file on which the disability decision largely rests. Accommodation of claimants who are illiterate, lack an education, have difficulty reading English, or have a mental impairment—regardless of whether they are represented—requires judges to be patient, understanding, and especially inquisitive to ensure that all the facts in the case are uncovered given the particular difficulty such claimants may have in articulating their problems. The failure-to-accommodate requirement stems from the mandate that “[a]ll Americans seeking assistance from their Government must know that the principles of fundamental fairness and equity will be afforded them regardless of race, sex or national origin” (Labaton 1992).

In sum, legal safeguards designed to accommodate and engage such claimants as the unrepresented, the illiterate, the uneducated, those suffering from mental impairments, and those who do not speak English well are deeply embedded in legal doctrine and in constitutional law. In theory, these safeguards are designed to ensure that claimants who are at an inherent disadvantage due to their differences from the majority culture in general and ALJs in particular are treated with the special care they require to negotiate an otherwise uniform system that allegedly treats everyone as competent and capable of presenting their case.

In the next chapter I explore whether the rules themselves are susceptible to bias and examine the record of physicians who generate and interpret medical evidence for the system. In addition, I review the studies that predate my research and provide foundational material for exploring ALJ decision-making practices in more depth.