May 1971

The Disability Insurance Benefits Program and Low Income Claimants in Appalachia

James B. Haviland
Michael B. Glomb

Follow this and additional works at: https://researchrepository.wvu.edu/wvlr

Part of the Insurance Law Commons, and the Law and Economics Commons

Recommended Citation
Available at: https://researchrepository.wvu.edu/wvlr/vol73/iss2/3

This Article is brought to you for free and open access by the WVU College of Law at The Research Repository @ WVU. It has been accepted for inclusion in West Virginia Law Review by an authorized editor of The Research Repository @ WVU. For more information, please contact researchrepository@mail.wvu.edu.
THE DISABILITY INSURANCE BENEFITS
PROGRAM AND LOW INCOME
CLAIMANTS IN APPALACHIA*
JAMES M. HAVILAND** AND MICHAEL B. GLOMB***

This article discusses the difficulty substantial numbers of low
income West Virginians encounter in establishing their eligibility for
Disability Insurance Benefits under section 233 (d) of the Social Se-
curity Act.1 These persons are characteristically middle-aged, un-
skilled workers who lose their employment as the result of a mental
or physical condition of a non-traumatic, chronic origin. Because of
their medical condition, combined with their advancing age and lack
of skills, these persons are "disabled", yet they are denied Disability
Insurance Benefits.

An analysis of twenty-six "difficult" claims denied on the first
filing, but refiled, reveals a pattern of unjustified denials in the pri-
or filings.2 The claims were denied for two reasons: (1) erroneous in-

*This article was prepared under O.E.O. grant no. CG-8308 A/O, and
and the Office of Economic Opportunity reserves a royalty-free, non-exclusive and
irrevocable license to reproduce, publish, or otherwise use, and to authorize
others to use any copyrightable materials resulting from work performed under
this grant. Opinions expressed herein are not necessarily those of the grantor.
**Attorney at Law, Charleston, W. Va.; B.A., 1964, Westminster College;
J.D., 1967, University of Michigan; Member W. Va. and Mo. Bars.
***Attorney at Law, Charleston, W. Va.; B.A., 1966, J.D., 1969,
Georgetown University; Member W. Va. Bar.

1 42 U.S.C. § 423(d) (1964) (hereinafter referred to as § 223(d) ).
The Disability Insurance Benefit program, commonly referred to as Social
Security disability, contained in 42 U.S.C. §§ 401 et seq. (1964), was originally
adopted in 1956, some twenty years after the adoption of the federal "Social
Security Program" contained in Title II of the Social Security Act. Unlike
the depression-bred Social Security program, the Disability Insurance Benefits
program was "adopted in a period of affluence [when] disability had risen
in prominence as a remaining cause of poverty . . . . An unusually strict
definition of disability was adopted, which . . . . amounts for all practical
purposes to permanent and total disability in its classic meaning." Pollock,
Disability Insurance under Social Security, in OCCUPATIONAL DISABILITY AND
PUBLIC POLICY 172 (E. Cheit, M. Gordon eds. 1963) [hereinafter cited as
Pollock].

2 The authors have represented numerous elderly and functionally aged
low income persons who could not otherwise obtain representation in applying
for Disability Insurance Benefits. The article is based on an analysis of
twenty-six claims for Disability Insurance Benefits selected at random, from
the cases the authors have represented, for study because the claims were
denied by the Social Security Administration one or more times, and because
the claimants consented to lengthy personal interviews. The cases studied
are typical of the type of claimant who may seek legal assistance after
interpretation by the Social Security Administration of the medical proof of disability requirements of Section 223(d) and faulty evaluation of medical evidence; and (2) unreasonable application of two statutory eligibility criteria—the "national employability test" and the "current insurance requirement." The bulk of this article will explain this pattern of error in interpretation and application of section 223(d) so that the exact nature of the errors may be understood. Once the problem areas of the law and regulations are identified, they may be overcome, to some extent, by advocacy, or corrected through reform measures undertaken by the Administration itself, by Congress, or in the courts.

I. PROFILE OF LOW INCOME APPALACHIANS STUDIED

A. PROFILE-AGE, VOCATIONAL SKILLS, CAUSE OF DISABILITY

The bulk of persons in the study, about sixty per cent, were between ages 45 and 60. All of these persons had been employed having their claims denied by the Social Security Administration. Most cases were refiled; a few were handled at the appeals stages of the original filing. Thus far, twelve of the twenty-six claims have been granted, twelve are pending, none have been lost, and two were not filed as they were deemed to be without merit. In all twenty-six cases, the reasons for the denial have been carefully studied in order to determine why the claimants lost the first time, since many have been awarded benefits on second filing and more claims awards are anticipated. The characterization "difficult" denotes Disability Insurance Benefits claims in which either the complexity of the eligibility requirements in question, or the discovery of hard to get evidence, or both, present proof of eligibility problems, which ordinarily would require that the claimant obtain private representation to substantially increase chances of a favorable determination. This classification of cases is based on our conclusion that the claimants studied did not receive adequate assistance from the Social Security Administration in developing their own claims on their first application. Other conclusions which may be drawn from the study are outside the scope of this article. The lack of coordination between the Disability Insurance Benefits program and the federal-state Vocational Rehabilitation program causes many persons who are unable to work to be denied both disability benefits and vocational rehabilitation. The absence of a publicly-funded medical benefits program for the moderately or severely disabled results in many persons becoming disabled who might otherwise recover their working capacity. Many severely disabled persons live in desperate need of medical care. For the disabled, medical care benefits are nearly as essential as the income benefits provided by the Disability Insurance Benefits program. The deteriorating medical conditions of many persons studied were caused in part by the inadequate delivery of health services. Finally, as discussed herein, the idea of evaluating disability on the basis of pathology norms—the presumptive proof of disability by evidence of pathology method—should be questioned on many scientific grounds.

3 Hereinafter referred to as the Administration.

4 Both the "national employability test" and the "current insurance requirement" will be discussed at II (A) and (B), infra.
most of their productive lives, an average of 25 to 30 years. Of the
26 persons studied only 4 were forced to leave their employment
by traumatic injury (job related or not), while 19 were forced to
leave their primary employment because of physical or mental con-
ditions of a non-traumatic origin. Some examples of disabling physi-
cal or mental conditions of a non-traumatic origin include occupa-
tional respiratory dust diseases which develop over a period of years
with associated damage to other body organs such as the heart;
"nerves", a psychiatric problem which usually expresses itself in the
form of fainting spells or physiological complaints such as shortness
of breath or skin reactions; and arthritic pain and motion limitations
which may be related to present injuries of the bones and joints.
More than half of those persons who left employment due to non-
traumatic conditions suffered from cross-system complaints, a com-
bination of abnormalities which develop slowly in different body sys-

5 Profile of persons in the study.

Sex: Male 25, Female 1

<table>
<thead>
<tr>
<th>Years Worked</th>
<th>Age Younger than 40</th>
<th>40-45</th>
<th>46-50</th>
<th>51-55</th>
<th>56-60</th>
<th>Older than 60</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below 5</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5-10</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11-15</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16-20</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21-25</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26-30</td>
<td>4</td>
<td></td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31-36</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>More than 36</td>
<td></td>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total for each age group</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

Employment
Skilled—2, Semi-Skilled—3, Unskilled—21.

Type of Work

"Unemployed, unskilled, and marginal workers are, however, increasingly
disadvantaged . . . as they age. Biological capacities diminish without a
compensating increase in skills, specialized competence, occupational adaptation,
or employment security." The author concludes that "severe disability"
(disability which causes inability to work or work regularly) increases sharply
with age. Haber, The Effect of Age and Disability On Access To Public
Income-Maintenance Programs, HEW, The Social Security Survey of the
tems, no one of which would be disabling by itself.  \( ^{6} \) Under existing regulations, it is more difficult to prove that "total disability" is caused by complaints affecting more than one body system when no single impairment is disabling. \(^{7} \)

B. THE DISABILITY INSURANCE BENEFITS PROGRAM DID NOT PROVIDE THE "FIRST LINE OF DEFENSE" AGAINST LOSS OF INCOME FOR THE PERSONS STUDIED.

Although the Disability Insurance Benefits program, as part of the broad Social Security program, is supposed to provide the "first line of defense"\(^{8} \) against loss of income to persons and the dependents of persons who lose their primary source of income—employment—due to disability, it is interesting to note that although most of the persons in the study applied for disability benefits once they were disabled, only one person received the benefits. More than one-third had to rely upon various forms of categorical assistance under the

---

\(^{6}\) Reasons for leaving primary employment.

I. Health Impairment—23

<table>
<thead>
<tr>
<th>Type</th>
<th>Trauma</th>
<th>Non-Trauma</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Single System</td>
<td>Cross System*</td>
</tr>
<tr>
<td>Musculoskeletal System (injuries, arthritis)</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Special Sense Organs (hearing loss, etc.)</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Respiratory System (black lung, tuberculosis, shortness of breath)</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Cardiovascular System (high blood pressure, heart disease)</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Neurological (multiple sclerosis, etc.)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Mental (&quot;nerves&quot;, neuroses, psychoses)</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

II. Unemployed—3

* Indicates total number of times impairment of one body system combined with impairments of other systems contributed to loss of primary employment. Total number of persons studied who suffered from cross system complaints is ten. All three of those persons who left employment due to unemployment subsequently developed disabilities of a non-traumatic origin.

\(^{7}\) Although 20 C.F.R. § 404.1502(a) (1970) does allow disability to be established by a combination of impairments, the criteria are so vague as to be of little assistance in preparing such a case.

\(^{8}\) At the time of the passage of the original Disability Insurance Benefits program in 1956, Senator George referred to public assistance as the "second line" of defense against loss of income due to disability, thereby inferring that the newly enacted program was to be the first line of defense. Pollock, supra note 1, at 168.
federal public assistance programs for income maintenance. It is also significant that it took, on the average, between two and three years to receive a final determination of eligibility or ineligibility for the Disability Insurance Benefits program. Once primary employment was lost, the physical or mental condition which caused disability in the first place deteriorated in every case.

The hypothesis of this article is that the Disability Insurance Benefits program is not geared to the pattern of cases described herein, and, accordingly, will not work well for a predictably significant group of claimants throughout the nation who suffer from chronic diseases or injuries of a non-traumatic nature. Rather, the program is geared to the more middle-class claimant who has worked on a regular basis all of his life until some traumatic event robbed him

---

9 After loss of primary employment, the persons studied received an average of between $100 to $150 per month. Eight persons received Public Assistance benefits, three received Veterans benefits, two received private pensions and four received wage income. None received Disability Insurance Benefits.

10 Number of years between filing with Social Security Administration and final disposition of the claim by Social Security Administration on first application.

<table>
<thead>
<tr>
<th>Number of Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

Level of Administrative claims procedure before being abandoned or receiving final disposition.

1. Initial (20 C.F.R. § 404.905 (1970)) 4
2. Reconsideration (20 C.F.R. § 404.909 (1970)) 1 11
3. Hearing (20 C.F.R. § 404.914 (1970)) 1 1
4. Appeals Council (20 C.F.R. § 404.942 (1970)) or judicial review in federal court (20 C.F.R. § 404.951 and 42 U.S.C. § 405(g) (1970) ) 2 1 1
5. Abandoned 1

* Three claims of the twenty-six discussed here had not been filed before taken under study.

11 In such an institution [Social Security Administration] it is necessary that the external participants, here the claimants, fit the images of themselves which have been programmed into the system. They must apply for benefits when they are supposed to apply, in the numbers which have been anticipated, according to the bureaucracy's understanding of entitlement and its statistical analysis of the insured population. They must provide the correct information or evidence which establishes entitlement to benefits. The most predictably dependent claimants are of course the middle class, and the social security program in this sense as well as others is a typical middle-class institution.

Viles, The Social Security Administration Versus the Lawyers . . . and Poor People Too, 39 Miss. L.J. 370, 392 (1968) [hereinafter cited as Viles].
of his ability to work. This person would usually have little difficulty with the medical evidence requirement in establishing that he is suffering from a physical or mental impairment—this could be documented by the trauma itself and his subsequent medical treatment for that trauma. Since the onset of his disability can be pin-pointed, he will have little difficulty with the current insurance requirement.\(^1\)

The pre-existing skills and residual capacity for retraining of our hypothetical middle-class worker make him more suited for rehabilitation for jobs which actually exist in the "national economy."\(^3\) For the middle class worker, the "national employability test" may be a realistic standard of employment, but for the type of person described in this study, it is not a realistic test, since his age, existing skills, and lack of trainability severely limit the likelihood of his rehabilitation.

The hypothesis, that the persons studied herein do not fit the programmed image of the Disability Insurance Benefits program, should alert the advocate to the fact that in presenting the cases of claimants who fit into the factual pattern discussed, he will be "swimming against the current" of the programmed image. To the reformer, the value of the hypothesis is that it identifies the basis of the need for reform of the Disability Insurance Benefits program as it affects the type of claimant discussed.

II. CERTAIN STATUTORY REQUIREMENTS AND CLAIMS DETERMINATION PROCEDURES FORM A STRUCTURE OF ELIGIBILITY REQUIREMENTS WHICH CAUSED THE DISABLED PERSONS STUDIED TO BE DENIED DISABILITY BENEFITS

A. PRIMARY PROOF OF DISABILITY, THE INABILITY TO FUNCTION OBJECTIVELY DEMONSTRATED, IS IGNORED IN FAVOR OF SECONDARY SUPPORTIVE MEDICAL EVIDENCE OF DISABILITY

Most determinations of disability, as a practical matter, turn on medical evidence (reports of examinations, testing procedures, and treatment of the claimant by a physician). However, it is im-

\(^1\) The current insurance requirement, in general terms, requires a disability claimant to have worked five of the last ten years immediately before the onset of his disability. See II (B) (2), infra.

\(^3\) The national employability test, in general terms, requires total disability to be proven by the vocational evaluation that the alleged disabling impairment keeps the claimant from employment theoretically available to him in the national job market. See II (B) (1), infra.
portant to understand that medical evidence can only serve to substantiate the allegations of the disability claimant that he cannot work by suggesting the physical or mental cause of his inability to function in the work setting. Primary evidence of disability is, of course, evidence of limitation in the function of the claimant which keeps him from working. Medical evidence is secondary to the question of inability to function; it merely explains in medical terms the reason the claimant cannot function. However, the practice of the Administration is to require and to rely almost exclusively upon medical reports in making determinations of whether or not claimants are disabled.

The rationale of the statutory medical evidence requirements is to keep down the cost of the Disability Insurance Benefits program and prevent lifetime awards of benefits to "malingers". The statements of disability claimants that they are unable to work on account of some mental or physical cause must be substantiated by medical proof that there is, in fact, some medically recognized physical or mental explanation for the claimant's disabling conditions. In the words of the statute, a person is "totally disabled" only if he is precluded from employment "by reason of any medically determinable physical or mental impairment" of a specified duration. The regulations defining the methods of proving disability under section 223 (d) (1) provide two basic methods of proof. The first method provides for proof of disability by medical evidence showing the existence of certain specified pathology, which is apparently presumed to be dis-

---


15 §§ 223(d)(1) and (d)(3) provide:

(d)(1) The term "disability" means—

(A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment 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; or

(B) in the case of an individual who has attained the age of 55 and is blind . . . inability by reason of such blindness to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which he has previously engaged with some regularity and over a substantial period of time.

(d)(3) For purposes of this subsection, a "physical or mental impairment" is an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.
abling without any actual showing that the pathology has any relationship to the claimed inability to work. The second method provides that the claimant must prove that a physical condition, regardless of the severity of the condition as contrasted to section 1502(a), in fact, prevents him from functioning in jobs theoretically available to him in the national economy. The claimant's burden of producing...
the medical evidence required by either method of proof of disability is usually met by the submission of written reports signed by a licensed physician reflecting an examination or a course of treatment.

The above cited portions of section 223(d) and the regulations simply require the claimant's statement that he is disabled due to some physical or mental condition to be verified by a physician. The remainder of this section will explain why the statute and regulations do not require determinations of disability to be made exclusively on the basis of medical evidence nor on the basis of demonstrable pathology. Neither does the law require determinations to be made on the basis of verification by "objective" testing procedures or specialists' opinions.

1. The Medical Evidence Requirements of § 223(d) Are Misunderstood and Misinterpreted.

a. Although the statute calls for evaluation of functional evidence, as a matter of practice, medical reports have become the focal point of consideration.

In one case studied the claimant was denied on his first application for the following reason: This 52 year old male applicant has a fourth grade education and has worked as a laborer. He alleges that he cannot perform SGA ["substantial gainful activity"] due to lung trouble, high blood pressure, weak and nervous condition. The most recent medical information contained in the file reveals his B/P to be 160/90. An EKG was normal and an examination revealed the heart to be normal. Examination of the chest revealed good motion in the chest cage and the breath sounds were normal with no wheezes or rales. The chest X-ray that was taken of the
heart revealed that the heart was normal in size. An X-ray of the lung fields revealed the lungs were not remarkable. The pulmonary function studies revealed a MBC of 75 and a TVC of 2980 which reveals a mild mixed obstructive restrictive ventilatory insufficiency. It is further noted that the examining physician believed that most of the W/E's symptoms were on the basis of a chronic psycho-neurosis that was made worse by inactivity. There is no medical evidence on file which would show that the W/E is suffering from an impairment of such severity as to preclude his engaging in SGA. Therefore, he is found to be “not” under a disability. The example given above is in error. It reveals a method of analyzing the facts of each case only in light of the presumptive proof of disability by evidence of pathology method under section 1502(a). This type of error is the most significant error in the evaluation of medical evidence observed in the case studies. On application, medical evidence was the only evidence considered in about seventy-five percent of the claims.\textsuperscript{18} To establish presumptive proof by evidence of pathology, the severity of a condition must be proven according to the Secretary’s regulations by reference to certain values registered in specific types of medical tests.\textsuperscript{19} The fact that a claimant does not meet the “objective” values contained in some of the Listings does not mean that he may not be disabled under the actual proof of disability by functional evidence method; yet, in at least seventy-five percent of the cases in the study, no attempt was made to see if the claimant was functionally disabled within section 1502(b).

Our experience indicates that nearly every case reaching the hearing examiner stage has been analyzed only in terms of whether or not the medical evidence in the claim file, however complete or incomplete, demonstrates a case of presumptive disability under sec-

\begin{table}
\centering
\begin{tabular}{|l|c|}
\hline
Initial Stage & Number of determinations = 12 \\
Medical evidence only & 9 \\
Functional evidence & 3 \\
\hline
Reconsideration Stage & Number of determinations = 16 \\
Medical evidence only & 16 \\
Functional evidence & 0 \\
\hline
Hearing Stage & Number of determinations = 7 \\
Medical evidence only & 4 \\
Functional evidence & 3 \\
\hline
\end{tabular}
\caption{Basis of determination:}
\end{table}

\textsuperscript{18} 20 C.F.R. § 404.1539 app. \textit{Listing of Impairments} (1970). For example, § 3.02 of the Listings requires proof of chronic obstructive airway disease, such as chronic bronchitis, by specific results in two types of breathing tests.
Advocacy can be employed most successfully at this stage to force the hearing examiner to decide whether or not the claimant is functionally disabled under 1502(b) by fashioning and preparing the presentation for the hearing examiner in terms of a 1502(b) case. According to the regulation, functional disability refers to the inability to work caused by a medical condition which is "the primary reason" for the inability to perform significant functions in the work setting. "Significant functions" include: "Moving about, handling objects, hearing, speaking, reasoning, and understanding." From the point of view of obtaining hard to get and often inconclusive medical evidence, the significance of preparing a functional case is that the only medical proof needed is that which establishes the existence of a "condition", regardless of its severity, which has some relationship to the claimant's inability to work. The requirement of proving severity, which exists under the presumptive-pathology 1502(a) method, does not exist under a functional case proven under section 1502(b). In a section 1502(b) case, once the existence of a "condition" is proven, the advocate may prove by means of non-medical evidence that the claimant cannot function in the work setting.

In holding that determinations of "total disability" are not exclusively a function of medical evidence, the courts have called for the consideration of other types of evidence. The best statement of the four elements of proof required was set forth by the United States Court of Appeals for the Fourth Circuit in the Underwood v. Ribicoff. (1) The medical findings of treating and examining physicians, (2) the diagnosis of treating and examining physicians and their expert opinion as to the significance of their findings, (3) the subjective testimony of the claimant as to pain and disability, corroborated by his wife and neighbor, and (4) the educational background, work history and age of the claimant.

---

20 See note 19, supra. Cf. ten Broek and Matson, The Disabled and the Law of Welfare, in The Law of the Poor 485, 487-490 (1966) (hereinafter cited as ten Broek), for a discussion of the tendency in American society to overclassify the physically disabled (the blind, lame, the deformed, etc.). Perhaps the simplistic reasoning behind the adoption of § 1502(a) and its nearly exclusive application when compared to §§ 1502(b) and (c) illustrates this.


22 298 F.2d 850 (4th Cir. 1962). See also Moore v. Finch, 418 F.2d 1224 (4th Cir. 1969); Flake v. Gardner, 399 F.2d 532 (9th Cir. 1968); Whitt v. Gardner, 389 F.2d 906 (6th Cir. 1968); Hayes v. Gardner, 376 F.2d 517 (4th Cir. 1967); Page v. Celebrezze, 311 F.2d 757 (5th Cir. 1963).
Use of the 1502(b) method will overcome many of the difficulties encountered in trying to prove the existence of a disabling impairment by medical evidence alone. In many cases adequate medical reports are not available, or if available, may be of questionable value. Frequently claimants will rely upon reports prepared by their family doctors. These family doctors may not have enough time to draft a comprehensive report dealing with the condition of the claimant, and they may not be fully informed of the specific standards of disability for the particular disability program. Many claimants do not realize when they need medical reports to improve their chance of winning, or do not have money to get these reports. Availability of medical evidence sufficient to prove disability under section 1502(a) may be further limited by encounters with unsympathetic doctors unwilling to provide medical reports adequate to prove disability, and by the somewhat omniscient feeling of many physicians that they know exactly what to say in a report of disability evaluation. The most common error committed by doctors preparing medical reports is the inclusion of irrelevant remarks at the expense of relevant analysis and foundation information.

Furthermore, the probative value of medical evidence, once it is acquired, depends upon how much medical science actually knows about the impairment in question and upon the real value of many testing procedures which are considered reliable due to their wide use and reference to numerical values. Some diseases, such as "black lung", are not fully understood by medical science, and the findings of many seemingly probative and objective tests are of questionable significance and reliability.

A further benefit of using the actual proof by functional evidence method is that it forces the Administration officials at least

---

23 20 C.F.R. § 404.1526 (1970) provides that conclusions of physicians stated in medical reports on the ultimate question of disability are not determinative. "The weight to be given such physician's statement depends on the extent to which it is supported by specific and complete clinical findings and is consistent with other evidence . . . ." Care must be exercised in obtaining medical reports. They should detail the reasoning process of the physician, and conclusions should be supported. Unfortunately, our analysis of medical reports revealed that only a few contained conclusions which were adequately supported. The most frequent errors were: (1) unsupported conclusions (many physicians apparently feel all they need do on a disability evaluation report is to utilize a few magic words, such as "permanently and totally disabled"); (2) gratuitous statements of no medical value ("I encouraged him to seek rehabilitation") with misleading legal significance; and (3) the failure to reveal the reasoning process which led the physician to his conclusion.

24 See notes 28-33 infra.
to listen to the claimant. In a 1502(a) case there is no reason for them to listen to the claimant, and they often do not. The advantage of the 1502(b) functional proof method is that it gives the attorney an opportunity to air the actual complaints of the claimant and, accordingly, gives the claimant the "right to be believed." Adequate preparation and competent presentation of a 1502(b) case will force Administration officials to look at the facts of the case rather than at abstractions, such as the lack of medical evidence showing sufficient severity to establish a presumption of disability and the national employability test, normally used to deny benefits. It will give the advocate the opportunity to convince the Administration that the claimant is unemployed and unemployable not because of some weakness in his character, but as a result of some very particular and understandable conditions that prevent his performing gainful work.

(b) Section 223(d) is frequently interpreted as requiring disability to be proven by "objective" medical findings.

One example of requiring disability to be proven by "objective" evidence is as follows: The claimant, a fifty-seven year old coal miner, was forced to leave his employment in the mines in 1954 due to repeated heart attacks, arthritis, and "nerves". In a Disability Determination Transmittal, the Administration denied benefits, among other reasons, because: "the above medical evidence indicates, by a bare diagnosis and nothing more by way of objective medical findings or data, that claimant had congestive heart failure in 1949 . . . . Although claimant's alleged impairments included "nerves" and the record does show diagnosis of anxiety state after examination of January, 1954, there is no record of objective medical evaluation of a mental or nervous condition . . . . which even approaches the strict levels of severity required for a finding of disability." The decision in the example above is erroneous; there is no requirement that an impairment be proven by "objective evidence". "Objective" medical evidence refers to the phenomena which the physician can observe, while "subjective" evidence refers to the information which can only be furnished by the patient. Neither the statute nor the

---

25 ten Brook Supra note 21, at 506.
26 Id. at 508.
27 "Objective information might be obtained by palpating a mass in the abdomen, measuring the patient's hemoglobin concentration, or testing the patient's tendon reflexes . . . . All information obtained from the clinical laboratory, as well as from radiographic studies and physical examination,
regulations require proof of disability by objective evidence.\textsuperscript{28}

The repeated use of the word "objective" suggests a misunderstanding of the phrases "medically determinable" and "demonstrated by medically acceptable clinical and laboratory techniques" in section 223(d).\textsuperscript{2} These phrases simply require that the physical or mental cause of disability be determined by methods usually employed by physicians, whether the diagnosis is based upon the most objective test results available or upon the most subjective, yet clinically acceptable words, uttered by the patient and believed by the doctor.

The section of the [Social Security] Act cited [section 223(d)] does not contemplate that lay testimony, coming within the sphere generally accepted by the courts, must be disregarded insofar as it relates to physical or mental symptoms or condition. It means rather that the \textit{type} of illness, impairment or disability involved, whether physical, mental, or both, must be one that is recognized and is capable of being determined medically \ldots . It is common knowledge that doctors and psychiatrists use information from laymen in arriving at their diagnosis. That is particularly true in mental cases.\textsuperscript{29}

The phrase "clinical and laboratory techniques" requires separate explanation. "Clinical" refers to symptoms observed and believed by the physician when he actually examines the patient. "Not all subjective complaints of a patient are accepted by a doctor but one skilled in the art may well be able, by medically acceptable clinical techniques, to sort them out, to decide which to believe, and to make a diagnosis accordingly."\textsuperscript{30} "Laboratory" refers to testing procedures which extend by the means of mechanical or chemical means the powers of observation of the physician.\textsuperscript{31} The

\textsuperscript{28} Flake v. Gardner, 399 F.2d 532, 540 (9th Cir. 1968); Whitt v. Gardner, 389 F.2d 906, 909 (6th Cir. 1968); Redden v. Celebrezze, 361 F.2d 815 (4th Cir. 1966); Marion v. Gardner, 359 F.2d 175 (8th Cir. 1966); Ber v. Celebrezze, 332 F.2d 293 (2d Cir. 1964); Page v. Celebrezze, 311 F.2d 757 (5th Cir. 1963). \textit{See also} Walters v. Gardner, 397 F.2d 89 (6th Cir. 1968).

\textsuperscript{29} Clifton v. Celebrezze, 228 F. Supp. 251, 256 (N.D. Tex. 1964). \textit{See} Hayes v. Celebrezze, 311 F.2d 648 (5th Cir. 1963); Page v. Celebrezze, 311 F.2d 757 (5th Cir. 1963).

\textsuperscript{30} Flake v. Gardner, 399 F.2d 523, 541 (9th Cir. 1968).

\textsuperscript{31} Laboratory tests are simply "means to extend the physician's power of
"and" in the phrase "clinical and laboratory techniques" should be read disjunctively.²

(c) Undue weight is frequently given to reports of medical specialists, particularly those retained by the Administration, while relevant and probative reports of treating physicians or general practitioners are brushed aside.

The following is an analysis of the rationale for the termination of disability benefits of a miner who received an injury in the coal mines and subsequently developed other disabling problems: The claimant is a 49-year-old miner who was crushed between a mine car and the roof of a mine, receiving a fractured skull and fractured fifth and seventh cervical vertebrae. Once the fractures healed, his disability insurance benefits were terminated on the basis of reports of specialists, an orthopedist and a neurologist, who referred to the healed fractures, offered no explanation for the claimant's allegations of pain, but did suggest that he needed to improve his attitude toward rehabilitation. The claimant continued to complain of extreme pain and inability to move. The Disability Determination Transmittal stated "an examination . . . performed at [a time shortly after the fractures healed] . . . as well as current medical evidence indicates no findings that would prevent you from engaging in activities which require light exertion." The above "current medical evidence" also included reports from two general practitioners, one of whom had treated the claimant, which were not referred to in the determination. Both reports were considerably longer than the specialists' reports and both, unlike the specialists' reports, revealed that the physicians had taken histories of the claimant and had performed complete examinations. In reaching the conclusion that the claimant was "totally and permanently disabled" both reports of the general practitioners referred to objective findings to support that conclusion: X-ray changes in the spine, localization of pain by pin-

observation to include quantities not visible, palpable or audible." Conn, Supra note 28, at 3.

Understanding the laboratory and its limitations more particularly is part of the art of medicine. Laboratory tests in and of themselves mean precisely nothing. It is only when the result with all its error and uncertainty is applied to the living, changing patient that it contributes something to diagnosis. The laboratory cannot begin to replace the brain of the physician as a diagnostician's tool . . . . The skillful diagnostician cannot depend upon purely mechanical devices.

P. WILLIAMSON, OFFICE DIAGNOSIS 15 (1960).

²² Flake v. Gardner, 399 F.2d 523 (9th Cir. 1968).
prick testing, and limitation of motion of certain limbs. This example illustrates the error of the Administration of relying exclusively upon the reports of specialists and ignoring the opinions of the treating doctors.

While the opinion of physicians who specialize may be quite valuable within their area of expertise, usually the opinion of the specialist tends to be limited and fails to take into account the overall picture of the patient's condition. As Professor Wigmore stated, while the perception of the expert is increased by his greater skill and experience, the value of his testimony may be lessened by the likelihood that he will interpret matters according to his own preconceptions. 33 The general practitioner who can obtain an overview is just as valuable, and his opinion should be given just as much weight as that of the doctor who studies one particular area in detail. Some courts have held that while the opinion of the claimant's treating physician, usually a general practitioner or family doctor, is not conclusive on the issue of disability, it must be accorded substantial weight. 34

2. The Failure of the Administration to Recognize the Limited, Secondary Value of Medical Evidence Has Engendered the Practice of Accepting Medical Evidence at Face Value Without Needed Explanation.

(a) There is a right to cross-examine authors of medical reports and to have reports of authors not cross-examined excluded from consideration.

As is suggested by the above analysis, medical evidence is very complex and confusing. It is often difficult to understand what particular medical reports say or do not say about the impairments

33 J. Wigmore, The Science of Judicial Proof 376-79 (3rd ed. 1937). While the expertise of the expert may increase the range and accuracy of his perception and narration, . . . it may [also] decrease them . . . . That concentration which is involved in experience may decrease testimonial value. It tends to blunt the perceptions as to other topics, to develop a biased or fixed idea affecting the perception on certain topics, and to induce in narration an obstinate adherence to conclusions already reached on particular facts . . . . Medical witness should be carefully watched in these respects.

34 Combs v. Gardner, 382 F.2d 949 (6th Cir. 1967); Hayes v. Gardner, 376 F.2d 517 (4th Cir. 1967); Helsep v. Celebrezze, 382 F.2d 891, 894 (4th Cir. 1966).
alleged by the claimant. The cases studied suggest that the significance and meaning of medical evidence is often misunderstood and needs explanation. While explanation can be achieved through cross-examination of the physicians whose reports are in evidence, usually the authors of medical reports are not present at hearings, although a physician could be subpoenaed to appear for that purpose.

When a report is especially damaging or unclear, voluntary or involuntary attendance of the physician at the hearing should be sought. If the physician cannot attend and be cross-examined, then the advocate should object to the consideration by the hearing examiner of the particular report in question. The objection is not technically to the "admissibility" of the report, or to its "hearsay" quality; but that the report needs explanation, and since it needs explanation, it is not inherently reliable and probative evidence and cannot constitute "substantial evidence" as required by section 205(g) of the Social Security Act.


Certiorari was granted on the question:

Whether the court of appeals erroneously held that written medical reports, submitted by physicians who have examined a claimant for disability insurance benefits under the Social Security Act, cannot be deemed "substantial evidence" sufficient to support the denial of a disability claim if the reports have been contradicted by oral medical testimony and the claimant has objected to the admission of the reports into evidence.

Petitioner's Brief for Certiorari at 2. The Petitioner, in his brief, limits the substantial evidence argument to the question whether "written medical reports furnish reliable and probative evidence of a claimant's condition and therefore can constitute substantial evidence, even though objected to and contradicted by oral medical testimony." Id. at 17. For a thorough analysis of the application of the substantial evidence rule to "administrative hearsay evidence" see, Patterson, Hearsay and the Substantial Evidence Rule on the Federal Administrative Process, 13 MERCER L. REV. 294 (1961). See also Davis, Hearsay in Administrative Hearings, 32 GEO. WASH. L. REV. 689, 692 (1964). See also Breaux v. Finch, 421 F.2d 867 (5th Cir. 1970); contra, Whaley v. Gardner, 374 F.2d 9 (8th Cir. 1967); Gray v. Finch, 427 F.2d 336 (6th Cir. 1970).
(b) Illustrations of the need to cross-examine the authors of medical reports and the necessity of not accepting medical reports at face value.

The facts of the Perales case, although limited to the low back pain syndrome, illustrate the need for explanation of medical reports and tests. Cross-examination of physicians who rely upon laboratory tests (for example: "negative Myelogram," "chest X-rays") to reach a conclusion of non-disability may be necessary to establish (assuming the test was administered properly) precisely the significance of the laboratory finding and the reliability and accuracy of the findings. For example, in the Perales case, a "negative electromyogram (EMG)" was used as part of the basis for a finding by the hearing examiner that the claimant did not suffer from disabling back pain caused by a slipped intervertebral disc which the claimant alleged kept him from working. On the facts of that case, cross-examination could have established, as to "significance", that a negative EMG reading does not necessarily rule out the possibility that the back pain was caused by a slipped disc. As to reliability, cross-examination could have established that the "negative" EMG is only about seventy-five-eighty per cent reliable and is affected by many factors relevant to the case of that claimant.

Regardless of the significance or reliability of the findings of laboratory tests, it should also be established by cross-examination that the results of a laboratory test, however objective they might be in raw form, lose their objectivity when they are necessarily interpreted. In fact, some test results which are necessarily subject to ex-


\[\text{The completeness of the testing procedure, the fact that the EMG does not test all kinds of nerves which can cause back pain, the attitude of the person being tested, and the quality of his needed participation in the test are all factors which affect the reliability of the EMG. See note 41 supra; Walter, \textit{Electromyography}, 1 Trauma 40, 41 (June 1959).}\]

\[\text{"The feeling is that these marvelous, complex machines [electroencephalograph and electromyograph] in this electronic age, must really produce "objective" data. True, the machines themselves faithfully record squiggles and jogs without error, but \textit{objectivity is lost in the process of translation by the interpreter." Walter, supra note 42, at 44.}\]
tensive interpretation, such as EMG readings, are not admissible by themselves under the hospital records or business records exceptions to the hearsay rule since they are deemed to be opinion evidence.\textsuperscript{43}

The normal process of diagnosis begins with the doctor taking a history of the patient's medical problem and then proceeding with a thorough physical examination. At that point the physician may request laboratory work or a specialist's consultation. Then after studying the physical findings, history, and laboratory work, the treating physician reaches a conclusion.\textsuperscript{44}

Laboratory tests in and of themselves mean precisely nothing. It is only when the result, with all its error and uncertainty, is applied to the living changing patient that it contributes something to diagnosis . . . . The skillful diagnostician cannot depend upon purely mechanical devices.\textsuperscript{45}

Most orthopedic surgeons have found that attorneys, juries, insurance companies and State Industrial Commissions rely too heavily on myelograms for diagnosis of a ruptured intervertebral disc, and not sufficiently on the clinical findings and histories of such a condition. Many times a very sick person, because of a negative myelogram, may receive neither proper medical attention nor a fair verdict by jury.\textsuperscript{46}

\textsuperscript{43} Since the report of the electromyographer is based in part upon unrecorded data and since his conclusions are substantially opinion, EMG reports are frequently treated as being conclusions and are not by themselves admissible in jury trials, even under the business records exception to the hearsay rule. Gelfand & Houts, Planning the Neck Injury Case, 5 TRAUMA 44, 72 (1960). Medical records based upon "opinion or conjecture" are not admissible under the Federal Shop Book exception to the hearsay rule, 28 U.S.C. § 1732(a) (1964). New York Life Insurance Co. v. Taylor, 147 F.2d 297, 300 (D.C. Cir. 1945); Lyles v. United States, 254 F.2d 725, 731-33 (1957), cert. denied, 356 U.S. 961 (1958); See, Comment Controversial Diagnoses in Hospital Records, 14 BAYLOR L. REV. 47 (1951).


\textsuperscript{45} P. Williamson, Office Diagnosis 15 (1960).

\textsuperscript{46} Willberger, The Medico Legal Aspects of Low Back Pain, 15 Ohio St. B. J. 437, 443 (1954).

The laboratory study is extremely dramatic. It intrigues the court and jury. Frequently it receives credence and is accorded importance above and beyond actual reality . . . . [t]he proper diagnosis of disease or injury depends upon the opinion of the physician which
Cross-examination of the physician is necessary to force him to detail his entire reasoning process and to make it understandable to the layman.\(^{47}\)

**B. PARTICULAR ELIGIBILITY CRITERIA, INTENDED BY CONGRESS TO APPLY EVENLY TO ALL CITIZENS THROUGHOUT THE NATION, IN FACT DISCRIMINATES AGAINST THE CLASS OF DISABLED PERSONS STUDIED HEREIN.**

1. The "National Employability Test" Discriminates against the Persons Studied Who Are not Candidates for the National Job Market Due to their Advancing Age, Lack of Skills, and Physical or Mental Disability.

Proof of disability under the functional method of 1502(b) requires proof not only that the claimant's impairment precludes him from engaging in his "previous employment" or any equivalent employment, but also that he cannot, "considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specified job vacancy exists for him or whether he would be hired if he applied for work."\(^{48}\)

---

is based upon all that he has learned during his professional experience, upon reasonable medical certainty and upon *all* the factors of the case.

The same principle applies to the diagnosis and treatment of neck injuries. The electromyographic and myelographic studies are frequently suggestive, often markedly positive, occasionally diagnostic; but they are never entirely conclusive. The results of these procedures must be taken into account along with the entire clinical picture.


\(^{47}\) Professor Wigmore quotes Albert S. Osborne:

The requirement that expert testimony should, if possible, always include the reasoning by which the conclusion is justified, is highly important, not only that correct testimony may convincingly be presented, but also in order that the frail and unsound basis of incorrect testimony may thus be directly exposed . . . .

Correct, detailed, logical reasoning is necessary to show to technically untrained hearers the significance and force of various details of evidence, showing, for example, that a document was fraudulently written . . . .

The modern and progressive conception of expert testimony regarding all these technical subjects is a common sense and reasonable conception that requires a witness to give testimony so that its force or weakness can be determined.


\(^{48}\) 20 C.F.R. § 404.1502(b) (1970). For the complete text see note 17 supra. Hereinafter this will be referred to as the national employability test.
The "national employability test" of the total disability standard was added to the statute by the 1967 amendments to the Social Security Act. The conference reports on the amendments admitted candidly that the restrictive employability standard was adopted solely to cut down the number of claims paid and, hence, the cost of the program. Generally, the explanation for an overly restrictive definition of disability is that a cautious Congress and a cautious Administration were experimenting for the first time with a program designed to pay benefits to people who could not work.

The national employability standard is especially harsh when it is used to deny benefits to many low-income persons who live in the Appalachian area. For example, a middle-aged miner who has done no other work in his life, has a very marginal education, and is likely to be suffering from the effects of long years in the mines presents a very poor employment prognosis. Employers are not very likely to hire an individual who is likely to miss time and raise un-

49 42 U.S.C. § 423(d)(2)(A) (1964) provides that:
(A) an individual (except a widow, surviving divorced wife, or widower for purposes of section 402(c) or (f) (of this title) shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. For purposes of the preceding sentence (with respect to any individual), "work which exists in the national economy" means work which exists in significant numbers either in the region where such individual lives or in several regions of the country.
50 See note 11 supra.
51 POLLOCK, supra note 1, at 175-76.
52 20 C.F.R. § 404.1502(c) (1970) provides an exception to the national employability test of 20 C.F.R. § 404.1502(b) (1970):
(c) Where an individual with a marginal education and long work experience (e.g., [sic] 35 to 40 years or more) limited to the performance of arduous unskilled physical labor is not working and is no longer able to perform such labor because of a significant impairment or impairments and, considering his age, education, and vocational background is unable to engage in lighter work, such individual may be found to be under a disability. On the other hand, a different conclusion may be reached where it is found that such individual is working or has worked despite his impairment or impairments (except where such work is sporadic or is medically contraindicated) depending upon all the facts in the case. In addition, an individual who was doing heavy physical work at the time he suffered such impairment might not be considered unable to engage in any substantial gainful activity if the evidence shows that he has the training or past work experience which qualifies him for substantial gainful work in another occupation consistent with his
employment compensation rates, is not likely to be trainable, nor to be a prospect for lengthy employment. Low income persons have fewer residual vocational capacities than the higher income employee who is unable to perform his prior occupation. An executive or white collar employee has a definite advantage in employment prospects for light work (bread cutter, gas station attendant, night watchman) simply because of the natural discrimination on the part of employers against the poorly educated or "less desirable" type of employee.

Some courts have been unwilling, despite the strict requirements of the law, to allow a claimant to be denied benefits merely because his residual job skills fit the requirements of a job which exists somewhere in the nation. Such "theoretical" employment capacity has not been allowed to be the basis for a denial of benefits.53

Aside from the obvious need to reform the statute at least to take into account the special circumstances of middle-aged, semi-skilled persons as discussed above, the effect of the "national employability test" can be blunted by the advocate. Usually where residual capacity to perform substantial gainful activity is suspected, a vocational consultant will be called by the hearing examiner to testify impairment either on a full time or a reasonably regular part-time basis.

Example: B, a sixty year old miner, with a fourth grade education, after a history of arduous physical labor alleged that he was under a disability because of arthritis of the spine, hips, and knees and other impairments. Medical evidence shows a combination of impairments and establishes that these impairments prevent B from performing his usual work or any other type of arduous physical labor. His vocational background does not disclose either through performance or by similarly persuasive evidence that he has skills or capabilities needed to do lighter work which would be readily transferrable to another work environment. Under these circumstances, B may be found to be under a disability. Apparently this exception is applied sparingly. See Duty v. Richardson, 1A UNEMPL. INS. REP. ¶ 15,852 (S.D. W. Va. 1970). In spite of approximately thirty years labor in the coal mines and four or five years cutting timber claimant had to go to the district court to benefit from § 1502(c). The Secretary apparently found that claimant was capable of "light or sedentary jobs such as an industrial guard and night desk clerk at a hotel or motel."53

The courts have struggled with the concept of national employability. Literally, the Act requires benefits to be denied to any person whose residual job skills enable him to perform any job that "exists in the national economy." Some hearing examiners as a matter of practice restrict the availability of employment to the area or region in which the claimant lives. Perhaps because of their "existential" approach, see Viles supra note 11, at 403, the courts tend to take a more realistic view of employment possibilities. See Colwell v. Gardner, 385 F.2d 56 (6th Cir. 1967); Dillon v. Celebrezze, 345 F.2d 753 (4th Cir. 1965); Haskins v. Finch, 1A UNEMPL. INS. REP. ¶ 15,758 (W.D. Mo. 1969); Stokes v. Finch, 1A UNEMPL. INS. REP. ¶ 15,671 (S.C. 1969).
at the hearing as to the kind of work a man with the claimant's alleged limitations can perform. The hearing examiner will ask the consultant to assume that the claimant suffers from various limitations, the actual existence of which the examiner may ultimately find, and will interrogate him using a series of hypothetical questions. The nature of the hypothetical questions will vary somewhat according to the proclivities of the particular examiner. The hearing examiner may ask the consultant to assume that he finds the claimant suffers from a certain impairment or combination of impairments to a particular degree and ask the consultant to testify as to what work the claimant could perform with such impairments. Or, the hearing examiner may ask the vocational expert to assume that he finds the claimant can perform a certain level of work, for instance light work, and ask the consultant to testify what light work, if any, is available for the claimant.

The best way to minimize the effect of the vocational consultant's potentially unfavorable testimony as to the existence of light work available for the claimant is to build the strongest possible record as to the claimant's inability to do any kind of work. The actual proof by functional evidence method specifies the type of functional limitations that are significant in showing inability to work and which are taken into consideration by the determiner: "moving about, handling objects, hearing, speaking, reasoning, and understanding." Care should be taken to build a record as to the claimant's inability to perform such activities. In addition, some categories of impairments, especially mental impairments, include listings of functional impairments which must be shown as part of proving the existence of the alleged impairments itself, such as "marked constriction of interest", "change of daily habits", and the like. All kinds of functional impairments can and should be proved not only by the claimant's testimony but also by the corroborating testimony of family, friends, and co-workers.

Cross-examination of the consultant is essential if he testifies that light work exists which the claimant can perform. Cross-examination should focus on whether the functional abilities of the claimant which are already on record suit him, in fact, for the tasks that the consultant alleges he can perform. For example, can a man capable of performing only light work really be a competent night

---

54 20 C.F.R. § 404.1502(b) (1970).
watchman, a favorite category of light work found to be available to claimants, if his job would require him to act quickly and effectively in an emergency? Could he perform any job on a regular forty hour a week basis? Care should be taken on cross-examination to assure that the consultant's conclusion that light work exists for the claimant is based on the facts of the case and refers to jobs that actually exist rather than to jobs which theoretically exist. The basis of the consultant's opinion that the jobs exist and that they exist "in significant numbers in the national economy" should be elicited.  

Finally, some effort should be made to get the consultant to admit that the actual prospects for the claimant to be employed, considering his age, education, work experience, and present impairments, are minimal on the competitive job market, even though the actual possibility that the claimant would be hired is legally irrelevant. This type of admission is very helpful for two reasons: (1) to build a record for judicial review since courts are often willing to award benefits on the basis of the claimant's actual ability to get a job rather than merely looking to his theoretical ability to work; and (2) to lay the factual foundation for an argument under section 1502(c) that a person with a long work record and limited skills will be presumed to be unemployable.

Since work which the claimant has actually performed can be used to negate a case of medical disability, and since determiners, especially hearing examiners, like to fix on the work history question, the advocate should be careful to develop all the circumstances of any work performed by claimant during the period of disability. This question in particular has arisen with regard to work done by disability claimants in public assistance mandatory or voluntary work.
programs, such as the AFDC-U program, commonly referred to as the "crash" program.\textsuperscript{59}


The "current insurance" rule requires the applicant to have worked five of the last ten years immediately preceding the onset of his disability; that is, that he have fifty dollars credited to his social security account for 20 calendar quarters of the last 40 calendar quarters immediately preceding his disability onset date.\textsuperscript{60}

The most common reason for denial of claims (10 of 26 cases studied) and the most prevalent reason for the misunderstanding and bitterness toward the Social Security system on the part of low income people in this study was the inability of the claimants to establish the onset of their disability within the period required by the current insurance rule. The concept that, although unquestionably precluded from employment at the present time, the claimant is not entitled to benefits because he is no longer currently insured is not only difficult for low income people to understand; it is, in fact, a difficult concept to understand as a matter of social policy. Why a work history of 30 years, satisfying anyone's idea of the work ethic, is not sufficient to entitle a claimant to benefits when he is no longer able to support himself because of injury or diseases defies understanding.

The current insurance requirement discriminates against disabled workers whose inability to work is caused by a chronic, non-traumatic impairment which develops slowly over a period of years, and in which no exact point of time (such as the time of an accident in the case of impairments of a traumatic origin) may be associated with drastic changes in vocational abilities. It has the effect of destroying the eligibility potential of individuals who are too sick to work, but who are not yet disabled enough to meet the strict standards of disability under Social Security. As the worker with a chronic impairment continues to miss work, his current insurance requirement is running out, while he is progressively getting sicker.

\textsuperscript{59} See, e.g., Canady v. Celebrezze, 367 F.2d 486 (4th Cir. 1966); Abshire v. Gardner, 271 F. Supp. 927 (S.D. W. Va. 1967) aff'd on other grounds, 381 F.2d 737 (4th Cir. 1967). See also 20 C.F.R. § 404.1532 (c),(d), and (e) (1970).

The result of course is that by the time he is sick enough to get disability benefits, he is no longer currently insured and no longer eligible.

The current insurance requirement fails to take into consideration the special needs of those who become unemployed either by the vagaries of the business cycle or technological obsolescence. This factor is extremely important in Appalachia where many miners were thrown out of work in the late fifties and early sixties by mine mechanization. With no readily transferable skills, and a very poor job market, they were forced to go on public assistance, or to "shop around" for a "pick-up" job, which often did not have a Social Security tax, or Social Security credits for disability purposes.

A person must establish an onset date of his disability at some point in time when he meets the current insurance requirements. A person who is applying after his current insurance requirement has expired faces the difficult task of acquiring, developing, and presenting medical evidence that establishes his disability while he meets the earnings requirement. The problem is obtaining medical reports describing the claimant's condition when he was last covered, or obtaining medical reports prepared after the claimant was last covered which describe his condition during the period of coverage (retrospective evidence). Generally all levels of Social Security Administration determiners, especially hearing examiners, are reluctant to accept retrospective evidence. The regulations do not rule out the use of retrospective evidence. The courts have uniformly held in disability insurance benefit cases and other federal disability programs that the existence of a condition at an earlier time can be proven with the use of evidence from a later time. In Halliday v. United States the Supreme Court said:

[E]vidence as to petitioner's conduct and condition during the ensuing years is certainly relevant. It is a commonplace that one's state of mind is not always discernible in immediate events and appearance, and that its measurements must often await a slow unfolding. This difficulty

---


63 315 U.S. 94 (1942).
of diagnosis and the essential charity of ordinary men may frequently combine to delay the frank recognition of a diseased mind. Moreover, the totality and particularly the permanence of the disability as of 1920 are susceptible of no better proof than that to be found in petitioner's personal history for the ensuing fifteen years.\(^6\)

There are three ways in which the harsh effect of the current insurance requirement could be lessened by Congress. First, some sort of a "waiver of premium" principal could be adopted. That is, when a person is sick and unable to work and therefore unable to earn credits for purposes of Social Security, the period of time that he misses would not be counted as part of the 40 quarter period. The waiver of premium principle is already used for purposes of retirement benefits, in that the period in which a person is disabled under the Social Security definition of disability and therefore not working is not counted in the number of years that are used to compute the benefits payable upon reaching retirement age.\(^5\) A second possibility would be to simply require coverage for any 20 calendar quarters or 20 of any 40 calendar quarters. The final alternative would be a pro rata award of benefits based upon the number of quarters earned out of the required numbers of quarters.

Some claimants fail to meet the current insurance requirement because they worked for an employer who did not pay F.I.C.A. taxes. Usually it is difficult to prove that a person worked for an employer who did not pay the tax, but it can be done with appropriate records and witnesses.\(^6\) This situation usually occurs in the

\(^{64}\) Id. at 98.


\(^{66}\) Whether or not a person meets the current insurance requirement for Disability Insurance Benefit purposes is determined on the basis of the earnings record kept by the Social Security Administration. These records contain records of contributions made by employers and employees in employment covered under the Federal Insurance Contributions Act. 26 U.S.C. § 3101 et seq. (1964). The $50 earnings per quarter do not need to be earned in employment covered by the F.I.C.A. See note 62 supra, especially §§ 413(a)(2), 409, and 410(j)(2). See also 20 C.F.R. § 404.801(a) (1970). This is significant for workers whose wages were not reported who are attempting to establish that they meet the current insurance requirement. The problem, however, is that 42 U.S.C. § 405(d)(4)(B) (1964), provides that after the passage of three years, three months, and fifteen days, the absence of an entry in the Secretary's records shall be presumptive evidence that no "wages" were "paid". The presumption of § 405(c)(4)(B) may be overcome by probative evidence that wages were paid. Social Security Administration, O.A.S.I. Claims Manual § 1157. See Golding v. Celebrezze, 360 F.2d 611 (4th Cir. 1966); Lackey v. Gardner, 1A Unempl.
case of unskilled employees who are employed by marginal operations such as small coal mines and construction firms.

III. CONCLUSION

If this article accomplished nothing else, it should convince the reader that proving "total disability" under section 223(d) of the Social Security Act can be a very complex and demanding task. Understanding the medical evidence requirements of sections 1502(a) and (b), proving that a mental or physical abnormality existed some years ago, and working around the strict national employability standards are tasks suited only for a person who can read and understand the complexities of the law and regulations; who can realize what is needed to build a case; and who can build and present a case. The Social Security Administration makes notable efforts to assist claimants, but the cases studied demonstrate that in those cases which can be classified as "difficult", unrepresented claimants did not receive adequate assistance. In fact, the ostensible helpfulness of the Social Security office people and the demonstrable lack of claim development in several cases strongly suggest that the civility with which the claimants are treated by the Social Security office may be false comfort for those persons who have difficult claims. Claimants with difficult cases or even marginally difficult cases need more assistance than is presently afforded. They are not usually informed of the need for representation outside of the Administration.


Furthermore, the validity of the presumption of § 405(c)(4)(B) can be challenged, with respect to the type of claimant discussed in this article, on the grounds that the absence of reported earnings in the Secretary's records is just as consistent with the conclusion that wages were earned but not reported, as with the conclusion that the wages were not earned. Evidentiary presumptions are based on the probability that in certain recurrent fact situations it is accepted that the proof of one fact or group of facts renders the inference of the existence of a second fact or set of facts so probable that it is sensible to accept the second set of facts as proven, unless disproven. C. McCormick, Evidence 641 (1954). It is a denial of due process to base a presumption on a given set of facts which could reasonably either prove or disprove the fact presumed. Mobile, J. & K.C. Ry. v. Turnipseed, 219 U.S. 35, 43 (1928).

67 Viles, supra note 11, at 319-92.

68 Id. at 393-94. At no time is any sort of suggestion offered by the Administration that claimants may need outside assistance in preparing their claims. None of the carefully prepared pamphlets provided by the Administration suggest the need for representation. All that is said of outside representation is that the claimant has a right to representation. One booklet states, "most people handle their own affairs with the help of the people in the Social Security office." U.S. DEP'T OF HEW, SOCIAL SECURITY ADMINIS-
Several administrative reforms are necessary to provide assistance to claimants with difficult cases. (1) All claimants should be informed as fully as possible, rather than with the formalistic notices presently given, of why they have been denied benefits and the fact that there are two sides to the question of their denial. The Administration should ascertain that the notice is actually understood and that the claimant understands that he is in a position to give further proof as to his own claim. (2) Provide assistance from within the Administration in the form of an independent advocate. (3) Unequivocally suggest to claimants that they need outside representation, which in most cases would be a private attorney.

The determinations of the Social Security Administration appear to state only their side of the case, and the advocate-attorney is one of the few persons in our society equipped to deal with such a one-sided document. The Administration is careful to point out how full and complete its determination has been, that it has considered all the evidence in the file, that it may have ordered additional examinations, that it has undertaken to gather some evidence on its own. The decision of the Administration will refer to relevant law and regulations, frame the issue, and make a seemingly rational determination. If the attorney has the feeling that the person with a Social Security disability claim is in fact disabled or may be disabled, his duty is to look behind the seemingly full and complete determination.

[TRATION (OASI-856), THE RIGHT TO REPRESENTATION 2 (1963). Another booklet states that the people in the Social Security office will “help you in every way possible to fill out your application and get the necessary evidence.” U. S. DEP’T OF HEW, SOCIAL SECURITY ADMINISTRATION (SSI-29) IF YOU BECOME DISABLED 22 (May, 1970).]