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A Female Disease: The Unintentional Gendering of Fibromyalgia Social Security Claims

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A FEMALE DISEASE: THE UNINTENTIONAL GENDERING OF FIBROMYALGIA SOCIAL SECURITY CLAIMS

Dara E. Purvis*

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Abstract

Social Security disability claims are not supposed to be decided based on the gender of the applicant. Reliance on the apparently neutral mechanism of clinical medical evidence, however, has a disproportionate impact on women bringing disability claims based on fibromyalgia. Recognizing and identifying disability has been delegated by Congress and the Social Security Administration almost entirely to physicians, based upon the misguided belief that clinical medical evidence evaluated by a physician will answer with certainty whether an individual claimant is capable of working. Fibromyalgia, a diffuse syndrome characterized by excessive pain that is overwhelmingly diagnosed in women rather than men, is not easily shown with clinical evidence. The disabling aspect of fibromyalgia is widespread and prolonged pain, supported only by a patient's subjective reports. Even the diagnosis depends on whether a patient describes pain at specific points on her body. Fibromyalgia claims thus provide a case study for evaluating the effectiveness and objectivity of the disability evaluation process. This article explains why the Social Security Administration relies so heavily on clinical medical evidence, traces the history of excess pain claims and why they are so difficult to evaluate, and explains why the current standards disproportionately disadvantage female fibromyalgia claimants.

INTRODUCTION

In the 1950s, Congress created Social Security disability benefits as a wide-reaching safety net for Americans who were unable to support themselves due to disability.¹ As of December 2002, about 5.5 million Americans were receiving Social Security disability benefits.²

A significant number of Social Security recipients suffer from fibromyalgia, a diffuse syndrome primarily characterized by severe pain. Although the identification of fibromyalgia as a distinct syndrome is a recent phenomenon, fibromyalgia has not only become a familiar term to most Americans,³ but has also become an increasing source of Social Security disability claims.⁴ For example, in one survey of Social Security

1. *History: Vote Tallies of the 1956 Amendments*, SOCIAL SECURITY ONLINE (last visited Sept. 24, 2011), <http://www.ssa.gov/history/tally56.html>.

2. COMM. ON WAYS AND MEANS, 108TH CONG., 2004 GREEN BOOK: BACKGROUND MATERIAL AND DATA ON PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS 3–35 (Comm. Print 2004) [hereinafter GREEN BOOK].

3. For example, the cover of Time Magazine dated March 2, 2011 was titled “Understanding Pain,” and the issue featured a series of articles discussing chronic pain conditions such as fibromyalgia.

4. Frederick Wolfe et al., *Work and Disability Status of Persons with Fibromyalgia*,

recipients near Wichita, Kansas, fibromyalgia was the source of forty-six percent of disability awards.⁵

The process of evaluating disability for the purposes of Social Security benefits, however, seems ill-equipped to grapple with fibromyalgia. Fibromyalgia is an unusual syndrome in that it is not a physical injury or trauma, nor is it a disease that can be identified by a clinical test yielding a yes or no answer. As a result, people suffering from fibromyalgia face considerable challenges in navigating the Social Security process.⁶

Fibromyalgia is an unusual syndrome for another reason: it overwhelmingly affects women more often than men. In practical effect, therefore, fibromyalgia patients struggling to make disability claims are women. Moreover, these gendered disability claims are evaluated by a system that is already known to have a disparate effect according to the gender of the claimant. In 1992, the Ninth Circuit Gender Bias Task Force surveyed representatives of Social Security claimants to assess whether the evaluation process was gendered.⁷ Only thirty-nine percent of male representatives believed that the gender of a claimant affected the opinion of the medical experts evaluating his or her claim.⁸ Similarly, every male administrative law judge (ALJ) surveyed stated that gender played no role in making a determination of disability.⁹

By contrast, ninety-eight percent of female representatives believed that the gender of a claimant affected the opinion of medical experts.¹⁰ Female ALJs also said that many ALJs are biased as to the gender of claimants appearing before them.¹¹ Many scholars looking at the problems of women within the Social Security system blame this on bias on the part of ALJs tasked with evaluating the credibility of female claimants.¹²

It is the contention of this article that this does not tell the whole story.

24 J. RHEUMATOLOGY 1206 (1997) (conducting a study on the incidence of disability payments and concluding that it rose from 25% to 44.6% after 1988).

5. Jerome Groopman, *Hurting All Over*, THE NEW YORKER, Nov. 13, 2000, at 78; see also Wolfe et al., *supra* note 4.

6. See generally Aimée E. Bierman, Note, *The Medico-Legal Enigma of Fibromyalgia: Social Security Disability Determinations and Subjective Complaints of Pain*, 44 WAYNE L. REV. 259 (1998).

7. NINTH JUDICIAL CIRCUIT, UNITED STATES COURTS, THE PRELIMINARY REPORT OF THE NINTH CIRCUIT GENDER BIAS TASK FORCE, DECISION DRAFT 97 (1992).

8. Linda G. Mills, *Recent Development, A Calculus for Bias: How Malingering Females and Dependent Housewives Fare in the Social Security Disability System*, 16 HARV. WOMEN'S L.J. 211, 221 (1993).

9. *Id.* at 229.

10. *Id.* at 221.

11. *Id.* at 229.

12. See, e.g., Elaine Golin, Note, *Solving the Problem of Gender and Racial Bias in Administrative Adjudication*, 95 COLUM. L. REV. 1532, 1533 (1995); Mills, *supra* note 8.

Determinations of disability for the purpose of granting or denying Social Security benefits rest on a particular definition of disability as a clinically determinable state.¹³ Congress and the Social Security Administration (SSA) have delegated recognizing and identifying disabilities almost entirely to physicians, based upon a misguided belief that clinical medical evidence evaluated by a trained physician will answer with certainty whether an individual claimant is capable of working. Although the SSA and ALJs eventually make a final judgment of disability, physicians play a “critical gatekeeping role” in disability determinations, purportedly making the determination process objective.¹⁴ This places physicians in a peculiar and inappropriate role, wherein they are required to be decision makers in law as well as medicine, and called upon to make legal decisions in a context—the doctor’s office—that is designed for a very different purpose.

Certain types of disability claims and types of claimants, however, are disproportionately affected by this focus on clinical medical evidence. Fibromyalgia provides a helpful case study to evaluate and identify such claims. Examination of fact-specific circumstances is useful for evaluating whether the apparently neutral process of medical review generates truly neutral results, and surveying the fact-specific circumstances of fibromyalgia claims is an excellent test for the SSA’s process in this regard.

This article begins in Part I with an analysis of fibromyalgia as a disease and as a disability, and explains why people suffering from fibromyalgia cannot provide clinical medical evidence proving the severity of their symptoms. It then evaluates the interaction between fibromyalgia and the SSA’s supposedly neutral evaluation process, first turning in Part II to the Social Security Administration itself to explain the history of its reliance upon physicians to determine disability and how the evaluation process continues to defer to medical evidence and judgment. Part III focuses on the history of excess pain cases, characterized by claimants who

13. Although the government grapples with the definition of disability in other contexts, notably the Americans with Disabilities Act (ADA), defining and identifying “disability” began with and remains most common in the context of Social Security. Deirdre M. Smith, *Who Says You’re Disabled? The Role of Medical Evidence in the ADA Definition of Disability*, 82 TUL. L. REV. 1, 47 (2007). Additionally, the ADA is an antidiscrimination rather than a social welfare statute, and thus takes a different analytic approach to the definition of disability—an approach that some criticize as having “failed to achieve significant improvements in employment for people with disabilities.” Samuel R. Bagenstos, *The Future of Disability Law*, 114 YALE L.J. 1, 6 (2004). Similarly, other commentators have focused on the difficulty of bringing a successful worker’s compensation claim based on fibromyalgia, which uses a third and different approach. See Gené Stephens Connolly, *Hidden Illness, Chronic Pain: The Problems of Treatment and Recognition of Fibromyalgia in the Medical Community*, 5 DEPAUL J. HEALTH CARE L. 112 (2002).

14. Lars Noah, *Pigeonholing Illness: Medical Diagnosis as Legal Construct*, 50 HASTINGS L.J. 241, 282 (1999).

argue that their symptoms, rather than underlying disease or impairment alone, are the cause of their disability. Such cases, exemplified by fibromyalgia, have been the source of considerable difficulty for the SSA and courts. Part IV explains why the current standard for excess pain claims still fails to accurately and fairly assess fibromyalgia as a disability. Finally, Part V offers recommendations on how to better evaluate fibromyalgia claims, and what larger lessons can be drawn from fibromyalgia's example.

I. FIBROMYALGIA

Fibromyalgia is unlike most causes of disability in that it is neither a traumatic injury nor a disease. Rather, fibromyalgia is a syndrome, defined as "a form of chronic neuromuscular pain that meets statistically validated criteria."¹⁵ A form of rheumatism in the soft tissues,¹⁶ fibromyalgia is the second most common disorder seen by rheumatologists.¹⁷ While only about two percent of the population has fibromyalgia,¹⁸ diagnoses are strikingly gendered, with females making up between eighty and ninety percent of fibromyalgia sufferers.¹⁹

It is unclear how long the syndrome now described as fibromyalgia has been in existence. Tender points on the spine that are similar to some of the diagnostic criteria used today were first reported by a British physician in 1821,²⁰ but fibromyalgia was not identified as a distinct syndrome within the broader label of soft tissue rheumatism until the twentieth century. A more generic term, fibrositis, developed at the turn of the century to describe "diffuse aches and pains."²¹ Symptoms specific to what we now call fibromyalgia were first documented in Germany in

15. DANIEL J. WALLACE & JANICE BROCK WALLACE, *ALL ABOUT FIBROMYALGIA: A GUIDE FOR PATIENTS AND THEIR FAMILIES* 13 (2002) (emphasis omitted).

16. *Id.* at 9.

17. James A. Inman & Sandra L. Inman, *Fibromyalgia and the Americans with Disabilities Act: Overcoming Hurdles for Successful Litigation*, 13 MICH. ST. J. MED. & L. 39, 41 (2009).

18. John McBeth, *The Epidemiology of Chronic Widespread Pain and Fibromyalgia*, in FIBROMYALGIA & OTHER CENTRAL PAIN SYNDROMES 17, 17–18 (Daniel J. Wallace & Daniel J. Clauw eds., 2005).

19. See Michael Finch, *Law and the Problem of Pain*, 74 U. CIN. L. REV. 285, 289 n.23 (2005); Ruby Afram, Note, *New Diagnoses and the ADA: A Case Study of Fibromyalgia and Multiple Chemical Sensitivity*, 4 YALE J. HEALTH POL'Y L. & ETHICS 85, 93 (2004) (noting that women are ten times more likely than men to be diagnosed with fibromyalgia). See also McBeth, *supra* note 18, at 18 (estimating that 34 of 1,000 women suffer from fibromyalgia, versus 5 of 1,000 men).

20. Daniel J. Wallace, *The History of Fibromyalgia*, in FIBROMYALGIA & OTHER CENTRAL PAIN SYNDROMES, *supra* note 18, at 1, 2.

21. EDWARD SHORTER, *FROM PARALYSIS TO FATIGUE: A HISTORY OF PSYCHOSOMATIC ILLNESS IN THE MODERN ERA* 312 (1992).

1843,²² but the label “fibromyalgia” was not applied to those symptoms until 1976.²³

A patient with fibromyalgia generally complains of pain all over the body. Other common symptoms include stiffness, particularly in the joints, feelings of numbness or tingling, fatigue, and difficulty sleeping.²⁴ Because these symptoms are also associated with many other disorders, fibromyalgia is often a “diagnosis of exclusion,” made after other disorders are ruled out.²⁵

The American College of Rheumatology first published its diagnostic criteria for fibromyalgia in 1990.²⁶ A patient who has suffered from chronic and widespread pain is examined by his or her doctor, who applies pressure to specific “tender points” on the body. Fibromyalgia is diagnosed if the patient reports “excessive tenderness” in at least eleven of the eighteen tender points.²⁷ Obviously, because the diagnosis is made purely on the basis of a patient’s self-reported, subjective experience of pain, it could be argued that patients could easily fake symptoms in order to be diagnosed—although, as at least one court has pointed out, it would require, at minimum, researching and memorizing the eighteen tender points.²⁸ On the other hand, some physicians have criticized the tender

22. Amanda L. Van, Note, *Intolerable Uncertainty: An Examination of the Inconsistent Treatment of Fibromyalgia Under the Americans with Disabilities Act*, 27 T. JEFFERSON L. REV. 421, 426 (2005).

23. Afram, *supra* note 19, at 94.

24. Muhammad B. Yunus, *Symptoms and Signs of Fibromyalgia Syndrome: An Overview*, in FIBROMYALGIA & OTHER CENTRAL PAIN SYNDROMES, *supra* note 18, at 125, 125–27.

25. WALLACE & WALLACE, *supra* note 15, at 103.

26. Inman & Inman, *supra* note 17, at 41–42.

27. *Id.*

28. *Sarchet v. Chater*, 78 F.3d 305, 306–07 (7th Cir. 1996) (opinion for court by Posner). Noting that the symptoms are “easy to fake” is not to say that Posner was unsympathetic either to the individual plaintiff or skeptical of fibromyalgia in general—although he notes that fibromyalgia impacts only a minority of sufferers such that they cannot work, the court reversed the ALJ’s denial of benefits in this case. Judge Diane Wood later described Posner’s opinion in *Sarchet* by saying that “[n]o one could doubt from this passage or from the rest of the opinion that this woman’s medical condition received nothing but the most careful attention from the author of the opinion.” Hon. Diane P. Wood, *Health, Heart, and Mind: The Contributions of Richard A. Posner to Health Law and Policy*, 17 J. CONTEMP. HEALTH L. & POL’Y ix, xv (2000). Furthermore, in a later case also involving fibromyalgia, Posner articulated a robust defense of somatization versus malingering:

Pain is always subjective in the sense of being experienced in the brain. The question whether the experience is more acute because of a psychiatric condition is different from the question whether the applicant is pretending to experience pain, or more pain than she actually feels. The pain is genuine in the first, the psychiatric case, though fabricated in the second. The cases involving somatization recognize this distinction.

points diagnosis as too narrow, on the grounds that fibromyalgia is characterized by pain all over the body—almost *any* point on the body could be labeled a “tender point.”²⁹

The cause of fibromyalgia is currently unknown. Various theories have been considered by medical researchers, including a viral cause akin to the Epstein-Barr virus.³⁰ In the 1980s, many doctors believed that fibromyalgia was triggered by a traumatic event such as whiplash, and used the term “post-traumatic fibromyalgia syndrome,” but that theory and term are not in common usage today.³¹ Current research indicates that fibromyalgia patients may process pain differently than unaffected people. Some studies indicate that people with fibromyalgia have a higher level of chemicals that help amplify and transmit pain signals in their spinal fluid, and that they may have lower levels of serotonin, which helps to regulate those pain signals.³² Lyrica, the first drug approved by the FDA for the treatment of fibromyalgia, was initially developed to treat epilepsy by regulating electrical signals in the brain, but was discovered to ease fibromyalgia symptoms in some people, apparently because the drug regulates the signals causing chronic pain as well.³³ This state of flux in the medical understanding of fibromyalgia means that physicians called upon to evaluate the severity of an individual patient’s condition assess fibromyalgia from very different standpoints, depending on where they stand in the evolving clinical understanding of fibromyalgia.³⁴

Whatever the cause of fibromyalgia, the vast majority of people with fibromyalgia are not disabled by the condition. Thirty percent of fibromyalgia patients are homemakers or retired, and sixty percent work full time.³⁵ Only ten percent are disabled, wholly or partly, by their condition.³⁶

Carradine v. Barnhart, 360 F.3d 751, 755 (7th Cir. 2004).

29. ANDREW MALLESON, WHIPLASH AND OTHER USEFUL ILLNESSES 169–70 (2002).

30. Nat’l Inst. of Arthritis & Musculoskeletal & Skin Diseases, *Fibromyalgia Research: Challenges and Opportunities*, COUNSELLING [sic] RESOURCES EXTRAS (last visited Sept. 24, 2011), <http://crextras.com/lib/articles/distress/chronic/fibromyalgia/fibromyalgia-research/>.

31. MALLESON, *supra* note 29, at 166.

32. Joel Everest, Note, *Fibromyalgia and Workers’ Compensation: Controversy, Problems, and Injustice*, 60 ALA. L. REV. 1031, 1033–34 (2009).

33. *Id.* at 1036. See also Charles H. Bombadier & Dedra Buchwald, *Chronic Fatigue, Chronic Fatigue Syndrome, and Fibromyalgia: Disability and Health-Care Use*, 34 MED. CARE 924, 929 (1996) (noting that fifteen percent of more than 550 clinic patients with fibromyalgia and/or chronic fatigue surveyed self-reported social security disability benefits).

34. Frederick Wolfe, *Fibromyalgia: On Diagnoses and Certainty*, in MUSCULOSKELETAL PAIN, MYOFASCIAL PAIN SYNDROME, AND THE FIBROMYALGIA SYNDROME 17, 17 (Soren Jacobson et al. eds., 1992).

35. Daniel J. Wallace, *The Economic Impact of Fibromyalgia on Society and Disability Issues*, in FIBROMYALGIA & OTHER CENTRAL PAIN SYNDROMES, *supra* note 18, at 395, 396.

36. *Id.*

Finally, as with many syndromes without clear cause, there are many people, including physicians, who doubt that fibromyalgia actually exists. Even some physicians involved in the identification of fibromyalgia are now skeptical that it is a “real” disorder. Some believe that fibromyalgia patients exaggerate what are for other people quite normal levels of pain. For example, the psychiatrist Chan Gunn stated that “fibromyalgia merely describes the most extreme and extensive of mundane aches and pains that we all have, in various degrees, at one time or another.”³⁷ Doctor Frederick Wolfe, who played a major role in the development of fibromyalgia as a distinct disorder, now rejects it as “the emperor’s new clothes,” and believes that “we are creating an illness rather than curing one.”³⁸

The subjective nature of diagnosing fibromyalgia is frequently singled out as a source of skepticism. Andrew Malleon describes fibromyalgia’s emergence as “providential” for rheumatologists, whose diagnoses he believes are just as subjective as the self-reported pain by patients:

The presence of tender points is far from being an objective sign of disease, however. The examiner has to use subjective judgment as to how hard to press, and the patient has to evaluate subjectively when the pressure becomes painful. Attempts have been made to replace the examiner’s finger or thumb with a dolorimeter (an instrument adapted from the one used by the Egg Marketing Board to test the fragility of egg shells by delivering a measured amount of pressure), but they have been unsuccessful.... The fact that an *objective* dolorimeter performs less well than an examiner’s finger seems to illustrate the degree to which a rheumatologist’s subjectivity is involved in the detection of tender points. There is no reason to suppose that a patient’s subjectivity is any less involved.³⁹

Focusing on the patients, Edward Shorter described a story on fibromyalgia in *The New York Times* that included a chart of tender points as providing “a virtual roadmap for the unconscious,” concluding that “[t]housands of readers must have been suggested into coalescing their inchoate bodily symptoms into fibromyalgia as a result of this story.”⁴⁰

Regardless of this continuing doubt as to the legitimacy of the disease itself as well as the diagnosis of fibromyalgia, the Social Security Administration has recognized it as a “real” disorder that can be the basis, if properly supported, for a claim of disability.⁴¹ Part II follows the path of

37. MALLESON, *supra* note 29, at 178.

38. Groopman, *supra* note 5, at 78.

39. MALLESON, *supra* note 29, at 167–68.

40. SHORTER, *supra* note 21, at 316; see also Kristin Barker, *Self-Help Literature and the Making of an Illness Identity: The Case of Fibromyalgia*, 49 SOCIAL PROBLEMS 279 (2002).

41. Social Security Administration, Memorandum, *Fibromyalgia, Chronic Fatigue*

a fibromyalgia claimant through the Social Security evaluation process.

II. THE SOCIAL SECURITY ADMINISTRATION'S RELIANCE ON PHYSICIANS

There are two programs administered by the Social Security Administration. The older program, begun in 1935, is the Old Age, Survivors, and Disability Insurance Benefits Program (OASDI).⁴² The second is the Supplemental Security Income Program (SSI).⁴³ OASDI is more analogous to an insurance program, in that potential recipients must have paid taxes into the program in order to be eligible, and benefits are tied to a recipient's previous income.⁴⁴ In contrast, SSI disability benefits are need-based, and benefits are not contingent on a past work history.⁴⁵ A recent analysis of the demographics of the two programs found that OASDI recipients are 68% male, while recipients of SSI are skewed almost exactly to the opposite gender; 69% female.⁴⁶ Both programs provide disability insurance, and both use the same standards to ascertain disability. These standards, as this Part will outline, rely heavily on clinical medical evidence and the judgments of physicians—evidence that, as the next Part will discuss, presents particular problems for women.

A. *The History of Delegation to Physicians*

When Congress began to consider a long-term disability insurance program, some programs already existed to support disabled workers. All, however, were specific to types of jobs, such as veterans, railroad workers, the civil service, or disability protections in collective bargaining contracts.⁴⁷ The disputes regarding a broader disability program, therefore, were not focused on the proposed existence of the program so much as its implementation. As Deborah A. Stone points out in *The Disabled State*, because disability was already recognized as an “administrative category of entitlement” in some circumstances, the key controversy “centered on the

Syndrome, Objective Medical Evidence Requirements for Disability Adjudication 1 (May 11, 1998).

42. Peter V. Lee, Sheri Porath & Joan E. Schaffner, *Engendering Social Security Disability Determinations: The Path of a Woman Claimant*, 68 TUL. L. REV. 1477, 1483 (1994).

43. *Id.* at 1482.

44. *Id.*

45. *Id.* at 1483.

46. *Id.* at 1483–84. This disparity is likely due to the varying rates of participation in the workforce by gender.

47. DEBORAH A. STONE, *THE DISABLED STATE* 69 (1984).

definition of disability and the process of disability certification."⁴⁸

The two biggest hurdles for a broad insurance program based on disability were the administrative feasibility of determining disability claims and the cost of such a program.⁴⁹ From the beginning of debate about disability insurance, policymakers latched onto the idea of medically objective determination of disability as a way of constraining both the administrative and overall costs.⁵⁰ An Advisory Council report, for example, described reliance on "objective" medical judgments as a way to forestall "the problems involved in the adjudication of claims based on purely subjective symptoms."⁵¹ By restricting disability compensation to those disabilities "which can be objectively determined by medical examination or tests.... [t]he danger of malingering which might be involved in connection with such [subjective] claims would... be avoided."⁵²

When Congress debated the creation of Social Security disability insurance, supporters of a broad disability insurance program stressed the supposedly objective determination of disability made by physicians.⁵³ Congress had previously relied upon medical determinations in 1954, when it instituted a "disability freeze" for potential OASDI recipients.⁵⁴ Under the disability freeze, a worker who became disabled to the point that he was unable to continue working had his employment status "frozen," so that years later he would still be deemed eligible for OASDI retirement benefits even though he had spent some period of time since the onset of his disability not working.⁵⁵ Congress had created a panel of medical experts to draft a set of clinical guidelines establishing how to assess claims of eligibility for the disability freeze.⁵⁶

Faced with the prospect of a program in which benefits would be triggered by disability status, Congress again wanted to delegate the definition of disability to doctors. Presented with the suggestion, physicians testified before Congress that such determinations would not be as easy as politicians believed. For example, a representative from the

48. *Id.*

49. *Id.* at 71–72.

50. *Id.* at 111.

51. COMM. ON IMPROVING THE DISABILITY DECISION PROCESS, BD. ON MILITARY & VETERANS HEALTH, IMPROVING THE SOCIAL SECURITY DISABILITY DECISION PROCESS 73, (John D. Stobo et al. eds., 2007).

52. *Id.* at 79; see also Mary Crossley, *The Disability Kaleidoscope*, 74 NOTRE DAME L. REV. 621, 629 (1999).

53. Matthew Diller, *Entitlement and Exclusion: The Role of Disability in the Social Welfare System*, 44 UCLA L. REV. 361, 408 (1996).

54. Frank S. Bloch, *Medical Proof, Social Policy, and Social Security's Medically Centered Definition of Disability*, 92 CORNELL L. REV. 189, 197 (2007).

55. *Id.*

56. *Id.*

American Medical Association testified that “[t]he medical profession is concerned that they may be placed in the role of a policeman... the vast majority of the medical profession feel that the determination of disability is hazardous and difficult.”⁵⁷ Indeed, the majority of physicians who spoke to Congress “attempted to persuade Congressmen that physicians could not possibly provide the kind of objective determination desired by program advocates.”⁵⁸

Nonetheless, multiple members of Congress spoke confidently of the ease with which doctors could sort through disabled and non-disabled claimants. Senator Walter F. George of Georgia argued,

[M]any American doctors are afraid that they cannot determine when a man or a woman is disabled, when the plain requirement is that the disability must be a medically determined physical or mental impairment. Doctors have less confidence in themselves than I have.... I think more of the medical profession in this country than to believe that they cannot determine when a man or a woman worker has a permanent and total disability.⁵⁹

Similarly, Senator Albert Gore, Sr. invoked private insurance policies as well as other civil service retirement programs that determined disability by medical evaluation, and pointedly argued that because Members of Congress themselves were covered by programs that utilized the “accepted practice” of determining disability by medical evaluation, it was not “a sufficient answer to question the efficacy of medical determination.”⁶⁰

In keeping with this faith, the legislation enacted in 1956 emphasized a clinical determination of impairment.⁶¹ From the very creation of the Social Security disability insurance program, therefore, belief in the feasibility and integrity of the program rested upon “faith in the techniques of medical examination and the powers of clinical judgment.”⁶² From the outset, clinical and “objective” tests were seen as the reliable antidote to purely subjective complaints brought by malingerers or fraudulent opportunists.

57. 102 CONG. REC. 13,046 (1956) (alterations in original).

58. STONE, *supra* note 47, at 80.

59. 102 CONG. REC. 13,038 (1956). Ironically, later in the debate Senator Long, responding to “the argument that the medical profession could not determine disability,” listed the most common causes of disability according to government statistics as arteriosclerosis, vascular lesions of the central nervous system, pulmonary tuberculosis, hypertension, and then “the only one as to which the medical profession might possibly have some difficulty in determining disability—rheumatoid arthritis.” 102 CONG. REC. 13,039 (1956).

60. 102 CONG. REC. 13,052 (1956) (noting the second objection as the fear of free riders).

61. Crossley, *supra* note 52, at 629.

62. STONE, *supra* note 47, at 83.

B. *The Social Security Administration's Sequential Evaluation of Disability*

Under federal law, “[a]n individual shall not be considered to be under a disability unless he furnishes such medical and other evidence of the existence thereof as the Commissioner of Social Security may require.”⁶³ Subjective reports of symptoms are not, taken alone, sufficient to show disability. As Part III explains further, “there must be medical signs and findings, established by medically acceptable clinical or laboratory diagnostic techniques, which show the existence of a medical impairment that results from anatomical, physiological, or psychological abnormalities.”⁶⁴

In assessing a claim for disability benefits, the Social Security Administration conducts a sequential five-step process.⁶⁵ First, a claimant must have been unable to perform substantial gainful activity for at least one year.⁶⁶ The SSA defines substantial work activity as “work activity that involves doing significant physical or mental activities,” and gainful work activity as work activity “that you do for pay or profit.”⁶⁷ If a claimant is employed, federal regulations specify a monthly average income above which employment is automatically deemed substantial gainful activity.⁶⁸

Second, the SSA evaluates whether a claimant’s impairment (or each impairment, if a claimant alleges that she has more than one impairment) is severe.⁶⁹ In order to be severe, an impairment must “significantly limit [a claimant’s] physical or mental ability to do basic work activities.”⁷⁰ If an impairment is not severe, it may nonetheless be considered part of the claimant’s overall medical condition in later steps in the evaluation, but a

63. 42 U.S.C. § 423(d)(5)(A) (2000).

64. *Id.*

65. 20 C.F.R. § 404.905(a)(1) (2011).

66. *Id.*

67. *Id.* § 416.972(a), (b).

68. *Id.* § 416.974(b).

69. 20 C.F.R. § 416.920(a)(4)(2).

70. *Id.* § 416.920(c) (2011). Note that this is different than the ADA’s definition of disability, which requires a claimant to show that the alleged physical or mental impairment causes substantial limitation of a major life activity. Inman & Inman, *supra* note 17, at 45–49 (assessing in detail fibromyalgia litigants’ treatment under the ADA definition of disability). The “limitation of a major life activity” showing required by the ADA definition of disability is even harder for fibromyalgia patients to demonstrate, as the limitations they face are often related to duration of activities rather than to individual activities being prohibited entirely. *Id.* For further comparison between the treatment of disability in the ADA and Social Security, see generally Matthew Diller, *Dissonant Disability Policies: The Tensions Between the Americans with Disabilities Act and Federal Disability Benefit Programs*, 76 TEX. L. REV. 1003 (1998).

non-severe impairment is by definition non-disabling taken alone.⁷¹

Third, the SSA consults a regulatory Listing of Impairments.⁷² This Listing began as a set of guidelines developed by a panel of physicians intended to provide another physician-generated “objective” measure of disability.⁷³ If a claimant’s severe impairment appears on the list, or is equivalent to an impairment on the list, then the claimant is presumptively found to be disabled and the SSA’s evaluation ends.⁷⁴ If, however, the impairment is not on the list, then the SSA proceeds with the final two steps of evaluation.⁷⁵

The fourth step is to determine a claimant’s residual functional capacity (RFC).⁷⁶ A claimant’s RFC is what ability a claimant has in a work setting despite the physical or mental limitations due to her impairments.⁷⁷ The SSA will consider both severe and non-severe impairments in determining a claimant’s RFC, and will consider both medical and nonmedical evidence such as testimony from the claimant or observations from people close to her—although, as described below, the weight given to such evidence varies.⁷⁸

Finally, having determined what work activities the claimant is capable of, the SSA asks whether there is any work in the national economy that the claimant can perform.⁷⁹ The SSA first assesses whether the claimant can still do any job constituting substantial gainful activity that she had within the last fifteen years.⁸⁰ If not, the SSA then asks whether the claimant can perform *any* job that “exists in significant numbers in the national economy.”⁸¹ There are two ways to answer this question. First, the SSA has a grid that matches limitations with available jobs.⁸² This takes into account both the functional limitations—the medical impairments already assessed to determine the claimant’s RFC—and vocational limitations, meaning the age, education level, and past work experience of a claimant.⁸³ For example, jobs are classified as unskilled,

71. 20 C.F.R. § 404.920(c).

72. *Id.* § 416.920(d).

73. Diller, *supra* note 53, at 416–17.

74. 20 C.F.R. § 404.920(a)(4)(iii).

75. *Id.*

76. *Id.* § 416.920(a)(4)(iv).

77. 20 C.F.R. § 416.945.

78. *Id.* § 416.945(a).

79. *Id.* § 416.920(f).

80. *Id.* § 416.960(b).

81. *Id.* § 416.960(c).

82. 20 C.F.R. § 416.905(a).

83. 20 C.F.R. Pt. 404, Subpt. P, App. (2011). As Linda G. Mills pointed out, the more transferable skills a claimant has, the more likely that jobs can be found in the national economy that they can perform, and thus the less likely they are to be found to be disabled. In other words, people who have no work history at all (often homemakers) or people whose

semi-skilled, or skilled, in order to be able to label categories of jobs that a claimant can perform.⁸⁴ If the claimant's RFC can be matched to the grid, the SSA evaluator can either confirm that no jobs exist that she can perform or point to a list of jobs that she should be able to do.⁸⁵ If the claimant's RFC does not fit into the grid, however, then the SSA can call upon a vocational expert.⁸⁶ The grid focuses on physical or exertional limitations, so if a claimant has nonexertional limitations, a combination of exertional and nonexertional limitations, or her abilities do not fall within a predetermined skill level, a vocational expert will often be called to assess jobs that might be available to the claimant. Only if the SSA determines that there are no jobs that the claimant is capable of performing will the claimant be awarded disability benefits.⁸⁷

The first decision regarding the application is made by the Disability Determination Service (DDS), generally a state disability examiner and a state medical and/or psychological consultant, who review the specific medical claims. The first evaluation is conducted solely on paper—the DDS examiner and consultant review the application and relevant records sent in and make a determination on the records alone. The DDS examiner may, if she believes it necessary, require the claimant to be evaluated by a consulting physician—but again, all the examiner will eventually see is a report prepared by the consultant.⁸⁸

If a claimant's application is denied, she has three levels of administrative review available to her. First, she can request a *de novo* reconsideration of her application by the relevant DDS.⁸⁹ At that point, she may submit more evidence to supplement her claim.⁹⁰ Second, she can ask for a hearing before an agency ALJ.⁹¹ Such a hearing is the first time that the claimant will have an opportunity to testify on her own behalf.⁹² She may also call upon other witnesses to testify.⁹³ Furthermore, the ALJ has a statutory duty to develop a full and fair record of the claimant's condition.⁹⁴ Thus, the ALJ asks the claimant questions, and can request

job-related skills are purely physical (often men with strenuous jobs) are the least likely to have transferable skills. Mills, *supra* note 8, at 221.

84. 20 C.F.R. § 416.968.

85. 20 C.F.R. Pt. 404, Subpt. P, App. 200.00(a).

86. Rawlings v. Astrue, 318 Fed. App'x 593, 595 (9th Cir. 2009).

87. 20 C.F.R. § 416.905(a).

88. Mills, *supra* note 8, at 215.

89. 20 C.F.R. § 404.913 (1992); Mills, *supra* note 8, at 215–16.

90. Mills, *supra* note 8, at 216.

91. 20 C.F.R. § 404.929 (1992).

92. Anthony Taibi, *Politics and Due Process: The Rhetoric of Social Security Disability Law*, 1990 DUKE L.J. 913, 925 (1990).

93. 20 C.F.R. 404.950 (2010).

94. 42 U.S.C.A. § 405(b)(1) (2010).

that the claimant provide more documentary evidence.⁹⁵ The facts entered into the record before the ALJ form the record for all future appeals.⁹⁶ Finally, the ALJ also assesses the claimant's credibility; particularly important if subjective reports of symptoms make up a significant part of her disability claim.

Finally, if the ALJ affirms denial of benefits, the claimant may appeal to the SSA's Appeals Council.⁹⁷ The Council will only review the case on appeal in limited circumstances: if the ALJ abused her discretion, if the ALJ made an error of law in evaluating the claim, if the ALJ's findings were not supported by substantial evidence, or if there is a "broad policy or procedural issue that may affect the general public interest."⁹⁸ Additionally, the Appeals Council initiates its own review of cases "through random and selective sampling techniques,"⁹⁹ and will accept cases remanded by federal courts.¹⁰⁰

A few salient points may thus be gleaned from the path of a Social Security claim. First, in the case of a condition that is not per se disabling, the level of a claimant's symptoms is immensely important. In other words, if the claimant's impairments do not meet or equal a listed impairment, she will only be found disabled if her residual functional capacity is so low that there is no work in the national economy that she can perform. Her RFC, in turn, will be determined by which and how much of her reported symptoms are credited by the evaluator. Second, it takes several steps of review before a claimant ever meets the evaluator assessing her application. Instead, the SSA evaluator weighs the opinions of several physicians in deciding on a claim. Even the claimant's statements about the history of her illness are seen through her treating physician's notes. As a result, the opinions and records of physicians as to a claimant's self-reported symptoms are near-determinative of her disability status.

C. *The Reliance on Clinical Medical Evidence*

Evaluation of a claimant's medical conditions takes place at several

95. 20 C.F.R. § 404.929 ("The administrative law judge who conducts the hearing may ask you questions."); *id.* § 404.944 ("The administrative law judge may stop the hearing temporarily and continue it at a later date if he or she believes that there is material evidence missing at the hearing."). See Jeffrey S. Wolfe & Lisa B. Proszek, *Interaction Dynamics in Federal Administrative Decision Making: The Role of the Inquisitorial Judge and the Adversarial Lawyer*, 33 TULSA L.J. 293 (1997).

96. Lee et al, *supra* note 42, at 1503.

97. *Id.* at 1485.

98. 20 C.F.R. § 416.1470.

99. *Id.* § 416.1469.

100. *Id.* § 416.1483.

points within the process outlined above. No matter when assessment of medical evidence or a claimant's health takes place within the process, there are common threads of reliance on clinical judgment.

The focus on clinical evidence rather than symptoms is grounded in the Social Security Act itself: a qualifying impairment must, by law, "result[] from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques."¹⁰¹

In federal regulations, the SSA states that it will consider all of a claimant's symptoms, including pain, "and the extent to which your symptoms can reasonably be accepted as consistent with the objective medical evidence."¹⁰² Regulations go on, however, to make clear that symptoms alone cannot show disability:

However, statements about your pain or other symptoms will not alone establish that you are disabled; there must be medical signs and laboratory findings which show that you have a medical impairment(s) which could reasonably be expected to produce the pain or other symptoms alleged and which, when considered with all of the other evidence (including statements about the intensity and persistence of your pain or other symptoms which may reasonably be accepted as consistent with the medical signs and laboratory findings), would lead to a conclusion that you are disabled.¹⁰³

Regulations reiterate this focus on clinical evidence with reference to specific points in the five-step evaluation process. For example, when the SSA evaluates the severity of a claimant's alleged impairments, regulations echo the statutory requirement that any impairment result from "abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques."¹⁰⁴

The SSA also creates a clear hierarchy of whose opinion is accorded more weight, with certain kinds of medical professionals granted more deference. Regulations specify a category of "acceptable medical sources," which are listed as licensed physicians, psychologists, optometrists ("for purposes of establishing visual disorders only"), podiatrists ("for purposes of establishing impairments of the foot... only"); and qualified speech-language pathologists ("for purposes of establishing speech or language impairments only").¹⁰⁵ This is in contrast to "other sources," such as medical sources not listed as "acceptable medical sources" (chiropractors,

101. 42 U.S.C. § 423(d)(3) (2000).

102. 20 C.F.R. § 416.929.

103. *Id.*

104. *Id.* § 416.908.

105. *Id.* § 416.913(a).

for example) and non-medical sources such as spouses, friends, and caregivers, who may provide evidence that the SSA will use to assess the severity of an impairment and how it affects the claimant's ability to work (but not the existence of the impairment).¹⁰⁶

Even within the category of acceptable medical sources, there is a hierarchy. As regulations explain, “[g]enerally,” the SSA gives more weight to opinions given by a claimant's treating physicians.¹⁰⁷ (Similarly, the SSA gives more weight to the opinion of a physician who has examined the claimant than to the opinion of a medical source who did not personally examine the claimant but merely reviewed the claimant's medical records).¹⁰⁸ The treating physician's opinion, however, will only be given controlling weight if the opinion is “well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence.”¹⁰⁹ Regulations further explain that the more evidence a medical source provides, “particularly medical signs and laboratory findings,” the more weight the source's opinion will be given.¹¹⁰

As a result, information about a claimant's condition is mitigated in several ways. Her limitations are viewed through the lens of physicians, either those who have treated her or physicians consulted by the SSA, and those physicians' opinions are weighed according to their relationship to her and to the extent that each has grounded his or her opinions clearly in clinical evidence.

What if, however, fundamental portions of a disability claim cannot be shown through clinical evidence at all? The next Part deals with this question by examining the paradigm of this problem: excess pain.

III. OBJECTIVITY, SUBJECTIVITY AND CREDIBILITY IN PROOF OF EXCESS PAIN

Fibromyalgia is one example of a type of case that historically has been difficult for the SSA to evaluate. Known as excess pain cases, such claims are characterized by the alleged disabling condition being a *symptom*—pain—rather than simply the existence of an underlying disease or injury. As discussed above, one problem with excess pain cases is that the identification of disability was, from the outset, delegated to physicians who were supposed to be able to ascertain with objective certainty whether a person was disabled or not.

106. *Id.* § 416.913(d).

107. 20 C.F.R. § 416.927(d)(2) (2011).

108. *Id.* § 416.927(d)(1).

109. *Id.* § 416.927(d)(2).

110. *Id.* § 416.927(d)(3).

The inquiry into excess pain, however, is not a single yes/no identification of pain. By definition, it must also include a judgment of whether the claimant should or should not be disabled by the identified amount of pain. In other words, an assessment of disability based on pain involves two steps: first, assess the level of pain; and second, evaluate whether that pain is so severe that the claimant is actually incapacitated by it. An evaluator might find that pain is not disabling not because he believes no pain exists, but because he concludes that the claimant should be able to work despite her pain. Judging whether pain is disabling, therefore, involves a normative judgment of the character of the claimant.

Thus, there are two reasons why an SSA adjudicator might be skeptical of the excess pain claimant. First, excess pain symptoms might be seen to be somatic disorders: “pain symptoms are exaggerated or feigned and, ultimately, within the control of the sufferer.”¹¹¹ Second, as Lance Liebman argues, “disability as society’s categorization of those honorably disqualified from work”¹¹² invites judgment as to a claimant’s fortitude as compared to her suffering:

The claimant alleges that a certain injury is so painful that he cannot perform any work. The Secretary concludes that, because similar injuries have not completely disabled other workers, inability to work is caused by a failure of will, and hence he labels the disability as nonmedical. When courts review those cases, their opinions express a social judgment as to whether *that* level of pain is a sufficient reason to quit work altogether.¹¹³

The following traces the SSA’s reluctance to recognize any excess pain claims, and the development of a compromise standard by which such claims are currently evaluated.

A. *Before 1984*

As discussed above, the Social Security Act created a clear standard requiring clinical evidence of the existence of an impairment. For the first two and a half decades of SSI’s existence, there was not a clear standard as to what was required to show the severity of an impairment’s symptom—in other words, how to treat claims that symptoms, such as pain, caused a claimant’s disability.

The SSA issued regulations in 1961 that addressed how to prove symptoms such as pain, requiring the claimant to prove that the alleged

111. Finch, *supra* note 19, at 288.

112. Lance Liebman, *The Definition of Disability in Social Security and Supplemental Security Income: Drawing the Bounds of Social Welfare Estates*, 89 HARV. L. REV. 833, 852 (1976).

113. *Id.* at 852–53.

symptoms were caused by “structural, physiological or psychological changes which can be identified by the use of clinical and laboratory diagnostic techniques.”¹¹⁴ This standard illustrates the difficulty of regulating symptoms: it was already clear from the Social Security Act that a claimant must have some identifiable underlying impairment. The difficulty for excess pain claims goes one step further: how much information about the symptom must the claimant prove with objective, clinical evidence? Is it enough to show the existence of an impairment that might cause some level of pain, or must the claimant show clinical evidence of the *level* of pain she is experiencing? The 1961 regulations were typical of the early approach: they do not speak to the second question at all.

As a result, there was a great deal of variety in treatment of very similar claims. Even after appealing through the SSA into federal courts, some courts would credit subjective evidence of pain as sufficient to require a finding of disability.¹¹⁵ Two important developments began to change the field in 1980. First, the SSA issued regulations that said that symptoms such as pain could be the basis for a disability claim, as long as claimants could show clinical evidence of an underlying impairment causing the symptoms.¹¹⁶ The regulations did not make clear, however, whether the clinical evidence had to speak to the level of symptom as well. Second, Congress passed the Social Security Disability Amendments of 1980.¹¹⁷ The Amendments were intended to address the danger of malingers; claimants exaggerating their symptoms in the hopes of receiving benefits.¹¹⁸ A main element of the Amendments was to require “eligibility reviews” of benefit recipients every three years.¹¹⁹ In practice, the eligibility reviews resulted in considerable confusion: between 1980 and 1983, half a million people receiving benefits—many of them people with chronic pain problems—had their benefits terminated at the state level. Of those who appealed, however, sixty percent had their benefits reinstated.¹²⁰ Although eligibility reviews had a significant practical effect on claimants with excess pain, the real significance of the Amendments

114. 26 Fed. Reg. 5572 (1961).

115. Erin Margaret Masson, Note, *Social Security Administration Nonacquiescence on the Standard for Evaluating Pain*, 36 WM. & MARY L. REV. 1819, 1832–33 (1995).

116. Bloch, *supra* note 54, at 204–05.

117. *Historical Background and Development of Social Security*, SOCIAL SECURITY ONLINE (last visited Oct. 1, 2011), <http://www.ssa.gov/history/briefhistory3.html>.

118. *Id.*

119. Margaret C. Rodgers, Comment, *Subjective Pain Testimony in Disability Determination Proceedings: Can Pain Alone Be Disabling?* 28 CAL. W. L. REV. 173, 175 (1992).

120. Masson, *supra* note 115, at 1831 n.90.

was the ensuing protest.¹²¹ After the eligibility reviews came under serious criticism, Congress would eventually pass another set of amendments in 1984 that, for the first time, spoke directly to excess pain.¹²²

In the meantime, the SSA issued its first ruling specifically dealing with pain titled "Evaluation of Symptoms."¹²³ Ruling 82-58, as the First Circuit would later describe it, "seem[ed] to speak out of both sides of its mouth" when describing how much objective evidence a claimant had to present supporting the level of symptoms she alleged.¹²⁴

The ruling required that a claimant provide "objective clinical findings, including clinical data and a well-documented medical history," to show both the existence of pain *and* "the intensity and persistence of pain and its effect on the claimant's ability to work."¹²⁵ As the Eighth Circuit later described, the SSA subsequently "conceded" that "some adjudicators may have misinterpreted" SSR 82-58 to reject disability claims based on pain because they were unable to provide objective clinical findings that "fully corroborated" their claim.¹²⁶ On the one hand, the ruling acknowledged that "[s]ymptoms can sometimes suggest a greater severity of impairment than is demonstrated by objective medical findings alone."¹²⁷ This implies that the SSA might credit a claimant's reports of symptoms to support a finding of disability where the clinical evidence alone would not rise to that level. In other places, however, the ruling seems to require that a claimant present clinical evidence of the level of symptoms before those symptoms would be taken into account. For example, the ruling begins, "Symptoms will not have a significant effect on a disability determination or decision unless medical signs or findings show that a medical condition is present that could reasonably be expected to produce the symptoms which are alleged or reported."¹²⁸ Similarly, the ruling later states that "[c]linical and laboratory data and a well-documented medical history must establish findings which may reasonably account for the symptom in a particular impairment."¹²⁹ In a section explaining how to determine the impact of symptoms on a claimant's RFC, the ruling states that "any additional symptom-related functional limitations

121. See Ellen Smith Pryor, *Compensation and the Ineradicable Problems of Pain*, 59 GEO. WASH. L. REV. 239, 259 (1991).

122. *Id.* at 260.

123. Disability—Evaluation of Subjective Symptoms, Including Pain, Social Security Ruling 82-58, [Mar.-Feb. Transfer Binder] Unempl. Ins. Rep. (CCH) ¶ 14,358 (Oct. 1982) [hereinafter SSR 82-58].

124. *Avery v. Sec. of HHS*, 797 F.2d 19, 21 (1st Cir. 1986).

125. SSR 82-58, *supra* note 123.

126. *Polaski v. Heckler*, 739 F.2d 1320, 1322 (8th Cir. 1984).

127. SSR 82-58, *supra* note 123, at 2.

128. *Id.* at 1.

129. *Id.*

must largely be inferred from the history and the objective physical findings... and from medical knowledge as to what symptom-related effects on functional capacity can be reasonably expected.”¹³⁰ Relying on the latter language, the ruling was often interpreted to require that claimant’s produce clinical proof of the severity of their symptoms, and not just the underlying impairment.¹³¹

B. 1984 to 1991

The standard set out in Ruling 82-58 was controversial, and some courts resisted requiring claimants to prove the intensity of their symptoms.¹³² In response, Congress passed a Social Security Disability Benefits Reform Act in 1984 addressing the question of excess pain symptoms in an attempt to rein in “a judicial trend allowing ‘subjective’ evidence to carry the day in the disability calculus.”¹³³ Section 3, dealing with excess pain, read in part:

An individual’s statements as to pain or other symptoms shall not alone be conclusive evidence of disability as defined in this section; there must be medical signs and findings, established by medically acceptable clinical or laboratory diagnostic techniques, which show the existence of a medical impairment that results from anatomical, physiological, or psychological abnormalities which could reasonably be expected to produce the pain or other symptoms alleged and which, when considered with all evidence required to be furnished under this paragraph (including statements of the individual or his physician as to the intensity and persistence of such pain or other symptoms which may reasonably be accepted as consistent with the medical signs and findings), would lead to a conclusion that the individual is under a disability. Objective medical evidence of pain or other symptoms established by medically acceptable clinical or laboratory techniques (for example, deteriorating nerve or muscle tissue) must be considered in reaching a conclusion as to whether the individual is under a disability.¹³⁴

This standard was explicitly a temporary measure, set to expire at the end of 1986.¹³⁵ The Act directed the creation of a commission on pain to

130. *Id.* at 2.

131. Bloch, *supra* note 54, at 205.

132. Masson, *supra* note 115, at 1833.

133. Pryor, *supra* note 121, at 265–66.

134. 42 U.S.C. § 423(4)(A).

135. Social Security Disability Benefits Reform Act of 1984, Pub.L. No. 98-460, § 3(b)(6), 98 Stat. 1794, 1800.

help create a permanent standard before the 1984 standard expired.¹³⁶

The temporary language, however, did not clarify the standard for all evaluators.¹³⁷ Courts were not in agreement about whether the Act reiterated the existing standard as articulated by the SSA, or whether it changed the standard.¹³⁸

Furthermore, the SSA had just begun a protracted battle with the Fourth Circuit Court of Appeals over how the Circuit dealt with excess pain claims. A class action had been brought in North Carolina against the SSA, alleging among other things that SSR 82-58 was in conflict with a 1980 Fourth Circuit decision holding that the impact of pain on a claimant's ability to work should be considered even if the level of pain was shown only by subjective evidence.¹³⁹ The Fourth Circuit required medical evidence to show *existence* of an impairment that could reasonably be expected to produce pain, but did not require any medical evidence as to the *severity* of the pain, and thus would credit a credible claimant's subjective testimony alone.¹⁴⁰ By contrast, the SSA continued to require clinical evidence of both the existence and the severity of pain.¹⁴¹ The plaintiffs in the litigation repeatedly won reversals in their favor from the Fourth Circuit, but the SSA engaged in protracted court battles against the judgments.¹⁴²

Although the Commission on the Evaluation of Pain issued a report in June 1986, it did not propose a standard for evaluating excess pain claims, and the Reform Act's standard expired without replacement on January 1, 1987.¹⁴³ In 1988, the SSA issued ruling 88-13, at least partially in response to the Fourth Circuit conflicts.¹⁴⁴ The language of the ruling was not as strict as SSR 82-58, and arguably could allow some amount of reliance on a claimant's testimony as to her symptoms:

[R]easonable conclusions as to any limitations on the individual's ability to do basic work activities can be derived from the consideration of other information in conjunction with medical evidence. This is consistent with court decisions which require that statements of the claimant or his/her physician as to the

136. *Id.*

137. Masson, *supra* note 115, at 1831-32.

138. John C. Dubin, *Poverty, Pain, and Precedent: The Fifth Circuit's Social Security Jurisprudence*, 25 ST. MARY'S L.J. 81, 118 (1993).

139. Myers v. Califano, 611 F.2d 980, 983 (4th Cir. 1980).

140. *Id.* at 983.

141. Masson, *supra* note 115, at 1819-20.

142. *See generally id.*

143. Dubin, *supra* note 138, at 125.

144. Disability--Standards for Evaluating Subjective Complaints of Pain and Other Symptoms, Social Security Ruling 88-13, [July-Dec. Transfer Binder] Unempl. Ins. Rep. (CCH) ¶ 14,118A (July 20, 1988) [hereinafter SSR 88-13].

intensity and persistence of pain or other symptoms which may reasonably be accepted as consistent with the medical signs and laboratory findings are to be included in the evidence to be considered in making a disability determination.¹⁴⁵

In the statement of purpose, however, the ruling stated that it was intended to “reiterate our policy on the evaluation of pain and other symptoms.”¹⁴⁶ The Fourth Circuit interpreted “reiterate” to mean that the SSA used SSR 88-13 to “express[] adherence”¹⁴⁷ to SSR 82-58, which by that time had been invalidated, at least within the Fourth Circuit.¹⁴⁸ Other circuits similarly resisted pushes by the SSA to require clinical proof of the severity of symptoms, to the point that by 1991, only the Seventh Circuit was denying claims merely for lack of objective medical evidence demonstrating the severity of pain.¹⁴⁹ Meanwhile, the SSA continued to nonacquiesce in the court decisions attempting to apply a different standard of evaluation for excess pain claims,¹⁵⁰ explaining that it did “not believe that a Federal agency is constitutionally precluded from relitigating an issue within a circuit that has previously issued a ruling adverse to the Government’s position.”¹⁵¹

C. 1991 to the Present

As an attempt to deal with the confusion, the SSA promulgated new rules in 1991.¹⁵² The SSA described the new material as “amending our prior regulations... to include a more detailed description of the policy that we follow in evaluating symptoms, such as pain.... [T]hese final rules make no substantive change in our policy.”¹⁵³ Belying this assertion, the regulations gave considerably more credence to subjective reports of pain. The SSA described a two-step process used to evaluate excess pain claims. First, the claimant was required to establish, “by medical signs and laboratory findings, the presence of a medically determinable physical or mental impairment which could reasonably be expected to produce the pain or other symptoms alleged.”¹⁵⁴ Second, “once such an impairment is established, *allegations about the intensity and persistence of pain or other*

145. *Id.*

146. *Id.*

147. *Hyatt v. Sullivan*, 899 F.2d 329, 335 (4th Cir. 1990).

148. *Hyatt v. Heckler*, 579 F.Supp. 985, 1000 (W.D.N.C. 1984).

149. *Masson*, *supra* note 115, at 1833.

150. *Id.* at 1840.

151. *Application of Circuit Court Law*, 55 Fed. Reg. 1012, 1014 (January 11, 1990).

152. 56 Fed. Reg. 57,928 (November 14, 1991) (codified at 20 C.F.R. §§ 404.1529 (OASDI), 416.929 (SSI)).

153. *Id.* (emphasis added).

154. *Id.*

symptoms must be considered in addition to the medical signs and laboratory findings in evaluating the impairment and the extent to which it may affect the individual's capacity for work."¹⁵⁵ Current regulations still apply this standard, explaining to claimants that "statements about your pain or other symptoms will not alone establish that you are disabled; there must be medical signs and laboratory findings which show that you have a medical impairment(s) which could reasonably be expected to produce the pain or other symptoms alleged."¹⁵⁶

Four years later, the SSA again issued a ruling with the purpose of "restat[ing] and clarify[ing] the longstanding policies of the [SSA] of considering allegations of pain."¹⁵⁷ Similarly to the 1991 ruling, Ruling 95-5p stated that "[b]ecause symptoms sometimes suggest a greater severity of impairment than can be shown by objective medical evidence alone, careful consideration must be given to any available information about symptoms."¹⁵⁸ "[I]n all cases in which pain or other symptoms are alleged, the determination or decision rationale must contain a thorough discussion and analysis of the objective medical and the other evidence, including the individual's complaints of pain or other symptoms and the adjudicator's personal observations."¹⁵⁹

In 1996, the SSA superseded SSR 95-5p to "clarify when the evaluation of symptoms, including pain... requires a finding about the credibility of an individual's statements about pain."¹⁶⁰ Under SSR 96-7p, a claimant is required to present "medical signs and laboratory findings demonstrating the existence of a medically determinable physical or mental impairment(s) that could reasonably be expected to produce the symptoms."¹⁶¹ The ruling also explains in greater detail how to assess the credibility of a claimant:

155. *Id.*

156. 20 C.F.R. § 416.929.

157. Policy Interpretation Ruling Titles II and XVI: Considering Allegations of Pain and Other Symptoms in Residual Functioning Capacity and Individualized Functional Assessments and Explaining Conclusions Reached, Social Security Ruling 95-5p (Oct. 31, 1995).

158. *Id.*

159. *Id.* Additionally, as of 1996, if a claimant has a "medically determinable impairment[] that could reasonably be expected to produce the [reported] symptoms," and the evaluator finds that symptoms have "more than a minimal effect on an individual's ability to do basic work activities," the impairment will be deemed severe. See Policy Interpretation Ruling Titles II and XVI: Considering Allegations of Pain and Other Symptoms in Determining Whether a Medically Determinable Impairment is Severe, Social Security Ruling 96-3p (July 2, 1996). As described *supra*, however, a finding of severe impairment will not result in a finding of disability unless the impairment meets or equals a listed impairment.

160. Policy Interpretation Rule Titles II and XVI: Evaluation of Symptoms in Disability Claims: Assessing the Credibility of an Individual's Statements, SSR 96-7p (July 2, 1996).

161. *Id.*

In determining the credibility of the individual's statements, the adjudicator must consider the entire case record, including the objective medical evidence, the individual's own statements about symptoms, statements and other information provided by treating or examining physicians or psychologists and other persons about the symptoms and how they affect the individual, and any other relevant evidence in the case record. An individual's statements about the intensity and persistence of pain or other symptoms or about the effect the symptoms have on his or her ability to work may not be disregarded solely because they are not substantiated by objective medical evidence.¹⁶²

The last sentence makes explicit the SSA's rejection of its previous position that claimants must present medical evidence proving the *severity* of their symptoms. Admittedly, this is a small step—a claimant's subjective testimony about her pain is only considered in conjunction with the entire record, including the statements of treating and consulting physicians, and her self-reported symptoms will never control if she cannot prove through objective medical proof an underlying impairment that could reasonably be expected to produce pain. But this standard is the high point of credence given to reports of symptoms. Furthermore, it might seem that this standard strikes an ideal balance between concerns for fraudulent malingerers and genuinely impaired claimants. As Part IV will explain, however, the existing standard's focus on medical evidence fails to address gendered issues.

IV. WHY CONSIDERING SUBJECTIVE EVIDENCE FAILS TO ADDRESS GENDERED PROBLEMS

With the context of how far the SSA has come in its evaluation of excess pain claims, it might seem that the standard has reached an appropriate balance, and simply taking the subjective complaints of claimants into account is enough to ensure that their individual experiences are not overlooked by a disability claims evaluator. As discussed in Part II, however, even subjective claims are mitigated through the lens of physicians. For this reason, it is important to assess whether a claimant's subjective experiences as related to her physician are transmitted accurately to the SSA. As this Part will explain, there are several reasons to believe that women's experiences of pain are distorted by a view through the medical lens.

Most generally, this is true of all evaluations of pain, regardless of the gender of the patient. In the context of evaluating whether doctors provide adequate pain control and relief to patients with chronic pain conditions,

162. *Id.*

studies indicate that “physicians often do a poor job of evaluating a patient’s level of pain,” specifically noting that doctors are less likely to believe the self-reported level of pain from patients who claim high levels of pain.¹⁶³ Even before looking at specific causes, therefore, relying upon physicians as the gatekeepers to verify or approve the credibility of a claimant’s testimony is likely to inaccurately minimize the pain actually experienced by the claimant.

Physicians also, however, evaluate self-reported pain symptoms with differing levels of skepticism according to characteristics of the patient. Research indicates that physicians grant credibility to patient reports of pain differently depending on the physical attractiveness of the patient, the patient’s gender, age, and ethnicity.¹⁶⁴ One commentator concluded that “this research indicates that a physician’s assessment of the pain experienced by a person claiming disability has a substantial probability of being innocently inaccurate at best and biased at worst.”¹⁶⁵

There are several reasons why the peculiar gate-keeping function of physicians within the Social Security claims process affects women with fibromyalgia in a particularly salient way. This Part outlines why female fibromyalgia patients’ pain is particularly underestimated in the context of Social Security evaluations.

A. *Gender Differences in Pain*

Women’s reports of pain are treated with skepticism for a basic, possibly surprising reason: women experience pain differently than men do. A series of studies in medical publications indicate that women and men “appear to experience and respond to pain differently.”¹⁶⁶ Anita M. Unruh performed a survey of studies assessing different types of chronic pain in men and women for the purpose of assessing variation in how people experience pain by gender.¹⁶⁷ Unruh concluded that “[w]omen report more severe pain, more frequent pain and pain of longer duration than do men.”¹⁶⁸ It is unclear what is responsible for the variation—Unruh noted that possible explanations include “gender differences in brain chemistry, metabolism, physical structures, and hormonal variations.”¹⁶⁹ For the purposes of this paper, however, understanding *why* women

163. Crossley, *supra* note 52, at 692–93.

164. *Id.* at 693–95.

165. *Id.*

166. Diane E. Hoffman & Anita J. Tarzian, *The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain*, 29 J. L. MED. & ETHICS 13, 13 (2001).

167. Anita M. Unruh, *Gender Variations in Clinical Pain Experience*, 65 PAIN 123, 124 (1996).

168. *Id.*

169. *Id.* at 156.

experience pain as a more severe sensation than men do is less important than simply knowing that the difference in experience exists.

Interestingly, not only is fibromyalgia a predominantly female syndrome, but the pain of fibromyalgia may also be different for women than for men. In a small study of women with fibromyalgia, the patients reported that their pain symptoms fluctuated significantly according to where each woman was in her menstrual cycle.¹⁷⁰ Similarly, fibromyalgia patients asked about their pain symptoms after the fact report greater pain and other symptoms during pregnancy and immediately postpartum.¹⁷¹ The authors of the study concluded that, although it seems unlikely that hormonal variations explain the existence of chronic pain, they could help to explain the severity of chronic pain.¹⁷²

Although some literature on the problems of chronic pain have acknowledged a gender gap in pain experience,¹⁷³ it is unclear whether any physicians involved in the SSA evaluation process have reviewed, or are even aware of, the evidence suggesting that they should expect female claimants to report a higher level of pain severity than male claimants. This is not to say that female claimants reporting severe pain should be deemed credible where a male claimant would not be. As this Part discusses further below, however, female claimants already face gendered credibility problems within the SSA evaluation, which could be addressed in part by better awareness on the part of physicians and evaluators that female claimants could reasonably be expected to report more severe symptoms.

B. Gender Differences in Care

When women go to see a physician—well before they make any disability claim—they receive a different and worse experience of healthcare than men do in several measurable ways. This inequality is then replicated in the Social Security evaluation, as their treating physicians provide medical evidence supplementing the review performed by SSA consultants.

One reason that women receive a different level of care is due to structural problems in medical research. When medical research is performed, it overwhelmingly uses male research subjects.¹⁷⁴ As a result, the understanding of specific conditions, how well treatment works, the

170. McBeth, *supra* note 18, at 21 (noting that in a clinic-based study of sixteen patients, women with fibromyalgia reported “significant changes in pain symptoms” throughout the menstrual cycle).

171. *Id.*

172. *Id.*

173. Finch, *supra* note 19, at 289 nn.23–24.

174. Lee et al., *supra* note 42, at 1489.

possible side effects of different treatments, etc., assumes a male patient. If women's experiences are different in an important way—for example, as described above, if women report more pain than men do—their reaction is subsequently understood to be abnormal.

Possibly because women's pain is consistently underestimated, women are consistently judged by physicians to be less credible than men.¹⁷⁵ A review of the biological studies of pain perception of men and women concluded that “[w]omen are more likely to seek treatment for chronic pain, but are also more likely to be inadequately treated by health-care providers, who, at least initially, discount women's verbal pain reports and attribute more import to biological pain contributors than emotional or psychological pain contributors.”¹⁷⁶ Physicians tend to treat women less aggressively than men.¹⁷⁷ When women report pain, they are most often given sedatives as treatment, whereas men are more likely to be given pain medication.¹⁷⁸

The review of studies of pain reported an intriguing theory as to why women are more likely to receive less aggressive treatment:

A recent prospective study of patients with chest pain found that women were less likely than men to be admitted to the hospital. Of those hospitalized, women were just as likely to receive a stress test as men, but of those not hospitalized, women were less likely to have received a stress test at a one month follow-up appointment. The authors attributed the differences in treatment to the “Yentl Syndrome,” i.e., women are more likely to be treated less aggressively in their initial encounters with the health-care system until they “prove that they are as sick as male patients.” Once they are perceived to be as ill as similarly situated males, they are likely to be treated similarly.¹⁷⁹

This theory is particularly problematic for fibromyalgia patients. At a certain point, a woman with heart disease can “prove” that she is as sick as a man with heart disease. But fibromyalgia is overwhelmingly a female disease.¹⁸⁰ If there are so few similarly situated males with fibromyalgia—to the point that fibromyalgia is seen as intrinsically gendered—it seems impossible that a woman with fibromyalgia could ever be perceived as being as sick as a man.

175. *Id.* at 1505.

176. Hoffman & Tarzian, *supra* note 166, at 13.

177. Mills, *supra* note 8, at 219–20.

178. Hoffman & Tarzian, *supra* note 166, at 13.

179. *Id.* at 17.

180. *See supra* notes 18–19 and accompanying text.

C. Gender Differences in Credibility-Damaging Evidence

There are generally two ways to measure pain. First, a patient reports his or her subjective levels of pain.¹⁸¹ Second, observers can evaluate the “pain behaviors or the behavioral-functional abilities” of the patient.¹⁸²

In disagreements between claimants seeking disability benefits and the SSA, it is the second type of measurement that is used to attack a claimant’s credibility. For example, if a claimant argues that she is incapable of working full-time, the ALJ evaluating her case might point to the fact that her sister reports weekly visits from the claimant, or that the claimant is capable of doing laundry and cooking for her children. Just as gender differences in the experience of pain are different, pain behaviors also vary by gender. Evidence of pain behaviors that damages a claimant’s credibility, and thus reduces a physician’s perception of the veracity of her claimed level of pain, is also gendered.

First, studies show that women cope with pain differently than men do:

Women are frequently found to develop a greater repertoire of coping strategies that includes active behavioral and cognitive coping, avoidance, emotion-focused coping, seeking social support, relaxation, and distraction, whereas men rely on direct action, problem-focused coping, talking problems down, denial, looking at the bright side of life and tension-reducing activities such as alcohol consumption, smoking and drug abuse.”¹⁸³

Furthermore, when asked to describe their pain, women tend to respond with information about how pain has affected their personal relationships, whereas men are more likely to refer to work duties. Thus, men’s pain reports are more likely to be viewed as “an objective reporting of physical symptoms or functional limitations.”¹⁸⁴

Intriguingly, even the point at which women seek medical help may be influenced by gendered responses to pain. According to one study, women who were resilient or had a “positive regard for their ability to handle the problem” were *more* likely to seek medical help dealing with

181. Pryor, *supra* note 121, at 249.

182. *Id.*

183. Unruh, *supra* note 168, at 149. Studies focusing specifically on how men and women cope with chronic pain were not in agreement as to whether men and women dealt with long-term pain in significantly different ways. One study focusing on men and women with rheumatoid arthritis found that men’s and women’s coping strategies were similar, whereas another study focusing on patients with “intractable pain in the neck, shoulder or back area . . . found that women used more catastrophising, and reported more distress and general interference of pain in everyday life due to the pain than men.” *Id.* at 149–50.

184. Hoffman & Tarzian, *supra* note 166, at 16.

chronic pain.¹⁸⁵ By contrast, men were more likely to seek healthcare if they had a “negative attitude about the condition.”¹⁸⁶ This positive regard, however, could damage female claimants who are genuinely prevented from working – their ability to maintain a positive outlook could convince a physician that the claimant will overcome what is in reality a disabling condition.

Second, female claimants also face hurdles in disability claims that arise from societal expectations that women take care of more duties in the home. Women are generally responsible for household tasks such as cleaning and cooking even when they live with a male partner.¹⁸⁷ Evidence that a woman is able to complete tasks such as cooking dinner or shopping for food can be presented as proof that her claims of debilitating pain are not credible.¹⁸⁸ The SSA is careful to note that it will “generally” not consider “activities like taking care of yourself, household tasks, hobbies, therapy, school attendance, club activities, or social programs” to be disqualifying substantial gainful activity.¹⁸⁹ Such activities, however, can be used as evidence to show that a claimant is capable of full-time employment.¹⁹⁰ Furthermore, vocational experts assessing what jobs a disability claimant is capable of performing do not take into account whether a female claimant will also perform a “second shift” of household tasks.¹⁹¹ To the extent that an estimation of a claimant’s RFC never takes such a second shift into effect, the gendered second shift damages the claims of all female claimants.

In the case of fibromyalgia claimants, however, the second shift not only affects the RFC determination by showing what physical tasks they are capable of, but also attacks the underlying disability claim itself. Because the claim rests almost entirely on the claimant’s subjective reports of pain, a claimant who reserves energy to take care of her children or does household tasks on occasional days of less severe pain can be deemed not credible as to all her allegations of pain, rather than narrow statements of capability such as whether she is physically able to lift a load of laundry.

185. *Id.*

186. *Id.*

187. Katharine K. Baker, *The Stories of Marriage*, 12 J. L. & FAM. STUDIES 1, 23 (2010).

188. Hon. Dorothy W. Nelson, *Introduction to the Effects of Gender in the Federal Courts: The Final Report of the Ninth Circuit Gender Bias Task Force*, 67 S. CAL. L. REV. 731, 734 (1994); see also Diller, *supra* note 53, at 406 (quoting Senator Robert Byrd speaking in opposition to disability insurance in 1956 due to his concern for a married woman who “merely wants to stop work and take care of her home”).

189. 20 C.F.R. § 416.972(c).

190. See, e.g., *Flowers v. Commissioner of Social Security*, 441 Fed. Appx. 735, 742 (11th Cir. 2011) (agreeing with ALJ’s rejection of physicians’ medical opinions based on claimant’s self-reported ability to perform “some yard work and housework, including washing dishes, making beds, vacuuming, doing laundry and preparing meals”).

191. Lee et al, *supra* note 42, at 1511–12.

V. EVOLVING A SOLUTION

There are two implications to be drawn from the arguments presented here. First, there is the question of how to more fairly assess fibromyalgia claims, given that the gendered nature of the patient base and the difficulty in proving excess pain claims combine to suggest that such claimants face an unduly difficult claims process. It seems likely that most people involved in evaluating disability claims are unaware of gender differentials in pain experience and coping skills. Decisions written by ALJs and reviewing courts are devoid of discussions of such gendered aspects of the disability evaluation process. A better awareness of the existence of gendered medical issues could arguably begin to equalize the path faced by male and female claimants with excess pain claims. It seems unlikely, however, that efforts to increase awareness alone would produce substantial change, for a few reasons.

First, presenting information about gender differentials in pain as an addendum to the existing review process tacitly accepts a credibility problem for female claimants. In other words, bringing medical literature showing gendered aspects of pain levels and pain coping skills accepts the view of female claimants with excess pain as less credible than male claimants, and seeks to fix that problem with the band-aid of an explanation of why the female claimants seem untrustworthy. To the extent that overreliance on clinical medical evidence is itself a problem, specific information to address particular symptoms of that problem does not address the underlying issue.

Second, the growing field of studies in implicit bias and what it means for the law indicate that the intersection of gender and disability presents an especially thorny field. Through the use of the Implicit Association Test (IAT), researches have shown that the average person has pervasive and significant prejudices or stereotypes along lines of race, gender, disability, religion, sexual orientation, and all sorts of other characteristics.¹⁹² These stereotypes exist even in the conscious, self-reported beliefs of individuals—in other words, a person who claims to view white and black people as equal often demonstrates a bias for viewing white people as law-abiding and black people as law-breaking in the IAT.¹⁹³ An ALJ asked to summarize his views of women and men, therefore, could truthfully explain his conscious view that women and men are equal and should be treated equally by the law, and yet at the same time implicitly view women

192. Jerry Kang & Kristin Kane, *Seeing Through Colorblindness: Implicit Bias and the Law*, 58 UCLA L. REV. 465, 473 (2010).

193. See Dale Larson, Comment, *Unconsciously Regarded as Disabled: Implicit Bias and the Regarded-As Prong of the Americans with Disabilities Act*, 56 UCLA L. REV. 451, 473 (2008).

as less credible than men, more likely to be malingering claimants, or be less hardworking than men in ways that would make him more skeptical of a female fibromyalgia claimant. Information alone seems unlikely to address the magnitude of such deep-seated and unconscious stereotypes.

Third, while female claimants with fibromyalgia are a compelling population facing difficulties in disability claims, reliance on clinical medical evidence likely has effects on other populations, both other demographics and claimants suffering from other conditions that are not well captured by clinical evidence. Patchwork solutions to each example of the problem would thus be an imperfect fix to a broader problem.

Therefore, this article instead suggests that the SSA should direct evaluators to consider—even to ask claimants—whether there are characteristics about the claimant that might affect how that claimant experiences or deals with pain. This would provide an opportunity for claimants to argue, on a case-by-case basis, that their self-reported levels of pain are not inconsistent with the clinical evidence. A stronger step would be to question and perhaps reject standards that only credit subjective reports of symptoms where those reports are not inconsistent with the medical evidence.

A directed, individualized consideration of each claimant's condition and the broader context of excess pain claims would be effective in several ways. Literature discussing implicit bias indicates that repetitive "practice at negating the stereotypic association" may eventually break down the unconscious bias.¹⁹⁴ Repetitive presentation of the larger context of different pain responses, as well as other gendered aspects of the disability evaluation process, would both make evaluators more aware of their own potential gender biases and be reminded of the stereotypes about weak or lazy women that they should consciously try to avoid.¹⁹⁵

Moreover, claimants would have an opportunity to explain in their own words areas of their disability claims that currently present problems. For example, a claimant's ability to perform household tasks or social activities is often presented as part of her medical record, usually a short sentence in doctor's notes or in a medical questionnaire. Devoid of context or explanation, an evaluator sees only that the claimant is physically capable of certain activities. By placing an affirmative focus on how individual claimants experience their condition, such a claimant would be given the opportunity to stress, for example, that a once-weekly coffee at home with a family member is a coping mechanism rather than a frivolous leisure activity.

194. See Antony Page, *Batson's Blind-Spot: Unconscious Stereotyping and the Peremptory Challenge*, 85 B.U. L. REV. 155, 242 (2005).

195. See Jerry Kang & Mahzarin R. Banaji, *Fair Measures: A Behavioral Realist Revision of "Affirmative Action"*, 94 CAL. L. REV. 1063, 1090–91 (2006).

This recommendation, furthermore, should be part of a larger effort to more broadly evaluate the disparate impact of reliance on medical evidence on different groups. The example of fibromyalgia and women prompts a broader question, as mentioned above, of whether other groups are similarly disproportionately affected by the SSA's overreliance on medical evidence. This article has investigated the specific characteristics of one syndrome that primarily afflicts women, but women are not the only group to have alleged disproportionately negative treatment by the SSA—they are not even the only group to have alleged disproportionately negative treatment in a way that can be partially explained by overreliance on medical judgment. In 1992, the General Accounting Office (GAO) issued a report identifying racial disparities in disability benefits.¹⁹⁶ The Commissioner of the SSA responded by arguing that the GAO's study was flawed, because

sample studies consistently show that blacks apply for benefits... with less severe impairments than do whites. When those individuals with 'not severe' impairments are removed from the sample, the findings show that blacks with severe impairments actually receive benefits at a higher rate than whites with severe impairments.¹⁹⁷

This reasoning assumes that the determination of severe and non-severe impairments is an objective question that cannot be influenced by racial factors. As explained above, however, medical determinations and evaluations of impairment are not objective and are not always neutrally made across patients of different personal characteristics.

The example of women with fibromyalgia, therefore, is merely a starting point. Fibromyalgia claims are an example of how overreliance on medical judgment leads to unintended discrepancies in how claims and claimants are treated, but are only one example of a problem that likely has many different applications. It may be that the original concept of a "worthy" disabled claimant—one with easily recognizable and clinically quantifiable symptoms—is simply too narrow, and does not encompass the reality of disabled Americans today.

CONCLUSION

From the outset of the Social Security disability program, Congress set up an evaluation process that it intended to be entirely neutral and objective, based on external analyses of a patient's condition by a medical

196. GENERAL ACCOUNTING OFFICE, SOCIAL SECURITY: RACIAL DIFFERENCE IN DISABILITY DECISIONS WARRANTS FURTHER INVESTIGATING 2 (Apr. 1992).

197. *Id.* at 74–75.

professional. Unfortunately, Congress's faith in the impartiality and determinacy of medical evidence has required physicians to make medical, normative, and legal judgments of claimants. As this article has shown, not all medical conditions can be adequately diagnosed or evaluated by this rubric, and the reliance on physicians and medical evidence has particularly negative effects on fibromyalgia claimants.

The disproportionate effects of reliance on medical evidence, furthermore, are likely not limited to female claimants with fibromyalgia claims. Clinical evidence and the evaluation of physicians likely also fail to accurately assess other types of claims and claimants. Fibromyalgia claims thus serve as just one compelling example illustrating why medical evidence and deferral to physicians is not the neutral process Congress intended.