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Treating Physicians as Expert Witnesses in Compensation Systems: The Public Health Connection

BY BRIAN C. MURCHISON*

INTRODUCTION

The practice of public health consists of an elaborate web of policies, strategies, and disciplines, including law.¹ Law is an instrument of public health in a broad sense when it is “used to establish norms for healthy behavior and to help create the social conditions in which people can be healthy.”² Law serves public health most directly through legislation

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¹ For a detailed argument that “[l]aw is an essential part of public health practice,” see Lawrence O. Gostin et al., *The Law and the Public's Health: A Study of Infectious Disease Law in the United States*, 99 COLUM. L. REV. 59, 61 (1999). The authors note that “public health” has been broadly defined to embrace organized community efforts for the sanitation of the environment, the control of community infections, the education of individuals in principles of personal hygiene, the organization of medical and nursing service for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health.

Id. at 69 (quoting Charles-Edward A. Winslow, *The Untilled Fields of Public Health*, 51 SCIENCE 23, 30 (1920)). Some commentators are concerned that public health encompasses such a multiplicity of tasks and perspectives that it “becomes . . . a little bit of everything, and therefore not enough of anything.” Jonathan M. Mann, *Public Health and Human Rights*, HUM. RTS., Fall 1998, at 2, 4. In the quest for “analytic and definitional clarity” of public health, Dean Mann proposed a human rights framework that could give rise to an ethics of public health, facilitating clearer articulation of public health positions relating to “respect for autonomy, beneficence, non-maleficence, and justice.” *Id.* at 5.

² Gostin et al., *supra* note 1, at 61.

aimed at preventing injury and disease within a given population.³ Other legal devices that address injury and disease within populations are compensation systems, including the common-law torts process and administrative systems, both federal and state, that adjudicate claims of disability, occupational disease, and occupational injury. However, the connection between compensatory systems and public health is less straightforward than the connection between preventative legislative programs and public health, and thus the former has received scant scholarly attention. In exploring the uncertain connection between compensation systems and public health, this Article makes two arguments: (1) that such systems can be important sources of information and public pressure on important health issues, and (2) that the current adjudicatory focus of some systems on the relationship between treating physicians and patients is a salutary development that, if not ignored by decision makers and if allowed to be more than an “empty formalit[y],”⁴ may enhance the credibility of specific decisions and promote public health objectives.

In what sense, if any, can compensation systems be classified as part of public health? In his magisterial work, *Public Health Law: Power, Duty, and Restraint*, Professor Lawrence O. Gostin places tort law under the rubric of public health law insofar as the tort system engages in “preventing risky behavior and providing incentives for safer product design.”⁵ However, Gostin emphasizes exceptionally high-profile litigation (tobacco lawsuits and actions against gun makers) as examples of “the value of tort law as a tool of public health,”⁶ and he does not delve deeply into the question of the deterrent value of less notorious uses of civil remedies for damages.⁷ Moreover, Gostin omits any sustained reference to non-tort

³ E.g., LAWRENCE O. GOSTIN, *PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT* 12 (2000) (noting that “[p]ublic health services are those shared by all members of the community, organized and supported by, and for the benefit of, the people as a whole”); see also *id.* at 269 (summarizing study of “regulation principally as the actions taken by legislatures and administrative agencies to prevent injury or disease and to promote the public’s health”).

⁴ LINDA G. MILLS, *A PENCHANT FOR PREJUDICE: UNRAVELING BIAS IN JUDICIAL DECISION MAKING* (1999) (finding the social security disability programs to be a system marred by judicial bias, neglect of rules, and other problems).

⁵ GOSTIN, *supra* note 3, at 270.

⁶ *Id.*

⁷ On deterrence as one of the principal aims of tort law, see generally DAN B. DOBBS, *THE LAW OF TORTS* § 11 (2000). As Professor Dobbs explains:

The idea of deterrence is not so much that an individual, having been held liable for a tort, would thereafter conduct himself better. It is rather the idea that all persons, recognizing potential tort liability, would tend to avoid

compensation systems.⁸ Perhaps his caution makes sense. If we try to place compensation systems, including tort, within the overarching scheme of public health law, we quickly encounter a well-known, bruising critique: that, despite legislative and common-law objectives, the unhappily frequent real-world effect of such systems is *not* to deter harmful practices or disease-causing conditions in the workplace, but rather simply to distribute damages or social insurance benefits to those deemed eligible.⁹ Perhaps,

conduct that could lead to tort liability. They might sometimes engage in the conduct in question, but only if they could get more out of it than the tort liability would cost.

Id. § 11, at 19. Deterrence is central to prominent theories of tort. *See, e.g.*, GUIDO CALABRESI, *THE COSTS OF ACCIDENTS: A LEGAL AND ECONOMIC ANALYSIS* (1970). Skeptics abound, however. Some maintain that the “simple deterrence model overemphasizes both the amount of overly dangerous activity that would occur without tort liability, and the amount of injury-reduction achieved.” Stephen D. Sugarman, *Doing Away with Tort Law*, 73 CAL. L. REV. 555, 561 (1985) (emphasis omitted). Others are doubtful that deterrence theory finds any support in “prevailing theories of human behavior.” Daniel W. Shuman, *The Psychology of Deterrence in Tort Law*, 42 U. KAN. L. REV. 115, 117 (1993).

⁸ Gostin does state that public health activities include governmental regulation of occupational health and safety, GOSTIN, *supra* note 3, at 11, 15, 87, but he does not specifically address administrative compensation systems. One reviewer of Gostin’s *Public Health Law* noted, “Gostin says little about many modern public health regulatory regimes—such as food and drug, occupational safety, and environmental law—or topics such as family law, which blend public health and other concerns.” John Akula, *Public Health and Personal Liberties: Striking a Balance*, HEALTH AFFAIRS, May/June 2001, at 288, 289 (book review).

⁹ *See* Emily A. Spieler, *Perpetuating Risk? Workers’ Compensation and the Persistence of Occupational Injuries*, 31 HOUS. L. REV. 119 (1994). Professor Spieler explores the paradox that rising compensation costs have done little to “stimulate employers to engage in efforts to prevent occupational injury and disease,” *id.* at 123, and argues that “the design of the program encourages motivated employers to attempt to prevent workers’ compensation costs by reducing the filing of claims instead of the occurrence of injuries,” *id.* at 127. *See also* PETER S. BARTH & H. ALLAN HUNT, *WORKERS’ COMPENSATION AND WORK-RELATED ILLNESSES AND DISEASES* 260 (1980) (emphasizing that workers’ compensation programs create “no adequate incentive for improving health at the workplace to prevent long latent diseases”) (emphasis omitted); Sidney A. Shapiro, *The Necessity of OSHA*, KAN. J. L. & PUB. POL’Y, Spring 1999, at 22, 29-30 (“[W]orkers’ compensation does not create significant incentives for employers to invest in safety and health improvements. . . . [T]he price of workers’ compensation insurance does not reflect, or only partially reflects, the claims experience of many employers. . . . [E]mployers will not invest in safety or health improvements if there

then, compensation systems have no real part to play in the work of public health.

The reverse may be true as well—that the work of public health has little or no relation to compensation systems. Support for this possibility comes from the dispiriting history of at least one major health problem that eventually led to the creation of a compensation system with virtually no help from public health authorities. In *Black Lung: Anatomy of a Public Health Disaster*,¹⁰ Allen Derickson recounts how state and federal governments ignored the problem of coal miners' respiratory diseases in the nineteenth century,¹¹ and how the U.S. Public Health Service ("PHS") in the first half of the twentieth century engaged in an "indecisive, fractured approach to producing and disseminating information" about mine-related lung disease, leaving the coal industry with "nothing to fear from federal officials [even in] the heyday of Progressivism."¹² Finally in 1963, twenty years after British research had led to the inclusion of coal workers' pneumoconiosis as a compensable disease under British law, the PHS undertook a prevalence study of respiratory problems among American miners but declined to publish the results of its findings until three years after field work ended.¹³ Even then, the PHS did little to probe the most pressing issue affecting the health of American coal miners: whether non-silicotic pneumoconiosis could affect the lungs of miners as seriously as silicosis.¹⁴ And it was only in 1969 after 40,000 protesting miners stopped working across West Virginia that state legislators and the U.S. Congress

are lower cost methods to avoid compensation payments."). Professor Shapiro points out that workers' compensation systems "fail[] to reimburse employees for all of their accident and illness costs." *Id.* at 28. Professor Shapiro further notes that this result is "not surprising because workers' compensation was never designed to serve the economic function of compensating workers for the costs of injuries and illnesses. The underlying policy of workers' compensation has always been to keep an employee from starving, not to compensate the workers for his or damages." *Id.* at 28-29. A publication of the American Public Health Association has stated flatly that "[w]orkers' compensation has not yet been shown to deter disease or injury or otherwise stimulate effective primary prevention of occupational injury or illness." PREVENTING OCCUPATIONAL DISEASE AND INJURY 78 (James L. Weeks et al., eds., 1991).

¹⁰ ALLEN DERICKSON, *BLACK LUNG: ANATOMY OF A PUBLIC HEALTH DISASTER* (1998).

¹¹ *Id.* at 15.

¹² *Id.* at 70.

¹³ *Id.* at 134.

¹⁴ *See id.* at 134-37.

took action by creating compensation systems for black lung disease.¹⁵ From the vantage point of the history of black lung in America, it is no wonder that compensation systems and public health agencies are so rarely linked in the public consciousness.

However, despite vulnerability to the charge of ineffective deterrence, and despite the fact that some systems came into existence in spite of, rather than because of, public health authorities, compensation systems should be seen as potentially important elements of public health law for several reasons. If Professor Gostin is right that the scope of "public health law" includes programs "designed to identify, prevent, and ameliorate health threats within society,"¹⁶ compensation systems surely qualify under at least the first and the third criteria. There is little doubt that compensation systems can be crucial sources of information for the public as well as lawmakers, regulators, and other policymakers engaged in public health efforts to identify dangerous conditions, "to monitor community health status[,] . . . and [to] research for new insights and innovations."¹⁷ For example, in the adjudication of claims involving complex issues of disease and causation, compensation systems turn a useful spotlight on how government regulation and inspection programs are succeeding in their efforts to prevent occupational disease and injury.¹⁸ In addition, these systems can provide testing grounds for evolving understandings of occupational disease and injury, thereby providing another source of information for regulatory reform.¹⁹ The case-by-case adjudication pro-

¹⁵ See *id.* at 160-61.

¹⁶ GOSTIN, *supra* note 3, at 18.

¹⁷ *Id.* at 17.

¹⁸ See BARTH & HUNT, *supra* note 9, at 262-65 (suggesting ways in which workers' compensation programs can add to worker and employer information and thus reduce disease). For an account of how asbestos litigation was "beneficial in uncovering hazards and company misconduct in the early cases," see also Elaine Draper, *Preventive Law by Corporate Professional Team Players: Liability and Responsibility in the Work of Company Doctors*, 15 J. CONTEMP. HEALTH L. & POL'Y 525, 554 (1999) (citing PAUL BRODEUR, *OUTRAGEOUS MISCONDUCT: THE ASBESTOS INDUSTRY ON TRIAL* (1985)).

¹⁹ For example, in the 1990s, federal black lung litigation addressed whether dust-induced lung disease can include obstructive lung disorders. See, e.g., *Warth v. S. Ohio Coal Co.*, 60 F.3d 173, 175 (4th Cir. 1995) (holding that "[c]hronic obstructive lung disease . . . is encompassed within the definition of pneumoconiosis for purposes of entitlement to Black Lung Benefits"). Eventually the Department of Labor amended the black lung regulations to include chronic obstructive lung disorders in the regulatory definition of compensable pneumoconiosis. See *Regulations Implementing the Federal Coal Mine and Safety Act of 1969*, as

vided by these systems can also place human faces on occupational harms; the personal histories disclosed by adjudication can provide lawmakers and regulators a deeper grasp of the practical realities of diseases and injuries in a variety of occupational contexts.²⁰

Of course, tort law and administrative benefits systems also serve to “ameliorate” existing conditions by compensating distressed individuals who are suffering present injury or illness and meet established criteria for compensation. These individuals can be part of a large and undifferentiated population, such as tort plaintiffs,²¹ or a legislatively specified population, such as claimants for social security disability benefits, black lung claimants, or other workers with job-related injury or illness.²² In some instances, these systems are products of sheer political necessity, and the modicum of repair they make possible is part of a larger public health initiative. For example, the black lung movement turned to federal legislators in 1969 with two objectives: (1) federal control of dust levels in coal mines as a means of preventing disease,²³ and (2) creation of a compensation system for those already afflicted.²⁴ Thus, although public health regulation is primarily forward-looking, legal remedies for past neglect and present harm also should be prominent and consistent concerns.

However, to make any strong contribution to the goals of communal information-building and individual recovery, compensation systems must have legitimacy. Intellectual integrity must govern the substance and

Amended, 65 Fed. Reg. 79,920, 79,923 (Dep’t Labor Dec. 20, 2000) [hereinafter *Final Rule*].

²⁰ For examples of works culling personal histories from compensation cases, see MILLS, *supra* note 4; Ron Nixon, *Black Lung a Stain on Miners’ Lives; Health Benefits Have Become Scarce for Virginia’s Miners*, ROANOKE TIMES & WORLD NEWS, Nov. 25, 2000, at A1 (detailing how Virginia coal miners have been frustrated by the black lung claims process); Ron Nixon, *A Coalfield Legacy: Black Lung; As Court Battles for Disability Benefits Drag On, Miners Slowly Suffocate*, ROANOKE TIMES & WORLD NEWS, Nov. 24, 2000, at A1 [hereinafter Nixon, *A Coalfield Legacy*] (same).

²¹ Gostin describes tort law as “[i]ndirect [r]egulation” implementing public health objectives. GOSTIN, *supra* note 3, at 269.

²² Gostin acknowledges that, although “public health is theoretically intended to safeguard the health and safety of whole populations, it often benefits those most at risk of injury and disease.” *Id.* at 19 (noting instances of public health initiatives that “hold particular significance” for groups who are “at immediate risk”).

²³ Derickson labels this a “straightforward public health approach” to disease prevention. DERICKSON, *supra* note 10, at 166.

²⁴ *Id.* at 167-82 (detailing efforts to obtain both dust controls and a federal compensation system).

procedure of their work, so that their results credibly contribute to public and individual good. Professor Stephen Carter variously defines “integrity” as a faculty of discernment, a quality of deliberativeness, and “a guide to being guided” in the assessment of reality.²⁵ Applying the term to a host of contexts, from marriage to legal ethics to civil disobedience, Professor Carter emphasizes integrity’s components of consistency, fidelity to principle, and avoidance of arbitrary action.²⁶ He thereby echoes John Rawls’ *A Theory of Justice*, which relates “integrity in the judicial process”²⁷ to the truth sought by that process, arguing that “a legal system must . . . contain rules of evidence that guarantee rational procedures of inquiry.”²⁸ According to Rawls, “[w]hile there are variations in these procedures, the rule of law requires some form of due process: that is, a process reasonably designed to ascertain the truth, in ways consistent with the other ends of the legal system.”²⁹ Professor Scott Brewer refers to the integrity of legal systems as “intellectual due process,” defined as a rule-of-law norm basing a system’s legitimacy on its capacity to render non-arbitrary decisions.³⁰ In the field of administrative compensation systems, Professor Jerry Mashaw delineates how these structures struggle with competing ideals of justice to pursue intellectual due process from within.³¹

A quest for more intellectually defensible elements of decision making has been prominent within a number of compensation systems, including the tort system, over the past ten years, but the results have been uncertain, and the quest is ongoing. This Article concerns the effort to refine the intellectual integrity of compensation systems through evidentiary rules about expert witnesses in cases of occupational disease and other forms of disability, where scientific knowledge is often incomplete and theories of causation are contested.³²

This Article’s premise is that the core concern of the compensation systems considered herein is distributive justice, a conception that “takes

²⁵ STEPHEN L. CARTER, INTEGRITY 19 (1996).

²⁶ See *id.* at 7.

²⁷ JOHN RAWLS, A THEORY OF JUSTICE 238 (1971).

²⁸ *Id.* at 239.

²⁹ *Id.*

³⁰ Scott Brewer, *Scientific Expert Testimony and Intellectual Due Process*, 107 YALE L.J. 1535, 1672-73 (1998) (citing RAWLS, *supra* note 27, at 238-39).

³¹ Jerry Mashaw, *Conflict and Compromise Among Models of Administrative Justice*, 1981 DUKE L.J. 181.

³² Professor Brewer defines an expert as one “who has or is regarded as having specialized training that yields sufficient epistemic competence to understand the aims, methods, and results of an expert discipline.” Brewer, *supra* note 30, at 1589.

justice in general to be concerned with apportioning fairly the burdens and benefits of social life."³³ Thus, the tort system seeks the fair apportionment of "the burdens and benefits of risky, yet valuable, activities,"³⁴ and is "only secondarily a matter of corrective justice" concerned with the rectification of wrongful acts.³⁵ Workers' compensation systems, too, are based on the distributive principle "that the toll beneficial activities exact in life, limb, and property damage should be fairly distributed,"³⁶ and the social security disability program is part of the larger social security system's goal of achieving a measure of "social adequacy" through income redistribution.³⁷ From this perspective, fact issues of causation and harm

³³ Gregory C. Keating, *Distributive and Corrective Justice in the Tort Law of Accidents*, 74 S. CAL. L. REV. 193, 195 (2000); see also Stephen R. Perry, *Tort Law, in A COMPANION TO PHILOSOPHY OF LAW AND LEGAL THEORY* 71-72 (Dennis Patterson ed., 1996). Professor Perry states that in tort theories "that take distributive justice as their starting point, . . . the point of distributive justice is understood to be the just distribution of material resources, and perhaps other goods, throughout society as a whole." *Id.* at 71. On this view, tort law can be seen as a device for "rectifying deviations from a pattern of holdings antecedently determined to be just (and also, perhaps, for moving an unjust pattern closer to a just one)." *Id.*

³⁴ Keating, *supra* note 33, at 195.

³⁵ *Id.* at 200.

³⁶ *Id.* at 219. Professor Dobbs has noted that "[w]orkers' compensation plans reflect the clearest expression of the enterprise liability ideas—that enterprise should bear the costs it systematically produces, including the costs of injury." DOBBS, *supra* note 7, § 392, at 1098. He adds that workers' compensation systems at the same time "show a strong intent to limit significantly the employers' liabilities." *Id.*

³⁷ For an account of the social security disability system as a need-based distributive system, see DEBORAH A. STONE, *THE DISABLED STATE* 15-28 (1984). For a review and analysis of the goals of individual equity and social adequacy of the social security system, see JEFFREY D. DUNN, *REAPPRAISING SOCIAL SECURITY: TOWARD AN ALTERNATIVE SYSTEM* 11-21 (1981). The Supreme Court long ago characterized the social security system as "a form of social insurance, enacted pursuant to Congress' power to spend money in aid of the general welfare." *Fleming v. Nestor*, 363 U.S. 603, 609 (1960) (internal quotation marks omitted), *quoted in* ROBERT J. MYERS, *SOCIAL SECURITY* 12 (2d ed. 1981). Professor Mashaw has described the disability benefits program of social security as "a part of the apparatus of the modern welfare state that touches most Americans" and states that "it is representative of our increasingly prevalent systems of mass justice." JERRY L. MASHAW, *BUREAUCRATIC JUSTICE* 18 (1983). Professor Mashaw notes that "countervailing tendencies" of caution and benevolence are built into the program: "Congress has continuously believed the program to be both essential to

assume crucial importance. Systems seeking to ensure the legitimacy of their decisions therefore place special value on accuracy in determinations of causation and harm, and they are at pains to develop rules of evidence to ensure that goal without compromising others.³⁸ The law of expert witnesses becomes central for compensation systems in these circumstances.

This Article focuses on one type of expert witness—the claimant’s or plaintiff’s treating physician, a figure whom American judges have often scorned but whom American regulators have increasingly embraced. Is the treating physician the most trustworthy of witnesses in a tort or an administrative compensation case, given that his medical opinion arises not from the litigation itself but from an effort to diagnose and to heal his own patient?³⁹ Or is the treating physician the least trustworthy of witnesses, likely possessed of personal pecuniary interests (i.e., receiving payment for medical services and retaining the claimant as a patient) in convincing the court that his patient should prevail?⁴⁰ Is the treating physician’s perfor-

a basic system of income security *and* an open invitation to drop out of the work force.” *Id.* at 20.

³⁸ For the view that those who determine eligibility for social security disability benefits must rely only on objective information, see STONE, *supra* note 37, at 23. For a classic analysis of how and why adjudication systems also pursue values other than accuracy, see Michael J. Saks, *Enhancing and Restraining Accuracy in Adjudication*, 51 LAW & CONTEMP. PROBS. 243 (1988).

³⁹ In the context of a claimant’s application for social security disability and supplemental benefits, the Ninth Circuit stated that “[b]ecause treating physicians are employed to cure and thus have a greater opportunity to know and observe the patient as an individual, their opinions are given greater weight than the opinions of other physicians.” *Edlund v. Massanari*, 253 F.3d 1152, 1157 (9th Cir. 2001) (quoting *Smolen v. Chater*, 80 F.3d 1273, 1285 (9th Cir. 1996)). Similarly, the dissenting judge on a Fourth Circuit panel wrote in a black lung case that “we should not forget that a treating physician knows his patient as a human being rather than as a claim number, and his opinions are generally developed in an attempt to treat the patient rather than to provide an opinion for hire.” *Grizzle v. Pickands Mather & Co.*, 994 F.2d 1093, 1101 (4th Cir. 1993) (Hall, J., dissenting).

⁴⁰ As Judge Easterbrook speculated for a Seventh Circuit panel in a recent black lung case, “[t]reating physicians often succumb to the temptation to accommodate their patients (and their survivors) at the expense of third parties such as insurers, which implies attaching a discount rather than a preference to their views.” *Peabody Coal Co. v. McCandless*, 255 F.3d 465, 469 (7th Cir. 2001). In the context of social security disability cases, Deborah Stone wrote in 1984 that the question of whether treating physicians are more lenient than other consulting physicians in

mance of clinical judgment⁴¹ sufficiently scientific to be placed before juries or accorded weight by administrative law judges,⁴² or is the treating physician's judgment inherently suspect when he or she assumes the role of "physician-advocate"?⁴³ These questions highlight the law's ambiguous regard of the treating physician; yet it is on this figure, the witness possibly most familiar with the medical matters in controversy yet often working beyond the realm of hard science and likely to benefit from a result that favors the patient, that several compensation systems have pinned their strong hopes for bolstering the accuracy—and, in time, the integrity—of their decisions.

This Article examines how disparate compensation systems—the common-law tort system, the social security disability benefits program, and the federal black lung system—have pursued the common objective of making the testimony of treating physicians increasingly important in the resolution of medical questions. This Article also considers how these

"justifying disability awards is . . . difficult to answer empirically." STONE, *supra* note 37, at 151. She cites pressures on treating physicians "to be strict with disability certifications" out of a "desire to believe that medical treatment is effective" and a "professional belief in the value of communicating a sense of hope to the patient." *Id.* On the other hand, she notes that "there is a pervasive belief amounting to 'street wisdom' among officials of disability programs that doctors indeed have enormous leeway in applying the concept of impairment and that there is a bias toward leniency among treating physicians." *Id.* at 152.

⁴¹ Clinical decision-making "is fundamentally scientific, as it is grounded in the discipline of medical science," but it need not be based on "hard scientific studies" and, when it takes the form of differential diagnosis, is "more in the nature of eyewitness testimony." Jean Macchiaroli Eggen, *Clinical Medical Evidence of Causation in Toxic Tort Cases: Into the Crucible of Daubert*, 38 HOUS. L. REV. 369, 390-91 (2001). Clinical judgment "refers to a method or approach of making judgments or decisions" when there is "no scientific research available on the issue," or where there is such research and the clinical judgment goes beyond the research. Daniel W. Shuman & Bruce D. Sales, *The Admissibility of Expert Testimony Based Upon Clinical Judgment and Scientific Research*, 4 PSYCHOL. PUB. POL'Y & L. 1226, 1227 (1998).

⁴² See Shuman & Sales, *supra* note 41, at 1248 (proposing, in an article written before the Supreme Court's ruling in *Kumho Tire Co. v. Carmichael*, 526 U.S. 137 (1999), a framework for admitting "pure clinical testimony for which there is no relevant scientific literature").

⁴³ Kevin F. Foley, *Physician Advocacy and Doctor Deception a Double-Edged Attack on Due Process*, FED. LAW, July 2001, at 24, 25 (detailing concerns of an Administrative Law Judge of the Social Security Administration that physician witnesses may elude ethical and legal standards).

systems work internally and suggests that systems with credible internal workings can affect an external public policy agenda such as public health.

As shown herein, each compensation system has its own narrative of justice—its own story of struggle and standard-setting in the pursuit of distributive goals—and its own account of the nature of legal truth, or accuracy, deemed necessary for the realization of the story's vision. In tort cases involving occupational disease, the struggle is *informational*, with courts rethinking the range of admissible expert testimony, and accuracy linked to a concept of medical-professional reliability. In the Social Security disability system, the struggle is *bureaucratic*, with a balance sought between standardized and individualized administration, and accuracy seen as a function of both—objective clinical data subjected to the professional judgment of the physician closest to the claimant. In the black lung system, the struggle is *proportional*, with decision makers seeking a balanced adversarial system for parties from long-time enemy camps, and accuracy seen as a function of roughly equivalent opportunities to influence a decision. Despite these differences in story and emphasis, the systems are linked by their deference to well-reasoned treating physicians' opinions, which are viewed as enhancing the likelihood of reaching accurate outcomes and attaining systemic integrity.

It is thus possible to conclude that the various "treating physician rules" used by these systems to help meet the demands of internal justice may have the external effects of (1) adding substantially to public knowledge about health issues, and (2) encouraging treating relationships between claimants and physicians, thereby enhancing the possibilities of improved health on an individual level. Compensation systems therefore have a more layered role in public health than has been previously understood, and scholars and others in the field of public health law should consider this role and how it might be enriched.

I. SELF-CORRECTION IN THE LAW OF EXPERTS AND THE IMPACT ON TORT

In four decisions over the past nine years, a united Supreme Court has sparked a "revolution" in the law of expert opinion testimony.⁴⁴ The Court lit the fire in 1993 in *Daubert v. Merrell Dow Pharmaceuticals, Inc.*,⁴⁵ a

⁴⁴ David L. Faigman, *The Law's Scientific Revolution: Reflections and Ruminations on the Law's Use of Experts in Year Seven of the Revolution*, 57 WASH. & LEE L. REV. 661 (2000).

⁴⁵ *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993).

personal injury action in which the Court declared that trial judges performing their function as gatekeepers of expert testimony under the Federal Rules of Evidence “must ensure that any and all scientific testimony or evidence admitted is not only relevant, but reliable.”⁴⁶ The Court held that the Federal Rules of Evidence superseded *Frye v. United States*,⁴⁷ the leading federal case on expert testimony.⁴⁸ *Frye* was an appellate decision that for seventy years had “reflected a general ‘hands-off’ process towards expert evidence.”⁴⁹ Interpreting Rule 702 to mandate significant judicial involvement, the *Daubert* Court articulated several non-definitive indicia of reliability, including whether the expert’s underlying methodology or technique had been or could be tested; whether it had been subjected to peer review; whether it had a known or potential rate of error; and whether and to what degree the methodology or technique had been accepted within the relevant scientific community.⁵⁰ In subsequent cases, the Court identified “abuse of discretion” as the standard of review of a trial court’s ruling on admissibility of expert testimony,⁵¹ extended *Daubert*’s reliability and relevance requirements to all expert witnesses in trials governed by the Federal Rules of Evidence,⁵² and held that an appellate court reversing a trial court’s admission of expert testimony on *Daubert* grounds could forego remand and dismiss the action.⁵³

Commentators trace these decisions to judicial concern over “lax threshold standards of admissibility for expertise” associated with practices of some lower courts in the 1970s and 1980s.⁵⁴ Triggered by a perception

⁴⁶ *Id.* at 589.

⁴⁷ *Frye v. United States*, 293 F. 1013 (D.C. Cir. 1923).

⁴⁸ *Daubert*, 509 U.S. at 589.

⁴⁹ Frank Tuerkheimer, *The Daubert Case and its Aftermath: A Shot-Gun Wedding of Technology and Law in the Supreme Court*, 51 SYRACUSE L. REV. 803, 812 (2001).

⁵⁰ *Daubert*, 509 U.S. at 593-94.

⁵¹ *Gen. Elec. Co. v. Joiner*, 522 U.S. 136, 141 (1997).

⁵² *Kumho Tire Co. v. Carmichael*, 526 U.S. 137, 141 (1999).

⁵³ *Weisgram v. Marley Co.*, 528 U.S. 440, 457 (2000).

⁵⁴ D. Michael Risinger, *Defining the “Task at Hand”: Non-Science Forensic Science After Kumho Tire Co. v. Carmichael*, 57 WASH. & LEE L. REV. 767 (2000); see also Peter David Blanck & Heidi M. Berven, *Evidence of Disability After Daubert*, 5 PSYCHOL. PUB. POL’Y & L. 16, 30 (1999) (noting that “the *Daubert* decision was meant to keep ‘junk science’ out of court by requiring judges to function as gatekeepers who admit scientific evidence found to be valid, relevant, and reliable”). Discussing the context of *Daubert*, Professor Eggen references a segment of the legal community who in the 1990s “claimed that vast amounts of

that “many experts came from disciplines in which consensus had replaced rigorous study,”⁵⁵ the *Daubert* quartet spurred “a major transformation in the way federal courts . . . respond to scientific experts.”⁵⁶ The central change was the enhanced gatekeeping role of the trial judge, who henceforth would be “expected to bring reasoned principles to the task of deciding which scientists may enter [the gate].”⁵⁷ At the heart of the Court’s enterprise, then, was a revitalized concept that trial judges must “exercise the judgment necessary to do justice.”⁵⁸

For the uninitiated, Jason Daubert was born with limb reduction birth defects, which he attributed to his *in utero* exposure to a drug that his mother took for morning sickness.⁵⁹ Jason and his guardian ad litem sued the manufacturer of Bendectin for damages.⁶⁰ Based on the opinion of a well-credentialed physician-epidemiologist, the manufacturer’s motion for summary judgment argued that no reasonable jury could find that Bendectin caused the child’s injuries because no study had linked Bendectin to human birth defects.⁶¹ Jason responded with affidavits of his own experts, who relied on test tube and live animal studies as well as pharmacological studies and a re-analysis of existing epidemiological

unreliable, so-called scientific evidence was being admitted in personal injury trials . . . [T]hey declared any theories not receiving general acceptance in the relevant scientific discipline to be scientifically invalid and unreliable.” Eggen, *supra* note 41, at 409-10 (citing, inter alia, PETER J. HUBER, GALILEO’S REVENGE: JUNK SCIENCE IN THE COURTROOM (1991)). She states that the *Daubert* Court, “both agree[ing] and disagree[ing]” with this line of thinking, “sought a balance of extremes” by rejecting the general acceptance test and “sweeping characterizations of categories of evidence” while accepting the need for “strict scrutiny” in ruling on the admissibility of expert testimony. *Id.* at 410. Discussing admission of forensic identification science, Michael J. Saks traces the problem of inadequate judicial scrutiny of proffered expert testimony to the early twentieth century cases in which the proffers were first made. Michael J. Saks, *Banishing Ipse Dixit: The Impact of Kumho Tire on Forensic Identification Science*, 57 WASH. & LEE L. REV. 879, 888 (2000).

⁵⁵ Faigman, *supra* note 44, at 664.

⁵⁶ DAVID L. FAIGMAN, LEGAL ALCHEMY: THE USE AND MISUSE OF SCIENCE IN THE LAW 60 (1999).

⁵⁷ *Id.* at 61.

⁵⁸ *Id.* at 60.

⁵⁹ *Daubert v. Merrell Dow Pharms., Inc.*, 727 F. Supp. 570, 571 (S.D. Cal. 1989), *vacated by* 509 U.S. 579 (1993).

⁶⁰ *See id.* at 570. Another plaintiff, Eric Schuler, and his guardian ad litem sued the same defendant on the same grounds. *See id.*

⁶¹ *Id.* at 575.

studies.⁶² The trial judge refused to admit the opinion testimony of Jason's experts, citing precedent that made admissibility dependent on general acceptability of the expert's underlying scientific methodology.⁶³ The Ninth Circuit affirmed.⁶⁴

Referring to the text and drafting history of Rule 702,⁶⁵ the Supreme Court held that the Rule superseded the seventy year old leading precedent, and that "general acceptability" was not a prerequisite to admissibility.⁶⁶ To this extent, *Daubert* was a victory for plaintiffs, particularly with its references to "the 'liberal thrust' of the Federal Rules and their 'general approach of relaxing the traditional barriers to 'opinion' testimony.'"⁶⁷ On the other hand, the Court found that Rule 702 imposed on trial judges an obligation to enforce limits on admissibility of scientific expert testimony.⁶⁸ The Court stated that the reference in Rule 702 to "scientific knowledge" meant that scientific expert testimony must be based on what is known and thus that the reasoning of an expert opinion must be reliable.⁶⁹ Most commentators agree that the effect of this reliability requirement, particularly as embellished by the Court's non-definitive yet crucially important indicia of reliability, has been "to raise the bar for admission" of scientific evidence.⁷⁰

But what of expert testimony addressing matters other than the kind of "hard science" that was at issue in *Daubert*?⁷¹ In *Kumho Tire Co. v.*

⁶² *Id.* at 573-75.

⁶³ *Id.* at 572, 576; *see also* *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579, 583-84 (1993).

⁶⁴ *Daubert v. Merrell Dow Pharm., Inc.*, 951 F.2d 1128, 1131 (9th Cir. 1991).

⁶⁵ *Daubert*, 509 U.S. at 588.

⁶⁶ *Id.* at 589.

⁶⁷ *Id.* at 588 (quoting *Beech Aircraft Corp. v. Rainey*, 488 U.S. 153, 169 (1988)).

⁶⁸ *Id.* at 589.

⁶⁹ *Id.* at 589-90. In addition, the Court held that the testimony must be able to assist the trier of fact in the resolution of a disputed issue and thus must be relevant to the matter at hand. *Id.* at 591-92.

⁷⁰ Risinger, *supra* note 54, at 769.

⁷¹ Professor Eggen uses "hard science" to refer to "epidemiological, toxicological, or other laboratory studies." Eggen, *supra* note 41, at 373 n.20. *See also* Note, *Navigating Uncertainty: Gatekeeping in the Absence of Hard Science*, 113 HARV. L. REV. 1467, 1468 n.6 (2000) ("'[H]ard science' . . . describe[s] scientific methodologies characterized by careful quantification and rigorous testability. In the context of medical causation, the reference is primarily to population studies and laboratory experimentation, the methodologies associated with epidemiology and toxicology, respectively.").

Carmichael,⁷² the Court addressed admissibility requirements for expert testimony using “technical, or other specialized knowledge”⁷³ under Rule 702. The plaintiff in a tire failure case planned to call an engineer whose testimony was not “scientific” in the *Daubert* sense but certainly “technical” or “specialized.”⁷⁴ The Court held that the *Daubert* decision’s requirements of reliability and relevance applied not only to the testimony of scientific experts but to all expert testimony under the Federal Rules, including “nonscientific or experience-based expert testimony.”⁷⁵ The Court emphasized that a trial court’s assessment of reliability was to be “flexible” and could employ the reliability factors found in *Daubert* or other factors appropriate to the facts of a particular case.⁷⁶ The trial court’s responsibility would be to determine that the expert, “whether basing testimony upon professional studies or personal experience, employs in the courtroom the same level of intellectual rigor that characterizes the practice of an expert in the relevant field.”⁷⁷ Turning to the facts, the Court upheld the trial judge’s ruling against admissibility: the judge reasonably had found that the engineer’s testimony was based on a theory that could not be supported by reference to the *Daubert* indicia or to any other “reasonable reliability criteria.”⁷⁸ In effect, the engineer’s proffered testimony was “too subjective.”⁷⁹ *Kumho Tire* prompted further commentary that the “net

⁷² *Kumho Tire Co. v. Carmichael*, 526 U.S. 137 (1999).

⁷³ FED. R. EVID. 702.

⁷⁴ *Kumho Tire*, 526 U.S. at 142-43.

⁷⁵ Eggen, *supra* note 41, at 385. In *Kumho Tire*, the Court explicitly stated that “no one denies that an expert might draw a conclusion from a set of observations based on extensive and specialized experience.” *Kumho Tire*, 526 U.S. at 156.

⁷⁶ *Kumho Tire*, 526 U.S. at 150. Commentators point out:

It would be a mistake . . . to read *Kumho* as saying that the trial court simply may ignore the *Daubert* factors in non-science cases. The Court noted that “a trial court should consider the specific factors identified in *Daubert* where they are reasonable measures of the reliability of expert testimony.” In a concurring opinion, Justices Scalia, O’Connor, and Thomas added that the discretion enjoyed by the trial court does not include the discretion to abandon the gatekeeping function or to perform it inadequately.

Joseph Sanders & Julie Machal-Fulks, *The Admissibility of Differential Diagnosis Testimony to Prove Causation in Toxic Tort Cases: The Interplay of Adjective and Substantive Law*, LAW & CONTEMP. PROBS., Autumn 2001, at 107, 117 (footnote omitted). See also FED. R. EVID. 702; FED. R. EVID. 702 advisory committee’s note (referencing *Daubert* and *Kumho Tire*).

⁷⁷ *Kumho Tire*, 526 U.S. at 152.

⁷⁸ *Id.* at 158.

⁷⁹ Eggen, *supra* note 41, at 386.

impact [of the Court's decisions] is to constrict, not expand, the admission of expert evidence."⁸⁰ Many praised the Court's rethinking of this segment of evidence law as overdue,⁸¹ others doubted the ability of the judicial process to engage meaningfully in the required scrutiny.⁸²

In its latest decision on expert testimony, *Weisgram v. Marley Co.*,⁸³ a unanimous Court referred to "the exacting standards of reliability such evidence must meet,"⁸⁴ thus confirming the Court's unmistakable intent that trial judges engage in "a powerful new way of thinking about evidence of the real world,"⁸⁵ and that they attend carefully to "drawing the line between valid empirical knowledge and value-driven empirical speculation."⁸⁶ Through these cases, the Court has sought to shore up the accuracy and credibility of outcomes and, by extension, the legitimacy of the tort system itself, which had increasingly come under fire.⁸⁷ By imposing new bounds on admissibility and new duties on trial judges, the Court recognized, as one commentator has noted in a slightly different context, "that the fundamental source of judicial legitimacy in our system is the giving of reasons for important decisions."⁸⁸

But questions still abound, particularly in occupational health cases in which "hard science" establishing causation is lacking, and plaintiffs

⁸⁰ Tuerkheimer, *supra* note 49, at 818.

⁸¹ Michael J. Saks, *The Aftermath of Daubert: An Evolving Jurisprudence of Expert Evidence*, 40 JURIMETRICS J. 229, 241 (2000) (approving the Court's work in this area as launching evidence law on "a voyage worthy of a new century," despite the need for "certain course corrections").

⁸² Brewer, *supra* note 30, at 1679-81.

⁸³ *Weisgram v. Marley Co.*, 528 U.S. 440 (2000).

⁸⁴ *Id.* at 455.

⁸⁵ Saks, *supra* note 54, at 898.

⁸⁶ Faigman, *supra* note 44, at 671.

⁸⁷ See, e.g., *Review and Outlook: The Law Disfigured*, WALL ST. J., June 24, 1999, at A22 (addressing breast implant litigation and a report released by the National Academy of Science's Institute of Medicine finding no link between silicone-gel implants and diseases such as cancer and lupus). The *Journal* lambasted the tort system for permitting the implant cases to have proceeded at all, and argued that "[a]t all levels of American society, especially business, the idea that American courtrooms strive toward justice is no longer taken seriously." *Id.* For studies of the breast implant cases and their implications, see Richard A. Nagareda, *Outrageous Fortune and the Criminalization of Mass Torts*, 96 MICH. L. REV. 1121, 1137-45 (1998); Laurens Walker & John Monahan, *Scientific Authority: The Breast Implant Litigation and Beyond*, 86 VA. L. REV. 801 (2000).

⁸⁸ Saks, *supra* note 54, at 900 (criticizing *Mitchell v. United States*, Crim. No. 96-409-1 (E.D. Pa. 2000), a post-*Kumho Tire* case involving expert testimony regarding fingerprint evidence, for not upholding this duty).

proffer clinical medical evidence in the form of a treating physician's opinion. A treating physician can be either a nonspecialist or a specialist whose "primary role is the examination, diagnosis, and treatment of patients."⁸⁹ This physician's usual role in a case involving occupational disease differs substantially from the role of the experts who testified in *Daubert* about Bendectin. The latter addressed general causation, i.e., whether a chemical or other substance had the capacity to cause the plaintiff's illness, whereas treating physicians focus on specific causation, i.e., whether an exposure has caused harm in a specific case.⁹⁰ The treating physician is often familiar with medical studies, if any, pertaining to general causation, but plaintiffs rely on this witness primarily to furnish clinical medical evidence based on "knowledge, experience, and performance of a differential diagnosis."⁹¹ Thus, a treating physician's opinion "is more in the nature of eyewitness testimony."⁹² Because his or her "methodologies do not normally rely on scientific analysis in the same manner as the testimony addressed in the *Daubert* case,"⁹³ but can more closely resemble the process of elimination employed by the engineer in *Kumho Tire*,⁹⁴ a question inevitably arises: can a treating physician's practice of clinical reasoning hold up under the Court's demand of evidentiary reliability?

The fundamental datum for courts that have admitted the testimony of a treating physician is the physician's performance of a differential etiology—or, as the law more frequently calls it, a differential diagnosis.⁹⁵

⁸⁹ Mary Sue Hinifin et al., *Reference Guide on Medical Testimony*, in REFERENCE MANUAL ON SCIENTIFIC EVIDENCE 439, 449 (Federal Judicial Ctr. ed., 2d ed. 2000).

⁹⁰ For an explanation of this distinction, see Note, *supra* note 71, at 1469.

⁹¹ Eggen, *supra* note 41, at 393.

⁹² *Id.* at 391.

⁹³ *Id.* at 387.

⁹⁴ Sanders & Machal-Fulks, *supra* note 76, at 117-18 (noting that "[m]uch of this testimony was the engineering equivalent of a differential diagnosis").

⁹⁵ The medical definition of "differential diagnosis" concerns identification of disease: "The term [is] used by physicians to refer to the process of determining which of two or more diseases with similar symptoms and signs the patient is suffering from, by means of comparing the various competing diagnostic hypotheses with the clinical findings." Hinifin et al., *supra* note 89, at 481. In the legal context, lawyers, judges, and expert witnesses use "differential diagnosis" interchangeably with "differential etiology" to refer to identification of the cause of disease or other harm; "differential etiology" is "[a] term used on occasion . . . to describe the investigation and reasoning that leads to a determination of external causation, sometimes more specifically described by the witness or court as a

Differential diagnosis in this sense refers to a multi-step process of reaching a medical conclusion:

First, the physician conducts a comparative analysis of the patient's illness in relation to known patterns of disease. Second, the physician applies certain diagnostic criteria to the patient to determine the probability that the diagnosis is one particular illness out of several. . . . Third, the physician undertakes a cause-and-effect analysis to determine if the appearance and progress of the disease in the patient is or has been consistent with generally known physiological and pathological information regarding the disease.⁹⁶

Thus, "differential diagnosis in the clinical medical setting is a combination of scientific information and experience."⁹⁷ Physicians performing a differential diagnosis generally use standard diagnostic techniques, including physical examinations, medical histories, and laboratory tests, all with the goal of "careful consideration of alternative causes,"⁹⁸ and sometimes with "less than full information."⁹⁹ Is this a methodology that can be found "reliable" under *Daubert* and *Kumho Tire*?¹⁰⁰

The United States Court of Appeals for the Fourth Circuit has said yes. In *Westberry v. Gislaved Gummi AB*,¹⁰¹ a worker in a window factory sued the manufacturer of a product used in making windows. The product was a rubber gasket that the manufacturer coated with talc as a lubricant.¹⁰² By using the gaskets, the plaintiff became exposed to airborne talc and developed sinus problems that eventually resulted in a number of surgeries.¹⁰³ The plaintiff proffered testimony of his treating physician whose opinion, based on a differential diagnosis supported by the temporal proximity between exposure and the symptoms, was that the talc exposure caused the sinus problems.¹⁰⁴ The defendant objected on grounds that the

process of identifying external causes by a process of elimination." *Id.*

⁹⁶ Eggen, *supra* note 41, at 392 (footnotes omitted).

⁹⁷ *Id.* at 418.

⁹⁸ *In re Paoli R.R. Yard PCB Litig.*, 35 F.3d 717, 758 (3d Cir. 1994).

⁹⁹ *Id.* at 759.

¹⁰⁰ "[A]n expert's testimony is admissible so long as the process or technique the expert used in formulating the opinion is reliable." *Id.* at 742 (citing *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579, 589 (1993)).

¹⁰¹ *Westberry v. Gislaved Gummi AB*, 178 F.3d 257 (4th Cir. 1999).

¹⁰² *Id.* at 260.

¹⁰³ *Id.*

¹⁰⁴ *Id.* at 262.

physician's opinion lacked support in any published or unpublished scientific studies and that clinical tests had not produced clear proof.¹⁰⁵ The Fourth Circuit ruled that the expert testimony was admissible under the framework of *Daubert* and *Kumho Tire*.¹⁰⁶

The court gave full recognition to differential diagnosis as "a standard scientific technique of identifying the cause of a medical problem by eliminating the likely causes until the most probable one is isolated."¹⁰⁷ The court noted that this technique "consists of a testable hypothesis, has been peer reviewed, contains standards for controlling its operation, is generally accepted, and is used outside the judicial context."¹⁰⁸ Moreover, "the overwhelming majority of the courts of appeals that have addressed the issue have held that a medical opinion on causation based upon a reliable differential diagnosis is sufficiently valid to satisfy the first prong of the Rule 702 inquiry."¹⁰⁹

Even assuming the validity of the treating physician's diagnostic technique, was his performance of the technique adequate? The defendant maintained that the differential diagnosis was flawed because the treating physician did not convincingly "rule in" talc as a possible cause of the illness, and because the physician had failed to "rule out" every other possible cause.¹¹⁰ On whether the physician had done enough to "rule in" talc, the court noted that the parties did not dispute that "inhalation of high levels of talc irritates mucous membranes,"¹¹¹ and that plaintiff's testimony was adequate to support a conclusion that he came into contact with "high concentrations of airborne talc."¹¹² Moreover, it was permissible for the trial judge to consider the temporal proximity of the plaintiff's exposure to "the onset and worsening" of his health problems.¹¹³ On the question of

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ *Id.* The court quoted a Third Circuit case, which in turn quoted from a standard reference work: "[d]ifferential diagnosis is defined for physicians as 'the determination of which of two or more diseases with similar symptoms is the one from which the patient is suffering, by a systematic comparison and contrasting of the clinical findings.'" *Id.* (alteration in original) (quoting *Kannankeril v. Terminix Int'l, Inc.*, 128 F.3d 802, 807 (3d Cir. 1997) (quoting *STEDMAN'S MEDICAL DICTIONARY* 428 (25th ed. 1990))).

¹⁰⁸ *Id.* at 263 (quoting *Heller v. Shaw Indus., Inc.*, 167 F.3d 146, 154-55 (3d Cir. 1999)).

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ *Id.* at 264.

¹¹² *Id.*

¹¹³ *Id.* at 265.

other possible causes, the court ruled that a differential diagnosis is unreliable and thus inadmissible when it is "so lacking that it cannot provide a reliable basis for an opinion,"¹¹⁴ although arguments about alternative causes usually pertain to the weight rather than the admissibility of a differential diagnosis.¹¹⁵ The court's application of these principles was sparse, but it concluded that the treating physician had sufficiently explained his exclusion of other potential causes.¹¹⁶

Westberry makes surprisingly little of the fact that the expert whose testimony was at issue was the plaintiff's treating physician. Perhaps the significance was already clear. In an earlier case involving the admissibility of a treating physician's differential diagnosis absent epidemiological data, the Fourth Circuit held that the methodologies of the plaintiff's treating physicians and other experts were reliable under *Daubert* "in light of the medical community's daily use of the same methodologies in diagnosing patients."¹¹⁷ This statement suggested that the importance of the treating physician's opinion is not that the opinion is necessarily wiser or inherently more accurate, but that it is reliable when it emerges from a treating relationship in which a customary, professionally credible mode of analysis is employed to address medical problems. This emphasis on the process of medical reasoning means that it is the "deliberative" treating physician whose differential diagnosis has worth in the context of tort.¹¹⁸

The focus on a physician's mode of analysis suggests, of course, that not all performances of differential diagnosis will pass the test of reliabil-

¹¹⁴ *Id.*

¹¹⁵ *Id.*

¹¹⁶ *Id.* at 266.

¹¹⁷ *Benedi v. McNeil-P.P.C., Inc.*, 66 F.3d 1378, 1384 (4th Cir. 1995).

¹¹⁸ As Charles Nesson has written perceptively of the thought process of the "treating doctor":

To be sure, the doctor is not saying he is absolutely or scientifically certain of the diagnosis, but to expect him to be so would discourage treatment in most medical situations. Certainty is a false god here, as elsewhere in judicial proof. A qualified medical diagnostician is familiar with the scientific and medical literature. He assesses the significance of experiments and studies, not in the technical scientific sense of the statistician, but in an intuitive way. He anticipates what the scientist would be able to prove if he could structure the perfect study, the perfect experiment. Lacking complete information, the diagnostician gives his best judgment. By its nature this judgment is not, of itself, *scientific proof*, but it may nonetheless constitute legal proof.

Charles Nesson, *Agent Orange Meets the Blue Bus: Factfinding at the Frontiers of Knowledge*, 66 B.U. L. REV. 521, 528-29 (1986) (footnote omitted).

ity. For example, in another Fourth Circuit case, *Cooper v. Smith & Nephew, Inc.*,¹¹⁹ a plaintiff sued the manufacturer of a device used in spinal fusion surgeries and proffered the testimony of a non-treating, consulting physician. The trial court rejected the expert's differential diagnosis as unreliable under *Daubert* and *Kumho Tire*.¹²⁰ One aspect of the expert's unreliability was his failure to reach a diagnosis in the manner of a deliberative treating physician. Unlike the plaintiff's treating physician, who on the basis of considerable medical literature had concluded that the plaintiff's smoking habit had some bearing on his spinal problems, the consulting expert ignored that potential cause.¹²¹ In addition, the expert's objections to the safety of the challenged device were no more than "boilerplate."¹²² Departing from his normal way of treating his own patients, the consulting physician formed his opinion about the plaintiff without conducting a physical examination, and he neglected to speak with physicians who had treated the plaintiff.¹²³ The expert thus failed to employ "in the courtroom the same level of intellectual rigor that characterizes the practice of an expert in the relevant field."¹²⁴ The Fourth Circuit's analysis amounted to a damning comparison of a tunnel-visioned litigation consultant with a deliberative clinical practitioner, and it signaled that the "intellectual rigor" required of a credible differential diagnosis will be that of a treating physician.

But questions remain. One is whether treating physicians, many of whom lack experience as witnesses in legal proceedings, can be expected to meet the law's ideal of a "deliberative diagnostician." Is clinical reasoning adaptable to the way lawyers think? Are physicians, even in the

¹¹⁹ *Cooper v. Smith & Nephew, Inc.*, 259 F.3d 194 (4th Cir. 2001).

¹²⁰ *Id.* at 203.

¹²¹ *Id.* at 202.

¹²² *Id.*

¹²³ *Id.* at 203.

¹²⁴ *Id.* (quoting *Kumho Tire Co. v. Carmichael*, 526 U.S. 137, 152 (1999)). In another case against the same defendant, *Fitzgerald v. Smith & Nephew, Inc.*, No. 00-1145, 11 Fed. Appx. 335, 2001 WL 648610 (4th Cir. June 12, 2001) (unpublished), the plaintiff proffered testimony of a non-treating, consulting physician whose methodology was also found unreliable by the trial court. Affirming the exclusion of the physician's testimony, the Fourth Circuit noted the expert's failure to review a large number of the plaintiff's medical records, any of her x-rays, or her deposition; failure to examine the plaintiff; and failure to speak with her or her treating physicians. *Id.* at 340, 2001 WL 648610, at *4. In effect, in failing to engage in the mode of analysis of a deliberative treating physician, the consulting physician rendered an opinion that lacked the "intellectual rigor" of the profession.

context of performing a differential diagnosis, likely to engage in the kind of step-by-step reasoned discourse that is commonplace to lawyers and persuasive to judges? Perhaps not. In *Turner v. Iowa Fire Equipment Co.*,¹²⁵ the Eighth Circuit found that a treating physician was “more concerned with identifying and treating [the plaintiff’s] condition than he was with identifying the specific substance that caused her condition.”¹²⁶ As a result, the court faulted the physician for “arriv[ing] at his opinion about [causation] more as an afterthought, in an ad hoc manner,”¹²⁷ and for “not systematically rul[ing] out all other possible causes.”¹²⁸ As the courts continue to develop the concept of the adequate differential diagnosis,¹²⁹ for the ends of promoting accurate case results and enhancing the credibility of the legal system, the risk is that some courts will hold physicians to an unrealistic standard of “intellectual rigor.”

And what sort of “intellectual rigor” is required—or possible—when evidence of general causation is completely lacking?¹³⁰ Some courts require that a physician’s differential diagnosis be based on “hard scientific studies” that pass the test of *Daubert*.¹³¹ Others take a different view, citing “the liberal thrust of the Federal Rules of Evidence, the flexible nature of the *Daubert* inquiry, and the proper roles of the judge and the jury in evaluating the ultimate credibility of an expert’s opinion.”¹³² Any other approach would, according to these courts, “resurrect a *Frye*-like bright-line standard, not by requiring that a methodology be ‘generally accepted,’ but by excluding expert testimony not backed by published (and presumably peer-reviewed) studies.”¹³³ Again, the touchstone of credibility is the ideal of the deliberative treating physician who

[i]n the actual practice of medicine . . . [does] not wait for conclusive, or even published and peer-reviewed, studies to make diagnoses to a

¹²⁵ *Turner v. Iowa Fire Equip. Co.*, 229 F.3d 1202 (8th Cir. 2000).

¹²⁶ *Id.* at 1208.

¹²⁷ *Id.*

¹²⁸ *Id.*

¹²⁹ For an interesting analysis of this objective, see generally Gary Sloboda, *Differential Diagnosis or Distortion?*, 35 U.S.F. L. REV. 301 (2001).

¹³⁰ As stated by the Third Circuit in *Heller v. Shaw Industries, Inc.*, 167 F.3d 146, 155 (3d Cir. 1999), “[t]he question . . . is whether the expert’s conclusion can be considered reliable if it is based on scientifically valid methods, but is not based on published studies.”

¹³¹ See Eggen, *supra* note 41, at 394-402 (gathering Fifth Circuit cases in which differential diagnoses are excluded in the absence of studies of the kind required in *Daubert*).

¹³² *Heller*, 167 F.3d at 155.

¹³³ *Id.*

reasonable degree of medical certainty However, experience with hundreds of patients, discussions with peers, attendance at conferences and seminars, detailed review of a patient's family, personal, and medical histories, and thorough physical examination are the tools of the trade, and should suffice for the making of a differential diagnosis even in those cases in which peer-reviewed studies do not exist to confirm the diagnosis of the physician.¹³⁴

In sum, the revolution in the law of expert evidence has had far-reaching effect. The treating physician plays a major role not only as an expert in litigation, particularly in cases involving occupational injury and disease, but increasingly as a standard of reasonableness in determining the quality of a differential diagnosis for purposes of admissibility. However, by requiring that physicians provide lawyerly reasons for their conclusions, the law may be asking too much of professionals whose training is foreign from that of attorneys and judges. Perhaps the law's insistence on detailed medical reasoning is an indirect way of acknowledging the legal system's need to monitor its own reasoning more effectively. In this sense, *Daubert* and *Kumho Tire* are not simply about the reasoning of experts; they are about the intellectual rigor of judges.

Intellectual rigor, whether of doctors or judges, has a connection to public health. The tort system's pursuit of accurate results can aid public health initiatives over time. A plaintiff's verdict in *Westberry* may or may not deter gasket manufacturers from using a certain lubricant, but the verdict does become known to regulators, perhaps signaling—in conjunction with other information—a need for investigation and even regulatory action. Moreover, recognition of differential diagnosis as a reliable methodology may prompt other occupational health claims, particularly where, as in *Westberry*, industry has had no incentive to study the impact of particular exposures in the workplace. Claims of this kind may prompt the kind of industry studies that were missing in *Westberry*, and perhaps government studies as well.

II. SOCIAL SECURITY DISABILITY: THE TREATING PHYSICIAN AND "CONTROLLING WEIGHT"

This Article now shifts from civil trials, which are subject to the Federal Rules of Evidence, to federal administrative proceedings of the

¹³⁴ *Id.* The *Heller* court noted that the Federal Rules of Evidence "recognize as much." *Id.*

Social Security Administration (“SSA”), in which juries play no part and the Federal Rules of Evidence have no applicability.¹³⁵ The SSA’s Administrative Law Judges adjudicate claims for Disability Insurance Benefits under Title II of the Social Security Act and claims for Supplemental Security Income under Title XVI of the same Act,¹³⁶ and their daily fare is a wealth of conflicting medical and vocational evidence.¹³⁷ In a non-adversarial setting, the Administrative Law Judge (“ALJ”) “operates in an investigatory mode, seeking out evidence, conducting an oral hearing, and ultimately deciding the case.”¹³⁸ The ALJ’s concern in these cases is far less with the *admissibility* of evidence than with the proper *weighing* of evidence that has been received into the record. This distinction between evidentiary issues in civil and administrative proceedings is well accepted. As early as 1941, the Supreme Court declared, “it has long been settled that the technical rules for the exclusion of evidence applicable in jury trials do not apply to proceedings before federal administrative agencies in the absence of a statutory requirement that such rules are to be observed.”¹³⁹ Several years later, in 1945, while contemplating the adjudicatory model of agency action that would become Section 554 of the Administrative Procedure Act (“APA”), the drafters recognized that an administrative hearing is comparable, not to a jury trial, but to “an equity proceeding in the courts”¹⁴⁰ and that evidentiary rules designed to protect a “lay jury . . . from improper influence”¹⁴¹ are simply unnecessary. Thus, although individual agencies may (and often do) promulgate rules addressing agency procedures and evidence¹⁴² and although agencies subject to the APA have

¹³⁵ For a survey of agencies’ evidentiary practices and rules, see Richard J. Pierce, *Use of the Federal Rules of Evidence in Federal Agency Adjudications*, 39 ADMIN. L. REV. 1 (1987).

¹³⁶ 42 U.S.C. §§ 401-433 (2000) (disability insurance benefits); *id.* §§ 1381-1383f (supplemental security income).

¹³⁷ For a description of the range of evidence in such a case, see generally *Richardson v. Perales*, 402 U.S. 389 (1971).

¹³⁸ JERRY L. MASHAW, BUREAUCRATIC JUSTICE 39 (1983).

¹³⁹ *Opp Cotton Mills, Inc. v. Adm’r*, 312 U.S. 126, 155 (1941).

¹⁴⁰ *Underwood v. Elkay Mining, Inc.*, 105 F.3d 946, 951 (4th Cir. 1997) (quoting S. DOC. NO. 79-248, at 208 (1946)).

¹⁴¹ *Id.* (quoting S. DOC. NO. 79-248, at 208 (1946)). Professors Davis and Pierce have pointed out that the law’s means of ensuring “that agency findings are based only on reliable evidence” are the requirement that agencies supply reasons for their findings of fact and the availability of judicial review of agency action. 2 KENNETH CULP DAVIS & RICHARD J. PIERCE, JR., ADMINISTRATIVE LAW TREATISE 127 (3d ed. 1994).

¹⁴² See *Richardson*, 402 U.S. at 400 (quoting the agency regulation on the ALJ’s duty to inquire fully into the issues and to receive relevant evidence).

the power to exclude “irrelevant, immaterial, or unduly repetitious evidence,”¹⁴³ administrative agencies as a general matter resolve disputes and adjudicate claims “through use of an evidentiary system that can be described in simple, pragmatic terms.”¹⁴⁴ The ALJ admits all evidence with any arguable materiality to the issues, and then he or she determines “the relative probative value of the admitted evidence.”¹⁴⁵

But what substantive goals are at stake in the disability program? The Social Security Act “provides for the payment of insurance benefits to persons who have contributed to the program and who suffer from a physical or mental disability.”¹⁴⁶ In the words of one U.S. magistrate judge, these claims are often “made by ordinary people in desperate circumstances.”¹⁴⁷ A compensable disability is “any medically determinable physical or mental impairment”¹⁴⁸ which prevents the claimant from engaging “in substantial gainful activity”¹⁴⁹ and is “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.”¹⁵⁰ The impairment must arise from “anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.”¹⁵¹ Benefits are paid only if the claimant’s impairments “are of such severity that he is not only unable to do his previous work but cannot, considering

¹⁴³ 5 U.S.C. § 556(d) (2000).

¹⁴⁴ DAVIS & PIERCE, *supra* note 141, at 117.

¹⁴⁵ *Id.*

¹⁴⁶ Bowen v. Yuckert, 482 U.S. 137, 140 (1987) (citing 42 U.S.C. § 423(a)(1)(D) (1982)).

¹⁴⁷ Thomas P. Smith & Patrick M. Fahey, *Some Points on Litigating Title II and Title XVI Social Security Disability Claims in United States District Court*, 14 QUINNIPIAC L. REV. 243, 272 (1994). Linda G. Mills writes that the disability insurance benefits and supplemental security income programs

are what people rely on if they become too sick to work. Both rich and poor need and use these safety nets. Social security disability applicants include a diverse cross-section of Americans: the parents of judges, the children of the rich and famous, and the otherwise faceless poor. As might be expected, a disproportionate number of poor women and people of color apply for these benefits. The bulk of applicants, however, are working people, people who, after years of on-the-job physical and emotional strain, become incapable of meeting the demands of full-time employment.

MILLS, *supra* note 4, at 2 (citation omitted).

¹⁴⁸ 42 U.S.C. § 423(d)(1)(A) (2000).

¹⁴⁹ *Id.* § 423(d)(1)(B).

¹⁵⁰ *Id.* § 423(d)(1)(A).

¹⁵¹ *Id.* § 423(d)(3).

his age, education and work experience, engage in any other kind of substantial gainful work which exists in the national economy."¹⁵² The concept of disability thus "consists of both medical and vocational components."¹⁵³

Originally proposed in the effort that led to the Social Security Act of 1935, but not "even haltingly begun until 1950,"¹⁵⁴ the disability insurance benefits program "did not become a full-fledged early-retirement benefits scheme until 1960."¹⁵⁵ Professor Mashaw describes the program as the embodiment "of a complicated new social goal—cautious benevolence."¹⁵⁶ According to Mashaw, the program developed in part on a model of justice conceived as "bureaucratic rationality,"¹⁵⁷ that is, the cost-effective administrative implementation of a legislative goal.¹⁵⁸ Since the Social Security Act's goal is to "pay disability benefits to eligible persons,"¹⁵⁹ administrative justice consists of "accurate decision making carried on through processes appropriately rationalized to take account of costs."¹⁶⁰ A competing model of administrative justice is a "moral judgment model" associated with the fair adjudication of each claim.¹⁶¹ This model not only seeks accurate outcomes but also "views decision making as value defining;"¹⁶² from this perspective, disability adjudication is meant to probe "not just who did what, but who is to be preferred, all things considered, when interests, and the values to which they can be relevantly connected, conflict."¹⁶³ These models co-exist in some tension, each assuming dominance in different phases of the administrative process.¹⁶⁴ Mashaw's

¹⁵² *Id.* § 423(d)(2)(A).

¹⁵³ *Edlund v. Massanari*, 253 F.3d 1152, 1157 (9th Cir. 2001).

¹⁵⁴ MASHAW, *supra* note 138, at 34.

¹⁵⁵ *Id.*

¹⁵⁶ *Id.* at 35.

¹⁵⁷ Jerry L. Mashaw, *Lessons for the Administration of Workers' Compensation from the Social Security Disability Insurance Program*, in *NEW PERSPECTIVES IN WORKERS' COMPENSATION* 97, 101 (John F. Burton, Jr. ed., 1988).

¹⁵⁸ *Id.*

¹⁵⁹ *Id.*

¹⁶⁰ *Id.*

¹⁶¹ *Id.* at 103.

¹⁶² *Id.*

¹⁶³ *Id.*

¹⁶⁴ *See id.* at 104-05. Another commentator similarly discusses "the two conflicting goals of the Social Security Administration: objective, general, and consistent determinations combined with individualized assessments." Rachel Schneider, Comment, *A Role for the Courts: Treating Physician Evidence in Social*

bureaucratic rationality model helps explain the genesis of the SSA's five-step sequential framework for determinations of disability,¹⁶⁵ a controlled analytic process designed to "allow the most straightforward cases to be decided quickly and efficiently on medical grounds alone"¹⁶⁶ and intended overall to produce "consistent, standardized decisions."¹⁶⁷ The agency's evolving treating physician doctrine, on the other hand, has been viewed by some as reflecting the competing model that strives for contextualized judgments.¹⁶⁸

The story of the SSA's use of treating physician testimony is one of conflict and change. In 1991 (two years, incidentally, before the *Daubert* revolution began in the federal courts), the SSA modified its procedures for adjudicating disability claims, particularly its practices of weighing medical evidence.¹⁶⁹ This was another action that some thought overdue. Without an agency regulation governing medical evidence in the 1970s and 1980s, the SSA had engaged in a highly publicized battle with the U.S. Court of Appeals for the Second Circuit over the weighing of treating physician

Security Determinations, 3 U. CHI. L. SCH. ROUNDTABLE 391, 415 (1996).

¹⁶⁵ The first two steps involve threshold determinations that the claimant is not presently engaged in substantial gainful activity and has an impairment or combination of impairments which significantly limits his physical or mental ability to do basic work activities. In the third step, the medical evidence of the claimant's impairment(s) is compared to a list of impairments presumed severe enough to preclude any gainful activity. If the claimant's impairment matches or is equal to one of the listed impairments, he qualifies for benefits without further inquiry. If the person cannot qualify under the listings, the evaluation proceeds to the fourth and fifth steps. At these steps, analysis is made of whether the person can do his own past work or any other work that exists in the national economy, in view of his age, education, and work experience. If he cannot do his past work or other work, the claimant qualifies for benefits.

Loza v. Apfel, 219 F.3d 378, 390 (5th Cir. 2000) (footnotes and citations omitted).

¹⁶⁶ FRANK S. BLOCH, *DISABILITY DETERMINATION: THE ADMINISTRATIVE PROCESS AND THE ROLE OF MEDICAL PERSONNEL* 7 (1992) (discussing steps two and three).

¹⁶⁷ *Schneider*, *supra* note 164, at 395. The Supreme Court has upheld different parts of the sequence of steps. *See Bowen v. Yuckert*, 482 U.S. 137 (1987) (upholding second step); *Heckler v. Campbell*, 461 U.S. 458 (1983) (upholding medical-vocational guidelines followed in step five).

¹⁶⁸ *Schneider*, *supra* note 164, at 415-16.

¹⁶⁹ Standards for Consultative Examinations and Existing Medical Evidence, 56 Fed. Reg. 36,932 (Dep't Health & Human Servs. Aug. 1, 1991) [hereinafter *1991 Standards*].

evidence.¹⁷⁰ For years, the Second Circuit had imposed a standard that was quite deferential to treating physicians,¹⁷¹ and the agency had resisted the standard to the point of non-acquiescence.¹⁷² By 1987, the SSA formally

¹⁷⁰ See generally Samuel Estreicher & Richard L. Revesz, *Nonacquiescence by Federal Administrative Agencies*, 98 YALE L.J. 679, 701-04 (1989) (detailing SSA refusal to follow Second Circuit case law on weight to be given treating physicians in social security disability adjudications, except in specific cases before the court); Robert J. Axelrod, Comment, *The Politics of Nonacquiescence: The Legacy of Stieberger v. Sullivan*, 60 BROOK. L. REV. 765, 776-778 (1994) (same).

¹⁷¹ E.g., *Gold v. Sec'y of Health, Educ. & Welfare*, 463 F.2d 38, 42 (2d Cir. 1972). In *Schisler v. Heckler*, 787 F.2d 76, 81 (2d Cir. 1986), the court summarized its rule:

The rule, which has been the law of this circuit for at least five years, provides that a treating physician's opinion on the subject of medical disability, i.e., diagnosis and nature and degree of impairment, is (i) binding on the fact-finder unless contradicted by substantial evidence; and (ii) entitled to some extra weight because the treating physician is usually more familiar with a claimant's medical condition than are other physicians, although resolution of genuine conflicts between the opinion of the treating physician, with its extra weight, and any substantial evidence to the contrary remains the responsibility of the fact-finder.

The *Schisler* court also noted "that there is no requirement that the [treating] physician's medical testimony be supported by objective clinical or laboratory findings." *Id.* at 82 n.2 (quoting *Bluvand v. Heckler*, 730 F.2d 886, 893 (2d Cir. 1984)).

¹⁷² See *Stieberger v. Heckler*, 615 F. Supp. 1315 (S.D.N.Y. 1985), *vacated sub nom.* *Stieberger v. Bowen*, 801 F.2d 29 (2d Cir. 1986). In this litigation, a district court ordered the Secretary of HHS to apply the Second Circuit's treating physician rule, but a Second Circuit panel vacated the order. The panel discussed Social Security Rulings ("SSRs") showing that the agency was not complying with the Second Circuit's treating physician rule. One SSR provided that "other things being equal, the fact that a physician treated a claimant will increase the weight accorded to that physician's opinion, but . . . [the SSR did] not mention that the treating physician's opinion is binding unless contradicted by substantial evidence." *Bowen*, 801 F.2d at 32. Another SSR indicated that "a treating physician's views sometimes ought not to be given controlling weight because that physician 'might have been leaning over backwards to support the application for disability benefits.'" *Id.* (quoting Soc. Sec. Ruling 83-6c (1983)). As explained in the third of another series of Second Circuit cases involving the agency's non-acquiescence in this context:

[T]he result of HHS's non-acquiescence was that claimants relying on the opinions of treating physicians were routinely denied benefits at the agency level. They were thus forced to take their cases one-by-one to the federal courts, which routinely remanded with instructions to apply the rule.

proposed its own regulation. In 1991, the SSA promulgated a final rule that was considerably less liberal than the Second Circuit's rule but still deferential to the opinions of treating physicians.¹⁷³ The Second Circuit upheld the rules in 1993.¹⁷⁴

In brief, the SSA rules provide that Administrative Law Judges in disability cases should give "controlling weight"¹⁷⁵ to the "medical opinion"¹⁷⁶ of a treating physician if the opinion is "'well-supported' by 'medically acceptable' clinical and laboratory diagnostic techniques [and is] 'not inconsistent' with the other 'substantial evidence' in [the] case record."¹⁷⁷ If an ALJ decides that controlling weight is not warranted, then the ALJ must supply specific reasons for that decision.¹⁷⁸ Even then, the ALJ must assign weight to the treating physician's opinion by consulting a list of factors, including the length, nature, and extent of the treating relationship, the evidence that supports the physician's opinion, the opinion's consistency with the record as a whole, and whether the treating physician is a specialist.¹⁷⁹

However, HHS never sought Supreme Court review of any of these many decisions. It thus appeared that HHS was non-acquiescing in the treating physician rule not as a matter of principle—which could have been resolved by seeking review in the Supreme Court—but as a means of discouraging claimants who relied upon the rule. This creation of unnecessary legal hurdles was understandably perceived as an abuse of process.

Schisler v. Sullivan, 3 F.3d 563, 565 (2d Cir. 1993).

¹⁷³ *Schisler*, 3 F.3d at 567.

¹⁷⁴ *Id.* at 568-69.

¹⁷⁵ Title II and XVI: Giving Controlling Weight to Treating Source Medical Opinions, 61 Fed. Reg. 34,490 (Dep't Health & Human Servs. July 2, 1996) (notice of ruling) [hereinafter Giving Controlling Weight]. To give controlling weight means to adopt. *Id.*

¹⁷⁶ *Id.* A medical opinion is an opinion about "the nature and severity of an individual's impairment(s)." *Id.*

¹⁷⁷ 20 C.F.R. § 404.1527(d)(2) (2002). In upholding the regulations, the Second Circuit noted that the social security legislation itself provides that "an impairment must be 'demonstrable by medically acceptable clinical and laboratory diagnostic techniques.'" *Schisler*, 3 F.3d at 568 (quoting 42 U.S.C. §§ 1382c(a)(3)(D), 423(d)(3) (2000)).

¹⁷⁸ 20 C.F.R. § 404.1527(d)(2) (2002). In two recent social security disability cases, *Myers v. Apfel*, 238 F.3d 617 (5th Cir. 2001), and *Drapeau v. Massanari*, 255 F.3d 1211 (10th Cir. 2001), reviewing courts reversed ALJ decisions that had failed to provide specific reasons for rejecting a medical report by a claimant's treating physician.

¹⁷⁹ Giving Controlling Weight, *supra* note 175, at 34,491.

Two of the purposes of the agency's rule were to encourage greater uniformity of disability adjudications within the SSA system¹⁸⁰ and to facilitate accurate outcomes.¹⁸¹ Ensuring uniformity of a sprawling bureaucracy's adjudication was seen as a public duty.¹⁸² Accuracy was a goal informed by the agency's conviction that "treating source evidence tends to have a special intrinsic value by virtue of the treating source's relationship with the claimant,"¹⁸³ and thus, "treating sources usually have the most knowledge about their patients' conditions."¹⁸⁴ Information arising from the treating relationship was presumptively credible because "the motivation for the relationship—and the information transmitted between them—is treatment."¹⁸⁵ If the legitimating effect of more reliable outcomes in the tort system was one of the aims of *Daubert* and *Kumho Tire*, a similar goal surely had resonance for a bureaucracy assessing individuals' ability to work and attempting to maintain political support for its implementation of "cautious benevolence."

Of course, treating physician testimony is not automatically accurate; the agency's rule simply uses that testimony as the starting point for analysis, in effect orchestrating a debate in the mind of the ALJ between the opinion of the treating physician and the rest of the evidence. In some cases, the treating physician loses the debate; even then, however, information arising from the treating relationship is central. For example, in *Burch v. Apfel*,¹⁸⁶ a treating physician's testimony in a disability claim was found to be anything but accurate. The ALJ reached this conclusion after comparing the physician's testimony with the physician's own treatment notes about the patient and finding substantial discrepancies.¹⁸⁷ The unquestioned statements in the treatment notes fatally undermined the physician's credibility as a witness in the claim. The case illustrates how a claimant can lose even with the support of a treating physician; more importantly, the case embodies the belief that a treating relationship,

¹⁸⁰ 1991 *Standards*, *supra* note 169, at 36,934.

¹⁸¹ *Id.* at 36,935 (discussing knowledge possessed by treating sources).

¹⁸² The agency stated that "judicial decisions in several circuits pointed to a need for a clear policy statement that would encourage uniformity of adjudication and provide the public and the courts with a definitive explanation of our policy on weighing treating source opinions." *Id.* at 36,934.

¹⁸³ *Id.*

¹⁸⁴ *Id.* at 36,935.

¹⁸⁵ BLOCH, *supra* note 166, at 142.

¹⁸⁶ *Burch v. Apfel*, No. 00-1402, 9 Fed. Appx. 255, 2001 WL 574634 (4th Cir. May 29, 2001) (unpublished).

¹⁸⁷ *Id.* at 259-60, 2001 WL 574634, at *3-*4.

particularly one outside the context of litigation, produces reliable information. The case suggests that a physician's treatment notes set a standard of credibility that the same physician's testimony in the disability claim must match.

Besides accuracy, the SSA's treating physician rule is said to serve the federal courts' interest in retaining a role in individualizing the SSA's program of mass justice.¹⁸⁸ Although this theory might explain a court-made doctrine like the Second Circuit's treating physician rule, it does not explain why the agency adopted its own treating physician rule; presumably the agency had no interest in creating a rule that licenses judicial over-intrusion. More likely, the agency sought to take power back from the courts by striking its own balance between bureaucratic control and individualized judgment.¹⁸⁹ By assigning controlling weight to a treating physician's opinion based on data ("medically acceptable clinical and laboratory diagnostic techniques") and consistency with other substantial evidence in the record, the rule defines accuracy as the product of objective and subjective components, numbers, and judgment. And by placing the presumptively most reliable witness, the treating physician, at the center of analysis, while still permitting that witness's opinion to be trumped by other evidence, the rule provides a detailed roadmap for efficient decision making, one that closely guides analysis but leaves room for particularized assessment. As noted above, the rule organizes that debate in the mind of the ALJ, but it is still a specific debate—about the facts and implications of a specific claim.

The treating physician rule also may serve external purposes or have important external effects, intended or not. The rule arguably creates a serious incentive for distressed individuals to seek the kind of contact with a physician that would amount to a treating relationship. In this sense, the rule encourages conduct: if one is impaired in any significant way, he or she should seek treatment, including a specialist's care. If the condition persists or worsens to the point that the individual seeks disability benefits, the treating relationship will be beneficial to the effort of qualifying for benefits.

Of course, a conduct-forcing rule can work against a claimant who enters into a treating relationship that improves his condition, or at least

¹⁸⁸ Schneider, *supra* note 164, at 415-16.

¹⁸⁹ See Bowen v. Yuckert, 482 U.S. 137, 157-58 (1987) (O'Connor, J., concurring) (recognizing that the agency "faces an administrative task of staggering proportions in applying the disability benefits provisions of the Social Security Act" but also recognizing the statutory requirement that those who meet the definition of disability should obtain benefits).

casts doubt on its severity. In *Johnson v. Apfel*,¹⁹⁰ a claimant suffering from a speech deficiency argued that he was disabled due to anxiety and depression.¹⁹¹ He offered the testimony of a treating psychiatrist, but the ALJ found that “treatment with medication and speech therapy [had] improved his communication.”¹⁹² The treating physician’s testimony supporting the claim was therefore inconsistent with the record as a whole; the ALJ denied the claim, and the appeals court affirmed.¹⁹³ Although the claimant might complain that the treating physician rule was not meant to work in quite this way, it is difficult to argue with a rule that prompts a positive therapeutic process.

In sum, the treating physician rule appears to serve goals of accurate and efficient decision making and may even promote conduct that benefits health. Still, none of these good effects is possible if decision makers ignore or evade the rule. The ALJs’ heavy caseload and any internal agency “pressure[] to deny claims” may affect outcomes more than a rule of evidence.¹⁹⁴ The “ethos of impartiality” may also blind judges to unconscious bias in deciding cases.¹⁹⁵ A compensation system’s rules may be eminently fair on paper, but ALJs may misapply them and courts may leave them unenforced. The sheer detail of the SSA’s evidence-weighting rules, however, may make them difficult to ignore; they do comprise a roadmap, leaving little to the imagination except the weighing itself. But in the end, it is good-faith fidelity to rules and critical reflection by judges at all levels of the system that will make the process credible and its outcomes worthy of “intellectual due process.”

III. FEDERAL BLACK LUNG PROGRAM: A QUESTION OF BALANCE

Another system with a prominent treating physician rule is the U.S. Department of Labor’s black lung benefits program.¹⁹⁶ Congress designed the program over thirty years ago to compensate victims of black lung disease and their survivors.¹⁹⁷ The program awards benefits, payable by coal company-employers, to eligible living coal miners, their dependents,

¹⁹⁰ *Johnson v. Apfel*, 240 F.3d 1145 (8th Cir. 2001).

¹⁹¹ *Id.* at 1147.

¹⁹² *Id.*

¹⁹³ *Id.* at 1148-49.

¹⁹⁴ MILLS, *supra* note 4, at 3.

¹⁹⁵ *Id.* at 6.

¹⁹⁶ 30 U.S.C. §§ 901-945 (2000).

¹⁹⁷ For a history of the problem of recognizing the existence of black lung disease in the U.S. coal mining industry, see generally DERICKSON, *supra* note 10.

and widows who lost husbands to the disease, also known as pneumoconiosis.¹⁹⁸ The cases invariably involve medical issues, including whether the miner has black lung disease, whether he is totally disabled in a respiratory or pulmonary sense, and whether his pneumoconiosis is at least a contributing cause of his total respiratory or pulmonary disability.¹⁹⁹ Like the social security disability program, the black lung system is not governed by the Federal Rules of Evidence but has its own regulatory procedures and evidentiary rules.²⁰⁰ Unlike social security cases, black lung cases are adversarial in nature.²⁰¹

The complexity of the issues, the adversarial structure of the claims process, and the practical unavailability of attorneys' fees for claimant lawyers often create insurmountable obstacles for coal miners, evidenced by the fact that in 1994, the national approval rate for federal black lung claims in the Office of Administrative Law Judges of the Department of Labor was a mere 7.6%.²⁰² Coal miners historically have been unable to attract attorneys, principally because delays and other problems in obtaining fees greatly discourage attorneys from taking black lung cases.²⁰³

¹⁹⁸ See 20 C.F.R. § 718.1 (2002) (summarizing statutory authority for black lung benefits).

¹⁹⁹ See *Toler v. E. Assoc. Coal Co.*, 43 F.3d 109, 111 (4th Cir. 1995) (citing 20 C.F.R. § 718.202-204 (2001)).

²⁰⁰ Department of Labor regulations governing procedures specific to the black lung benefits program are at 20 C.F.R. pt. 725, subpt. D (2002) ("Adjudication Officers"). Department of Labor rules of practice and procedure for administrative hearings before the Office of Administrative Law Judges are at 29 C.F.R. pt. 18 (2001). Admissibility of evidence is permissive because ALJ hearings are non-jury proceedings and the Federal Rules do not apply: "Because the ALJ is presumably competent to disregard that evidence which should be excluded or to discount that evidence which has lesser probative value, it makes little sense, as a practical matter, for a judge in that position to apply strict exclusionary evidentiary rules." *Underwood v. Elkay Mining, Inc.*, 105 F.3d 946, 949 (4th Cir. 1997).

²⁰¹ See 20 C.F.R. § 725.360 (2002) (providing the method for identifying parties to proceedings). See generally *Underwood*, 105 F.3d at 949-50 (describing common features of such adversarial hearings).

²⁰² Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as amended, 62 Fed. Reg. 3338, 3357 (Dep't Labor, proposed Jan. 22, 1997) [hereinafter *Proposed Rules*].

²⁰³ During recent rulemaking proceedings of the Department of Labor, "witnesses repeatedly brought to the Department's attention that few attorneys are willing to represent clients, in part because of the many restrictions on the award of attorneys' fees." *Final Rule*, *supra* note 19, at 79,980. The Supreme Court upheld, against a Due Process challenge, the Black Lung Benefits Act's restrictions

As a result, it is common for coal miners to appear unrepresented in hearings against coal operators that have seasoned counsel.²⁰⁴ Under these circumstances, the evidentiary records are predictably one-sided.²⁰⁵ With

on payment of fees to claimants' attorneys. Under the Act, attorney's fees for a claimant's attorney in a black lung case are permitted only if the claim succeeds, disposition of the claim is final, and the fee is approved by the Department. Dep't of Labor v. Triplett, 494 U.S. 715, 718 (1990) (describing system and citing statute and regulation). The Department also must take into account a number of stated factors in deciding whether to grant the fee. *Id.* An attorney argued that long delays faced by claimants' attorneys in receiving fees under this system discouraged attorney involvement and effectively deprived black lung victims of legal representation. *Id.* at 724. The West Virginia Supreme Court of Appeals agreed, having declared that "a law nondiscriminatory on its face may be grossly discriminatory in its operation." Comm. on Legal Ethics v. Triplett, 378 S.E.2d 82, 89 (W. Va. 1988) (quoting Griffin v. Illinois, 351 U.S. 12, 17 (1956)), *rev'd sub nom.* Dep't of Labor v. Triplett, 494 U.S. 715 (1990). However, the U.S. Supreme Court reversed, finding the factual record "blatantly insufficient" to support the constitutional claim that the fee system made attorneys unavailable. *Triplett*, 494 U.S. at 724. The decision is sharply criticized in Robert A. Campbell, United States Department of Labor v. Triplett: *Black Lung Claimants Will Continue to Suffer from a Lack of Legal Representation*, 93 W. VA. L. REV. 713 (1991). Campbell argues that it is a "mockery of justice for the Legislature to pass a piece of token legislation supposedly designed to provide black lung claimants with benefits while failing to provide the means necessary to procure these benefits." *Id.* at 733. A series of articles in the *Roanoke Times* in 2000 examined various issues in connection with the federal black lung program, including the fee regulations for claimants' attorneys. See Ron Nixon, *Lawyers Are Few and Far Between for Black Lung Plaintiffs; They Can Receive Compensation Only if They Win the Case*, ROANOKE TIMES & WORLD NEWS, Nov. 25, 2000, at A9 [hereinafter Nixon, *Lawyers Are Few*] (reporting that fee restrictions are a disincentive to claimants' attorneys); Nixon, *A Coalfield Legacy*, *supra* note 20 ("Few attorneys will take black lung cases because the cases can last for decades and miners' lawyers don't get paid unless they win. And even if the case is won, federal regulations allow coal companies to challenge the legal fees.").

²⁰⁴ Nixon, *Lawyers are Few*, *supra* note 203 ("The shortage of miners' attorneys means that thousands of relatively uneducated miners end up representing themselves. They go up against coal company lawyers who specialize in black lung litigation. No one tracks exactly how many miners represent themselves in black lung claims.").

²⁰⁵ In a 1997 rulemaking notice, the Department of Labor stated: "Currently, in establishing their eligibility to benefits, claimants must confront the vastly superior economic resources of their adversaries: coal mine operators and their insurance carriers. Often, these parties generate medical evidence in such volume that it overwhelms the evidence supporting entitlement that claimants can procure."

no attorney and little money with which to develop medical evidence, coal miners have trouble navigating the administrative process and usually submit much less evidence from consulting physicians than the coal operators.²⁰⁶ For years, the operators in each claim customarily submitted numerous reports from highly-credentialed physicians, while miners produced a physical examination, including x-ray and blood-gas evidence, and a report from a treating or examining physician.²⁰⁷ This imbalance fueled the bitterness endemic to these cases.²⁰⁸ In 2000, the Department of Labor finally addressed the financial disparity between the parties and the resulting disparities in record evidence.²⁰⁹ The agency placed limitations on

Proposed Rules, *supra* note 202, at 3338. The Department adopted the limitations on the amount of evidence that the parties to a black lung claim may submit to the record. *See Final Rule*, *supra* note 19, at 79,920.

²⁰⁶ On the problem of miners representing themselves, see Nixon, *Lawyers Are Few*, *supra* note 203 (“It can be a serious undertaking for [an unrepresented] miner with declining health: keeping track of hearing dates, preparing evidence for hearings and taking depositions.”). On the imbalance between parties in developing evidence, see *Woodward v. Director*, OWCP, 991 F.2d 314, 321 (6th Cir. 1993), where the court in a black lung case recognized that fairness is at risk when one side has the ability “to hire significantly more experts because it has infinitely more resources.” Under those circumstances, the court stated, “the truthseeking function of the administrative proceeding is skewed and directly undermined.” *Id.*

²⁰⁷ In *Westmoreland Coal Co. v. Bradley*, No. 00-1192, 2 Fed. Appx. 245, 249, 2001 WL 46492, at *3 (4th Cir. Jan. 19, 2001), the court reversed an ALJ who had relied on the medical opinion of a coal miner’s examining physician for a finding of pneumoconiosis. According to the court, the ALJ erred by failing to take into account the fact that the coal operator submitted “thirty negative [x-ray] readings, all by . . . six [different] certified readers” after the coal miner had submitted his physician’s assessment. In *Lisa Lee Mines v. Director*, OWCP, 86 F.3d 1358 (4th Cir. 1996) (en banc), the Fourth Circuit court showed awareness of the power of financial resources in black lung claims. The court discussed an earlier claim which had been denied by agency personnel but had never been appealed by the coal miner. Apparently the record of the claim contained strong evidence that the miner had complicated pneumoconiosis, a severe form of black lung disease, but the court said it could “only speculate” that the decision would have been overturned if the claimant had brought an appeal. *Id.* at 1361 n.6. The court stated that “[f]or all we can know, had [the claimant] requested a hearing, the [coal operator] would have produced a dozen radiologists to deny that his x-rays were positive for complicated pneumoconiosis.” *Id.*

²⁰⁸ Ron Nixon, *Benefits Claims Process Is As Slow, Painful as the Disease, Miners Say*, ROANOKE TIMES & WORLD NEWS, Nov. 24, 2000, at A13 (reporting anger of black lung claimants at slowness of the process and lack of finality).

²⁰⁹ *Final Rule*, *supra* note 19, at 79,989-94.

the amount of evidence that either side may submit, with an escape hatch in the form of a "good cause" exception.²¹⁰ Industry challenged the evidentiary limitations in a federal court case that is still pending.²¹¹ Even if the new rules survive judicial review, it is unclear how liberally ALJs will construe the "good cause" exception and thus whether the problem of evidentiary imbalance in black lung litigation has truly been solved.

From the inception of the federal black lung program in 1969 through the 1990s, courts have acknowledged the importance of treating physicians' opinions in black lung litigation.²¹² For example, in 1978, the Third Circuit cited Congress' expectation that "the diagnoses of treating physicians would play a major role in the determination of eligibility for black lung benefits."²¹³ In another early case, the Fourth Circuit stated that it "places great reliance on a claimant's treating physician."²¹⁴ By the 1990s, however, the Fourth Circuit appeared less receptive to treating physicians and limited circuit precedents to their precise holdings. In 1993, the court declared that a treating physician's opinion had no "greater weight"²¹⁵ than the opinion of other physicians and maintained that neither the Fourth Circuit nor the Benefits Review Board of the Department of Labor "ha[d] ever fashioned either a requirement or a presumption that treating or examining physicians' opinions be given greater weight than opinions of other expert physicians."²¹⁶ Writing for the court, Judge Luttig minimized prior statements about according "especial consideration" to opinions of treating and examining physicians,²¹⁷ and he rejected the notion that an ALJ

²¹⁰ See 20 C.F.R. § 725.414 (2002) (describing evidentiary procedures); *id.* § 725.456(b)(1) (delineating the "good cause" exception).

²¹¹ The rules were upheld in *National Mining Ass'n v. Chao*, 160 F. Supp. 2d 47 (D.D.C. 2001). The National Mining Association is seeking reversal in the U.S. Court of Appeals for the District of Columbia Circuit.

²¹² See *Proposed Rules*, *supra* note 202, at 3342 (listing cases).

²¹³ *Schaaf v. Mathews*, 574 F.2d 157, 160 (3d Cir. 1978) (citing S. REP. 92-743 (1972), reprinted in 1972 U.S.C.C.A.N. 2305, 2318). The Court also quoted the statement of Dr. Donald Rasmussen from the Senate Report:

I would like also to urge the people who administer the provisions of the black lung compensation to perhaps make more use of the opinion of the miner's family doctor in terms of the existence of lung disease. . . . I think very little attention is paid to the fact that the doctor may well know his patient suffers one of the general respiratory diseases.

Id., reprinted in 1972 U.S.C.C.A.N. 2305, 2318.

²¹⁴ *Hubbard v. Califano*, 582 F.2d 319, 323 (4th Cir. 1978).

²¹⁵ *Grizzle v. Pickands Mather & Co.*, 994 F.2d 1093, 1097 (4th Cir. 1993).

²¹⁶ *Id.*

²¹⁷ *Id.*

need even consider the treating relationship in evaluating the credibility of medical evidence.²¹⁸ In a dissent, Judge Hall agreed with the obvious point that treating physician opinions are not accorded “*per se* dispositive weight,”²¹⁹ but he stated that a doctor’s status as treating physician provided “a basis for credibility that should not be disregarded without articulable cause.”²²⁰ The majority and dissent thus differed on whether it was necessary for an ALJ to consider the treating status of the physician, the majority indicating that the answer was no. The Fourth Circuit appeared to have no treating physician rule, although it stopped short of making that statement outright.

The following year, another panel of the same Circuit seemed to think that a treating physician rule was alive and well. In *Grigg v. Director, OWCP*,²²¹ the court stated that although a miner’s treating physician “is not as highly qualified as the other physicians whose opinions appear in this record, his status as treating physician entitles his opinion to *great*, though not necessarily dispositive, weight.”²²² The Fourth Circuit, then, was less than crystal-clear on whether a treating relationship could have intrinsic value that an adjudicator should take into account.

The Seventh Circuit has been less ambiguous. In *Peabody Coal Co. v. McCandless*,²²³ the court baldly declared it “irrational” in black lung litigation to give preference to a physician’s opinion simply due to the treating relationship.²²⁴ Writing for the court, Judge Easterbrook ironically found the opposite assumption—that treating physicians are biased—to be quite rational. Judge Easterbrook stated: “Treating physicians often succumb to the temptation to accommodate their patients (and their survivors) at the expense of third parties such as insurers, which implies attaching a discount rather than a preference to their views.”²²⁵

As noted above, the Department of Labor proposed procedural and substantive reforms of the black lung benefits program in 1996. A three-year rule making procedure culminated in the promulgation of new regulations at the end of the Clinton Administration,²²⁶ and the Bush

²¹⁸ *Id.* at 1097-98.

²¹⁹ *Id.* at 1101 (Hall, J., dissenting).

²²⁰ *Id.* (Hall, J., dissenting).

²²¹ *Grigg v. Director, OWCP*, 28 F.3d 416 (4th Cir. 1994).

²²² *Id.* at 420 (emphasis added).

²²³ *Peabody Coal Co. v. McCandless*, 255 F.3d 465 (7th Cir. 2001).

²²⁴ *Id.* at 469 (quoting *Peabody Coal Co. v. Director, OWCP*, 972 F.2d 178, 180 (7th Cir. 1992)).

²²⁵ *Id.*

²²⁶ See *Final Rule*, *supra* note 19.

Administration chose to defend the rules against an industry court challenge.²²⁷ The reforms included a treating physician rule.²²⁸ The rule recognizes that a treating physician may have a “thorough understanding of the miner’s pulmonary condition”²²⁹—or may not. The rule provides “guidelines for the adjudicator to determine whether to afford special weight to an opinion from the miner’s treating physician.”²³⁰ Rejecting an “automatic acceptance” of the treating physician’s opinion,²³¹ the rule is designed, according to the Department of Labor, “to force a careful and thorough assessment of the treatment relationship.”²³² To that end, the rule lists “criteria for evaluating the quality of the doctor-patient relationship as indicia of the potential insight the physician may have gained from ongoing treatment of the miner.”²³³ ALJs therefore are to engage in “critical analysis” of the subject matter of the treatment, i.e., whether the physician provided pulmonary or respiratory treatment, how long the physician treated the patient, how often the treating took place, and what types of tests and examinations the physician carried out.²³⁴ The ALJ “must also weigh that report against all other relevant evidence in the record.”²³⁵

The rule creates no presumption in favor of the treating physician’s opinion; rather it delineates aspects of physician-patient relationship that must be considered before deciding whether the physician’s opinion on issues of disease, disability, and causation merit “controlling weight.” Although the social security and black lung rules are similar, the social security rule has a different legal effect, according to the Department. In declaring that “[g]enerally, we give more weight to opinions from your treating sources,”²³⁶ the social security rule “demonstrates an affirmative preference for reports from treating physicians,”²³⁷ whereas the black lung rule is “more qualified in permitting ‘controlling weight’ only if the regulatory criteria warrant it.”²³⁸ The difference appears to be a matter of

²²⁷ See *National Mining Ass’n v. Chao*, 160 F. Supp.2d 47 (D.D.C. 2001).

²²⁸ 20 C.F.R. § 718.104(d) (2002). For the agency’s discussion, see *Final Rule*, *supra* note 19, at 79,930-35.

²²⁹ *Final Rule*, *supra* note 19, at 79,932.

²³⁰ *Id.* at 79,931.

²³¹ *Id.* at 79,932.

²³² *Id.*

²³³ *Id.* at 79,931.

²³⁴ *Id.*

²³⁵ *Id.* at 79,934.

²³⁶ 20 C.F.R. § 404.1527(d) (2002).

²³⁷ *Final Rule*, *supra* note 19, at 79,934.

²³⁸ *Id.*

degree; both rules are non-mechanical, requiring deference to treating physicians if it is reasonable to do so in the context of the entire record.

The social security rule focuses first on the opinion's basis in medical testing and data and its consistency with the record; only if the opinion is either unsupported by data or inconsistent with other substantial evidence does the ALJ consider the list of factors for assigning less than controlling weight. In contrast, the black lung rule focuses from the outset on the quality of the treating relationship, asking whether the relationship was sufficient to afford the physician superior understanding of the miner's condition.²³⁹ Both rules share the conviction that the treating relationship can be, depending on its quality, decisive of crucial medical questions.

Like the tort system and the social security system, this rule seeks accuracy by requiring a high level of physician explanation as well as by encouraging a significant physician-treating relationship. But the black lung treating physician rule pursues accuracy a third way as well: by helping to balance, even roughly, the input of each side to the ultimate determinations. As noted above, the new regulations promulgated in December 2000 achieved significant reform, one part of which was to place numerical limitations on the amount of evidence that each side in a black lung claim could submit into the record.²⁴⁰ This was clearly an effort to keep one party's financial ability to obtain evidence from controlling the outcomes of cases and to make the system's results more rational.²⁴¹ The treating physician rule is part of the same effort. It focuses the adjudicator's attention on matters of quality rather than quantity. The underlying theory is that closer equivalence of opportunity between the parties to advance their positions, coupled with critical analysis of conclusions emanating from a doctor-patient relationship not based on litigation but on treatment, will generate better informed individual decisions and a more credible system overall.²⁴² In this sense, the black lung treating physician rule embraces not only the tort system's emphasis on the quality of expert opinion and the social security system's emphasis on the treating relationship, but also its own systemic concern that a fairer system of proof can improve the accuracy of results. If the story of justice in the tort system has been the effort to improve the intellectual quality of expertise to which juries are exposed and if the story of justice in the immense social security system has been the effort to devise rules of analysis that are administrable

²³⁹ *Id.*

²⁴⁰ See *supra* text accompanying notes 209-11.

²⁴¹ See *supra* text accompanying notes 209-11.

²⁴² See *Proposed Rules, supra* note 202, at 3342.

yet conducive to accurate results, then the story of justice in the black lung system has been the effort to seek accuracy by reforming skewed procedures and spelling out a fairer way to weigh the evidence.

But is there yet a better way? Are treating physicians the solution to the need for greater accuracy in these systems? What of Judge Easterbrook's strong doubt that treating physicians could be objective? Perhaps decision makers should look to independent physicians who have no other interest in a claim.²⁴³ Should the medical issues in federal black lung cases be delegated to medical experts who are wholly independent, as is now the practice in the Kentucky state black lung system? It is to that compensation system that we turn for a final comparison.

IV. KENTUCKY BLACK LUNG SYSTEM: PRESUMPTIVE WEIGHT TO UNIVERSITY EVALUATORS

In Kentucky, workers are permitted to file for workers' compensation benefits for occupational disease arising out of their employment.²⁴⁴ The Kentucky Revised Statutes authorize benefits for coal workers who have pneumoconiosis²⁴⁵ and impose financial liability on a claimant's last employer.²⁴⁶ Proceedings are adversarial. Pursuant to amendments passed in 1994, each side is limited in the amount of evidence that can be submitted into the record.²⁴⁷

In 1996, Kentucky Governor Paul Patton called for reform of the state's black lung program, calling it "a program which has long ago outlived its usefulness"²⁴⁸ and urging a legislative cut of the program by 67%.²⁴⁹ He noted that "[m]iners constitute less than 2% of Kentucky's workforce, and receive about 55% of all workers' compensation benefits."²⁵⁰ Following the

²⁴³ Consultative examiners already play a significant role in social security disability proceedings. They serve various functions, including filling in the record and testing claimants' medical evidence. *See* BLOCH, *supra* note 166, at 138-41 (noting sentiment among some decision makers that consultative examiners have more credibility than treating physicians).

²⁴⁴ *National Mines Corp. v. Pitts*, 806 S.W.2d 636 (Ky. 1991).

²⁴⁵ KY. REV. STAT. ANN. [hereinafter K.R.S.] § 342.732 (1997).

²⁴⁶ *Id.* § 342.316(a)(1), (10); *see* *Begley v. Mountain Top, Inc.*, 968 S.W.2d 91 (Ky. 1998).

²⁴⁷ K.R.S. § 342.033 (1997).

²⁴⁸ Press Release, Reform Bill to Protect the Injured Worker and Their Job, Governor Disappointed by Labor Leaders (Dec. 10, 1996) (on file with author).

²⁴⁹ *Id.*

²⁵⁰ *Id.*

Governor's lead, the General Assembly passed legislation providing authority for administrative law judges, on their own motion or at the request of a party, to obtain independent evaluations of medical issues from physicians at the University of Kentucky and the University of Louisville.²⁵¹ In cases of occupational disease, referral to a university evaluator is mandatory.²⁵² The university evaluator is required to render a written report to the commissioner within fifteen days of the examination.²⁵³

The key provision relates to the decisional impact of the evaluator's report. The statute provides that "[t]he clinical findings and opinions of the designated evaluator shall be afforded presumptive weight by arbitrators and administrative law judges and the burden to overcome such findings and opinions shall fall on the opponent of that evidence."²⁵⁴ If the ALJ rejects the evaluator's findings and opinions, the ALJ "shall specifically state in the order the reasons for rejecting that evidence."²⁵⁵ Several years after enactment of this legislation, Governor Patton indicated that the purpose underlying the 1996 legislation was to promote impartial medical review and accurate results.²⁵⁶

In a 2000 case, *Magic Coal Co. v. Fox*,²⁵⁷ the Kentucky Supreme Court explained that by according "presumptive weight" to the reports of university evaluators, "the legislature intended to create a rebuttable presumption" in favor of an evaluator's report.²⁵⁸ The court observed that in cases of occupational disease, "fact-finders are confronted with medical evidence in which the clinical findings and opinions introduced on behalf of one party are vastly different from those introduced on behalf of the

²⁵¹ K.R.S. § 342.315 (Supp. 2000).

²⁵² *Id.* § 342.316(3)(b)(4)(b); see also *Magic Coal Co. v. Fox*, 19 S.W.3d 88, 91, 94 (Ky. 2000); James Michael Kemp & Laurie Goetz Kemp, *Kentucky Workers' Compensation Law Update: Issues Facing Employers, Employees, Medical Providers, Insurers And Practitioners As House Bill 1 Continues To Evolve*, 26 N. KY. L. REV. 67, 81-83 (1999).

²⁵³ K.R.S. § 342.315(3) (Supp. 2000).

²⁵⁴ *Id.* § 342.315(2).

²⁵⁵ *Id.*

²⁵⁶ The Governor stated that "[o]ne of the very important reforms made in 1996 was to place the diagnosis of black lung in our public universities' medical schools." Statement, Gov. Paul E. Patton, Workers' Compensation Statement, Feb. 16, 2000, available at http://gov.state.ky.us/legislativeinits/2000/2_17start.pdf. He expressed "great confidence in the ability of the professional staffs of these schools to provide accurate and unbiased medical opinions." *Id.*

²⁵⁷ *Magic Coal Co. v. Fox*, 19 S.W.3d 88 (Ky. 2000).

²⁵⁸ *Id.* at 95.

opponent."²⁵⁹ In these circumstances, findings and opinions "from an unbiased medical expert would reasonably be expected to provide an accurate assessment of the medical status of the [claimant] . . . and would assist the fact-finder in weighing the conflicting evidence."²⁶⁰ The court found it reasonable for the legislature

to infer that . . . the clinical findings and opinions of physicians who are affiliated with a medical school are informed by some degree of expertise and are more likely to be free from a preconceived bias toward either the plaintiff or the defense than those of a physician who has been hired to testify on behalf of the plaintiff or defendant.²⁶¹

A university evaluator's conclusions are therefore presumed to be accurate, and the party whose position is contrary to the university evaluator's has the burden of going forward with rebuttal evidence.²⁶²

A dissenting Justice ridiculed the legislature's assumption that university evaluators possess greater objectivity or accuracy in their diagnostic assessments.²⁶³ Justice Graves maintained: "There is no rational reason to believe a university physician is better qualified solely because he works in Lexington or Louisville."²⁶⁴ Finding the statute's premise to be "nothing more than sophistical conjecture,"²⁶⁵ the dissent concluded that K.R.S. § 342.315(2) constituted an arbitrary government act in violation of the Kentucky Constitution.²⁶⁶

At issue in *Magic Coal* were several black lung claims which were referred to university evaluators. In one claim, although the university evaluator read an x-ray as negative for pneumoconiosis and the employer's doctors read two x-rays as negative, the ALJ ruled for the claimant because two "well-qualified pulmonary specialists"²⁶⁷ rendered opinions supporting the claim. The Supreme Court upheld the ALJ's grant of benefits.²⁶⁸ In another claim discussed in *Magic Coal*, the Supreme Court again upheld the ALJ's conclusion that a claimant's evidence—reports of the same two

²⁵⁹ *Id.*

²⁶⁰ *Id.*

²⁶¹ *Id.* at 95-96.

²⁶² *Id.* at 96.

²⁶³ *Id.* at 98 (Graves, J., dissenting).

²⁶⁴ *Id.* at 99 (Graves, J., dissenting).

²⁶⁵ *Id.* (Graves, J., dissenting).

²⁶⁶ *Id.* (Graves, J., dissenting).

²⁶⁷ *Id.* at 98 (internal quotation marks omitted).

²⁶⁸ *Id.* at 97-98 (opinion of the Court).

well-credentialed, examining specialists—successfully rebutted the presumption favoring the university evaluator’s negative conclusions.²⁶⁹

This fascinating case prompts at least two observations. First, although compensation systems differ in the choice of presumptively trustworthy experts, they share a rather constant search for the most reliable and cost-effective means of achieving accurate results. In the Kentucky workers’ compensation system for occupational disease, the means to that end has been the university evaluator; in social security and federal black lung, it has been the treating physician; in some tort cases, it has been the physician who provides a well-reasoned differential diagnosis. Kentucky’s search is ongoing. In 2001, convinced that state black lung process has been too restrictive, the Governor backed legislation to amend the system.²⁷⁰ He proposed eliminating the university evaluator’s function in black lung claims, indicating that it had not been quite the perfect solution after all.²⁷¹ As 2001 came to a close, legislators were still debating on how to build a fair, accurate system.²⁷²

A second observation is that regardless of how or where a system sets its evidentiary baseline, compensation cases may well turn on a combination of credentials and contact with the claimant. In *Magic Coal*, the university evaluator’s presumed correctness was overcome by the opinion of examining specialists. When a specialist with “independent judgment” collides with a specialist having “first-hand knowledge” and when the

²⁶⁹ *Id.* at 98.

²⁷⁰ *Only 11 Black Lung Claims Ok’d in Ky. After New Law*, CHARLESTON GAZETTE, Nov. 17, 2001, at 8A [hereinafter *Only 11*] (reporting that Governor Patton, “a former coal operator,” initially championed the tougher eligibility rules but now acknowledges they “went too far”).

²⁷¹ The proposed modification, which did not pass, involved achieving a consensus on interpretations of x-ray films submitted by the employee and the employer in a black lung workers’ compensation claim. If x-ray interpretations conflict, the Commissioner of Workers’ Compensation would send the x-ray films to a third x-ray reader selected randomly from a list of x-ray specialists (B-readers). The third x-ray reader would choose the “most diagnostic” of the films and report his reading of that film. If “consensus” is thereby reached (basic agreement by two of the three x-ray readers), the consensus reading becomes the correct classification unless overcome by clear and convincing evidence. H.B. 132, 2001 Gen. Assem., Reg. Sess. (Ky. 2001) (proposing to amend K.R.S. §§ 342.315-.316, but failing to pass before the end of the Regular Session).

²⁷² *Only 11*, *supra* note 270 (reporting enthusiasm of industry group for continuation of university evaluator program, and complaint of Kentucky State AFL-CIO president: “Yet the current method of identifying black lung has found only a handful of miners afflicted with this disease. There is something wrong here”).

decision maker reasonably chooses to rely on the latter, then we hear echoes at least of why other systems have placed faith in the treating physician.

CONCLUSION

This Article, written for a symposium on public health, has examined the quest for intellectual due process in several prominent compensation systems. Each system has developed evidentiary rules calculated to improve the chances of attaining accurate and more credible results. Whether these systems succeed or fail is, of course, a function of much else besides the choice of evidentiary rules. But the rules—particularly as they reflect a common interest in the potential reliability of the treating physician and as they encourage treating relationships across a range of contexts—are an important part of a larger picture. Public health scholars and authorities should be aware of these efforts. They should recognize that these systems offer an important source of credible information about health hazards that still afflict the American workplace in the new century. And they should actively participate in further reforms of systems that in design and application still too often fall short of justice.