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Somebody Call My Doctor: Repeal of the Treating Physician Rule in Social Security Disability Adjudication

CHARLES TERRANOVA†

INTRODUCTION

Millions of Americans depend on disability benefits programs managed by the Social Security Administration (“SSA”). In the mid-2010s, an uptick in applications and administrative appeals sparked a crisis for both the Agency and program beneficiaries.¹ Although a sizeable percentage of the federal budget is dedicated to Social Security, funding has failed to keep pace with the rising number of claims.² As a result, administrative law judges (“ALJs”) face crushing backlogs of cases,³ and claimants wait in line for nearly two

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1. Terrence McCoy, *597 Days. And Still Waiting.*, WASH. POST (Nov. 20, 2017), https://www.washingtonpost.com/sf/local/2017/11/20/10000-people-died-waiting-for-a-disability-decision-in-the-past-year-will-he-be-next/?utm_term=.d981cbd003a8 (stating that 10,000 people died while waiting for a decision on a disability benefits claim).

2. *See id.* (describing the budget as “stagnant”).

3. Jonah B. Gelbach & David Marcus, *Crushed*, JUDICATURE, Autumn 2017, at 65, 66 (“To forestall an intolerable backlog, the Social Security Administration expects Administrative Law Judges to render an average of 500 to 700 ‘legally sufficient’ decisions each year.”). Administrative Law Judges are the officers charged with disability hearing adjudication. *See infra* Section I.B.

years before sitting for a hearing.⁴ As one ALJ bluntly remarked, “We have decided it’s better for people to die than to adequately fund this program.”⁵

This problem is partly attributable to the role of the federal courts in SSA disability determinations.⁶ Appeals of disability decisions weigh heavily on a district judge’s docket. In 2016, for instance, these cases dwarfed the number of appeals of other administrative agency decisions and constituted seven percent of all district court filings nationwide.⁷ Furthermore, the judges who hear these cases sometimes feel ill-equipped to address the relevant issues in disability cases.⁸ Although district court judges are experienced in trial work, disability cases require them to work in an appellate capacity.⁹ The disconnect between the trial judge’s skill set and the nature of the work leads to frustration and despair.¹⁰ Relatedly, SSA has suggested judicial misapplication of the standard of review causes high rates of remands to the Agency,¹¹ which in turn creates more work for the already burnt-out ALJs.

4. Gelbach & Marcus, *supra* note 3; see also Lizzie O’Leary, Peter Balonon-Rosen, & Sean McHenry, *Wait Times for Social Security Benefit Appeals Leave People in Limbo*, MARKETPLACE (Oct. 20, 2017, 4:38 PM), <https://www.marketplace.org/2017/10/20/world/wait-times-social-security-disability-benefit-hearings-leave-people-limbo>.

5. McCoy, *supra* note 1.

6. Final Agency determinations regarding disability are reviewable by federal district courts. See *infra* Part I.

7. JONAH GELBACH & DAVID MARCUS, ADMIN. CONFERENCE OF THE U.S., A STUDY OF SOCIAL SECURITY LITIGATION IN THE FEDERAL COURTS 4, 9–10 (2016).

8. See *id.* at 10 n.21.

9. *Id.* at 10.

10. *Id.* One federal judge described Social Security cases as “the bane of [district court judges] existence” and another remarked that disability appeals are “horribly ill fit for the skill set of Article III judges and clerks.” *Id.* at 10 n.21.

11. See Revisions to Rules Regarding the Evaluation of Medical Evidence, 81 Fed. Reg. 62,560, 62,572 (proposed Sept. 9, 2016) (to be codified at 20 C.F.R. pts. 404, 416) (“[T]hese courts, in reviewing final agency decisions, are reweighing evidence instead of applying the substantial evidence standard of review . . .”).

In 2017, SSA promulgated sweeping regulatory reform in part to relieve the burden of remands from federal courts. Most notably for this Comment, the Agency repealed the decades-old “treating physician rule.” This rule, which is used to evaluate medical opinion evidence, caused frequent remands. Both Agency adjudicators and federal judges alike struggled to apply the old-fashioned rule to the modern landscape of healthcare delivery and physician-patient relationships. By repealing the rule, remands may decrease, and systemic tensions may decline.

The benefits of increased judicial and administrative economy through repeal of the treating physician rule could be significant. However, increasing efficiency may also cause a decline in fairness to individual participants in the legal system.¹² The Social Security Act, which is the law that established federal disability programs, is a remedial and inclusive statute designed to provide relief from life’s hardships.¹³ To maintain the spirit of the statute, fairness must not be sacrificed at the altar of efficiency. While the treating physician rule needed reform, it also provided for fair consideration of the claimant’s medical evidence in certain contexts. Thus, steps should be taken to mitigate the potential negative consequences the repeal might bring for claimants.

This Comment provides an in-depth examination of the repeal of the treating physician rule in Social Security Disability law. Part I explains the fundamental legal principles of SSA disability determinations. Part II discusses the historical development of the treating physician rule, the

12. See, e.g., Elijah Yip & Eric K. Yamamoto, *Justice Ruth Bader Ginsburg’s Jurisprudence of Process and Procedure*, 20 U. HAW. L. REV. 647, 667 (1998) (explaining that procedural values of efficiency and fairness often collide and overlap).

13. See *Marcus v. Califano*, 615 F.2d 23, 29 (2d Cir. 1979) (“The Social Security Act is a remedial statute which must be ‘liberally applied’; its intent is inclusion rather than exclusion.”); *Rodriguez v. Celebrezze*, 349 F.2d 494, 496 (1st Cir. 1965) (“[T]he Social Security Act is to be construed liberally to effectuate its general purpose of easing the insecurity of life . . .”).

Agency justifications for repealing it, and the current state of the law. Finally, Part III examines two circumstances where the treating physician rule's repeal may impact the rights of claimants: cases where a claimant's mental health is at issue and the qualified right to subpoena physicians for disability hearings. Part III also suggests regulatory changes which seek to maintain the bulk of SSA's policy overhaul while addressing the potential adverse effects of repealing the treating physician rule.

I. THE BASICS OF SOCIAL SECURITY LAW AND PRACTICE

This Part will explain the fundamental concepts of Social Security Disability law. First, I provide a brief historical overview and substantive discussion of the Social Security Act. The next section explains the adjudication process for disability claims. Finally, I explore the meaning of “disabled” under the Social Security Act and explain how adjudicators apply that definition to make decisions on claims.

A. *A Brief Overview of the Social Security Act and Disability Benefits*

The Social Security Act (“the Act”) was signed into law on August 14, 1935, by President Franklin D. Roosevelt.¹⁴ The Act originally contained no provisions relating to disability benefits.¹⁵ However, in 1956, the law was amended to provide benefits to disabled workers.¹⁶ Upon authorizing the amendments, President Dwight Eisenhower promised to administer disability benefits “efficiently and effectively.”¹⁷ In 1972, the Act was amended again to include the Supplemental Security Income program, which is still in effect today.¹⁸

The modern Social Security Act provides disability benefits through two programs administered by the Social Security Administration: Social Security Disability Insurance (“SSDI”) and Supplemental Security Income (“SSI”). To qualify for SSDI, a person must demonstrate past employment and payment into the Social Security program through taxes.¹⁹ By contrast, SSI has no past employment or

14. OFFICE OF RET. & DISABILITY POLICY, SOC. SEC. ADMIN., ANNUAL STATISTICAL REPORT ON THE SOCIAL SECURITY DISABILITY INSURANCE PROGRAM 1 (2017) [hereinafter DISABILITY REPORT].

15. *Id.*

16. *Id.*

17. *Id.*

18. *Id.*

19. Nate Ghubril, *Social Security Disability Reform: Steps Toward Economic*

tax payment requirement; the program is distributed to those in financial need.²⁰ Both programs require beneficiaries to show they are disabled within the meaning of the Social Security Act.²¹

The Social Security Administration is an independent agency that administers disability benefits programs. The Agency is the largest provider of social welfare in the United States and accounts for twenty-two percent of the federal government's total costs.²² It is headed by the Commissioner of Social Security ("the Commissioner"). This position requires nomination by the President and confirmation by the U.S. Senate.²³ Appointees serve for a term of six years,²⁴ meaning the office is somewhat isolated from partisan politics. The current Commissioner, Andrew M. Saul, was appointed by President Donald J. Trump and sworn in on June 17, 2019.²⁵

B. *The Journey of a Claim from Online Application to Federal Court*

A claim for disability benefits begins with an online or paper application.²⁶ The claimant provides SSA with information about her work history, medical conditions, doctors, and other health care providers.²⁷ After receiving the

Efficiency and Improved Claimant Care, 74 U. PITT. L. REV. 549, 554 (2013).

20. *Id.*; see also 42 U.S.C. § 1382(a) (2012).

21. See 42 U.S.C. §§ 423(a)(1)(E), 1382c(a)(3) (2012).

22. STEVEN T. MNUCHIN, U.S. DEP'T OF THE TREASURY, FINANCIAL REPORT OF THE UNITED STATES GOVERNMENT 3 (2017).

23. 42 U.S.C. § 902(a)(1) (2012); see also U.S. CONST. art. II.

24. 42 U.S.C. § 902(a)(3).

25. Jim Borland, *Social Security Welcomes its New Commissioner*, SOC. SEC. ADMIN. BLOG (June 17, 2019), <https://blog.ssa.gov/social-security-welcomes-its-new-commissioner/>.

26. Emily C. Russell & Hon. Glynn F. Voisin, *A Primer on Social Security Disability Law*, 62 LOY. L. REV. 829, 834 (2016).

27. See *Disability Benefits*, SOC. SEC. ADMIN., www.ssa.gov/benefits/disability/ (last visited Dec. 14, 2018).

application, the Agency develops the claimant's medical history by requesting records from the claimant's medical sources.²⁸ The Agency then makes an initial determination whether the claimant is disabled.²⁹ If the Agency finds the claimant disabled, she is eligible for benefits.³⁰ In 2016, only 35.4% of applicants prevailed at the first level of disability adjudication.³¹

A claimant who receives an unfavorable initial decision—a finding of “not disabled”—may file for reconsideration within sixty days.³² If the claimant is unsatisfied with the decision after reconsideration, she may request a hearing with an ALJ.³³ The ALJ reviews the claim *de novo* to determine whether the claimant is disabled.³⁴ Prior to the hearing date, the ALJ continues to collect the claimant's medical evidence and fully develops the facts of the case.³⁵ During the hearing, the ALJ elicits testimony from the claimant and any lay or expert witnesses called to

28. 20 C.F.R. §§ 404.1512(b), 416.912(b) (2016).

29. Russell & Voisin, *supra* note 26, at 834.

30. In addition to proving disability, claimants must also demonstrate either the work requirements for SSDI or the needs-based qualifications for SSI. *See supra* Section I.A. Generally, regulations pertaining to disability determination for SSDI are codified at 20 C.F.R. Part 404, and for SSI at Part 416. However, the adjudication process is similar for both programs. *See* Ghubril, *supra* note 19, at 554–55.

31. DISABILITY REPORT, *supra* note 14, at 159.

32. 20 C.F.R. §§ 404.909(a)(1), 416.1409(a) (2016). Some commentators have suggested eliminating reconsideration from the disability adjudication process. *See, e.g.*, FRANK S. BLOCH, REPORT AND RECOMMENDATIONS ON THE SOCIAL SECURITY ADMINISTRATION'S ADMINISTRATIVE APPEALS PROCESS 363 (1989).

33. 20 C.F.R. §§ 404.930, 416.1430 (2018).

34. Oren R. Griffin, *Social Security Disability Law and the Obstacles Facing Claimants with Mental Disabilities*, 36 L. & PSYCHOL. REV. 147, 153 (2012).

35. *See* 20 C.F.R. §§ 404.1512(b), 416.912(b) (2018) (detailing SSA's duty to request medical evidence); *Richardson v. Perales*, 402 U.S. 389, 410 (1971) (“The social security hearing examiner, furthermore, does not act as counsel. He acts as an examiner charged with developing the facts.”); *Snead v. Barnhart*, 360 F.3d 834, 838 (8th Cir. 2004) (“Well-settled precedent confirms that the ALJ bears a responsibility to develop the record fairly and fully, independent of the claimant's burden to press his case.”).

provide information relevant to the case.³⁶ Once the ALJ makes a determination, she issues a written opinion detailing the findings of fact and conclusions of law underlying her decision.³⁷ If the ALJ gives an unfavorable decision, the claimant may request review by the SSA Appeals Council.³⁸ The decision of the Appeals Council is binding.³⁹ If a claimant receives an unfavorable decision from the Appeals Council, she has exhausted all available administrative remedies.⁴⁰

If the claimant receives an unfavorable final determination from the Appeals Council, she may file a civil action against the Commissioner of Social Security in a federal district court.⁴¹ Procedurally, the parties file cross-motions for judgment on the pleadings and the district court judge disposes of the case by granting either the plaintiff's motion or the Commissioner's motion.⁴² The Court has authority to uphold, reverse, or remand the Commissioner's determination of disability.⁴³ However, the Court is bound to uphold the Commissioner's findings of fact if they are supported by "substantial evidence."⁴⁴ Decisions on claims by

36. 20 C.F.R. §§ 404.929, 416.1429 (2018); Griffin, *supra* note 34, at 154.

37. 20 C.F.R. §§ 404.917, 416.1417 (2018).

38. 20 C.F.R. §§ 404.967, 416.1467 (2018).

39. 20 C.F.R. §§ 404.981, 416.1481 (2018).

40. *See id.*; *see also* Charles H. Koch, Jr. & David A. Koplou, *The Fourth Bite at the Apple: A Study of the Operation and Utility of the Social Security Administration's Appeals Council*, 17 FLA. ST. U. L. REV. 199, 231 (1990).

41. *See* 42 U.S.C. § 405(g) (2012); 20 C.F.R. §§ 404.981, 416.1481.

42. *See* FED. R. CIV. P. 12(c); *Igonia v. Califano*, 568 F.2d 1383, 1389 (D.C. Cir. 1977) (explaining that the Social Security Act "directs the court to enter its judgment upon the pleadings and the transcript of the record"). There is no discovery in Social Security cases because the evidentiary record is developed at the administrative level.

43. 42 U.S.C. § 405(g) (2012).

44. *Id.* *See also* *Richardson v. Perales*, 402 U.S. 389, 401 (1971) (defining the substantial evidence standard as "more than a mere scintilla" and "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion."); *Jones v. Comm'r of Soc. Sec.*, 336 F.3d 469, 477 (6th Cir. 2003)

district court judges may be appealed to the United States Circuit Courts of Appeals and subsequently to the Supreme Court of the United States.⁴⁵

C. *Determining Disability*

The definition of “disabled” found in the Social Security Act is complex and narrow. A person is disabled when he is unable to engage in “substantial gainful activity”⁴⁶ because of a physical or mental impairment expected to last longer than twelve months or result in death.⁴⁷ The impairment must be so severe that it precludes the person from doing any past work, or any other kind of work the person could do considering his work experience, education, and age.⁴⁸ If a person has multiple impairments, the combined impact of those impairments on the person’s ability to work must be considered throughout disability determination.⁴⁹

The Act authorizes the Commissioner to promulgate regulations to carry out disability programs.⁵⁰ Thus, SSA devised a regulatory scheme—known as the “five-step

(“[T]he Commissioner’s decision cannot be overturned if substantial evidence, or even a preponderance of the evidence, supports the claimant’s position, so long as substantial evidence also supports the conclusion reached by the ALJ.”); *Jesurum v. Sec’y of the U.S. Dep’t of Health & Human Servs.*, 48 F.3d 114, 117 (3d Cir. 1995) (“[Substantial evidence] is less than a preponderance of the evidence but more than a mere scintilla.”).

45. *See, e.g.,* *Biestek v. Comm’r of Soc. Sec.*, 880 F.3d 778 (6th Cir. 2017), *cert. granted*, 138 S. Ct. 2677 (2018).

46. The phrase “substantial gainful activity” is defined in regulations. Activity is “substantial” if it involves “doing significant physical or mental activities” and “gainful” if it is done for pay or profit, whether or not a profit is realized. 20 C.F.R. §§ 404.1572, 416.972. Even unlawful work—such as prostitution—may qualify as substantial gainful activity. *See* Margaret A. Baldwin, “*A Million Dollars and an Apology*”: *Prostitution and Public Benefits Claims*, 10 HASTINGS WOMEN’S L.J. 189, 216–18 (1999).

47. 42 U.S.C. § 423(d)(1)(A) (2012).

48. 42 U.S.C. § 423(d)(2)(A).

49. 42 U.S.C. § 423(d)(2)(B).

50. 42 U.S.C. § 405(a)–(b).

sequential evaluation process”—for disability adjudication⁵¹:

(1) If the claimant is engaged in substantial gainful activity, he is not disabled.⁵²

(2) If the claimant is not engaged in substantial gainful activity, the agency determines whether the claimant has a severe mental or physical impairment, or a combination of impairments that is severe. If the claimant does not have a severe impairment (or a severe combination), he is not disabled.⁵³

(3) If the claimant has a severe impairment, SSA determines whether one of the claimant's impairments meets or equals a "listing."⁵⁴ If an impairment meets this level of severity, the claimant is disabled; if an impairment does not meet this level, SSA proceeds to Step Four.⁵⁵

(4) SSA considers the claimant's ability to perform past work. If the claimant can perform any of his past work, he is not disabled; if he cannot perform any of his past work, SSA moves to Step Five.⁵⁶

(5) If a claimant cannot perform his past work, SSA considers whether there are any jobs the claimant could perform considering his vocational background and medical impairments. If the claimant can perform other work, he is not disabled; if he cannot perform other work, he is disabled.⁵⁷

Before proceeding to step four, SSA assesses the claimant's "residual functional capacity" ("RFC"). RFC is "the most you can still do despite your limitations."⁵⁸

51. 20 C.F.R. §§ 404.1520(a)(4)(i)–(v), 416.920(a)(4)(i)–(v) (2018); *see also* Russell & Voisin, *supra* note 26, at 836 (providing a graphic representation of the five-step sequential process).

52. 20 C.F.R. §§ 404.1520(a)(4)(i), 416.920(a)(4)(i).

53. §§ 404.1520(a)(4)(ii), 416.920(a)(4)(ii).

54. "Listings" refer to a listing of impairments contained in the first appendix to 20 C.F.R. Pt. 404, Subpt. P. If a claimant can demonstrate he meets the requirements found in a listing, he is disabled.

55. §§ 404.1520(a)(4)(iii), 416.920(a)(4)(iii).

56. §§ 404.1520(a)(4)(iv), 416.920(a)(4)(iv).

57. §§ 404.1520(a)(4)(v), 416.920(a)(4)(v).

58. 20 C.F.R. §§ 404.1545(a)(1), 416.945(a)(1) (2018); *see also* Jon C. Dubin, *Overcoming Gridlock: Campbell After a Quarter-Century and Bureaucratically Rational Gap-Filling in Mass Justice Adjudication in the Social Security Administration's Disability Programs*, 62 ADMIN. L. REV. 937, 974 (2010).

Specifically, SSA evaluates the claimant's ability to meet the physical, mental, and sensory demands of work.⁵⁹ SSA considers all the relevant medical evidence in the claimant's record to determine the extent of the claimant's physical,⁶⁰ mental,⁶¹ and other abilities.⁶² RFC is applied at step four to determine if the claimant can do any past work, and at step five to determine if there are any other jobs in the national economy the claimant could do.⁶³

The claimant carries the burden of proof through the first four steps, either to refute a finding of "not disabled" or to demonstrate a finding of "disabled."⁶⁴ At step five, the burden shifts to SSA.⁶⁵ If the claim proceeds to step five, then the Agency must prove what other work the claimant could perform.⁶⁶ During a hearing, an ALJ elicits testimony from a Vocational Expert ("VE"), who opines about specific jobs the claimant could or could not perform considering the claimant's RFC.⁶⁷ For cases that reach the hearing stage, the VE testimony is central to SSA's determination at step five.⁶⁸

Medical evidence is essential to the five-step process and disability determinations in general. SSA relies on several types of evidence to determine whether or not an individual is disabled: (1) objective medical evidence, (2) medical

59. §§ 404.1545(a)(4), 416.945(a)(4).

60. §§ 404.1545(b), 416.945(b) (including, for example, the ability to sit, stand, walk, lift, carry, push, and pull).

61. §§ 404.1545(c), 416.945(c) (including the ability to understand, remember, carry out instructions, and deal with workplace stress).

62. §§ 404.1545(d), 416.945(d) (including abilities limited by impairments of vision and hearing).

63. §§ 404.1545(a)(5), 416.945(a)(5).

64. *Shaibi v. Berryhill*, 883 F.3d 1102, 1106 (9th Cir. 2017).

65. *Id.*

66. *Id.*

67. See Nathaniel O. Hubley, *The Untouchables: Why a Vocational Expert's Testimony in Social Security Hearings Cannot Be Touched*, 43 VAL. U. L. REV. 353, 368–70 (2008).

68. *Id.* at 377–78.

opinions, (3) other medical evidence, (4) evidence from non-medical sources, and (5) prior administrative medical findings.⁶⁹ “Objective medical evidence” includes medical signs⁷⁰ and laboratory findings.⁷¹ A “medical opinion” is a statement from a medical source explaining what a disability claimant can still do despite his physical, mental, or sensory impairments.⁷² “Other medical evidence” includes any evidence from a medical source other than objective medical evidence or medical opinions.⁷³ The fourth category, “evidence from nonmedical sources,” introduces the distinction between medical and nonmedical sources. Medical sources include physicians, psychologists, speech-language pathologists, registered nurses, and physician assistants.⁷⁴ Nonmedical sources include the claimant’s own testimony, school teachers, public and private social welfare personnel, and the claimant’s friends and family.⁷⁵

The claimant bears the ultimate responsibility for submitting medical evidence in support of her claim.⁷⁶ However, if the Agency cannot decide a claim based on the evidence submitted, it will purchase a consultative examination (“CE”) to develop the record.⁷⁷ The CE is a

69. 20 C.F.R. §§ 404.1513, 416.913 (2018).

70. A medical “sign” is “one or more anatomical, physiological, or psychological abnormalities that can be observed, apart from your statements (symptoms).” 20 C.F.R. § 404.1502(g). Signs must be observable through “medically acceptable clinical diagnostic techniques.” *Id.*

71. 20 C.F.R. §§ 404.1513, 416.913.

72. *Id.*

73. *Id.* This category includes judgments about the nature and severity of a claimant’s conditions, medical history, diagnoses, and prognoses.

74. 20 C.F.R. §§ 404.1502(a), 416.902(a) (2018).

75. §§ 404.1502(e), 416.902(j).

76. §§ 404.1512, 416.912 (“In general, you have to prove to us that you are blind or disabled.”).

77. §§ 404.1517, 416.917; Frank S. Bloch, Jeffrey S. Lubbers & Paul R. Verkuil, *Developing a Full and Fair Evidentiary Record in a Nonadversary Setting: Two Proposals for Improving Social Security Disability Adjudications*, 25 CARDOZO L. REV. 1, 30–31 (2003).

physical or mental examination by a health care provider purchased by the Agency to provide additional information to aid in disability determination. Specifically, the CE physician examines the claimant and produces a report.⁷⁸ The report should provide a summary of the claimant's medical history, objective medical findings, and an opinion statement about the activities the claimant can still do despite her impairments.⁷⁹ The regulations suggest that the Agency should ask a claimant's own physician or other treating source to perform the CE,⁸⁰ but in practice the examiner is rarely the claimant's doctor.⁸¹

78. DAVID WITTENBURG ET AL., AN ASSESSMENT OF CONSULTATIVE EXAMINATION (CE) PROCESSES, CONTENT, AND QUALITY: FINDINGS FROM THE CE REVIEW DATA 10–12 (2012).

79. *Id.*

80. §§ 404.1519h, 416.919h. *But see* §§ 404.1519i, 416.919i (explaining situations where a claimant's medical source will not be used).

81. *See* WITTENBURG, *supra* note 78, at 26–27 (in a study on consultative examinations, only five percent were performed by a treating source).

II. THE TREATING PHYSICIAN RULE & ARTICULATION REQUIREMENTS: APPLICATION, HISTORY, & REPEAL

Part I of this Comment explored the basic legal principles behind Social Security Disability law. This Part will provide an in-depth examination of the treating physician rule, from its inception in the mid-twentieth century to its repeal in 2017. First, I will discuss the origin of the rule and its development over time. Next, I will discuss the way federal judges and ALJs applied the rule before 2017. This Part ends with a discussion of the rule's repeal and what, if anything, remains of the rule post-2017.

Broadly stated, the treating physician rule (or “treating source rule”) is an evidentiary rule that regulates the influence of medical opinion evidence on disability determinations. When the administrative record contains one or more medical opinions, adjudicators must decide how much “weight,” or persuasive value, each opinion has in relation to the other opinions and other types of evidence in the record. For many decades, the treating physician rule guided adjudicators in the task of weighing opinion evidence. While slight variations developed over time, the rule's core idea remained: the opinion of a claimant's treating source deserves great weight because of her unique perspective on the claimant's conditions.⁸² A treating source is a physician or other medical source with an “ongoing treatment relationship” with the claimant.⁸³ The rule applies only to a

82. *See, e.g.*, 20 C.F.R. §§ 404.1527(c)(2), 416.927(c)(2) (2018); *Rosa v. Callahan*, 168 F.3d 72, 78–79 (2d Cir. 1999) (“The opinion of a treating physician is given controlling weight if it is well supported by medical findings and not inconsistent with other substantial evidence.”); *Walters v. Comm’r of Soc. Sec.*, 127 F.3d 525, 529–30 (6th Cir. 1997) (“In general, the opinions of treating physicians are accorded greater weight than those of physicians who examine claimants only once.”); *Heslep v. Celebrezze*, 356 F.2d 891, 894 (4th Cir. 1966) (reversing the Commissioner's decision partly because he “unwarrantedly disregarded the testimony of Dr. Smith, the treating physician.”).

83. 20 C.F.R. § 404.1527(a)(2) (2018) (“Generally, we will consider that you have an ongoing treatment relationship with an acceptable medical source when the medical evidence establishes that you see, or have seen, the source with a

physician's findings concerning the nature and severity of a claimant's conditions; it does not apply to issues reserved for the Commissioner such as whether the claimant is disabled as a matter of law.⁸⁴ This Part explores three distinct periods of treating physician doctrine: early common-law applications, the 1991–2016 regulatory regime, and the 2017 repeal.

A. *Common-Law Origins and Inception of the Treating Physician Rule*

Understanding the development of the treating physician rule over time is important for understanding the rule's use as a tool of federal courts to ensure fair consideration of evidence in disability cases. Indeed, the rule originated as a judicial construct.⁸⁵ As Justice Ginsburg once observed, it was “originally developed by Courts of Appeals as a means to control disability determinations by administrative law judges under the Social Security Act.”⁸⁶

frequency consistent with accepted medical practice for the type of treatment and/or evaluation required for your medical condition(s).”). Courts have typically decided on a case-by-case basis whether or not a treating physician relationship exists. *See, e.g.*, *Jasen v. Comm’r of Soc. Sec.*, No. 16-CV-6153P, 2017 WL 3722454 at *10 (W.D.N.Y. Aug. 29, 2017) (“[I]t is unclear whether [the physician] qualifies as a treating physician because the record suggests that she met with [the claimant] on only two occasions before rendering her opinion”); *Patterson v. Astrue*, No. 5:11-CV-1143 (MAD/DEP), 2013 WL 638617 at *8 (N.D.N.Y. Jan. 24, 2013) (“[T]hree examinations by [a physician] over the course of four months . . . does not constitute the type of ‘ongoing relationship’ that is required for finding that s/he is plaintiff’s treating physician”).

84. *West v. Barnhart*, 254 F. Supp. 2d 1216, 1222 (D. Kan. 2003) (“A treating physician’s opinion of an issue reserved to the Commissioner, such as disability, is not controlling because determining the ultimate issue is the responsibility of the Commissioner.”).

85. *See Rachel Schneider, A Role for the Courts: Treating Physician Evidence in Social Security Disability Determinations*, 3 U. CHI. L. SCH. ROUNDTABLE 391, 396 (1996).

86. *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 829 (2003). This case was not a Social Security case; rather, the Court answered the question of whether the treating physician rule used in SSA disability determinations also applies to disability determinations under employee benefits plans covered by ERISA.

Each Circuit Court articulated the rule somewhat differently. For example, the Tenth Circuit required the Commissioner to give “substantial weight” to a treating physician’s testimony, unless she could show “good cause” for disregarding the testimony.⁸⁷ The Second Circuit required particularly strict deference to the treating physician: a treating physician’s opinion was binding on the fact-finder unless substantial evidence contradicted that opinion.⁸⁸ By contrast, the First Circuit used a much less deferential standard, holding that a treating physician’s opinion is “not necessarily entitled” to more weight than a physician who has only examined a claimant once.⁸⁹

In the late 1980s, the Second Circuit’s highly deferential formulation of the treating physician rule became the subject of three class action suits: *Schisler I*, *II*, and *III*.⁹⁰ As explained below, the plaintiffs in these suits sought to force SSA to comply with the Second Circuit’s formulation of the rule. Ultimately, the decisions in *Schisler I* and *II* prompted the Agency to codify the treating physician rule in federal regulations, which were upheld by the Second Circuit in *Schisler III*.

In *Schisler I*, the plaintiff class of disability claimants challenged termination decisions by SSA,⁹¹ arguing that benefits were wrongfully terminated pursuant to an arbitrarily imposed evidentiary standard.⁹² After a

87. *Id.*; *Frey v. Bowen*, 816 F.2d 508, 513 (10th Cir. 1987).

88. *Schisler v. Heckler*, 787 F.2d 76, 81 (2d Cir. 1986).

89. *Sitar v. Schweiker*, 671 F.2d 19, 22 (1st Cir. 1982) (citing *Perez v. Secretary of HEW*, 622 F.2d 1, 2 (1st Cir. 1980)).

90. *Schisler v. Heckler*, 787 F.2d 76 (2d Cir. 1986) (“*Schisler I*”); *Schisler v. Bowen*, 851 F.2d 43 (2d Cir. 1988) (“*Schisler II*”); *Schisler v. Sullivan*, 3 F.3d 563 (2d Cir. 1993) (“*Schisler III*”); see also *Schneider*, *supra* note 85, at 398–400.

91. *Schisler I*, 787 F.2d at 78.

92. *Id.* As explained by the *Schisler I* court, SSA changed the standard for benefits termination in 1976 without any relevant statutory change. Before 1976, SSA used a “medical improvement” standard for termination which required the Agency to demonstrate a claimant’s medical condition had improved after he

complicated series of procedural steps,⁹³ the plaintiffs moved for an injunction that would require SSA to comply with the Second Circuit's treating physician rule.⁹⁴ The motion was denied, and plaintiffs appealed to the Second Circuit.⁹⁵ On appeal, the Court reversed the district judge's order denying the plaintiffs' motion. In its opinion, the Court noted that SSA had consistently failed to apply the treating physician rule in practice, as evidenced by the high volume of ALJ decisions vacated by federal courts on the basis of the rule.⁹⁶ Additionally, the Court suggested that if SSA wished not to abide by the Second Circuit's rule, it should have sought review in the Supreme Court.⁹⁷ To ensure compliance with the rule, the Court remanded the case to the district court and ordered SSA to produce "relevant publications" instructing disability adjudicators to apply the Second Circuit's formulation of the rule.⁹⁸

On remand, the Secretary of Health and Human Services proposed a draft Social Security Ruling ("SSR")⁹⁹ attempting

began receiving benefits. This standard was changed in 1976 to a "current disability" standard, which allowed for termination of benefits if the claimant could not produce substantial evidence of continuing disability regardless of whether there was medical improvement. In 1984, Congress passed the Social Security Disability Benefits Reform Act, which reinstated the medical improvement standard. See Eileen P. Sweeney, *The New "Medical Improvement" Standard In Social Security and SSI Disability Cases*, 14 SOC. SEC. REP. SERV. 965, 967 (1986).

93. The district court judge found in favor of the plaintiffs, ordering that class members' termination decisions be "expeditiously remanded" for further administrative proceedings. Subsequently, both the plaintiffs and the Agency moved to amend the judgment. The Agency sought to reduce the size of the plaintiff class, while plaintiffs sought an injunction requiring SSA to follow the Second Circuit formulation of the treating physician rule. *Schisler I*, 787 F.2d at 78.

94. *Schisler I*, 787 F.2d at 78.

95. *Id.*

96. *Id.* at 82 ("[C]ases reversing SSA in district courts and in this court on [the treating physician rule] are 'almost legion.'").

97. *Id.* at 83.

98. *Id.* at 84.

99. Social Security Rulings are publications made under the Commissioner's

to enshrine the Second Circuit's treating physician rule as official administrative policy.¹⁰⁰ However, the district court found the draft SSR's articulation of the rule deviated considerably from Second Circuit caselaw.¹⁰¹ The district court subsequently edited the draft SSR to more accurately reflect Second Circuit precedent and to follow the Court's order in *Schisler I*.¹⁰² SSA appealed, claiming the district court exceeded its authority by rewriting the draft SSR.¹⁰³ The decision on that appeal became known as *Schisler II*.

In *Schisler II*, the Second Circuit largely upheld the district court's revisions and added a few revisions of its own. It reasoned that if SSA wanted to substantively elaborate on the treating physician rule, it would need to resort to "customary administrative processes."¹⁰⁴ The final version of the SSR approved by the Second Circuit purported to contain "nothing that is not clearly authorized by [Second Circuit] caselaw."¹⁰⁵

In 1991, SSA published new regulations creating a uniform treating physician rule through formal notice and comment rulemaking.¹⁰⁶ Plaintiffs challenged these regulations in *Schisler III*, claiming the new regulations—which deviated from the Second Circuit's judge-made

authority that reflect the administration's interpretations of the law. These rulings do not have the effects or force of law, but are binding upon SSA employees and adjudicators. *Social Security and Acquiescence Rulings*, SOC. SEC. ADMIN., https://www.ssa.gov/OP_Home/rulings/rulings-pref.html (last visited Apr. 18, 2020).

100. *Schisler II*, 851 F.2d 43, 44 (2d Cir. 1988).

101. *Id.* For example, the draft SSR made the treating physician rule one of several factors an adjudicator considered rather than making the treating physician's opinion binding on the adjudicator. *Id.*

102. *Id.* at 45.

103. *Id.*

104. *Id.*

105. *Id.* at 46.

106. Standards for Consultative Examinations and Existing Medical Evidence, 56 Fed. Reg. 36,932 (Aug. 1, 1991); Schneider, *supra* note 85, at 400. This regulatory scheme is discussed further in Section II.B *infra*.

treating physician rule—violated the previous holdings in *Schisler I* and *II*.¹⁰⁷ In this final iteration of the *Schisler* saga, the court sided with SSA. It held that SSA had statutory authority to create a regulatory scheme regarding the weight to be afforded to a treating physician's opinion.¹⁰⁸ Despite various departures from Second Circuit caselaw, the new rules were neither arbitrary nor capricious and thus valid.¹⁰⁹ Accordingly, the court reversed the lower court's decision that the new regulations were not binding on the courts.¹¹⁰ Under the decision in *Schisler III*, Agency regulations prevailed as the highest authority on deference to the treating physician.¹¹¹

As stated in the beginning of this Section, the history of the rule and the challenges it faced show how federal courts sought to use the rule to constrain SSA and promote fair consideration of a claimant's medical evidence. Under the Social Security Act, courts may only overturn an administrative decision if the decision is not supported by substantial evidence.¹¹² Since there is no explicit statutory authority for the treating physician rule, its genesis and subsequent affirmations in the *Schisler* cases are properly viewed as judicial elaboration of the substantial evidence standard. Essentially, an administrative decision which does not consider the opinion of a treating physician is not a decision supported by substantial evidence.¹¹³ This

107. *Schisler III*, 3 F.3d 563, 567 (2d Cir. 1993).

108. *Id.* at 564.

109. *Id.*

110. *Id.* at 565.

111. See *Schaal v. Apfel*, 134 F.3d 496, 503 (2d Cir. 1998) ("In *Schisler III*, we upheld the new regulations and clarified that they superseded the more deferential treating physician rule previously in force in this Circuit.").

112. 42 U.S.C. § 405(g) (2012); *Richardson v. Perales*, 402 U.S. 389, 401 (1971).

113. See *Broadbent v. Harris*, 698 F.2d 407, 412 (10th Cir. 1983) ("In determining the question of *substantiality of evidence*, the reports of physicians who have treated a patient over a period of time or who are consulted for purposes of treatment are given greater weight than are reports of physicians employed

construction of the law ensured that administrative decisions were guided by physicians with a complete and intimate understanding of a claimant's conditions.

B. *Applying the Treating Physician Rule: Weighing Opinion Evidence for Claims Filed Before March 27, 2017*

The regulatory regime established post-*Schisler* is still applied by Agency adjudicators and federal courts for all claims filed before March 27, 2017.¹¹⁴ Under the regulations, SSA ordinarily defers to the opinions of a claimant's treating source.¹¹⁵ The rules explain that treating sources are "most able to provide a detailed, longitudinal picture" of a claimant's medical impairments and "may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone . . ."¹¹⁶ If a treating source's opinion is supported by other substantial evidence in a claimant's record, SSA gives the opinion "controlling weight."¹¹⁷ If the Agency does not give a treating source's

and paid by the government . . .") (emphasis added); Richard E. Levy & Robert L. Glicksman, *Agency-Specific Precedents*, 89 TEX. L. REV. 499, 546–47 (2011). In the article by Professors Levy and Glicksman, two views are advanced regarding the relationship between the treating physician rule and the substantial evidence standard. On one hand, it may be that where an ALJ does not explain his rejection of a treating physician in favor of a consulting physician, there is not enough evidence such that a "reasonable mind" could come to the same conclusion as the ALJ, and therefore the decision is not supported by substantial evidence. On the other hand, it may be that the treating physician rule arose out of "judicial mistrust" of the SSA and is not really an application of the substantial evidence standard.

114. 20 C.F.R. §§ 404.1527, 416.927 (2018); see also Michael N. Rhinehart, *Treating Physician Rule Eliminated in Social Security Regulations*, FED. LAW., Oct.–Nov. 2017, at 5, 5 ("The regulations in effect before March 27, 2017, generally provide for the giving of greater weight to the opinion of a treating physician over the opinion of a one-time examining physician.").

115. §§ 404.1527(c)(2), 416.927(c)(2).

116. *Id.*

117. *Id.*; see also *Martinez v. Chater*, 64 F.3d 172, 176 (5th Cir. 1995) (treating physician's opinion not entitled to controlling weight where the physician did not provide a medical explanation for his opinion and was contradicted by two other opinions); *Franklin v. Shalala*, 876 F. Supp. 168, 173 (N.D. Ill. 1995) (treating source not given controlling weight where the source opined on issues reserved

opinion controlling weight, it must apply a number of factors to determine how much weight to assign to that opinion.¹¹⁸ Additionally, the Agency must provide in writing “good reasons” for the weight given to a claimant’s treating source.¹¹⁹

While treating sources are given great weight, consulting sources (*e.g.*, the physician who performs a claimant’s CE) are given limited weight.¹²⁰ A consulting source is a medical source who has only examined the claimant once or twice during a limited time period. If opinions from a treating source and a consulting source are conflicting, the Agency should generally favor the treating source.¹²¹ However, the opinion of a consulting source properly overrides that of a treating physician if it is supported by substantial evidence and the treating source’s opinion is not.¹²²

The findings of nonexamining state agency consultants (or “reporting physicians”) are also considered expert opinion evidence.¹²³ These consultants review the claimant’s medical

for the commissioner); Revisions to Rules Regarding the Evaluation of Medical Evidence, 81 Fed. Reg. 62,560, 62,572 (proposed Sept. 9, 2016) (to be codified at 20 C.F.R. pts. 404, 416) (“To give a treating source’s opinion controlling weight means to adopt it.”).

118. §§ 404.1527(c)(2), 416.927(c)(2) (“When we do not give the treating source’s medical opinion controlling weight, we apply the factors listed in paragraphs (c)(2)(i) and (c)(2)(ii) of this section, as well as the factors in paragraphs (c)(3) through (c)(6) of this section in determining the weight to give the medical opinion.”).

119. *Id.* (“We will always give good reasons in our notice of determination or decision for the weight we give your treating source’s medical opinion.”); *see also* *Garrison v. Colvin*, 759 F.3d 995, 1012 (9th Cir. 2014) (“If a treating or examining doctor’s opinion is contradicted by another doctor’s opinion, an ALJ may only reject it by providing specific and legitimate reasons that are supported by substantial evidence.”).

120. *Cruz v. Sullivan*, 912 F.2d 8, 13 (2d Cir. 1990).

121. *See Camille v. Colvin*, 104 F. Supp. 3d 329, 343 (W.D.N.Y. 2015).

122. *E.g.*, *Jones v. Shalala*, 900 F. Supp. 663, 669 (S.D.N.Y. 1995) (citing *Diaz v. Shalala*, 59 F.3d 307, 313 n.5 (2d Cir. 1995)).

123. *Frye ex rel. A.O. v. Astrue*, 485 F. App’x 484, 487 (summary order) (2d Cir.

records and produce a report for the Agency, but do not actually examine the claimant.¹²⁴ The report is produced for the first level of adjudication, and must subsequently be evaluated by an ALJ at the hearing level.¹²⁵ The opinions of state agency consultants are typically given limited weight.¹²⁶ However, these opinions may be given more weight if they are corroborated by other evidence in the record.¹²⁷ If the Agency gives great weight to a nonexamining source opinion, there must be sufficient reasons for doing so. For example, the source must provide a sufficient explanation for their opinion, or have a specialization relevant to the claimant's conditions.¹²⁸

In sum, the pre-2017 rules for weighing medical opinion evidence focused around the relationship between the medical source and the claimant. SSA gave treating sources the greatest weight, while giving consulting sources and nonexamining sources the least weight. Generally, as the relationship between the claimant and the source became more attenuated, adjudicators applied greater scrutiny of the opinion when weighing it.¹²⁹ The following section explains

2012) (citing 20 C.F.R. § 416.927(e)(2)(i)) (“The report of a State agency medical consultant constitutes expert opinion evidence which can be given weight if supported by medical evidence in the record.”).

124. 20 C.F.R. §§ 404.1513a, 416.913a (2018).

125. *Id.*

126. *See* *Gayheart v. Comm’r of Soc. Sec.*, 710 F.3d 365, 376 (6th Cir. 2013); *Wildman v. Astrue*, 596 F.3d 959, 967 (8th Cir. 2010); *Lester v. Chater*, 81 F.3d 821, 831 (9th Cir. 1995).

127. *See, e.g., Camille v. Colvin*, 104 F. Supp. 3d 329, 343 (W.D.N.Y. 2015) (holding that a state agency consultant’s opinion was appropriately afforded greater weight than the treating physician where it was more consistent with the record).

128. *See* Social Security Ruling 96-6p, 61 Fed. Reg. 34,466, 34,467 (July 2, 1996) (stating that nonexamining source opinions should be weighted based on “medical evidence, qualifications, and explanations for the opinions”).

129. *Gayheart*, 710 F.3d at 375 (“[T]he regulations provide progressively more rigorous tests for weighing opinions as the ties between the source of the opinion and the individual become weaker.” (quoting Soc. Sec. Rul. 96-6p, 61 Fed. Reg. at 34,467)).

the reasons why this system was ultimately disposed of for all claims filed after March 27, 2017.

C. Repeal of the Treating Physician Rule and Changes to the Policy for Weighing Medical Opinions

On September 9, 2016, SSA published a notice of proposed rulemaking¹³⁰ announcing major forthcoming revisions to medical evidence rules.¹³¹ One such revision, found under the heading “Consideration and Articulation of Medical Opinions and Prior Administrative Medical Findings,” suggested repealing the 1991 treating physician regulatory regime.¹³² The Agency laid out several “adjudicative issues” that arose from the treating physician rule and the general policy for weighing medical opinion evidence. In total, five reasons were given for repealing the rule.¹³³

First, the Agency pointed to the number of findings required by Agency adjudicators.¹³⁴ While not expressly stated, this justification implied the rule imposed too heavy a burden on adjudicators to sustain, as the policy required adjudicators “to make a large number of findings that need[ed] to be included in their determinations and decisions.”¹³⁵ Some files contained upwards of ten medical opinions, and the regulations required adjudicators to articulate reasons for assigning a particular weight to each

130. When SSA promulgates new regulations, it must follow the Administrative Procedure Act. *See* 5 U.S.C. § 553 (2012) (procedure for agency rulemaking); *Morton v. Ruiz*, 415 U.S. 199, 232–33 (1974) (explaining the purpose of providing public notice of proposed administrative rules).

131. Revisions to Rules Regarding the Evaluation of Medical Evidence, 81 Fed. Reg. 62,560, 62,560 (proposed Sept. 9, 2016) (to be codified at 20 C.F.R. pts. 404, 416).

132. *Id.* at 62,570.

133. *Id.* at 62,572–74.

134. *Id.* at 62,572.

135. *Id.*

opinion.¹³⁶ The result was a high rate of remand from federal district courts on the grounds that ALJs failed to assign proper weight to one of the many opinions in the record.¹³⁷ This finding is well supported by data from SSA, which shows that 28.5% of federal court remands in 2018 were related to an ALJ's misapplication of the treating physician rule.¹³⁸

The second reason for repeal, labeled "Federal Court Perspectives," suggested that the rule influenced federal courts to misapply the "substantial evidence" standard of review.¹³⁹ Rather than merely deciding whether the Commissioner's decision was supported by substantial evidence, reviewing courts improperly focused on whether the ALJ adequately articulated his reasons for rejecting a treating source opinion.¹⁴⁰ By challenging the reasons given by ALJs for rejecting a treating source opinion, courts effectively reweighed the evidence instead of applying the deferential substantial evidence standard.¹⁴¹ SSA further noted that some courts recognized problems with the rule,

136. *Id.*; see also 20 C.F.R. §§ 404.1527(c), 416.927(c) (2018) (stating that SSA gives "good reasons" for assigning a particular weight to the medical opinions).

137. Revisions to Rules Regarding the Evaluation of Medical Evidence, 81 Fed. Reg. at 62,572.

138. See SOC. SEC. ADMIN., TOP 10 REMAND REASONS CITED BY THE COURT ON REMANDS TO SSA, https://www.ssa.gov/appeals/DataSets/AC08_Top_10_CR.html. In FY 2018, the top reason for remand was "Treating Source—Opinion Rejected Without Adequate Articulation," representing 15.4% of all remands. Also related to the treating physician rule were "Consultative Examiner—Inadequate Support/Rationale for Weight Given Opinion" (7.0%), "Non-Examining Source—Inadequate Support/Rationale for Weight Given Opinion" (3.3%), and "Non-Examining Source—Opinion Accepted Without Adequate Articulation" (2.8%).

139. Revisions to Rules Regarding the Evaluation of Medical Evidence, 81 Fed. Reg. at 62,572.

140. *Id.*; see also ADMIN. CONFERENCE OF THE U.S., SSA DISABILITY BENEFITS PROGRAMS: ASSESSING THE EFFICACY OF THE TREATING PHYSICIAN RULE 16 (2013).

141. Revisions to Rules Regarding the Evaluation of Medical Evidence, 81 Fed. Reg. at 62,572. *But see* Levy & Glicksman, *supra* note 113, at 546–47 (presenting the view that the treating physician rule may actually be an application of the substantial evidence standard).

such as the treating physician's bias towards the claimant.¹⁴² While the Supreme Court never directly weighed in on the issue, the Court cautioned in *Black & Decker Disability Plan v. Nord* that a treating physician's bias towards her patient may unduly influence a finding of disabled.¹⁴³

Third, the Agency cited the Ninth Circuit's "Credit-as-True" rule as an example of an adjudicative issue related to the treating physician rule.¹⁴⁴ The Credit-as-True rule provided a three-part test that, if satisfied, triggered immediate judgment for the claimant on the issue of disability rather than a remand to the Agency for further administrative proceedings.¹⁴⁵ Combined with the treating physician rule, an ALJ's failure to provide sufficient explanation for rejecting a treating source opinion could be grounds for this extraordinary remedy.¹⁴⁶ The Agency stated that this rule denied it the opportunity to re-evaluate the evidentiary record and caused judicial encroachment on administrative power.¹⁴⁷ While this rule was not applied outside the Ninth Circuit, the Agency's concern was reasonable considering about twenty percent of the United States population falls within the Ninth's jurisdiction.¹⁴⁸

142. Revisions to Rules Regarding the Evaluation of Medical Evidence, 81 Fed. Reg. at 62,572–73; see *Hofslie v. Barnhart*, 439 F.3d 375, 377 (7th Cir. 2006) (“[T]he fact that the claimant is the treating physician’s patient also detracts from the weight of that physician’s testimony, since, as is well known, many physicians . . . will often bend over backwards to assist a patient in obtaining benefits.”).

143. Revisions to Rules Regarding the Evaluation of Medical Evidence, 81 Fed. Reg. at 62,572–73; 538 U.S. 822, 832 (2003).

144. Revisions to Rules Regarding the Evaluation of Medical Evidence, 81 Fed. Reg. at 62,573.

145. See *Garrison v. Colvin*, 759 F.3d 995, 1019, 1021–22 (9th Cir. 2014). To grant this remedy, the Court remands to the Agency for the “calculation and award of benefits” rather than for re-examining the issue of disability. *Id.* at 1023.

146. Revisions to Rules Regarding the Evaluation of Medical Evidence, 81 Fed. Reg. at 62,573 (citing *Smolen v. Chater*, 80 F.3d 1273, 1292 (9th Cir. 1996)).

147. See *id.* (stating that the credit-as-true rule “effectively supplant[s] the judgment of our decision makers”).

148. Dylan Matthews, *How the 9th Circuit Became Conservatives’ Least*

The fourth reason for repealing the treating physician rule was “Difficulty Determining Treating Source Status Due to the Changing Nature of the Primary Healthcare System.”¹⁴⁹ SSA argued that when the rule was promulgated in 1991, it was justified by the “unique perspective” a treating physician provided that could not be found by looking only at objective medical evidence.¹⁵⁰ However, modern health care delivery had changed drastically since that time. Instead of developing a close relationship with one primary doctor, claimants now treat with “coordinated and managed care organizations.”¹⁵¹ These organizations are highly specialized, meaning each individual organization is unlikely to have a complete picture of a claimant’s medical situation.¹⁵² Because of the changing landscape of health care delivery, courts granted “treating source” status to providers who do not fit the traditional meaning of the term.¹⁵³ In sum, the physician-patient relationship morphed into something so different than what it used to be that the modern “treating physician” does not deserve the kind of deference afforded under the treating physician rule.¹⁵⁴

Favorite Court, VOX (Jan. 10, 2018, 2:30 PM), <https://www.vox.com/policy-and-politics/2018/1/10/16873718/ninth-circuit-court-appeals-liberal-conservative-trump-tweet> (“The Ninth [Circuit] covers a population of 64.3 million people . . . or nearly 20 percent of the US.”).

149. Revisions to Rules Regarding the Evaluation of Medical Evidence, 81 Fed. Reg. at 62,573.

150. *Id.*

151. *Id.*

152. *Id.*

153. *E.g., id.* (listing “physicians with relatively sporadic treatment relationships to claimants,” “all members of a healthcare team,” and “a physician who coordinated care among medical sources but who did not personally examine the claimant” as examples of nontraditional treating sources identified by courts); *see also* Johnson v. Astrue, 597 F.3d 409, 411 (1st Cir. 2009); Shontos v. Barnhart, 328 F.3d 418, 426 (8th Cir. 2003).

154. *See* Revisions to Rules Regarding the Evaluation of Medical Evidence, 81 Fed. Reg. at 62,573 (“This ‘devaluation’ of the physician-patient relationship calls into further question whether any deference—let alone ‘controlling weight’—should be afforded to the opinions of this type of medical practitioner.”).

Finally, SSA cited scholarly criticism of the treating physician rule as a reason for repeal.¹⁵⁵ The scholarly arguments cited mostly speak to the Agency's second proposition, "Federal Court Perspectives," which stated that the rule influences courts to improperly apply the substantial evidence standard.¹⁵⁶ Thus, this reason is best understood as additional support for the Agency's second argument instead of an independent justification.

All the issues identified by SSA circle back to a central theme: tension between the federal court's application of the treating physician rule and the Agency's interest in independent and efficient administration of its programs. Essentially, the treating physician rule permitted a great degree of judicial scrutiny of Agency decisions.¹⁵⁷ Consequently, courts issued a high number of remands, which bogged down the administrative docket. The next section discusses how SSA addressed these issues and created the modern doctrine for weighing opinion evidence.

D. *Weighing Opinion Evidence for Claims Filed After March 27, 2017: What Is Left of the Treating Physician Rule?*

On January 18, 2017, SSA published final rules regarding the weighing of opinion evidence for claims filed after March 27, 2017.¹⁵⁸ In these final rules, SSA responded to public comments submitted after the September 9, 2016

155. *Id.*

156. *Id.*; *see, e.g.*, Levy & Glicksman, *supra* note 113, at 547 ("It may be . . . that the rule is the product of judicial mistrust of the SSA rather than a generalizable application of the substantial evidence standard."). *But see* Revisions to Rules Regarding the Evaluation of Medical Evidence, 82 Fed. Reg. 5,844, 5,857 (Jan. 18, 2017) (to be codified at 20 C.F.R. pts. 404, 416) (stating that during the public comment period after the September 2016 notice of proposed rulemaking, Professors Levy and Glicksman submitted comments complaining that the Agency misrepresented their position on the treating physician rule).

157. Schneider, *supra* note 85, at 415–16.

158. Revisions to Rules Regarding the Evaluation of Medical Evidence, 82 Fed. Reg. 5,844 (Jan. 18, 2017) (to be codified at 20 C.F.R. pts. 404, 416); *see also* 20 C.F.R. §§ 404.1520c, 416.920c (2018).

notice of proposed rulemaking.¹⁵⁹ Commenters were split over the treating physician rule.¹⁶⁰ Ultimately, the Agency stuck to its decision to repeal the rule, relying largely on the fourth justification from the notice of proposed rulemaking.¹⁶¹

The regulatory regime for weighing medical opinion evidence for claims filed after March 27, 2017 is codified at 20 C.F.R. §§ 404.1520c & 416.920c. Under the new rules, SSA adjudicators no longer give specific evidentiary weight or deference to any medical opinion, including a treating source opinion.¹⁶² Instead, the Agency applies a list of factors and articulates how each medical opinion influenced its final decision.¹⁶³ The factors include supportability, consistency, relationship to the claimant, specialization, and “other factors.”¹⁶⁴ While adjudicators use all of these factors in evaluating a medical opinion, they need only articulate their considerations of supportability and consistency.¹⁶⁵ The regulations specifically highlight supportability and consistency as “the most important factors.”¹⁶⁶

If a medical opinion fulfills the two main factors, supportability and consistency, it is a persuasive opinion.¹⁶⁷

159. See 5 U.S.C. § 553(c) (2012) (“After notice required by this section, the agency shall give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments . . .”).

160. Revisions to Rules Regarding the Evaluation of Medical Evidence, 82 Fed. Reg. at 5,852 (“Multiple commenters asked us to retain the current treating source rule, while some commenters agreed with our proposal to eliminate it.”).

161. See *id.* at 5,853 (“Since we first adopted the current treating source rule in 1991, the healthcare delivery system has changed in significant ways that require us to revise our policies in order to reflect this reality.”).

162. 20 C.F.R. §§ 404.1520c(a), 416.920c(a); *cf.* §§ 404.1527, 416.927 (“Generally, we give more weight to medical opinions from your treating sources . . .”).

163. §§ 404.1520c(a), 416.920c(a).

164. §§ 404.1520c(c)(1)–(5), 416.920c(c)(1)–(5).

165. §§ 404.1520c(b)(2), 416.920c(b)(2).

166. *Id.*

167. §§ 404.1520c(c)(1)–(2), 416.920c(c)(1)–(2). Because claims filed after

An opinion has supportability if the explanations and objective medical evidence cited by the source are relevant to support the opinion.¹⁶⁸ The consistency element requires comparison of a medical opinion with other evidence in the record. The more consistent the opinion is with evidence from other sources, the more persuasive the opinion is.¹⁶⁹

The third factor, relationship with the claimant, is split into five sub-factors.¹⁷⁰ When analyzing the relationship with the claimant, the adjudicator should consider (1) the length of the treatment relationship, (2) the frequency of examinations, (3) the purpose of the treatment relationship, (4) the extent of the treatment relationship, and (5) whether there was an examining relationship.¹⁷¹ Specialization, the fourth factor, suggests that a medical opinion is more persuasive if the source is a specialist in an area relevant to the claimant's conditions.¹⁷² Finally, the catch-all provision—"other factors"—permits adjudicators to consider "other factors that tend to support or contradict" a medical opinion.¹⁷³

Under this scheme laid out in 20 C.F.R. §§ 404.1520c & 416.920c, remnants of the treating physician rule lie in the third factor, "relationship with the claimant." For example, the five sub-factors of factor three are traceable to the factors applied under the 1991 rules for weight determination.¹⁷⁴ As

March 27, 2017 have not yet reached federal district courts, there is no caselaw to explain the application of these factors.

168. §§ 404.1520c(c)(1), 416.920c(c)(1).

169. §§ 404.1520c(c)(2), 416.920c(c)(2).

170. §§ 404.1520c(c)(3), 416.927c(c)(3).

171. *Id.*

172. §§ 404.1520c(c)(4), 416.927c(c)(4).

173. §§ 404.1520c(c)(5), 416.927c(c)(5) (including, but not limited to, "evidence showing a medical source has familiarity with the other evidence in the claim or an understanding of our disability program's policies and evidentiary requirements.").

174. *Compare, e.g.,* 20 C.F.R. § 404.1520c(c)(3)(i)–(ii) (listing "length of treatment relationship" and "frequency of examinations" in the 2017 regulations)

stated above, however, factor three need not be articulated in the Agency's decision. In fact, it is questionable whether an adjudicator is required to consider it at all.¹⁷⁵ Thus, the nature of the relationship between an opinion's source and the claimant is arguably an optional consideration, not subject to judicial enforcement or review. For better or for worse, the treating physician rule is no longer a viable tool for claimants seeking relief from a negative Agency decision in federal court.

with 20 C.F.R. § 404.1527(c)(2)(i) (listing "length of the treatment relationship and frequency of examination" in the 1991 formulation).

175. See §§ 404.1520c(a), 416.1520c(a) ("[W]e will consider those medical opinions . . . from that medical source together using the factors listed in paragraphs (c)(1) through (c)(5) of this section, *as appropriate*." (emphasis added)). The "as appropriate" qualification, the repeated insistence that supportability and consistency are the "most important" factors, and the lack of articulation requirements for factors three through five suggest the decision to consider factors other than supportability and consistency is a matter of Agency discretion.

III. POTENTIAL EFFECTS OF REPEALING THE TREATING PHYSICIAN RULE AND PROPOSALS FOR MITIGATING ADVERSE IMPACT ON CLAIMANTS

The treating physician rule was unquestionably due for revision. Despite the 1991 switch from common law to regulation, the substance of the rule—broad deference or “controlling weight” to treating sources—has lingered since the middle of the 20th century. SSA presented several compelling reasons for repealing the rule in its September 2016 notice of proposed rulemaking. Perhaps most persuasive is the assertion that the U.S. healthcare delivery system and the physician-patient relationship have changed so radically that there is little justification for keeping the rule. Additionally, the Agency understandably wants to decrease the number of federal court remands and keep control over its unwieldy caseload.

However, it is important to keep in mind the core promise of the Social Security Act: to provide relief to individuals vulnerable to financial and social hardships.¹⁷⁶ Despite being somewhat outdated, the treating physician rule provided important protections for disability claimants. As one commentator pointed out, subjective and contextual considerations are inherent to disability determinations.¹⁷⁷ While objective medical evidence is similarly important, an individualized assessment by a physician intimately familiar with the claimant’s conditions provides invaluable guidance for subjective considerations. Since the treating physician is capable of “producing the most individualized assessment,” the treating physician rule ensured adjudicators favorably

176. See *Brown & Bartlett v. United States*, 330 F.2d 692, 696 (6th Cir. 1964) (“Generally, in construing the Social Security Act, our court has favored that interpretation which gives effect to the beneficent purposes of the Act.”); Arianna Tunsy-Brashich, *Offsetting Justice: Protecting Federally-Exempt Benefits from Garnishment and Bank Set-Offs*, 29 BOSTON COLL. THIRD WORLD L.J. 323, 330 n.49 (2009).

177. Schneider, *supra* note 85, at 415.

weighed the best evidence a claimant could produce.¹⁷⁸ Thus, a wholesale repeal of the treating physician rule raises concerns about maintaining individualized assessments in Social Security cases.

This Part proposes two changes to the current rules regarding medical opinion evidence to account for potential adverse impacts. First, the treating physician rule should still be applied to medical opinions written by a claimant's treating psychotherapist or mental health counselor. Second, the qualified right to subpoena physicians for hearings should be strengthened to more closely resemble an absolute right. These two changes will preserve the Agency's desire to modernize the rules of medical opinion evidence while upholding some of the important protections the treating physician rule provided.

A. *The Treating Physician Rule for Mental Health Care Providers*

As discussed above, one of the main justifications SSA provided for repealing the treating physician rule was, in the Agency's words, the "devaluation" of the physician-patient relationship.¹⁷⁹ SSA stated that doctors' offices have changed to accommodate high volumes of patients, delegating patient care to a team of providers instead of one physician.¹⁸⁰ Essentially, the Agency argued that physicians and patients no longer have the kind of intimate, personalized relationships that deserve the deference of the traditional treating physician.¹⁸¹ While perhaps compelling in the context of primary health care, this argument is

178. *Id.* at 411.

179. Revisions to Rules Regarding the Evaluation of Medical Evidence, 81 Fed. Reg. 62,560, 62,573 (Sept. 9, 2016) (to be codified at 20 C.F.R. pts. 404, 416); *see supra* Part II.

180. Revisions to Rules Regarding the Evaluation of Medical Evidence, 81 Fed. Reg. at 62,573.

181. *Id.* In the January 2017 notice of final rules, the Agency cited several medical journals.

unpersuasive in the context of psychotherapy and mental health counseling. Psychotherapy involves detailed discussion of the most intimate details of a person's life. The importance of a quality relationship between psychotherapists and their patients is recognized not only in the field of psychology, but also by the law. A claimant's psychotherapist undoubtedly still provides the "unique perspective" and "detailed, longitudinal" view sought from a treating source.¹⁸²

In psychological literature, the psychotherapist-patient relationship is called the "therapeutic alliance."¹⁸³ The very nature of the term "alliance" implies a thorough and cooperative relationship.¹⁸⁴ According to a publication of the American Psychological Association, an effective alliance requires "trust, understanding[,] and belief from the client."¹⁸⁵ Furthermore, the psychotherapist must maintain an "acceptable and adaptive" explanation of the client's conditions,¹⁸⁶ a requirement echoing the §§ 404.1520c & 416.920c supportability test.¹⁸⁷ Patient engagement in the alliance is also important. Patients who are confident in and committed to a "positive, valuable [,] and purposeful" relationship with their therapists attain more positive treatment results.¹⁸⁸

182. 20 C.F.R. §§ 404.1527(c)(2), 416.927(c)(2).

183. LYNNE KNOBLOCH-FELDERS, PHD, THE FAMILY INSTITUTE AT NORTHWESTERN UNIVERSITY, THE IMPORTANCE OF THE RELATIONSHIP WITH THE THERAPIST 1 (2008), https://www.family-institute.org/sites/default/files/pdfs/csi_fedders_relationship_with_therapist.pdf.

184. *Alliance*, MERRIAM-WEBSTER.COM DICTIONARY, <https://www.merriam-webster.com/dictionary/alliance> (last visited May 26, 2020).

185. A. Brownawell & K. Kelley, *Psychotherapy is Effective and Here's Why*, MONITOR ON PSYCHOL., Oct. 2011, at 14, 14.

186. *Id.*

187. See 20 C.F.R. §§ 404.1520c(c)(1), 416.920c(c)(1) (stating that medical opinion evidence is more persuasive if it contains relevant "supporting explanations").

188. Robert L. Hatcher & Alex W. Barends, *Patients' View of the Alliance in Psychotherapy: Exploratory Factor Analysis of Three Alliance Measures*, 64 J.

Given its beneficial impact on treatment outcomes, the therapeutic alliance is something that should be fostered by the law. Indeed, the importance of the psychotherapist-patient relationship is already acknowledged in federal courts. For example, a psychotherapist-patient privilege is recognized under the Federal Rules of Evidence.¹⁸⁹ In federal proceedings, claims of privilege are governed by common law interpreted “in the light of reason and experience” of the federal courts.¹⁹⁰ Privilege doctrine provides for the exclusion of otherwise highly relevant evidence from trial in order to “protect interpersonal relationships outside of the courtroom.”¹⁹¹ While many privileged relationships have been recognized across U.S. jurisdictions, only a few have been officially recognized by the Supreme Court. These relationships include attorney-client, marital relationships, and critically for this analysis, psychotherapist-patient.¹⁹²

The Supreme Court first recognized the psychotherapist-patient privilege in *Jaffee v. Redmond*. That case revolved around the fatal shooting of Ricky Allen by Illinois police officer Mary Lu Redmond.¹⁹³ During discovery, the petitioner became aware that Redmond engaged in fifty counseling sessions with a licensed social worker after the shooting.¹⁹⁴

CONSULTING & CLINICAL PSYCHOL. 1326, 1331–32 (1996).

189. *Jaffee v. Redmond*, 518 U.S. 1 (1996).

190. FED. R. EVID. 501 (1974); see also Christine P. Bartholomew, *Exorcising the Clergy Privilege*, 103 U. VA. L. REV. 1015, 1021 (2017).

191. EDWARD J. IMWINKELRIED, *THE NEW WIGMORE: A TREATISE ON EVIDENCE: EVIDENTIARY PRIVILEGES* § 1.1 (3d ed. 2019), Westlaw WIGEVV.

192. *Jaffee*, 518 U.S. at 1; Kenneth S. Broun, *Giving Codification a Second Chance—Testimonial Privileges and the Federal Rules of Evidence*, 53 HASTINGS L.J. 769, 781–82 (2002).

193. *Jaffee*, 518 U.S. at 4. The petitioner, administrator of Allen’s estate, brought a civil suit against Redmond alleging deprivation of Allen’s civil rights through use of excessive force. *Id.* A number of factual disputes arose between the parties during litigation. For example, while Redmond claimed the shooting was lawful because Allen was threateningly wielding a knife, the petitioner claimed Allen was unarmed when the incident occurred. *Id.*

194. *Id.* at 5.

Redmond refused petitioner's request for production of the treatment notes from those sessions, claiming they were protected by psychotherapist-patient privilege.¹⁹⁵ The District Court was not swayed by this argument, but Redmond's claim to privilege was vindicated by the Seventh Circuit and subsequently by the Supreme Court.¹⁹⁶ In its holding, the Supreme Court likened the newly found psychotherapist privilege to the marital and attorney-client privileges, stating the relationship "depends upon an atmosphere of confidence and trust."¹⁹⁷ By protecting communications from disclosure in a courtroom, the law encouraged the development of the "willingness and ability to talk freely" required for successful psychiatric treatment.¹⁹⁸ Furthermore, the Court found the psychotherapist privilege served crucial public interests, stating in no uncertain terms that "[t]he mental health of our citizenry, no less than its physical health, is a public good of transcendent importance."¹⁹⁹

Although the justifications for evidentiary privileges differ from those for the treating physician rule, *Jaffee* still illustrates why the treating physician rule should be preserved for psychotherapists. The stakes in *Jaffee* were extremely high. The counselor's treatment notes, after all, could have shed light on whether a man was wrongfully killed by a police officer. And yet, the Court still found exclusion of the evidence was warranted by the compelling public policy interests in facilitating effective mental health treatment. The Supreme Court's reasoning in this case cuts sharply against SSA's suggestion that treating physician relationships no longer have a place in the modern healthcare delivery apparatus, insofar as psychotherapists

195. *Id.*

196. *Id.* at 6, 9–10.

197. *Id.* at 10.

198. *Id.*

199. *Id.* at 11.

are concerned.²⁰⁰ To the contrary, *Jaffee* suggests that the relationship between psychotherapists and their patients maintains a special place in society. In the context of Social Security Disability law, treating sources who have this kind of relationship with a claimant can still provide the unique perspective sought by the treating physician regulations applied to pre-2017 applications.²⁰¹

Additionally, compared with a treating psychotherapist, a consulting source's opinion may be particularly unreliable in the context of mental health. People with mental illness face great levels of societal stigma.²⁰² In a 2012 article, Professor Christopher Pashler explained the myriad burdens carried by claimants with stigmatized disabilities during the disability adjudication process.²⁰³ Specifically, a claimant may use coping mechanisms which impair his ability to communicate about his condition with his treating physician, an adjudicator, or his own attorney.²⁰⁴ Stunted communication may result in an underdeveloped record that negatively impacts disability adjudication.²⁰⁵ Expanding on Professor Pashler's argument, it follows that a claimant who is guarded around his own physician or lawyer will be even more unwilling to communicate with a consulting physician, especially a consultative examiner. More often than not, the consultative examiner is a stranger to the claimant:²⁰⁶ it is

200. Revisions to Rules Regarding the Evaluation of Medical Evidence, 81 Fed. Reg. 62,560, 62,573 (Sept. 9, 2016) (to be codified at 20 C.F.R. pts. 404, 416).

201. See 20 C.F.R. §§ 404.1527, 416.927 (2018).

202. See, e.g., Heather Stuart, *Fighting the Stigma Caused by Mental Disorders: Past Perspectives, Present Activities, and Future Directions*, 7 WORLD PSYCHIATRY 185, 185–88 (2008).

203. See Christopher E. Pashler, *Mirror, Mirror on the Wall: Stigma and Denial in Social Security Disability Hearings*, 43 U. MEM. L. REV. 419 (2012). Professor Pashler's article focuses on the stigma faced by claimants with obesity, but he discusses stigma in the context of mental illness as well.

204. *Id.* at 478.

205. *Id.*

206. See WITTENBURG, *supra* note 78, at 26–27.

someone paid by the government to complete the administrative record. By contrast, as discussed above, a claimant's own counselor or psychologist will have worked to build trust and foster an open dialogue necessary for psychological treatment. Thus, these treatment sources should be presumed more reliable than a consulting physician who did not have an opportunity to break through the communication barriers faced by claimants with a stigmatized mental health condition.

The solution is simple: require that Agency adjudicators give deference to a treating psychotherapist's opinion about the claimant's mental health conditions. The presumption in favor of the treating psychotherapist's conclusions could still be rebutted by applying the §§ 404.1520c & 416.920c consistency and supportability factors. This solution would ensure, for example, a psychologist who has formed a therapeutic alliance with the claimant is presumed more reliable than a psychological consultative examiner, who only examines the claimant once for the sole purpose of producing a report. However, if substantial medical evidence contradicted the treating psychologist's conclusions, an adjudicator could find that the opinion fails the consistency and supportability tests and rely on the consultative examiner's opinion instead. In this case, the adjudicator would still be required to explain how he considered the psychologist's treatment relationship with the claimant.

Significantly, this approach is consistent with *Jaffee* and privilege doctrine as currently applied under the Federal Rules of Evidence. While courts continue to apply the psychotherapist-patient privilege,²⁰⁷ a generalized physician-patient privilege has never been declared.²⁰⁸

207. See, e.g., *United States v. Fattah*, 914 F.3d 112, 178–82 (3d Cir. 2019); *United States v. Blue*, 340 F. Supp. 3d 862 (D.S.D. 2018).

208. *Whalen v. Roe*, 429 U.S. 589, 602 n.28 (1977) (“[P]hysician-patient evidentiary privilege is unknown to the common law.”); *Cappetta v. GC Servs. Ltd. P’ship*, 266 F.R.D. 121, 126 (E.D. Va. 2009); *In re Grand Jury Subpoena John Doe No. A01-209*, 197 F. Supp. 2d 512, 514 (E.D. Va. 2002) (“But no federal

Likewise, the rules proposed here for amending the treating source rule would not apply outside of the mental health context. For the opinions of primary care physicians and specialists outside of mental health, the rules for weighing medical opinion would apply as written under the current regulations.²⁰⁹

SSA has expressed concerns about laborious articulation requirements,²¹⁰ and it is true that the changes proposed here could impose such requirements. This is because the ALJ would need to provide an explanation whenever he chooses to reject a treating psychotherapist's opinion. However, courts have previously imposed additional duties on Agency adjudicators when a claimant's mental illness is at issue. For example, in the context of a disability hearing, the ALJ has a heightened duty to fully develop the administrative record where a claimant "may be mentally ill and thus unable to protect her own interests."²¹¹ Just as an ALJ must exercise greater diligence in developing the record of a mentally ill claimant, she should similarly take care when weighing the medical opinion evidence in the record. While the changes proposed here would create an articulation burden for adjudicators, the burden is justified because it is limited to opinions from mental health care providers. Ultimately, these modifications would maintain the core of SSA's changes to the rules for weighing opinion

statute creates a physician-patient privilege, and the federal courts have not recognized such a privilege."); Jenna Phipps, *State of Confusion: The Hipaa Privacy Rule and State Physician-Patient Privilege Laws in Federal Question Cases*, 12 SUFFOLK J. TRIAL & APP. ADVOC. 159 (2007).

209. 20 C.F.R. §§ 404.1520c, 416.920c (2018).

210. That is, the requirement that an ALJ provide detailed explanations for the weight afforded to an opinion. See Revisions to Rules Regarding the Evaluation of Medical Evidence, 81 Fed. Reg. 62,560, 62,572 (Sept. 9, 2016) (to be codified at 20 C.F.R. pts. 404, 416).

211. *Struck v. Astrue*, 247 F. App'x. 84, 86 (9th Cir. 2007) (quoting *Tonapetyan v. Halter*, 242 F.3d 1144, 1150 (9th Cir. 2001)); see also *Marinez v. Comm'r of Soc. Sec.*, 269 F. Supp. 3d 207, 215 (S.D.N.Y. 2017) ("The obligation to develop the record is enhanced when the disability in question is a psychiatric impairment." (internal quotation marks omitted)); Pashler, *supra* note 203, at 470.

evidence while preserving deference for providers who treat within the “atmosphere of confidence and trust” so vital to mental health care.

B. *Expansion of the Right to Subpoena Physicians*

The first regulatory change discussed above deals with a modification to the rules regarding weighing medical opinion evidence. In this Section, I propose a change to a rule separate from the medical opinion regulations: the rule establishing a qualified right to subpoena physicians in disability hearings. For the reasons discussed below, changing the qualified right to an absolute or near-absolute right could ensure protections similar to the protections that used to be provided by the treating physician rule.

The right to cross-examine witnesses during trial is fundamental to the American system of justice.²¹² However, the extent of this right in SSA disability proceedings has long been a subject of debate among the federal courts. For its part, the Supreme Court provided meager guidance in the case of *Richardson v. Perales*. In an opinion described by Professor Victor Rosenblum as “a triumph of verbosity over clarity,”²¹³ Justice Blackmun referred to both a claimant’s “right” to subpoena a physician and the mere “opportunity” for cross-examination.²¹⁴ Subsequently, the circuit courts split over whether the holding in *Perales* defined an absolute right or a qualified right to subpoena physicians for cross-

212. For criminal defendants, the opportunity to cross-examine witnesses is a Constitutional right. U.S. CONST. amend. VI. While this right is not explicit in the Constitution for civil cases or administrative proceedings, judges and scholars have noted the importance of cross-examination in all contexts. *See, e.g.*, *Greene v. McElroy*, 360 U.S. 474, 497 (1959) (“For two centuries past, the policy of the Anglo-American system of Evidence has been to regard the necessity of testing by cross-examination as a vital feature of the law.” (internal quotation marks omitted)) (citing 5 WIGMORE ON EVIDENCE § 1367 (3d ed. 1940)).

213. Victor G. Rosenblum, *The Right to Cross-Examine Physicians in Social Security Disability Cases*, 26 FLA. ST. U. L. REV. 1049, 1049 (1999).

214. *Richardson v. Perales*, 402 U.S. 389, 402 (1971); Rosenblum, *supra* note 213, at 1049–50.

examination.²¹⁵ SSA regulations follow the “qualified right” approach, maintaining that a claimant’s timely subpoena request need only be fulfilled if it is “reasonably necessary for the full presentation of a case.”²¹⁶

One justification for the qualified approach is the nonadversarial nature of the adjudication process.²¹⁷ Regarding disability proceedings, the Supreme Court has stated that SSA “operates essentially . . . as an adjudicator and not as an advocate or adversary.”²¹⁸ Thus, the majority in *Perales* was reluctant to ascribe anti-claimant bias to reporting physicians independently contracted with the government.²¹⁹ Because the risk for bias is low, the need for cross-examination was reduced in a Social Security hearing, and an absolute right to subpoena was unnecessary. In a fierce dissent, Justice Douglas balked at this argument, accusing the government of recruiting “circuit-riding doctors who never see or examine claimants to defeat their claims.”²²⁰ In a 1999 essay, Professor Rosenblum echoed

215. For example, the Fifth Circuit took an absolutist approach, interpreting *Perales* to hold that “by requesting a subpoena, a claimant has the right to cross-examine an examining physician.” *Lidy v. Sullivan*, 911 F.2d 1075, 1077 (5th Cir. 1990), *cert denied*, 500 U.S. 959 (1991). Several years later, the Sixth Circuit rebuked the Fifth Circuit’s interpretation, stating “we do not see why cross-examination should necessarily follow from the filing of a subpoena request that fails to comply with a regulation requiring that there be some showing of an actual need for cross-examination.” *Calvin v. Chater*, 73 F.3d 87, 92–93 (6th Cir. 1996).

216. 20 C.F.R. § 404.950(d) (2018). After the Supreme Court denied certiorari in *Lidy*, SSA published an acquiescence ruling laying out the difference between SSA official policy and the Fifth Circuit’s absolutist approach. *See* Social Security Acquiescence Ruling 91-X(5), 56 Fed. Reg. 67,625 (1991). However, the Agency agreed to apply the absolutist approach in all Fifth Circuit cases. *Id.*

217. Rosenblum, *supra* note 213, at 1062–65.

218. *Perales*, 402 U.S. at 403.

219. *Id.* at 402–03.

220. *Id.* at 413. Justice Douglas further reasoned that reporting physicians were likely to be “defense-minded” and proceeded to lambast the government for using a “stable of defense doctors without submitting them to cross-examination.” *Id.* at 414. Other courts have implied that physicians paid by the government may be biased against claimants. *See, e.g., Broadbent v. Harris*, 698 F.2d 407,

Justice Douglas's sentiments and called for the recognition of cross-examination in disability hearings as an "integral component of fairness" that should not be weakened by "pretenses of nonadversariality."²²¹

The repeal of the treating physician rule provides new perspective to the ongoing debate over the right to subpoena physicians in disability proceedings. Regardless of whether Justice Douglas's accusations were accurate, the treating physician rule equipped claimants with a tool to overcome anti-claimant biases from reporting or consulting physicians if such biases existed. This is because the regulations required great deference to the claimant's treating physician, while generally providing little weight to consulting physicians and state Agency consultants.²²² So, even if an Agency-paid physician held biases, the claimant could rest easy knowing his own physician's report had to be given controlling weight, or alternatively, an adjudicator had to explain how the treatment relationship of each physician was considered.²²³ In that environment, a qualified right to subpoena was more justified because of the protective rules for weighing opinion evidence. For example, if a claimant was denied the opportunity to cross-examine a consulting physician, that report would ultimately not be as strongly weighted as the claimant's treating physician's report.

This justification for the qualified approach, however, no longer exists after the repeal of the treating physician rule. Under the qualified approach, claimants face a situation

412 (10th Cir. 1983) ("In determining the question of substantiality of evidence, the reports of physicians who have treated a patient over a period of time or who are consulted for purposes of treatment are given greater weight than are reports of physicians employed and paid by the government . . .").

221. Rosenblum, *supra* note 213, at 1065 ("[T]he SSA is about as nonadversarial as whiskey is nonalcoholic.").

222. *See supra* Section II.B.

223. It could be argued that this arrangement simply replaces anti-claimant bias in favor of pro-claimant bias. While it may be impossible to eliminate biases entirely, it is more justifiable to permit bias from physicians with the most thorough understanding of the claimant's conditions.

where an adjudicator can both rely on a physician's report without acknowledging that physician's treatment relationship with the claimant *and* deny the claimant an opportunity to cross-examine that physician. Because SSA removed the protection of the treating physician rule, a stronger right—though not necessarily an absolute right—to subpoena should be enforced. For example, Professor Rosenblum suggests the appropriate solution is shifting the burden of proof.²²⁴ Instead of placing the burden on the claimant to show the necessity of cross-examination, the Agency would have to demonstrate through clear and convincing evidence that cross-examination is unwarranted.²²⁵ While this right can be enforced through new regulations, it can also be enforced judicially through greater scrutiny of subpoena denials.²²⁶

224. *See* Rosenblum, *supra* note 213, at 1065.

225. *Id.*

226. Under the current regulations, a subpoena can be denied if it is not “reasonably necessary” for the presentation of the case. 20 C.F.R. § 404.950(d) (2018). Thus, courts could require greater evidence to meet the “reasonably necessary” standard in light of the treating physician rule repeal.

CONCLUSION

This Comment has provided a comprehensive overview of the treating physician rule from its common-law origins to its repeal. Beginning in the middle of the twentieth century, courts applied the rule to provide oversight for final Agency decisions. By 2017, the Agency determined the rule was no longer helpful in disability decisions and repealed it through standard notice and comment rulemaking. While there are persuasive justifications for repealing the rule, further changes should be considered to protect the individualized assessment that treating physicians contribute to the decision-making process.

The disability adjudication process will never be perfect. As the federal administrative state continues to expand, agencies must constantly revise and re-examine their rules. Different values must be balanced and calibrated to keep consistent with those of society. All things considered, the repeal of the treating physician rule is a reasonable action in light of the rapid changes to our healthcare system and high remand rates. That is not to say, however, that there should never be a place for the rule. Going beyond just the proposals of this Comment, SSA must be willing to stay flexible to accommodate changes to protect fair process for claimants. Americans entrust the Social Security Administration with the awesome responsibility of managing social welfare for the most vulnerable among us. In order to carry out this duty, the Agency must continue to consider all the tools at its disposal, including those that may seem old-fashioned or outdated. We should continue to examine the rules for weighing medical opinion evidence and change them accordingly to maximize fairness for beneficiaries.