Pain Is Enough: Chronic Pain as Disability

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Pain Is Enough: Chronic Pain as Disability

KATHERINE L. MOORE†

ABSTRACT

Both the medical community and the laws of the United States have historically failed to recognize chronic pain as a disability. In medicine, chronic pain has gained increasing recognition as a disability in and of itself, even absent a current, medically determinable physical impairment. The law, however, has been slow to catch up. This Article argues that chronic pain is a disability, even without medical evidence of an underlying impairment, because of pain’s significant functional impact on the body and mind. In the 2018 case of Saunders v. Wilkie, the United States Court of Appeals for the Federal Circuit recognized that “pain is enough” for a veteran to be eligible for disability compensation, even when the claimant is unable to establish a current, underlying cause of their pain. This Article argues

†Associate Professor, Seton Hall University School of Law. I am grateful to early readers of this Article for their suggestions including Jennifer Bennett Shinall, Jennifer Erkulwater, Matthew Cortland, Doron Dorfman, and the participants at the 2020 AALS Annual Meeting’s Disability Law Section Panel, Reconsidering Disability Benefit Programs; Christian Sundquist, Joseph Connors, and the faculty at Albany Law School’s Spring 2020 Colloquium; and Jennifer Oliva, Jenny-Brooke Condon, Jon Romberg, Lori Nessel, and the Seton Hall Law School faculty.
that Saunders is an important first step in judicial recognition that chronic pain is a disability, and that disability benefit programs should recognize and compensate chronic pain for the disabling condition that it is.

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Although pain is a widespread and highly debilitating human experience, little attention has been paid to the fact that chronic pain, on its own, has not been recognized as a disability under the law. This Article argues that the physiological and psychological features of chronic pain make it a disability because of its significant functional impact on the human body. The Article further argues that claimants asserting pain as a disability should not be required to prove that the pain arises from any particular underlying medical impairment.

Pain has typically been excluded from disability definitions in the law, including in most disability benefit programs, because of traditional views of pain as simply a derivative symptom of other conditions. The recent case of *Saunders v. Wilkie* reflects an important change of course. In the context of the veterans disability benefit compensation program, the United States Court of Appeals for the Federal Circuit recognized that pain—standing alone—qualifies as a disability under Title 28 of the U.S. Code, because it is a functional impairment.

Melba Saunders was a decorated United States Army and Persian Gulf War veteran who, by all accounts, served
her country honorably throughout her seven-year tour of service. Following her time in service, she suffered from continuing knee pain that limited her ability to stand and walk for extended periods of time, interfering with her ability to work.

Although Ms. Saunders had an underlying condition of a bilateral knee disorder while she was in service, she was originally ineligible for veterans disability compensation, because she did not have a “present disability.” No one disputed that she had pain. What was in dispute was whether pain itself is a disability.

When Ms. Saunders took her case to the Federal Circuit in 2018, she successfully argued that her pain, as a functional impairment, did amount to a disability under the plain language of the governing statute. As a result, pain is enough to entitle a veteran to benefits. This Article argues that other courts should adopt a similar view of pain when assessing other benefit programs.

Chronic pain is a disability because it has tremendous functional impact on the body and mind. The functional, personal, and social impacts of chronic pain should be sufficient to meet the definition of disability under any of the legal schemes for disability.

Whether the law recognizes chronic pain as a disability in and of itself has significant normative and practical importance because chronic pain is a pervasive condition affecting 100 million adults in the United States, many of whom experience negative impacts in participating in life, work, and society. The majority of those 100 million,

3. Id.
4. Saunders, 886 F.3d at 1359.
5. Id. at 1360.
6. Id. at 1364.
however, cannot access disability benefit programs unless they also have another qualifying disability. By and large, their pain is simply not enough. In spite of this conundrum, few scholars have addressed whether chronic pain alone warrants protection under disability benefit programs and in other legal realms such as tort.

This Article argues that certain disabilities are unfairly privileged in the law because they are objectively provable by scientific testing. On the other hand, the subjective nature of disabilities like chronic pain creates an evidence problem for the courts. This problem extends to mental disabilities and some sensory and cognitive disabilities, along with symptoms like fatigue, nausea, and dizziness that often fail to fall neatly into established medical diagnoses. The Saunders case identifies the problem and offers some solutions but does not fully resolve the subjectivity challenge.

The current literature on pain tends to center around the connection between pain treatment and opioid use—rather than pain’s status as a disability. Furthermore, the literature that does acknowledge pain as a disability focuses on how to build an evidentiary foundation to establish the condition, such as through neuroscientific advances in identifying pain, rather than taking on the overarching issue of subjective disabilities. This Article expands the focus to examine how chronic pain is treated in the law and to argue for broader protection of chronic pain as a disability. More and more, pain is being recognized as a disability within the medical community, and the law must be responsive to changing definitions and the expansion of medical understanding.

Part I examines how various statutory schemes and benefits programs define chronic pain and identifies the circumstances under which pain is considered a disability. Part II analyzes the complexity of disability definitions and determines that pain is indeed a disability. Part III uses the case of Saunders v. Wilkie to show that a radical shift in the law to recognize pain as a disability is possible. Finally, Part
IV investigates subjective disabilities and inquires whether broadly allowing evidence of subjective experience is possible, warranted, and practical. This Article sheds new light on the neglected issue of chronic pain as a disability.

I. CHRONIC PAIN: A SUBJECTIVE EXPERIENCE

Pain is a universal experience among humans.\(^7\) It is also a highly subjective experience.\(^8\) Whether the same stimulus produces the same or a different amount or quality of pain can depend on a wide variety of factors such as individual bodily structure, experience, race, gender, culture, support,

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Pain is always subjective. Each individual learns the application of the word through experiences related to injury in early life. Biologists recognize that those stimuli which cause pain are liable to damage tissue. Accordingly, pain is that experience we associate with actual or potential tissue damage. It is unquestionably a sensation in a part or parts of the body, but it is also always unpleasant and therefore also an emotional experience. Experiences which resemble pain but are not unpleasant, e.g., pricking, should not be called pain. Unpleasant abnormal experiences (dysesthesias) may also be pain but are not necessarily so because, subjectively, they may not have the usual sensory qualities of pain. Many people report pain in the absence of tissue damage or any likely pathophysiological cause; usually this happens for psychological reasons. There is usually no way to distinguish their experience from that due to tissue damage if we take the subjective report. If they regard their experience as pain, and if they report it in the same ways as pain caused by tissue damage, it should be accepted as pain. This definition avoids tying pain to the stimulus. Activity induced in the nociceptor and nociceptive pathways by a noxious stimulus is not pain, which is always a psychological state, even though we may well appreciate that pain most often has a proximate physical cause.

and other factors. The section that follows offers a conception of pain rooted in a critical disability legal studies analysis, which looks at all impactful aspects of pain—bodily effects, social and psychological effects, and disparities in treatment.

Pain is also disabling. It affects participation in life, work, and society. The impact of pain on the ability to work has a direct impact on the law of benefit programs such as Social Security, Workers’ Compensation, and Veterans Disability Benefits. The impact in society might lead to discrimination in employment or otherwise, giving rise to lawsuits under the Americans with Disabilities Act. And the treatment of pain is currently in the crosshairs of a national debate about the use of opioids and the appropriate legal and policy decisions related to them.

Pain is one of the most powerful and common signals from our bodies. Our bodies, when properly functioning, give us signals: when to eat, when to sleep, etc. And pain in our bodies gives us a signal, too—to stop doing something—to avoid touching the hot stove or to stop moving the broken arm to avoid further injury, for example. Pain is often functional in that it tells us to start or stop behavior.

The history of how humans think about pain is similar to the history of how we consider disability. Ancient philosophers wrote about pain and disagreed about whether it was “useful” to the sufferer or if it should be avoided.

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9. See infra Section I.B.


Medieval church leaders taught that pain was a punishment from God, just like they taught that disability was a punishment. Medieval stoics “viewed pain as both a form of divine retribution, or as a sign of having been especially chosen and, as such, deserving of rewards in the hereafter.” This mirrors many of the historical beliefs regarding people with disabilities.

The traditional medical model characterizes pain as a “simple cause-and-effect problem.” In this view, pain begins with an injury to a person, resulting in a “nerve signal” to the spinal cord and then the brain. Once at the brain, a person feels “a sensation of pain, the severity of which [is] directly proportional to the tissue injury.” Over time, perhaps the structure heals on its own or medical intervention assists. When the tissue injury heals, the pain recedes, and the person moves on.

If the pain does not recede as expected, however, there is a problem. The traditional medical model posits two possibilities: either the problem was “overwhelming, such as rheumatoid arthritis or cancer,” or there was a “character flaw in the patient.” The conception of an individual flaw is tied intimately with the medical model of disability, discussed below in Part II.

As the modern medical era confronted pain, debates about the utility of pain remained, including disagreement about the role of intervention. Specifically, physicians debated whether it was their job to alleviate patients’ pain,

12. Id. at 48–49.
13. Id. at 48.
15. Id.
16. Id.
17. Id.
18. Id.
19. Id.
or if pain had value.\textsuperscript{20}

Today, 100 million adults in the United States suffer from chronic pain.\textsuperscript{21} But, the origins of that pain are widely varied. Sometimes the cause of pain is obvious, testable, and relatively uncontroversial. For example, cancer patients, people with multiple sclerosis, and people with AIDS frequently experience pain. Rheumatoid arthritis and fibromyalgia can also cause pain. On the other hand, some pain, especially some chronic pain, is described as “unexplained.”\textsuperscript{22} Chronic pain can exist even without a prior injury, through means that are not well-understood.\textsuperscript{23}

The origin of an individual’s pain can be critically important in predicting that individual’s success in the legal

\begin{footnotesize}
\begin{enumerate}
\item \textsuperscript{20} REY, \textit{supra} note 11, at 48. Rey discusses the view that pain can have utility as an “alarm signal” or warning sign for problems that require investigation. \textit{Id.} at 275.
\item \textsuperscript{21} NAGEL, \textit{supra} note 14, at 9; INST. OF MED., \textit{RELIEVING PAIN IN AMERICA: A BLUEPRINT FOR TRANSFORMING PREVENTION, CARE, EDUCATION, AND RESEARCH} 302 (2011) [hereinafter IOM REPORT], https://www.ncbi.nlm.nih.gov/books/NBK91497/.
\item \textsuperscript{22} See, e.g., Silvia Maria Lattanzio, \textit{The Gadolinium Hypothesis for Fibromyalgia and Unexplained Widespread Chronic Pain}, 129 MED. HYPOTHESES, Aug. 2019, at 1, 5.
\item \textsuperscript{23} From the National Institute of Health’s National Institute of Neurological Disorders and Stroke, on the definition of chronic pain:
There may have been an initial mishap—sprained back, serious infection, or there may be an ongoing cause of pain—arthritis, cancer, ear infection, but some people suffer chronic pain in the absence of any past injury or evidence of body damage. Many chronic pain conditions affect older adults. Common chronic pain complaints include headache, low back pain, cancer pain, arthritis pain, neurogenic pain (pain resulting from damage to the peripheral nerves or to the central nervous system itself), psychogenic pain (pain not due to past disease or injury or any visible sign of damage inside or outside the nervous system). A person may have two or more co-existing chronic pain conditions. Such conditions can include chronic fatigue syndrome, endometriosis, fibromyalgia, inflammatory bowel disease, interstitial cystitis, temporomandibular joint dysfunction, and vulvodynia. It is not known whether these disorders share a common cause.
\end{enumerate}
\end{footnotesize}
system. For example, in the veterans disability benefits process, a claimant must be able to prove service-connection, essentially pointing to evidence in their in-service medical records showing an inciting cause for their current disability. If the current disability is chronic pain, what inciting cause can they point to when their pain is multifactorial and could have come from any number of sources?

The International Association for the Study of Pain defines pain as an “unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.” Pain can start with a stimulus and has both a “structural” and “neurological” aspect. There might be an injury that incites the pain, but the pain might then be amplified by a neurological aspect.

Experts now recognize that a wide variety of factors influence the experience of pain in the individual and the perception of that pain by medical professionals and lay people alike. These varied perceptions impact individuals’ ability to receive care and respond to treatment. Indeed, an individual’s past experiences with pain and its effects, their prior treatment and interactions with medical professionals, and whether they have been exposed to others’ pain all influence how they experience pain. In addition, familial and genetic factors, including sex and race, influence one’s experience of pain. Those factors in turn powerfully determine how pain is treated by medical professionals and

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25. NAGEL, supra note 14, at 37.
26. Id.
28. Id.
29. Id.
how it is viewed by family, friends, and the community. Finally, comorbidities, cultural background, psychological, economic, and environmental factors, not to mention the origin of the pain itself, can also modulate and differentiate the experience of pain. This complex constellation of factors can mean that an individual’s subjective perception of their pain and others’ perception of that pain often differ greatly.

Pain is also a significant public health challenge. Surveys indicate that between 11 percent and 40 percent of the US population reports some level of chronic pain. In addition to the 100 million American adults affected by pain, there is a huge public and private cost. The Institute of Medicine (IOM) estimates that pain costs society between $560 and $635 billion annually, and federal and state costs amount to almost $100 billion annually. The private cost to quality of life and psychological wellbeing is infrequently measured, but it is critical to a full understanding of the impact of pain.

There are significant disparities on both the individual and societal level that need to be accounted for and addressed in this public health challenge. For example, pain is more prevalent and more “disabling,” and care is more likely to be inadequate for people with limited access to health care. Racial and ethnic minorities figure prominently within that category, likely due to disparate treatment. People with low income or education, children, and older adults are at risk because of low status and access to care. Those at increased risk because of where they live or work, and those at increased risk because of limited communication skills, are also more likely to experience the

30. Id. at 13.
31. IOM REPORT, supra note 21.
32. IPRCC PAIN STRATEGY REPORT, supra note 27, at 13.
33. Id. at 14.
34. Id. at 5.
35. Id.
disabling effects of pain.\textsuperscript{36} Compounding those disparities are stigmatization and bias.

Modern conceptions of pain show that it is a highly subjective and complex condition. Some aspects of pain are well-understood, and some are not.

A. \textit{Acute Pain Is Unpleasant. Chronic Pain Is Disabling.}

In order to understand why chronic pain is a disability, it is important to understand, as much as possible, its full effects on both the body and mind. Acute pain is more easily understood, but chronic pain can be confounding—both for the individual and for those working to help. Broadly speaking, acute pain is non-controversial in the sense that it is not regularly challenged or doubted and maintains a fairly uncontroversial place in the legal system. It is also not generally considered a disability.

Acute pain can serve an important purpose. It alerts us to a problem within our body. We can then take steps to protect that body part, which enables it to heal. Once healing has occurred and the signal is no longer needed, the pain goes away.\textsuperscript{37} Acute pain is an expected, physiologic response, normally sudden in onset and time limited. Acute pain motivates some sort of behavior to protect the body and avoid actual or potential damage.\textsuperscript{38}

Chronic pain is different. It does not serve the same type of useful purpose that acute pain often does. Once healing has occurred, if it has occurred, the pain persists, even in the absence of damage. If acute pain motivates potentially remedial behavior, chronic pain cannot be said to perform a similar function. There is no protective behavior that would aid in healing, for example. Chronic pain can be high impact in that it can cause a substantial disruption of participation.

\textsuperscript{36} \textit{Id.}
\textsuperscript{37} \textit{Id.} at 13.
\textsuperscript{38} \textit{Id.} at 11.
in work, social, and self-care activities.\textsuperscript{39} Chronic pain is typically described as occurring on “at least half the days for six months or more.”\textsuperscript{40}

The disabling effects of chronic pain are numerous. Chronic pain creates a “complex biopsychosocial phenomenon,” meaning it has the power to affect every aspect of an individual’s life.\textsuperscript{41} The effects can be physical, mental, and social. The ability to work, engage in social activities, and maintain physical and mental health are all impacted by the persistence of pain.\textsuperscript{42}

\textsuperscript{39} Id.

\textsuperscript{40} Id.; see also NAGEL, supra note 14, at 33. Nagel has described the arbitrary characterizations of acute and chronic pain by “how long they last.” Pain that lasts less than three months is usually defined as acute pain and pain that lasts longer as chronic. He notes:

Acute pain is also referred to as nociceptive pain. Nociceptive pain serves an important purpose. It alerts us to a problem within our body. We then take steps to protect that body part, which enables it to heal. Once healing has occurred and the signal is no longer needed, the pain goes away.

Chronic pain does not serve a useful purpose. Once healing has occurred, the pain persists. It is not serving as a signal, and it unnecessarily restricts the sufferer. It is considered a disease process in itself and is referred to as pathological pain. There are two types of chronic pain, which are not mutually exclusive: inflammatory and neuropathic. Inflammatory pain results from damage to nonneural tissue, and neuropathic pain results from damage to neural tissue.

We must make one more very important distinction: between pain and suffering. Pain is the body’s physical (nociceptive or biological) response to tissue injury. Suffering is the person’s psychosocial response to the injury.\textsuperscript{\textit{Id.}} (emphasis omitted). So-called “diagnostic clusters” of pain for research purposes include the following: back pain; neck pain; limb/extremity pain, arthritis disorders, including osteoarthritis and joint pain; fibromyalgia and wide-spread muscle pain; headache; orofacial, ear, and temporomandibular disorder pain; abdominal pain and bowel pain; chest pain; urogenital, pelvic, and menstrual pain; fractures, contusions, sprains and strains; and other painful conditions, which includes sickle cell disease, complex regional pain syndrome, systemic lupus erythematosus, acquired deformities (excluding spinal disorders), spinal cord injury, Lyme disease, and neuropathic pain. IPRCC PAIN STRATEGY REPORT, supra note 27, at 67.

\textsuperscript{41} IPRCC PAIN STRATEGY REPORT, supra note 27, at 13.

\textsuperscript{42} Id.
The source of chronic pain can be critically important in an individual’s ability to access care, be believed, and receive compensation. Chronic pain can be “primary,” in that it does not derive from any other condition or injury, or can be “secondary,” in that it does derive from some other source. Even when chronic pain is secondary, it might be out of proportion with the initial injury or condition. For example, when an initial injury heals but the pain “chronifies” or continues to persist. Another type of secondary chronic pain is where there is a persistent, peripheral disease, an effect of which is chronic pain. Examples of this type of chronic pain are irritable bowel syndrome or advanced arthritis. In those cases, the peripheral disease itself causes some of the pain, but additional pain is caused by “neurologically altered pain perception.” There is also a bounce-back effect where pain impacts life in certain ways, which in turn impact and worsen pain. Psychosocial and physical problems that result from pain can, in turn, make pain worse, and the threats to health and well-being can escalate.

The aspects of chronic pain described above provide a key piece of the explanation for why the law should recognize it as a disability. The impacts of persistent or chronic pain are truly life and death. Chronic pain has been linked to premature death, and the challenges associated with living with chronic pain contribute to a higher suicide rate than that of the general population. Given these impacts,

44. Id.
45. Id. at 1115. There is also research to suggest that chronic pain is a central nervous system disorder, which would help to “explain the distress and match the symptomology of many forms of chronic pain.” Id.
46. IPRCC PAIN STRATEGY REPORT, supra note 27, at 13.
47. Id.; see also Nagel, supra note 14, at 244. Nagel indicates that there was a rise in drug-related suicides from 2005 to 2009. While the “assumption was that these incidents were merely due to substance abuse,” that is not necessarily accurate, since “the government researchers made no attempt to determine how
understanding whether pain is chronic or acute is critical to understanding pain as a disability.

B. Disparate Treatment in the Measurement of Pain

To assess how disability law should account for pain necessarily raises the question of how to measure pain, and following that, how to compensate for it. That question is fraught. How an individual experiences pain is a personal and individualized experience, but it has broad implications. The severity of pain impacts the response to that pain from both a medical and social perspective. Bias and prejudice about groups’ perceived ability to feel and endure pain impacts not only the treatment provided but also the mental health and well-being of the individual.

Pain is, by its nature, subjective. While pain scales may appear objective, an individual’s perception of their own pain level can vary widely from another’s. Chronic pain is a

many people attempting suicide in this manner were suffering from chronic, unresolved pain. There is reason to believe at least some of them might have suffered from chronic, unresolved pain, because risk factors for suicide in the pain population are high. A 2004 study found that 19 percent of pain patients studied had passive ideas about suicide, 13 percent had active thoughts, 5 percent had a plan, and 5 percent had made a previous attempt. Seventy-five percent identified drug overdose as their preferred method for suicide. Id. (internal citations omitted).

48. Samulowitz et al., supra note 8, at 1.
49. For an example of a pain scale, see the Faces Pain Scale, developed for children, from the International Association for the Study of Pain. Faces Pain Scale–Revised (FPS–R), INT’L ASS’N FOR THE STUDY OF PAIN, https://www.iasp-pain.org/Education/Content.aspx?ItemNumber=1519 (last visited Dec. 20, 2021). The guidelines included with this scale instruct medical professionals to utilize it as follows: “In the following instructions, say ‘Hurt’ or ‘Pain,’ whichever seems right for a particular child: These faces show how much something can hurt. This face [point to left-most face] shows no pain. The faces show more and more pain [point to each from left to right] up to this one. [point to right-most face] It shows very much pain. Point to the face that shows how much you hurt [right now]. Score the chosen face 0, 2, 4, 6, 8, or 10, counting left to right, so 0 = ‘no pain’ and 10 = ‘very much pain.’ Do not use words like ‘happy’ or ‘sad.’ This scale is intended to measure how children
“moving target” in that it can change constantly.\textsuperscript{50} On an individual basis, each person’s pain is unique.\textsuperscript{51}

Measuring the severity of pain is a key component of disability law, in benefit programs and tort especially. There are key differences between how individuals experience pain, along with a load of cultural norms and assumptions. There are also differences in how physicians perceive that their patients experience pain, informed by biases about gender, race, and other characteristics. Measuring pain is not simple, nor is it necessarily objective. This fact frustrates people’s ability to access quality medical care and receive appropriate therapeutic responses to pain. It also complicates how the law treats pain for purposes of compensation and rating, because the amount of pain someone has will be tied to their level of disability or level of damages in tort, for example.

Courts, adjudicators, and raters may desire a measurement derived from X-rays, MRIs, or other visual evidence, but these are often irrelevant when looking for corroborating evidence of pain.\textsuperscript{52} Pain may not be tied to a feel inside, not how their face looks.” \textit{Id.} For other examples of pain scaling tools, see Erica Jacques, \textit{10 Common Types of Pain Scales}, VERYWELLHEALTH, https://www.verywellhealth.com/pain-scales-assessment-tools-4020329 (Dec. 19, 2021).

\textsuperscript{50} NAGEL, \textit{supra} note 14, at 38. Nagel notes that chronic pain is challenging because of its uniqueness to the individual. He notes that “[e]ach person brings different intrinsic and extrinsic factors to the pain experience. Each person processes the sensory experience of pain differently, with very different outcomes. Each patient must therefore be treated individually. . . . For these reasons, we cannot understand another person’s pain based on our own experiences.” \textit{Id.} Furthermore, as to the psychological aspect, he cautions “[w]hile chronic pain may be pathological, it is physiologically real. It is not a character flaw or a purely psychological problem. Psychological dysfunction in those who suffer is most often the result of chronic pain, not the reverse.” \textit{Id.}

\textsuperscript{51} \textit{Id.} at 28. Nagel also notes the factors playing a role in pain perception, “such as past pain experience, stress level, mood, supportiveness of the environment, and so on. Culture and heredity are also important.” \textit{Id.} at 37. Furthermore, Nagel notes that the origins and development of pain can be complex, in that “[s]tructural injury may incite the pain, but a neurological adaptation or maladaptation maintains or amplifies it. Treatments that attend only to the structural element are bound to fail in chronic pain.” \textit{Id.}

\textsuperscript{52} See, \textit{e.g.}, David Borsook et al., \textit{Neuroimaging Revolutionizes
The measurement of pain is of great importance, because it can dictate treatment and standard of care. Research suggests that there are substantial racial disparities in the treatment of pain, for example. Racial bias plays a large role in the perception of pain measurement. Black Americans in particular are “systematically undertreated” for pain in

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53. See Pustilnik, supra note 43, at 1105.

the United States relative to their white counterparts.55 In both the lay and medical contexts, racial bias is related to false, prejudicial beliefs.56

Furthermore, the underlying racial biases dictate inaccurate and damaging beliefs about biological differences. One study found that white laypeople and medical students and residents “believe that the black body is biologically different—and in many cases, stronger—than the white body.”57 That study also found evidence that these beliefs about the biological differences between white and black bodies were “associated with racial bias in perceptions of others’ pain, which in turn predict accuracy in pain treatment and recommendations.”58 Racial biases are therefore not just passively present: they have an impact on treatment and the perception of severity. That severity component has a key relationship to the law.

These biases also have an enormous real-world impact. A physician’s perception of their patient’s pain will dictate whether the patient is prescribed pain medication and the prescribed dosage of that medication. If that initial perception of pain is rooted in bias, it will be an incorrect perception, resulting in inaccurate diagnoses and incorrect treatment. For example, black patients are less likely to receive painkillers for broken bones in the emergency room relative to white patients, even when the injuries and self-reports of pain are similar.59 These disparities in treatment persist even among young children. For example, “a study of nearly one million children diagnosed with appendicitis revealed that, relative to white patients, black patients were

56. See id.
57. Id.
58. Id.
59. Knox et al., supra note 54, at 11–12.
less likely to receive any pain medication for moderate pain and were less likely to receive opioids—the appropriate treatment—for severe pain.\textsuperscript{60}

Furthermore, research shows that these disparities are “likely not the result of racist individuals acting in racist ways.”\textsuperscript{61} This means that the biases are pervasive and structural, not just attributable to “bad apples.”

Gender bias, too, plays a role in the disparate treatment of patients’ pain. A large body of research shows that gender norms about male and female responses to pain impact treatment. Women make up the majority of chronic pain diagnoses, but women often receive less intervention even when they report more pain.\textsuperscript{62}

Research shows that men and women perceive pain differently.\textsuperscript{63} They also describe and express it differently.\textsuperscript{64} The coping strategies they use are different.\textsuperscript{65} Men and

\begin{itemize}
  \item[60.] Hoff\mbox{man} et al., supra note 55, at 4296; see also Goyal et al., supra note 54, at 999.
  \item[61.] Hoff\mbox{man} et al., supra note 55, at 4297.
  \item[62.] See, e.g., Samulowitz et al., supra note 8, at 10.
\end{itemize}
women also respond to particular treatments differently.\textsuperscript{66} There are biological and hormonal differences that may account for some variation, but social factors also play a role.\textsuperscript{67} Specifically, “boys and girls are socialized along gender norms for how to respond to pain. . . . [B]oys and men are taught to be tough, tolerate pain, and sustain painful experiences, while girls and women are socialized to be sensitive, careful, and to verbalize discomfort.”\textsuperscript{68} Physicians may dismiss women’s pain more than they do men’s, and evidence shows that women’s pain is “often less thoroughly investigated, especially initially, when the cause of pain is unknown.”\textsuperscript{69} Doctors are less likely to believe women when they report their pain. This may be linked to the crisis in maternal mortality in the United States.\textsuperscript{70}

Critically, the intersection of race and gender means that black women in particular in the United States are often dismissed when reporting pain.\textsuperscript{71} This can have drastic health consequences. Black women have worse health outcomes than white women. They are forty percent more likely to die from breast cancer, more likely to die from cancer generally, less likely to receive pain medication, and

\begin{itemize}
\item \textsuperscript{66} See id. at 630–31; Bartley & Fillingim, supra note 63, at 52.
\item \textsuperscript{67} Cynthia D. Myers et al., Psychosocial Contributions to Sex-Correlated Differences in Pain, 19 CLINICAL J. PAIN 225, 230 (2003).
\item \textsuperscript{68} Samulowitz et al., supra note 8, at 1–2.
\item \textsuperscript{70} See generally The U.S. Maternal Health Crisis: 14 Numbers You Need to Know, AMNESTY INT’L (May 3, 2011), https://www.amnestyusa.org/the-u-s-maternal-health-crisis-14-numbers-you-need-to-know/ (“African-American women are 3 to 4 times as likely to die from pregnancy-related causes as white women.”).
\item \textsuperscript{71} Consumer Reps., supra note 69.
\end{itemize}
more likely to die of heart disease at a younger age than white women. For example, black women are less likely than white women to undergo genetic testing for breast cancer, because physicians are less likely to recommend it to them. Unequal health care drives this disparity.

These healthcare disparities exist on an individual patient-provider level, but also structurally. Interventions to reduce disparities “fail” when the problem is viewed only through the lens of individual interactions and the race of individual actors within the system. Black women, for example, face pervasive stereotypes and disparities in health care settings and in general.

These disparities persist at all stages of the pain experience, from the onset of pain to its diagnoses, treatment, and outcome. And they track on to the law, because they dictate how the courts evaluate an individual’s benefits application or a plaintiff’s claim.

C. The Impact of Stigma and the Impact of Pain on the Mind

Chronic pain’s impact on the mind, and in particular on mental health outcomes, is important to understanding its role as a disability. Because these effects can be overwhelming, the degree to which they are understood will


75. Id. at 5; see also JONATHAN M. METZL, THE PROTEST PSYCHOSIS: HOW SCHIZOPHRENIA BECAME A BLACK DISEASE 202 (2009).

help to show why chronic pain is disabling.

The effects of chronic pain are not limited to physical impacts. Chronic pain is often accompanied by posttraumatic stress disorder (PTSD), for example, which can develop after the onset of chronic pain or be exacerbated by it.\(^{77}\)

Furthermore, the stigma that chronic pain patients experience can be disabling in itself.\(^{78}\) There are negative attitudes, beliefs, perceptions, and misconceptions about people experiencing pain and about the nature of pain.\(^{79}\) These attitudes can be held by clinicians, other medical professionals, social workers, program administrators, and others in decision-making roles, meaning that these attitudes can disparately impact patient care and treatment.\(^{80}\)

Pervasive stigma and misconceptions about pain have a

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\(^{77}\) Nagel, supra note 14, at 44–45 (writing about PTSD and its relationship to chronic pain, noting that “[p]osttraumatic stress disorder (PTSD) is an underappreciated accompaniment of chronic pain, and it plays a role in many ways. . . . In effect, it backs the pain patient into a corner, and . . . has the potential to amplify and perpetuate the response to pain. PTSD in pain patients is often ignored. Yet failure to acknowledge and treat it can have negative effects on outcome. I have observed four different types of PTSD in the setting of chronic pain. First, PTSD can precede the pain disorder, as for the many chronic pain patients who have a history of physical, verbal, or sexual abuse. . . . Second, pain patients can experience posttraumatic stress related to the event that brought on their pain. . . . While some would characterize this behavior as malingering, it is the result of a very real anxiety disorder that needs to be respected and treated as a separate entity if rehabilitation is to be successful. Third, PTSD occurs in those whose trauma is the result of abuse by insurance companies, the courts, attorneys, or the workplace. . . . Fourth, the trauma may be inflicted by the medical system.”).

\(^{78}\) See IPRCC Pain Strategy Report, supra note 27, at 29.


\(^{80}\) IPRCC Pain Strategy Report, supra note 27, at 29.
real-world impact on treatment and care.81 In its recommendations regarding public education and communication, the Interagency Pain Research Coordinating Committee (IRPCC) Pain Strategy Report recommends the following steps, among several, to address stigma:

- Increase public awareness and knowledge about the pervasiveness of chronic pain, its complexity, and the importance of access to prompt and effective treatments.
- Change cultural attitudes about chronic pain, debunking stereotypes and myths related to people with chronic pain and various pain treatment options and emphasizing the value of pain self-management programs in enabling people to live better with chronic pain.82

The impacts on treatment and care can be vast. The IPRCC Pain Strategy Report notes that “[p]eople with pain who encounter these biases can feel stigmatized, which may decrease their willingness to report pain in a timely way, participate in decisions about their care, adhere to a recommended treatment plan, or follow a self-care protocol. This perception also may negatively affect their psychological state.”83 People experiencing chronic pain who also experience bias or stigma will, simply put, be worse off.

Members of vulnerable populations are most at risk of experiencing the negative effects of stigma.84 For example, research has documented the particular stigma against women with chronic fatigue syndrome.85 Similar patterns

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81. See id. at 46.
82. Id.
83. Id. at 29. See also Nagel, supra note 14, at 50, on stigma, noting that “[w]e shun chronic pain patients as though they were lepers. . . . [T]hey are sometimes treated almost like criminals, as if they are deliberately fabricating their ailments. As a society, we deny these patients not only medical care but jobs as well.”
84. IPRCC Pain Strategy Report, supra note 27, at 29.
85. Id.
exist for people who are prescribed opioids for chronic pain.\textsuperscript{86} Other groups, like non-verbal children who cannot communicate in traditional ways, experience stigma.\textsuperscript{87} Furthermore, when there is an underlying disease such as sickle cell disease or HIV, the patients experiencing pain related to these conditions experience increased stigma.\textsuperscript{88} These are just a few of the groups and vulnerable populations for whom stigma impacts the experience and treatment of pain.

Meanwhile, medical professionals may be under-equipped to deal with these challenges. Many physicians, for example, do not have the requisite skills and knowledge to “contribute to the cultural transformation in the perception and treatment of people with pain.”\textsuperscript{89} Practitioners are more likely to rely on siloed approaches in procedure and pharmacology that may not be effective alone, and lack the core competencies in pain care and management that would provide comprehensive knowledge and understanding.\textsuperscript{90}

Moreover, cultural bias against people with pain, generally, and those with chronic pain, particularly, impacts how individual medical professionals respond to pain.\textsuperscript{91} Research shows that as medical training progresses, bias emerges and empathy declines.\textsuperscript{92}

\begin{itemize}
\item \textsuperscript{86} Id.
\item \textsuperscript{87} Id.
\item \textsuperscript{88} Id.
\item \textsuperscript{89} Id. at 41.
\item \textsuperscript{90} See id.
\item \textsuperscript{91} Hoffman et al., \textit{supra} note 55, at 4296. See generally Richard L. Nahin, \textit{Estimates of Pain Prevalence and Severity in Adults: United States, 2012}, 16 J. PAIN 769 (2015) (discussing associations between pain severity and selected demographic variables including race, ethnicity, preferred language, sex, and age).
\item \textsuperscript{92} See Melanie F. Neumann et al., \textit{Empathy Decline and Its Reasons: A Systematic Review of Studies with Medical Students and Residents}, 86 ACAD. MED. 996, 1001 (2011); Christina Amutah et al., \textit{Misrepresenting Race—The Role of Medical Schools in Propagating Physician Bias}, 384 NEW ENG. J. MED. 872, 872 (2021).
\end{itemize}
Bias, stigma, and mental health impact the experience, treatment, and outcomes for chronic pain. Like disparate treatment, individuals experiencing these effects will ultimately be disfavored in the legal system as a result.

D. Pain Treatment

The “Opioid Epidemic” in the United States has drastically changed how medical professionals treat pain. This development also impacts how the general public views chronic pain. It has impacts both for opioid users and non-opioid users alike.93

How pain is treated can have a direct impact on its legal status, because it can allow courts to make inferences about the severity of pain on the basis of its treatment. For example, if a physician does not prescribe an opioid to treat an individual’s pain, it could be inferred that the pain was not particularly disabling, even if that failure to prescribe a particular treatment was based on another factor like bias, stigma, discrimination, or fear of prosecution due to opioid restrictions.

The racial disparities referred to above in the diagnosis and rating of pain carry over here too. While there is evidence of over-prescription of pain medication for white patients, there is similar evidence of under-prescription for black

93. See, e.g., Khiara M. Bridges, Race, Pregnancy, and the Opioid Epidemic: White Privilege and the Criminalization of Opioid Use During Pregnancy, 133 HARV. L. REV. 770, 787 (2020); Roseann B. Termini & Rachel-Malloy Good, 50 Years Post-Controlled Substances Act: The War on Drugs Rages On with Opioids at the Forefront, 46 OHIO N.U. L. REV. 1, 9–10 (2019); What is the U.S. Opioid Epidemic?, U.S. DEP’T HEALTH & HUM. SERVS., https://www.hhs.gov/opioids/about-the-epidemic/index.html (last visited Sept. 7, 2021); NAGEL, supra note 14, at 241, on opioid use and tolerance versus dependence (“Tolerance occurs when more medication is needed to achieve the same effect. Dependency occurs when abstinence from the drug results in a withdrawal state. . . . Addiction occurs when someone compulsively engages in a behavior despite negative consequences to herself or those around her; in this case, compulsive use of pain medication. Pseudoaddiction occurs when a person seeks to obtain a substance illegally or inappropriately to treat a legitimate problem that is not being properly managed by health-care professionals.” (emphasis omitted)).
patients.94 Viewing chronic pain from a public health and disability perspective allows the public health knowledge and disease models to add precision to the concept of pain prevention and treatment.95 The purpose of a broad public health approach is to not only reduce individual experiences of pain but to reduce the impact of pain on individuals, families, and society as a whole.96

Nonetheless, there have been significant public health concerns related to the misuse or diversion of prescription opioid pain medications. The risk for dependence and overuse related to long-term opioid prescribing adds to the complexity.97 The public health challenge has been to balance efforts to improve pain management with efforts to manage the rise in adverse health consequences related to opioid use.98

The number of opioid prescriptions dispensed increased from 76 million in 1999 to 219 million in 2011,99 peaking at 255 million in 2012 and settling back down to 168 million in 2018—more than double what it was 20 years prior.100 While the number increased, so did the amount per prescription, the duration of the supply, and the cumulative dose.101 At the same time, there was a rise in opioid-related substance abuse treatment admissions, and a rise in opioid-involved overdose deaths.102

As concerns about opioid prescription rise and new

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94. Hoffman et al., supra note 55, at 4296.
95. IPRCC PAIN STRATEGY REPORT, supra note 27, at 14.
96. Id.
97. Id.
98. Id.
99. Id.
101. IPRCC PAIN STRATEGY REPORT, supra note 27, at 14.
102. Id.
programs endeavor to curb prescribing, simultaneous concerns persist about use and access to these drugs for appropriate and quality pain management. Oftentimes, opioids are simply the best option for pain management. For individual patients, opioids can be the only intervention to have any appreciable effect.\textsuperscript{103} By contrast, pharmacy shortages, regulated dispensing, and other regulatory measures can result in inadequate pain treatment.\textsuperscript{104} Most patients who use opioids use them without dependency.\textsuperscript{105} Nevertheless, primary care physicians, who are the majority treatment providers for chronic pain patients, report their reluctance to prescribe opioids for non-cancer pain, because they are concerned about dependence, addiction, and abuse.\textsuperscript{106}

Debates about the appropriate use of opioids to treat pain overshadow other critical issues in pain management. For example, ensuring access to “high-quality integrated care based on clinical evidence” is a challenge.\textsuperscript{107}

\textsuperscript{103} Id.

\textsuperscript{104} Id.

\textsuperscript{105} See David A. Fishbain et al., What Percentage of Chronic Nonmalignant Pain Patients Exposed to Chronic Opioid Analgesic Therapy Develop Abuse/Addiction and/or Aberrant Drug-Related Behaviors? A Structured Evidence-Based Review, 9 PAIN MED. 444, 452, 454 (2008). See generally Michael F. Fleming et al., Substance Use Disorders in a Primary Care Sample Receiving Daily Opioid Therapy, 8 J. PAIN 573 (2007).

\textsuperscript{106} Holly Blake et al., Prescribing Opioid Analgesics for Chronic Non-Malignant Pain in General Practice—A Survey of Attitudes and Practice, 9 BRIT. J. PAIN 225, 226 (2015); Robert N. Jamison et al., Beliefs and Attitudes About Opioid Prescribing and Chronic Pain Management: Survey of Primary Care Providers, 10 J. OPIOID MGMT. 375, 376 (2014); Esmond D. Nwokeji et al., Influences of Attitudes on Family Physicians’ Willingness to Prescribe Long-Acting Opioid Analgesics for Patients with Chronic Nonmalignant Pain, 29 CLINICAL THERAPEUTICS 2589, 2590 (2007).

\textsuperscript{107} IPRCC PAIN STRATEGY REPORT, supra note 27, at 35. These challenges include: pain management limited to one modality (only pharmacological treatment, for example); uncoordinated care; care not aligned with the best available evidence or expected outcomes; care provided by primary care practitioners without specialized expertise; lack of quality research on the effectiveness of interventions; lack of knowledge about models of care delivery; lack of drug research on safe alternatives to opioids; lack of prevention programs
Multidisciplinary treatment for chronic pain, in a center or clinic setting, can be effective in providing care that is coordinated, delivered in a programmed and patient-centered manner, evidence-based, and provided with pain management expertise.108

Nevertheless, there are significant structural barriers to fully addressing pain on both an individual and population level. There are disincentives to pain management. These include insurance companies that “refuse to pay for pain medication” even after a valid prescription and includes medical training that does not sufficiently involve the management of pain.109

II. PAIN AS DISABILITY

A. Disability: Defined, Disputed

The definition of disability—what it refers to, what it does not, and what aspects of the definition are important—is disputed. Scholars use many different terms to describe and define disability, some of which are discussed here. Disability can be an impairment of some particular function. Some scholars take a more neutral terminology and use the term characteristic or trait, rather than disability. On the medical side, disabilities are frequently referred to as conditions or diagnoses. Some scholars take a functional approach and refer to bodily function or body structure.

and services; lack of funding and payment for pain self-management programs; lack of family and community or social services support; inadequate patient education on the biopsychosocial effects of pain; value-driven approaches rather than integrative health approaches; lack of access to and the affordability of pain medication; and limiting approaches such as rationing, medication shortages, and inadequate insurance and payment procedures. Id. at 35–36.


Referring to societal impact, disability is sometimes defined in terms of participation in, and restriction from, society, work, and life.110

For the impact of disability, one or more disabilities might affect a person’s movement, vision, hearing, thinking, learning, mental health, memory, communication, or social relationships. Some disabilities are frequently described purely in terms of a physical impairment and body structure, while some are more commonly defined in terms of functional limitations—what a person is or is not able to do—rather than body structure. Some disabilities only affect one dimension (vision, for example), while some affect multiple. There is, as should be clear by now, an extremely wide variety of disability definitions.111

In the broadest of terms, the majority of disability definitions contain the following two pieces in common: “a physical or mental characteristic labeled or perceived as an impairment or dysfunction”112 and “some personal or social limitation associated with that impairment.”113

Furthermore, the classification of a physical or mental variation as an impairment may be statistical, based on the average in some reference groups; biological, based on a theory of human functioning; or normative, based on a view of human flourishing. However classified, impairments are generally seen as traits of the individual that he or she cannot readily alter.114

111. Id.
112. Id. The authors note that “in the remainder of this entry, we will refer to such characteristics as ‘impairments,’ without assuming the objectivity or validity of that label.” Id. I will do the same.
113. Id.
114. Id. The definition goes on: “

Just what makes a condition a trait or attribute of an individual is obscure and debatable, but there seems to be agreement on clear cases . . . . Thus,
The take-away here is that, for most scholars, disability can be defined as an impairment that cannot be changed and that results in some limitation. Beyond that, there is little commonality that can encompass every disability that is indisputably included in any definition, let alone those that create controversy like chronic pain.

People with disabilities were not considered a distinct group until the nineteenth century, when early categorizations of “normality” and “abnormality” or “deviance” became prominent. Prior to this time, disabilities were thought of as part of variations in the human function and form. Generalizations and classifications on the basis of perceived or inferred characteristics in the case of disability, and definitions of who “counts” as disabled, are, therefore, relatively new.

Consider the large number of impairments, characteristics, and traits that may plausibly be included in any definition of disability: paraplegia, deafness, blindness, diabetes, autism, epilepsy, depression, HIV, congenital absence or adventitious loss of a limb or a sensory function, multiple sclerosis, arteriosclerosis (a chronic disease), inability or limited ability to perform cognitive functions like memorization and calculations, schizophrenia and bipolar disorder, cancer, and so many more.

The range of difference captured by any definition of disability is as wide as the difference between disabled and poverty is not seen as an impairment, however disabling it may be, nor is tasteless clothing, even if it is a manifestation of impaired fashion-sense rather than scarce income. On the other hand, diseases are generally classified as impairments, even though they are rarely permanent or static conditions. Diseases that are not long-lasting, however, such as the flu and the measles, do not count as impairments.

Id. (citations omitted).
115. Id.
116. Id.
117. Id.
118. Id.
non-disabled persons, and in some cases wider. There is such a wide variety in function and experience among people with disabilities that some scholars have called disability a category “highly problematic” in terms of developing a narrow or strict definition.119

It is worth considering here why we might need to define disability at all. There seem to be at least three purposes: remedial, categorical, and social.120

First, people with disabilities overwhelmingly face discrimination, stigma, and bias.121 If we want to be able to end discrimination against people with disabilities, and if we seek to remedy that harm, then we may need to have a strict sense of what the term disability means. It may be necessary, for example, to utilize some classification in order to distinguish disability discrimination from other types of discrimination—to point out the particularities of disability


120. These purposes could also be categorized differently, for example into legal and extra-legal, social, or normative purposes. Some of the definitional categories described here could also be categorized as either derived from authority or self-derived. This might also encompass in-group or out-group definitions. See, e.g., Elizabeth F. Emens, Framing Disability, 2012 U. ILL. L. REV. 1383, 1403 (2012).

discrimination.\textsuperscript{122} Legally, we need that definitional (and evidentiary) clarity in order for a lawsuit or American Disabilities Act (ADA) claim to be successful. And in society, we might at least need self-defined parameters to help guide remedies like anti-bias training or integration initiatives.

Second, definitions in this context serve as a proxy for eligibility. Disability benefit programs, for example, frequently provide broad categories of eligible disabilities, along with lists of "eligible conditions." This can encompass eligibility for benefit programs, such as Social Security or veterans benefits, as well as workers' compensation. It can also mean eligibility for certain social services, such as programs to assist people with intellectual disabilities.\textsuperscript{123}

For children, this is an especially important definition, since a particular diagnosis can lead to protections under the Individuals with Disabilities in Education Act (IDEA), including access to an Individualized Education Plan (IEP) requiring certain in-school services, accommodations, and entitlement to special school programs and initiatives. So, the list of "eligible" disabilities that qualify for SSA or IDEA can be crucial for an individual seeking monetary or other support.

Finally, the ability to self-define as disabled, if one chooses, can be beneficial in terms of community support and resources. It can aid in self-identify formation. And a "coherent disability identity" can help an individual adapt to disability.\textsuperscript{124}

I want to distinguish the complexity of the definition of disability from the separate, but also critically important, questions of individual medical diagnosis and proof. On the

\textsuperscript{122} See generally JEROME E. BICKENBACH, PHYSICAL DISABILITY AND SOCIAL POLICY (1993).

\textsuperscript{123} See, e.g., Eligibility: Determine your Eligibility for Services, N.Y. STATE OFF. FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES (OPWDD), https://opwdd.ny.gov/eligibility (last visited Dec. 21, 2021).

\textsuperscript{124} Dana S. Dunn & Shane Burcaw, Disability Identity: Exploring Narrative Accounts of Disability, 58 REHAB. PSYCH. 148, 155 (2013).
broad definitional front, initially, there is the question of whether a particular trait falls into the disability category. If there is a list, a determination is made whether a particular disability is included on that list or not. Next, there is the question of the medical community’s acceptance of a particular disability as a medical condition or impairment: the diagnosis. Finally, there is the problem that some disabilities, even when listed, and even when recognized by doctors, still are then subject to evidence and proof problems due to the subjective nature of the expression of that disability. This results in a category of disabilities that are compatible with a diagnosis but have a proof problem due to their subjective nature. Disabilities in this category may or may not be “on the list” or included in legal categorizations. Omissions may be due to that very subjectivity or other reasons.

As an example of the subjective disability category, the veterans disability benefit compensation program will ostensibly compensate a veteran with a service-connected diagnosis of PTSD. It is “on the list,” so to speak, in that it is a mental disorder, which is listed in the benefit regulations. PTSD is broadly recognized in psychiatry, and it is certainly possible for an individual to obtain a diagnosis. However, many veterans still report that they receive skepticism as claimants when attempting to utilize the veterans disability benefit program—essentially, evaluators accuse them of lying, exaggerating, or making it up. The relationship between subjectivity and evidence is discussed in greater depth below.

The American historical definition of disability begins at

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least in the 1930s, when the League of the Physically Handicapped opposed discrimination in government and employment. 129 This was the era of the 1935 Social Security Act, providing income and vocational rehabilitation for people with disabilities. 130 Even at that early stage of a nascent disability rights movement, the League “perceived themselves as a minority unprotected by the law rather than ‘medical models’ victimized by physical impairments.” 131

As to current definitions, institutions have been, and remain, inconsistent. Consider, for example, the following current definitions:

The Americans with Disabilities Act:

“A person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment.” 132

The Social Security Administration:

“A person who is not able to engage in any substantial gainful activity (SGA) because of a medically-determinable physical or mental impairment(s): That is expected to result in death, or that has lasted or is expected to last for a continuous period of at least 12 months.” 133

The United Nations:

“Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis

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129. Fleischer & Zames, supra note 109, at 5.
130. Id.
131. Id.
The Center for Disease Control and Prevention identifies disabilities that affect a person’s “vision, movement, thinking, remembering, learning, communicating, hearing, mental health, and social relationships.”

The World Health Organization identifies three dimensions to disability:

1. Impairment in a person’s body structure or function, or mental functioning; examples of impairments include loss of a limb, loss of vision or memory loss.
2. Activity limitation, such as difficulty seeing, hearing, walking, or problem solving.
3. Participation restrictions in normal daily activities, such as working, engaging in social and recreational activities, and obtaining health care and preventive services.

In 1999, the Supreme Court attempted in Cleveland v. Policy Management Systems Corp. to reconcile some of the different definitions in the Social Security Disability Insurance (SSDI) provision of the Social Security Act (SSA) with definitions contained in the Americans with Disabilities Act (ADA). Justice Breyer identified different purposes for the two statutes, indicating that the SSA provides monetary benefits, while the ADA seeks to eliminate unwarranted discrimination. He went on to hold that the plaintiff could be considered “totally disabled” for purposes of SSDI while also able to “perform the essential functions” of her job when reasonable accommodations were considered.

While this case allowed claimants to pursue both SSA benefits and ADA claims, it nevertheless failed to take on the

136. Id.
138. Id. at 807.
foundational issue of what it means to be disabled.

The field of critical disability studies frequently refers to the evolution from the “medical model” to the “social model” of disability. As Elizabeth Emens explains:

The traditional understanding of disability—the so-called medical model—views disability as a medical problem requiring a medical solution. By contrast, the social model says that someone is disabled by the interaction between her body (or mind) and the disabling environment that is built for one kind of body (or mind) rather than another.

Few disability scholars or activists embrace a pure social model. Most recognize that not all disability is culturally constructed, but that culture still creates much of the disability associated with what we consider impairments. This middle-ground position recognizes that there can be pain or difficulty associated with disability, and that sometimes disability does require more resources or more support than other states of being, but still emphasizes that much of what makes disability disabling is the way the world is currently constructed.

Despite the efforts by advocates and scholars to promote the social model, the medical model arguably prevails in the broader culture, as does the sense that a disability is a lack that requires costly filling. It seems plausible that this understanding of disability primes courts, commentators, and others to see the accommodations made for disability as beneficial to those for whom they are designed, and costly for others, particularly for those others who are not disabled.139

There are, on the one hand, definitions that continue to utilize biological impairments as the main definitional component of disability. In the other direction, there have been definitions of the term “disability” that view any limitations faced by people with disabilities solely through the lens of “contemporary social organization”—that is, a purely social model. In that view, the undesirable aspects of an impairment, such as chronic pain, are not denied, but neither are they a necessary part of the meaning of disability.140

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140. Wasserman et al., supra note 110.
components from both, in that “individual impairment and the social environment are jointly sufficient causes of limitation.”

There is some imprecision in the literature here, because some scholars investigate the “meaning of disability” along the lines of which traits might “count” as a disability, while others consider the word “disability” to refer only to the social, and not diagnostic or medical, elements.

B. Subjectivity in Disability and Pain

As a preliminary, and perhaps overtly philosophical matter, all experience is inherently subjective. In this Article, I am making a distinction between disabilities that gain recognition by virtue of their objective verification and those that cannot be so verified. This by no means, however, indicates that an objectively verifiable disability has no subjective component.

There is wide variation in the experience of disability, just as there is wide variation within any definition of disability. This is true in terms of the physical, sensory, cognitive, or affective functions that differ by virtue of being atypical in terms of body structure or function. This is also true in terms of the social experience, including facing stigma or discrimination on the basis of atypical body structure or functioning.

There are a number of dimensions or categories of disability, some of which have already been identified or explained in this Article, especially as they relate to chronic

141. *Id.*

142. See, e.g., René Descartes, *Meditations on First Philosophy* 9 (John Cottingham trans., Cambridge Univ. Press 1986) (1641). For additional discussion about the idea that experience is inherently subjective as it relates to pain, see works on philosophy of the mind by Thomas Nagel, Daniel Dennett, and others. See, e.g., Thomas Nagel, *The View From Nowhere* (Oxford Univ. Press 1986); Bryce Huebner, *The Philosophy of Daniel Dennett* (Oxford Univ. Press 2016).
pain. One “shadow” category that seems to overarch the decision-making process relates to whether a disability can be independently and objectively assessed.

Some disabilities simply cannot be denied. A CT scan can show a spinal cord injury.143 Diabetes can be diagnosed from a blood glucose measurement.144 Disabilities that can be confirmed by testing, by and large, are favored both in terms of their inclusion in classifications and in terms of being easily provable. I will revisit the evidence issue below. For now, the existence of disabilities that can be proven—definitively, with lab tests—means that there is a potentially favored class of objectively assessed disabilities.

On the other hand, there are impairments that require a self-report of subjective experience in order to be medically diagnosed. These impairments are less likely to be classified as disabilities in the first place, and if they are classified, are more likely to have evidence problems.145 This includes chronic pain that is not identifiable with testing and various psychiatric disabilities.146


145. See generally Andrew Malleson, Whiplash and Other Useful Illnesses 362 (2003) (“What science cannot encompass, it discredits. Neither medicine nor science has ever been comfortable with subjectivity, though for most of us, such interiority provides meaning and significance to our lives.”).

146. Though not the main point of this Article, there is quite a significant controversy on this point. The psychologist Gary Greenberg has written on the subject of the problem of psychiatric diagnostic procedure and classification. In a 2013 interview with The Atlantic, Dr. Greenberg was asked about the DSM-5 and the difference between a disease on the one hand, and a disorder, which is what the DSM purports to classify. He responded:

The difference between disease and disorder is an attempt on the part of psychiatry to evade the problem they’re presented with. Disease is a kind of suffering that’s caused by a bio-chemical pathology. Something that can
Various symptoms, including fatigue, dizziness, and nausea, cannot be objectively tested. Other relatively uncontroversial diagnoses, such as migraine headaches and epilepsy, lack diagnostic tests. Then there are disabilities like fibromyalgia. People with fibromyalgia pain syndrome have historically struggled for medical recognition, though today it has been recognized by the American Medical Association, the National Institute of Health, and the World Health Organization.

Courts and legal systems struggle with this. Indeed, the Administrative Conference of the United States (ACUS) has issued an entire report on the subject titled Evaluating Subjective Symptoms in Disability Claims. In that report, be discovered and targeted with magic bullets. But in many cases our suffering can’t be diagnosed that way. Psychiatry was in a crisis in the 1970s over questions like “what is a mental illness?” and “what mental illnesses exist?” One of the first things they did was try to finesse the problem that no mental illness met that definition of a disease. They had yet to identify what the pathogen was, what the disease process consisted of, and how to cure it. So they created a category called “disorder.” It’s a rhetorical device. It’s saying “it’s sort of like a disease,” but not calling it a disease because all the other doctors will jump down their throats asking, “where’s your blood test?” The reason there haven’t been any sensible findings tying genetics or any kind of molecular biology to DSM categories is not only that our instruments are crude, but also that the DSM categories aren’t real. It’s like using a map of the moon to find your way around Russia.


150. DANIEL J. WALLACE & JANICE BROCK WALLACE, ALL ABOUT FIBROMYALGIA, at ix (2002).

151. See generally ADMIN. CONF. OF THE UNITED STATES, EVALUATING
ACUS reminds evaluators that “subjective symptoms,” including pain, are not within the statutory definition of disability, and that any compensable impairment must be “demonstrable by medically acceptable clinical and laboratory diagnostic techniques.”\(^\text{152}\) I will revisit this below during the discussion of evidence in Part IV.

Importantly, as to the objective or subjective question, there is overlap but not exclusion from the visible and invisible disability categories. Disability scholars, activists, and advocates have identified that some disabilities are “visible” and some “invisible,” though this line is not always clear-cut and, indeed, visibility can be subjective and change over time.\(^\text{153}\) In broad categories, however, visible disabilities are those which are immediately perceived or identified by others, while invisible disabilities might require a proactive disclosure or longer-term interaction in order to be “seen.” A wheelchair user would have a visible disability, while someone with bipolar disorder might have an invisible disability. Visibility might be predicated on the observable physical structure of someone’s body or because of the use of an assistive device.\(^\text{154}\) Some assistive devices are readily “hideable” or not as visible, such as hearing aids, while some are harder to miss.

Jasmine Harris has also argued compellingly that visible disability markers profoundly affect interactions with and perceptions of people with disabilities.\(^\text{155}\) She has also noted that this can be manipulated, as she charged that Harvey Weinstein’s use of a walker during his trial “create[d]...
impressions and . . . reinforce[d] prejudices.”

There is complexity here in that people with invisible disabilities may be able to “pass” for non-disabled if they choose, but on the other hand they may face more doubt as to the existence of their disability than those with visible disabilities. By contrast, people with visible disabilities might face regular stigma or discrimination because they cannot “hide” their disability. While it is possible that they might also be more readily “believed” as to their disability, on the other hand they might be tasked more often with “proving” that it exists, especially by strangers in public.

The reason that these terms are not completely apt here is that there are invisible disabilities—including those that cannot be identified immediately upon viewing a person’s body—that can be assessed via measures such as lab tests. One such example is multiple sclerosis (MS), which is typically diagnosed via blood testing, spinal tap, MRI, and other tests. However, depending on the person, the progression, and the day, someone with MS may or may not be “visibly” disabled.

Finally, on not understanding subjective experience, it should be noted that people without disabilities seem routinely unable to accurately predict or understand the experience of disability. Furthermore, subjective

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157. See id.


160. See, e.g., Peter A. Ubel et al., Misimagining the Unimaginable: The Disability Paradox and Health Care Decision Making, 24 Health Psychol. S57, S57 (2005); Carol J. Gill, Health Professionals, Disability, and Assisted Suicide:
disabilities do not necessarily “make sense” under the typical model, where there is an objectively determined pathology such as tissue damage or dysfunction.161

C. Pain as Disability

According to data from the Centers for Disease Control, “35.8 percent of all reported disabilities are due to painful conditions (back, spine, arthritis, rheumatism).”162 The historic refusal to acknowledge pain as a disability can be tied to a number of factors.163 The medical community has traditionally referred to the “underlying” condition, or disability, and treated pain as a symptom. If, by contrast, there is no underlying condition, or the previous underlying condition has healed, then the standalone symptom of pain would not be recognized in its own right.


161. See Robert M. Bennett, Fibromyalgia and the Disability Dilemma, 39 ARTHRITIS & RHEUMATISM 1627, 1627 (1996). I would also like to acknowledge the large body of scholarship on mental health parity in insurance plans, which informs many discussions of disability definitions and theory. The Mental Health Parity Act (MHPA) of 1994 and the Mental Health Parity And Addiction Equity Act (MHPAEA) of 2008 were necessary to address the lack of requirement for health insurers to cover any mental health or addiction treatment in their plans. This history is a direct result of the disparate treatment of non-visible disabilities in comparison to their visible counterparts. See, e.g., Samuel Bagenstos, The Future of Disability Law, 114 YALE L.J. 1, 29 (2004); Mary Crossley, Discrimination Against the Unhealthy in Health Insurance, 54 U. KAN. L. REV. 73, 105–07 (2005).

162. NAGEL, supra note 14, at 138.

163. See id. at 142–43, on pain as a disability, noting that

[i]n the past, it was assumed that pain was ubiquitous and similar from person to person and merely an accompaniment of another disabling condition such as a broken leg or a spinal cord injury. . . . Experts have only recently come to appreciate the complexity of pain and to acknowledge that all pain is not alike. This new understanding has profound implications for the concept of pain as a disability in itself, an issue that is further complicated by the way we have chosen to explain, measure, and compensate disability.
More recently, however, there has been movement in the medical community on this issue. The National Academy of Medicine (formerly the Institute of Medicine), a private, nonprofit institution, provides advice on public health and medicine in the public policy arena.\textsuperscript{164} In 2011, a report from the then-named Institute of Medicine (IOM) provided findings and recommendations on pain that were influential to the current understanding of pain in \textit{Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research} (IOM Report).\textsuperscript{165}

The IOM Report produced a long list of findings and recommendations, a few of which are particularly notable, and therefore reproduced here:

- The public at large and people with pain would benefit from a better understanding of pain and its treatment in order to encourage timely care, improve medical management, and combat stigmatization.
- Increased scientific knowledge regarding the pathophysiology of pain has led to the conclusion that chronic pain can be a disease in itself that requires adequate treatment and a research commitment. . . .
- Significant barriers to pain care exist, especially for populations disproportionately affected by and undertreated for pain and need to be overcome.
- People with pain are too often stigmatized in the health care system and in society, which can lead to delayed diagnosis or misdiagnosis, bias in treatment, and decreased effectiveness of care.\textsuperscript{166}

Following the IOM Report, the Interagency Pain Research Coordinating Committee (IPRCC), a collaboration between the National Institute of Health and the former Institute of Medicine, was created and a report from that

\begin{footnotesize}
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\item 164. \textit{About Us: Who We Are}, NAT'L ACADS. OF SCI., ENG'G, & MED., https://www.nationalacademies.org/about (last visited Dec. 21, 2021). Note that because of the name change, the organization is still often referred to as IOM.
\item 165. IOM REPORT, \textit{supra} note 21.
\item 166. \textit{Id.} (internal citations omitted); IPRCC PAIN STRATEGY REPORT, \textit{supra} note 27, at 3–4 (citations omitted).
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body was released in 2016.  


The IPRCC *Pain Strategy Report* used sweeping and forceful language to declare that chronic pain is a disability. The National Pain Strategy Strategic Vision included the following language:

The Strategy envisions an environment in which: . . .

- All people with pain would be assured of receiving needed preventive, assessment, treatment, and self-management interventions, regardless of race, color, nationality, ethnicity, religion, income, gender, sex, age (neonatal through end of life), mental health and substance use disorders, physical or cognitive disability, sexual orientation and gender identification, geographic location, education, language proficiency, health literacy, or medical condition. All pain-related services would be provided without bias, discrimination, or stigmatization.

- Americans would recognize chronic pain as a complex disease and a threat to public health and productivity. Individuals who live with chronic pain would be viewed and treated with compassion and respect.

- A more robust and well trained behavioral health work force would be available to support the needs of patients who suffer from chronic pain, including those at risk who need mental health care and substance abuse prevention and recovery treatment.

If the IPRCC *Pain Strategy Report* is an indication of acceptance in the medical community, then chronic pain has made great strides. The key components discussed in Part I of subjectivity, bias, stigma, disparate treatment, and impact on mental health are being recognized in medicine. Law has, so far, not followed suit.

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167. IPRCC PAIN STRATEGY REPORT, supra note 27.


169. IPRCC PAIN STRATEGY REPORT, supra note 27, at 6–7 (citations omitted).
D. Social Security’s Failure to Recognize Pain as a Disability

The Social Security Administration historically, and explicitly, excludes chronic pain, absent a connection to an underlying, medically determinable impairment, from the definition of disability. At best, it is an exacerbating factor of another disability; at worst, it is ignored entirely.

Each entitlement and benefit system in the United States utilizes its own criteria to determine eligibility for services, although many of them are interconnected, refer to each other, and may use the same or similar references.

Some entitlement systems use the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment to determine whether someone is qualified to receive services. Many state workers’ compensation systems and boards, federal systems, personal injury, and tort cases use these Guides to “rate” the level of impairment. This allows comparison between people and across disabilities—even if that comparison is ultimately arbitrary, invalid, or inaccurate.

In state workers’ compensation schemes, for example, a physician will provide a “rating” calculation for a permanent, partial disability, based on a reference like the AMA Guides. However, treatment outcomes for chronic pain resist classification in such a system, ultimately failing chronic pain patients seeking compensation.

These programs typically “do not compensate for pain independently; rather, they largely compensate lost-earning
capacity to some degree. Yet these programs process an enormous number of claims in which the worker alleges that the compensable loss-wage-earning capacity results in whole or part from the pain he or she experiences." 175 Deciding which types and levels of pain will "count," and determining how to measure and compensate for that pain, remains a significant issue. 176

In contrast to the above scheme, the SSA defines "disability" as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment." 177 This definition applies to both the Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). 178 The Act goes on to specify that the physical or mental impairment must "result[] from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques." 179

Moreover, the SSA states that "[a]n individual's statement as to pain ... shall not alone be conclusive evidence of disability as defined in this section." 180 Rather, "there must be medical signs and findings, established by medically acceptable clinical or laboratory diagnostic techniques, which show the existence of a medical impairment that results from anatomical, physiological, or psychological abnormalities which could reasonably be expected to produce the pain." 181

176. See id. at 241–42.
178. See, e.g., Kohler v. Astrue, 546 F.3d 260, 265 n.3 (2d Cir. 2008) ("The definition of 'disability' is the same for SSDI and SSI benefits." (citing Perez v. Chater, 77 F.3d 41, 46 (2d Cir. 1996))).
181. Id.
To meet the definition of disability, an applicant must not be able to engage in any substantial gainful activity (SGA) because of a medically determinable physical or mental impairment that is “expected to result in death” or “has lasted or can be expected to last for a continuous period of at least 12 months.” 182

In the Social Security Medical Listings Book (the Blue Book), chronic pain may qualify if there is physical or mental impairment. 183 It is not considered a stand-alone condition, disease, or disability. 184 The SSA relies on disability definitions that are “medically determinable,” meaning in this context, objectively verifiable with symptoms and lab or other testing. 185 So-called “symptoms”—like pain—are not sufficient, no matter their severity. 186 As has been explained above, this is contrary to the current move in the medical understanding of pain.

The SSA specifically identifies in the Code of Federal Regulations that there must be a “medically determinable impairment” causing claimed pain. 187


183. See, e.g., SOC. SEC. ADMIN., DISABILITY EVALUATION UNDER SOCIAL SECURITY pt. A, § 1.00 [hereinafter THE SSA BLUE BOOK], https://www.ssa.gov/disability/professionals/bluebook/ (last visited Dec. 21, 2021) (under adult listings for musculoskeletal disorder, discussing how to consider pain: “D. How do we consider symptoms, including pain, under these listings? 1. Musculoskeletal disorders may cause pain or other symptoms; however, your statements about your pain or other symptoms will not alone establish that you are disabled. We will not substitute an alleged or a reported increase in the intensity of a symptom, such as pain, no matter how severe, for a medical sign or diagnostic finding present in the listing criteria. Pain is included as just one consideration in 1.15A, 1.16A, and 1.18A, but it is not required to satisfy the criteria in 1.15, 1.16, and 1.18.”).

184. See id.

185. See id.

186. See id.

187. 20 C.F.R. § 404.1529(b) (2021).
From the SSA:

(b) Need for medically determinable impairment that could reasonably be expected to produce your symptoms, such as pain. Your symptoms, such as pain, fatigue, shortness of breath, weakness, or nervousness, will not be found to affect your ability to do basic work activities unless medical signs or laboratory findings show that a medically determinable impairment(s) is present. Medical signs and laboratory findings, established by medically acceptable clinical or laboratory diagnostic techniques, must show the existence of a medical impairment(s) which results from anatomical, physiological, or psychological abnormalities and which could reasonably be expected to produce the pain or other symptoms alleged.\(^{188}\)

All other provisions within the SSA flow from the presumption that there must be a medically determinable impairment, including the potential catch-all category of “residual functional capacity,” which might plausibly include chronic pain.\(^{189}\)

Finally, even if the pain can be shown to link to an underlying impairment, claimants must still show that the underlying impairment “could reasonably be expected to produce” the pain.\(^{190}\) The reasonableness link itself must be established by clinical or lab data and be part of a well-documented medical history.\(^{191}\)

The varied definitions of disabilities used across benefits programs and statutory schemes amount to a significant hurdle to recognizing pain as a disability and ensuring that people who are suffering pain receive the recognition and benefits they deserve. In order to overcome these hurdles, courts and legislators will have to change their view of subjective evidence of disability.

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188. Id.
191. See Pryor, supra note 175, at 263.
Although the veterans disability benefits system historically treated pain the same way the SSA did, essentially ignoring it, a recent Federal Circuit case determined that, by contrast, “pain is enough” for veterans disability benefits.

A. The Veterans Benefits Service-Connected Disability Compensation Program

The Veterans Benefits Service-Connected Disability Compensation Program provides benefits to veterans who have a service-connected disability. The closest analogue to the current veterans benefits system began when Congress first adopted “a schedule for rating veteran service-connected disability on a percentage basis with a methodology similar to the current system.”192 This was the War Risk Insurance Act of 1914, and the important feature of this Act was a disability rating schedule. The schedule was specifically designed to rate the reduction in earning capacity—how much less a person might earn due to disability experienced as a result of military service. The other important feature is that it is based on average reduction in earning, rather than an actual reduction specific to the individual.193 This could help or hurt an individual. For example, someone who earns above the “average” for their disability would still earn the same benefit as someone who earns below the average. Major revisions to that schedule made in 1945 form the basis of the modern schedule.194

The focus on reduction in earning capacity makes this definition of disability distinct from some other legal

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193. Id. at 310–11.
194. See id.
definitions, as examined below. When the system was created and the definitions put in place, there was no modern understanding of disability at all. This would prove to be a problem for individual claimants.

B. The Law of Service-Connected Disability Compensation

Within the Department of Veterans Affairs, the Veterans Benefits Administration (VBA) administers the service-connected disability benefits program, which is the subject of this Part. Service-connected disability compensation is awarded to a claimant who proves

that he or she has completed satisfactory military service, that he or she incurred an injury or disease while in the service, and that he or she currently experiences symptoms of the injury or disease. In addition, the courts also mandate that the claimant establish by expert medical evidence that the service-connected injury or disease is related to the current symptoms suffered by the veteran.195

There are five elements of a claim, which include two salient elements: the existence of a current disability (at the time of the claim), as defined by the statute and regulations, and a “connection” between the veteran’s service and the disability.196

The statutory backdrop of this area of law is found in Title 38 of the U.S. Code, Veterans Benefits, specifically in section 1110, the purpose of which is to provide compensation to veterans for the impairment to their earning capacity resulting from disability. This statute explains that wartime veterans are entitled to disability compensation.197

195. 121 AM. JUR. Trials 357 § 7 (2021) (internal citation omitted). Put another way, a veteran seeking compensation under this provision must establish three elements: “(1) the existence of a present disability; (2) in-service incurrence or aggravation of a disease or injury; and (3) a causal relationship between the present disability and the disease or injury incurred or aggravated during service.” Shedden v. Principi, 381 F.3d 1163, 1167 (Fed. Cir. 2004).


The statute does not define disability. It does, however, provide a schedule for rating disabilities, which is the Veterans Affairs (VA) Schedule for Rating Disabilities (VASRD). There are myriad criticisms with the VASRD. Of notable relevance to this discussion, one criticism is that the rating schedule’s medical criteria often are obsolete or have inadequately integrated current and accepted diagnostic procedures. The current VASRD, therefore, fails to reflect the realities of the modern U.S. economy, which demands a predominantly knowledge- and service-based labor market. It also has failed to keep up with the myriad advances in medicine over the ensuing seven-plus decades since the conclusion of the Second World War.

The rating schedules for physical disability are extremely specific. For example, under the broad category “musculoskeletal system” there are 296 disabilities listed and over 40 rating schedules. This means that, for example, rheumatoid arthritis has a different rating schedule than impairment of the scapula. Each schedule is specific to a physical disability; there are multiple schedules for amputation of a finger, for example, specific to the particular finger at issue and where on that finger the amputation was done.

198. The Rand Corporation, among others, lists criticisms of the VASRD in the following categories: it is out of date; it can shortchange individuals; it blends quality of life with earning reduction; and it crowds out retirement compensation. Richard Buddin & Bing Han, Is Military Disability Compensation Adequate to Offset Civilian Earnings Losses from Service-Connected Disabilities?, 2 RAND HEALTH Q., no. 3, Fall 2012, https://www.rand.org/pubs/periodicals/health-quarterly/issues/v2/n3/09.html.

199. Oliva, supra note 192, at 315 (citations omitted).

200. 38 C.F.R. § 4.40–105 (2020). The broad categories listed are: the Musculoskeletal System; the Organs of Special Sense; Impairment of Auditory Acuity; Infectious Diseases, Immune Disorders and Nutritional Deficiencies; the Respiratory System; the Cardiovascular System; the Digestive System; the Genitourinary System; Gynecological Conditions and Disorders of the Breast; the Hematologic and Lymphatic Systems; the Skin; the Endocrine System; Neurological Conditions and Convulsive Disorders; Mental Disorders; and Dental and Oral Conditions.

201. See, e.g., 38 C.F.R. § 4.71a.
C. The Law of Pain in Veterans Courts

The Federal Circuit has twice before come close to truly wrestling with a case like that of Melba Saunders, once in 2001, and again in 2014.202 However, long before that, the Veterans Court had dispensed with pain-related claims with regularity.

The law of pain in the Veterans Court mirrors the history of pain in medicine and in other benefit systems—for the most part, it was discounted and ignored. The cases fall largely into two broad categories: cases where pain “alone” was alleged, and therefore, compensation was denied; and cases where the court found additional grounds for compensation.

One unique aspect of veterans and administrative law must be noted here. First, until a veteran’s case reaches a federal appellate court, the administrative process is non-adversarial with the agency.203 Then, upon a veteran appealing a decision (a denial of benefits, for example), the veteran has two opportunities for federal appellate review.204 First, at the Court of Appeals for Veterans Claims (CAVC) and, second, at the Federal Circuit.205 Finally, the Federal Circuit will only review issues of law on appeal.206 It will frequently resist interpretations of fact, and the review is not de novo, which differentiates it from other benefits and administrative appeals.


205. Id.

206. See 38 U.S.C. § 7292(d)(1), (2); see, e.g., Robinson v. O’Rourke, 891 F.3d 976, 979 (Fed. Cir. 2018).
1. When Pain Was Not Enough

The first group of cases involve claimants with varying degrees of disability who could not show an underlying pathology sufficient enough to satisfy the court.

Tyra K. Mitchell, a veteran of the U.S. Navy and the U.S. Air Force Reserves, is a typical example. During training one day, Ms. Mitchell experienced a torn ACL and a torn anterior aspect of the lateral meniscus in her left knee. She collapsed in pain and subsequently underwent surgery to repair the tears.

Even after surgery, Ms. Mitchell continued to experience a great deal of pain in her knee. She reported intense pain when standing, when walking, and during certain movements. This pain was a hindrance to her job as a security guard and was also limiting her movement in her daily life. Her range of motion was impaired, with limited flexion in her knee.

Ms. Mitchell at first received a full denial at the VA Regional Office level, and then eventually received a 10 percent disability rating based solely on the range of motion impairment. She appealed for a Board review and received the same result. The other functional impacts—her intense pain, her weakened movements, excess fatigability, diminished endurance, and incoordination—did not warrant any increase in her rating.

Ms. Mitchell argued that moving her knee was possible—but painful. Citing a line of cases concerning arthritis, she argued that moving her knee was so painful that her movement was effectively limited. The Secretary,

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209. See id.
210. See id. at 33–34. The two cases cited contained statements regarding the relationship between painful movement and limited movement. See id. at 34 (first citing Lichtenfels v. Derwinski, 1 Vet. App. 484 (1991); and then citing Hicks v.
by contrast, argued that painful motion is not a functional loss—if you can move, you can move, no matter how painful it is; and, therefore, you cannot be compensated.

The CAVC held that “pain itself does not rise to the level of functional loss.”211 In so holding, the Court essentially denied that chronic pain was a disability—its manifestation and effects did not matter to the question of compensation.

How did it happen that Ms. Mitchell experienced that degree of pain during her regular movement, and yet faced a Board that refused to compensate her? The answer comes in part from the much-cited Federal Circuit case Sanchez-Benitez v. Principi (Sanchez-Benitez II).212 Courts also refer to the lower level, Veterans Court Sanchez-Benitez decision (Sanchez-Benitez I).213

Jose A. Sanchez-Benitez, a 15-year Army veteran, sought compensation related to neck and lower back pain.214 During his service, he started complaining of back pain while lifting heavy equipment.215 He testified that after his discharge, he experienced “constant” pain in his back, which radiated down his back and caused sleeplessness, as well as preventing him from engaging in recreation.216 His neck pain caused “popping” and also radiated down his back.217 He received diagnoses of “lumbar muscle spasm” and “history of trauma to the cervical area with residual pain.”218 Nevertheless, the VA examiner was unable to find “a definite

Brown, 8 Vet. App. 417 (1995)).
211. Id. at 38.
212. Sanchez-Benitez v. Principi (Sanchez-Benitez II), 259 F.3d 1356 (Fed Cir. 2001).
214. Id. at 283.
215. Id.
216. Id.
217. Id.
218. Id.
or specific cause” for the pain.\footnote{Id. at 282–84.}

The Veterans Court in \textit{Sanchez-Benitez I} was clear. The court declared an oft cited holding that “pain alone, without a diagnosed or identifiable underlying malady or condition, does not in and of itself constitute a disability for which service connection may be granted.”\footnote{Id. at 285.}

The Court further clarified that pain could only be considered as it related to other claims. Pain was, in essence, a symptom that could change the \textit{rating} of a disability but was not a disability \textit{itself}. For example, pain could be considered alongside functional loss of musculoskeletal system, a joint disability causing pain on movement, or pain associated with a muscle disability.\footnote{See id.} But “pain alone” was not enough.

In \textit{Sanchez-Benitez II}, the Federal Circuit further confirmed that pain is relevant in determinations of disability. However, the Court declined to decide the ultimate issue of “pain alone,” calling the question of whether pain alone is a compensable disability an “interesting” and “perplexing” question.\footnote{See \textit{Sanchez-Benitez II}, 259 F.3d at 1361.}

The Court determined that a nexus must still exist, even if “pain alone was sufficient,” between the current disability and an in-service disease or injury. Because Mr. Sanchez-Benitez could not show an in-service injury sufficiently tied to his claimed current disability, the Court did not have to determine if his pain was “enough.”\footnote{Id. at 1361–62.}

A divided Federal Circuit panel thus affirmed the denial of service connection based on the factual finding of a lack of nexus, without addressing the “interesting, indeed perplexing, question” of whether pain alone is a compensable
disability. That failure to address the question led to the subsequent denial of pain-related claims in nearly every case. Before *Saunders*, discussed in Section III.D, the rule that pain alone is not a compensable disability was enforced nearly one hundred times since its original pronouncement in *Sanchez-Benitez II.*

Then in 2014, in *Joyner v. McDonald*, the Federal Circuit declined to address the interpretation of § 1110 discussed above, finding instead that the veteran had not properly raised the issue before the Veterans Court, and resolving the case instead on a related but distinct question of the interpretation of § 1117.

Tarell Joyner, a Marine who served one tour of duty in the Persian Gulf, was twice treated in service for neck pain. The question before the court was whether his neck pain could evidence a chronic disability when it was a symptom of an “undiagnosed illness.” Ultimately, the court confirmed that pain *could* evidence a disability; however, the court was still determined to rely on the idea of an underlying diagnosis. Even if undiagnosed, the statutory requirements for “undiagnosed illness” still presume that there is, in fact, an underlying illness that *could* be diagnosed, but that simply has not been.

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224. *Id.*

225. *Saunders v. McDonald*, No. 15–0975, 2016 WL 3002862, at *4 (Vet. App. May 25, 2016) (“The Court has handled *Sanchez-Benitez* more than 100 times since its issuance. The Court either itself relied upon or affirmed the Board’s application of *Sanchez-Benitez* at least 83 times. It cited without comment or noted without question the Board’s application of the case on at least 15 other occasions. It noted the Board’s application of the case and either disagreed with how the Board applied it or decided the appeal on other grounds on at least 12 occasions.” (citations omitted)), rev’d sub nom. *Saunders v. Wilkie*, 886 F.3d 1356 (Fed. Cir. 2018).


227. *See id.* at 1394–95.

228. *See id.* at 1395.
2. Pain as a Symptom of a Different Disability

Of course, the Veterans Court did find ways to compensate some pain, but only where there was an additional “something” to hang their hat on.

In *Allen v. Brown*, for example, Alfred E. Allen sought compensation for knee and hip pain. The court held that, “as used in § 1110,” disability “refers to impairment of earning capacity, and that such definition mandates that any additional impairment of earning capacity resulting from an already service-connected condition, regardless of whether or not the additional impairment is itself a separate disease or injury caused by the service-connected condition, shall be compensated.”

This case stands for the proposition that service connection may be granted as long as the disability can be traced to service, even if the specific onset of the disability cannot be pinpointed.

D. Melba Saunders and Pain as Impairment

Melba Saunders served on active duty in the Army for almost seven years. During her service, she sought treatment for knee pain and was diagnosed with patellofemoral pain syndrome (PFPS). Upon exiting the Army, her exam noted a history of swollen knee and hip joints and bone spurs on her feet.

As part of her subsequent disability benefit claim, Ms. Saunders underwent a medical examination at the VA. While her functional limitations were noted during the exam, she was not observed to have any “anatomic abnormality, weakness, or reduced range of motion.”

After initially diagnosing Ms. Saunders with “bilateral

231. *Id.*
knee pain,” the VA examiner in a subsequent report acknowledged that there was “no pathology” to render a diagnosis, other than her pain.\textsuperscript{232} Essentially, according to her medical exam, she did indeed have pain—but that was all she had. The lower court determined that “pain alone” was not a disability and therefore denied her claim.

After the initial denial, Ms. Saunders appealed to the VA Board, the last stage of administrative exhaustion before the Federal Circuit review process. In presenting her case to the Board, Ms. Saunders argued that she had a diagnosis in service, and now she had pain; she had a VA examiner willing to link the two, establishing service connection.

What she did not have, according to the Board, was a present disability.\textsuperscript{233} Relying on \textit{Sanchez-Benitez I}, the Board, and later the Veterans Court, found that pain alone was not a disability.\textsuperscript{234} Without a \textit{current} underlying pathology, the Board and Veterans Court would not find service connection.

When the Federal Circuit Court of Appeals took the \textit{Saunders} appeal, it finally addressed head-on what it had punted in \textit{Sanchez-Benitez II}: whether pain alone could be the basis of a current disability. The court held that it could, and in the case of Ms. Saunders, that it was the basis of a current disability. The Federal Circuit reversed and remanded, finding that the lower court “erred as a matter of law in finding that Saunders’ pain alone, absent a specific diagnosis or otherwise identified disease or injury, cannot constitute a disability under 38 U.S.C. § 1110 (2016).”\textsuperscript{235} The innovation in \textit{Saunders} was to treat pain as a “functional impairment” and therefore a disability in and of itself.\textsuperscript{236}

\begin{flushleft}
\textsuperscript{232} \textit{Id.}\\
\textsuperscript{233} \textit{See id.} at 1358–59.\\
\textsuperscript{234} \textit{See id.} at 1359.\\
\textsuperscript{235} \textit{Id.}\\
\textsuperscript{236} \textit{See id.} at 1368.
\end{flushleft}
This is exactly the argument that Tyra K. Mitchell made, and lost, just a few years before.237

Crucial to the court’s ability here to find for Saunders was that the lower court did not make findings that took the case outside of its jurisdiction for appeal. The lower court did not find that the pain was unrelated to an injury or disease, for example.238 In fact, the lower court acknowledged that there was a diagnosis while she was in service. It was the component of “present disability” that was the problem.

1. Disability as a Functional Impairment

The central issue of Saunders is whether pain alone constitutes a § 1110 disability. The Saunders court defined disability as a functional impairment, rather than the underlying cause of the impairment.239 This is a critical distinction because the court could have defined disability as synonymous with injury or disease. For example, the court notes that Congress has done just that in another section of the statute:

When Congress has decided to depart from this distinction by defining “disability” as equivalent to an injury or disease, it has done so explicitly, according to Saunders. For example, in chapter 17 of Title 38, referring to VA medical and nursing facilities, Congress stated that “[t]he term ‘disability’ means a disease, injury, or other physical or mental defect.”240

But the Saunders court asserted that Congress has made no such explicit statement as to the meaning of “disability” in § 1110. Furthermore, “the statutory purpose to compensate veterans based upon degree of impairment of earning capacity” led to a different meaning of the term in § 1110—namely, that it “refers to impairment of earning

238. Saunders, 886 F.3d at 1360.
239. Id. at 1362.
240. Id. at 1363 (quoting 38 U.S.C. § 1701(1)).
Applying that definition, the court held that “any additional impairment of earning capacity resulting from an already service-connected condition, regardless of whether or not the additional impairment is itself a separate disease or injury caused by the service-connected condition, shall be compensated.”

Finally, the court found “that ‘disability’ in § 1110 refers to the functional impairment of earning capacity, not the underlying cause of said disability.”

2. The Meaning of Functional Impairment

The meaning of “functional impairment of earning capacity,” according to the Federal Circuit, is connected to the ability of the body to function. The court held that pain alone can functionally impair earning capacity because it “diminishes the body’s ability to function, and that pain need not be diagnosed as connected to a current underlying condition to function as an impairment.”

The Saunders court further elaborated that:

Dictionary definitions for the term “impairment” support the Court’s conclusion that pain can serve as a functional impairment. Dorland’s Medical Dictionary defines “impairment” as “any abnormality of, partial or complete loss of, or loss of the function of, a body part, organ, or system,” and this dictionary uses pain as a specific example of an impairment. Webster’s defines “impair” as “diminish in quantity, value, excellence, or strength.” Merriam–Webster’s defines “impaired” as disabled or functionally defective. “None of these definitions preclude finding that pain may functionally impair a veteran.”

241. Id.
243. Id.
244. Id. at 1364.
245. Id. (first quoting Impairment, Dorland’s Illustrated Medical Dictionary (32d ed. 2012); then Impair, Webster’s Third New International Dictionary (1961); and then Impaired, Merriam-Webster’s Collegiate
The court also discussed situations where pain alone may not be enough—in the Social Security Act, for example, there is a different definition. The court noted that the regulations on disability ratings themselves treat “pain” as a form of “functional impairment.” For example, 38 C.F.R. § 4.10 reads that “[t]he basis of disability evaluations is the ability of the body as a whole, or of the psyche, or of a system or organ of the body to function under the ordinary conditions of daily life including employment.” The “functional loss” regulation, 38 C.F.R. § 4.40, “makes clear that functional loss may be due to pain and that pain may render a part seriously disabled.” Functional loss is compensable even if the range of motion is not limited.

Finally, the court noted that subjective pain alone is not sufficient to establish disability. A veteran’s pain must amount to a functional impairment. The Veteran would have to show that their pain “reaches the level of a functional impairment of earning capacity. The policy underlying veterans compensation—to compensate veterans whose ability to earn a living is impaired as a result of their military service—supports the holding we reach today.”

Therefore, while the Saunders decision indeed stretched the bounds of disability in a meaningful way, it did not go far enough. As discussed above, chronic pain is a disability, even

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246. Id. at 1365; see supra Section II.D (discussing some of the differences for SSI purposes).

247. Thompson v. McDonald, 815 F.3d 781, 785–86 (Fed. Cir. 2016); Saunders, 886 F.3d at 1364.

248. Schafrath v. Derwinski, 1 Vet. App. 589, 591–92 (1991) (noting that 38 C.F.R. § 4.40 contemplates multiple types of functional loss, and that functional loss is compensable regardless of whether it is caused by pain or by limited flexion); Petitti v. McDonald, 27 Vet. App. 415, 422, 424–30 (2015) (rejecting Secretary’s argument that 38 C.F.R. § 4.59, which governs the evaluation of painful motion, requires evidence observed during range-of-motion testing, and rejecting the Secretary’s argument that “the mere presence of joint pain is not sufficient”); Saunders, 886 F.3d at 1367.

249. Saunders, 886 F.3d at 1367–68.
when fully subjective, and should not be disfavored by the courts for that reason alone. It is not the fault of the individual with chronic pain that their particular disability is one which is less objectively verifiable, though this does create a problem for courts to grapple with.

E. Pain Post-Saunders

In the wake of this decision, there have been as of this writing250 214 cases in the Veterans Court citing Saunders, 180 of which mention “pain” in some capacity.

The Veterans Court seems to be frequently remanding cases to comply with the decision. For example, in Delmastro v. Wilkie, the Veterans Court chastised the Board for its failure to explain a denial of benefits for Army Veteran Dominick Delmastro, who sought compensation for ankle and foot pain. The court stated that, based on the denial and lack of explanation, it was “concerned that the Board did not fully understand the Federal Circuit’s decision.”251

By contrast, the Veterans Court has asserted that, even when there is pain that might establish a disability, functional impairment of earning capacity is still a required element.252

F. Is Veterans Law Too Special?

In order to flesh out a fully formed idea of pain as disability, perhaps Veterans Law is not the perfect starting place. It is, after all, a special system.

There are multiple aspects of Veterans Benefits that make it different from other compensation and disability programs in the United States. To highlight just a few, the

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250. As of November 2021.
VA has a duty to assist Veterans with their claims up to the appeals process, in a non-adversarial system, highly distinct from other benefits and entitlement systems. Furthermore, the Veterans Benefits system is available to any and all who qualify, regardless of income or need, which distinguishes it from need-based systems. And unlike Workers’ Compensation schemes, an injury leading to disability qualifies for benefits even if the Veteran was on leave.

Despite these unique aspects of Veterans Law, the reasoning in *Saunders* can be a guide for practitioners, advocates, and others to advance the notion that pain is a disability. The nuances of Veterans Law were not the basis of the legal reasoning in *Saunders*. The qualification or not of a condition, symptom, or other characteristic need not be tied to the peculiarities of the benefits system. If chronic pain meets the definition for disability by all commonly accepted standards, then it should be considered a disability for all disability-related programs and services.

IV. IS SUBJECTIVE EXPERIENCE ENOUGH?

A. The Legal Problem of Subjectivity

As described above, there are disabilities whose presentation is largely, or entirely, subjective. This can mean not only that diagnosis (where necessary) relies primarily on self-reports, rather than lab and testing, but also that the courts rely on testimony and credibility determinations, rather than direct medical evidence, to assess the nature and severity of those disabilities.

This means, in practice, that some disabilities are favored over others. It is widely believed that disability benefit programs are much easier to access for people with physical disabilities rather than on mental health grounds.\(^{253}\) This is the case even though psychiatry has

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\(^{253}\) See, e.g., *Social Security Disability Insurance And Supplemental Security*
similar levels of objectivity, as measured by observation
dependence and reliability as compared to other medical
disciplines.\textsuperscript{254} Or to take another example, the law of
negligence “imposes a bifurcated rule for adult tortfeasors,
according to which physical disabilities of adults are
considered in determining liability, but mental disabilities
are ignored.”\textsuperscript{255} In cases where objective medical evidence is
not possible, because no lab test exists for that particular
disability, claimants are frequently out of luck.

As to why subjective disabilities might be disfavored
generally and in the law, one answer seems to be a fear of
fakers.\textsuperscript{256} The pervasive sense that people might be faking a
disability in order to get compensation has a long history.\textsuperscript{257}

The literature attempting to address this problem has,
so far, focused mainly on how to make subjectivity more
objective. To that end, scholars have suggested moving the
courts toward acceptance of new medical technologies for
brain imaging, pain detection, and other neuroscientific
advances.\textsuperscript{258}

\textit{Income: NAMI Public Policy Position, Nat’l All. on Mental Illness,
https://www.nami.org/NAMI/media/NAMI-Media/Public\%20Policy/SSI-
SSDI_final.pdf (last visited Dec. 23, 2021).}

\textsuperscript{254} Ronald Pies, \textit{How “Objective” are Psychiatric Diagnoses? (Guess Again)},
Psychiatry (Edgmont), Oct. 2007, at 18, 22; cf. supra text accompanying note 142.


\textsuperscript{256} Dorfman, supra note 153, at 1055. Dorfman also notes that “[s]ocial psychologists claim that uncertainty and lack of evidence regarding a person’s eligibility or belonging to a certain group cause distrust. Therefore, it is fair to assume that the less visible the disability, the more likely it is suspected as fake. It is unsurprising that, of the narratives about situations in which respondents felt suspected of faking disability, 42 percent (43 out of 102) mentioned having ‘nonapparent’ disabilities or ‘not looking sick/disabled.’ Nevertheless, people with visible disabilities are also subject to the social expectation of proving their disability to others.” Id. at 1067–68 (citations omitted).


\textsuperscript{258} See, e.g., Pustilnik, supra note 43, at 1121–56; Henry T. Greely,
This response does not fully address the problem, which is that there are disabilities that can never be measured by a blood test or MRI. As long as the focus is on prioritizing medical evidence over subjective experience, those disabilities will always be disfavored.

B. Subjectivity in Action: PTSD in Veterans’ Cases

An example of a continuing problem that may not be solved by a Saunders analysis is that posttraumatic stress disorder (PTSD) in particular, and “mental disorders” in general, are under-diagnosed, misdiagnosed, and downplayed in the veterans disability benefit context, due to a variety of factors.

This means that disability claims on the basis of mental disorders are regularly denied. Veterans who do not receive an initial appropriate diagnosis from a Veterans Administration doctor may never pursue an appeal or benefit claim at all. Next, if they do pursue a claim, they are not likely to receive appropriate compensation if their condition is minimized or misdiagnosed due to these same factors. Finally, on appeal, the court will look at their diagnoses and compare it to the rating schedule. This may result in the court not being able to appropriately remedy the issue because the schedule does not map to the diagnoses, or because the particular symptoms of the individual do not correspond.

A veteran must exhibit current symptomatology, or have “a current medical diagnosis,” of PTSD, for example. However, this is problematic for a few reasons. First, diagnosis must come from a military psychiatrist. “A

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psychological diagnosis is supposed to be based on C & P exam results and on a clinician’s observances during a psychiatric interview. However, the psychiatric interviews are optional, and the veteran generally is not allowed to present the medical opinion of his or her own private psychiatrist.  

Next, misdiagnosis is common.

Even if symptoms of PTSD are detected, they may be misattributed as symptoms of other disorders. . . . In addition, the guidelines for physicians conducting PTSD examinations are completely void of references to physical symptoms of PTSD, even though research indicates that individuals who suffer from PTSD frequently exhibit symptoms such as limb pain, back pain, headaches, and indigestion.

Diagnoses of any mental disorder or disability must conform to the DSM-5 criteria, per the Code of Federal Regulations. For PTSD, for example, there must be a finding by medical exam and report, and the exam must be “based upon consideration of the veteran’s prior medical history as well as previous and current examinations.” However, there is a potential bias or conflict of interest for military psychiatrists who seek to minimize costs to maximize capacity for troops. Veterans may have a fear of disclosing actions taken while in service or after. This could well include triggering trauma events or behavior resulting from the condition. This will be on top of the fear that many psychiatric patients have of disclosing mental health issues even without these compounding factors. “[S]ervice members must sign a vague waiver that explains that conversations


261. Id. at 981.


264. Langan, supra note 128, at 5.
with their therapist might not be kept confidential if they admit to violating military laws... This fear of prosecution may prevent service members from opening up in discussions with their doctors.”265 Furthermore, there is a great deal of pressure to under-diagnose serious mental health conditions.266

As described above, proving a service connection is sometimes difficult. This problem is exacerbated for PTSD and other mental health diagnoses. First, there must be an in-service stressor, and different standards exist for veterans in a combat versus a non-combat role.267 Non-combat veterans have a higher evidentiary burden placed on them to provide evidence of an in-service stressor.268

This higher burden is even more difficult when there are incomplete, lost, or destroyed records. There must be adequate records of the stressor event, and if not, the veteran’s testimony alone is not sufficient. There was a 2010 amendment that expanded the definition of “stressor,” but the proof problem remains.269

1. How “Functional Impairment” Could Be Used in “Mental Disorder” Cases

The functional impairment of earning capacity is what the Saunders court says makes a disability. It is what makes “pain alone” enough to qualify as a disability, even without a current diagnosable condition. To reiterate, the Federal Circuit concluded that “pain is an impairment because it diminishes the body's ability to function, and that pain need not be diagnosed as connected to a current underlying

265. Id. at 6–7.
266. Id. at 7.
268. Id.
condition to function as an impairment.”

Keep in mind the extreme specificity of the Regulations relating to the Ratings Schedule: even with the ability to enumerate hundreds of identifiable disabilities, there are still cases, such as in Saunders, where the Regulations fail to adequately capture the experience of someone who is clearly in need of disability benefits assistance. Contrast this with the “Mental Disorders” category, which lists only a few disabilities and forces the Raters to compare a veteran’s experience with an extremely limited set of symptoms that are not specific to that disorder or that individual.

Taking the next step, then, if a symptom diminishes the mind’s ability to function, that symptom need not be diagnosed as connected to the current underlying condition in order to count as an impairment, according to Saunders. This could be helpful to veterans with certain disabilities, where symptoms may not perfectly map on to the criteria in the regulations.

Furthermore, it seems to be the case that there are large numbers of veterans who have a private diagnosis but who are not able to either reproduce that diagnosis for the VA, or who do not experience the exact symptoms listed in the Ratings Schedule. A proxy of “mental pain” or distress could be used at the diagnosis and initial claim stage, which is where many of these cases are knocked out. Because PTSD can be difficult to diagnose and in fact veterans with PTSD may be avoiding treatment for a variety of reasons, “mental pain” that results in an impaired function could help to capture that group. In addition, since the regulatory

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271. This is somewhat anecdotal, in that there seem to be many claims at the R.O. level that are denied and not appealed. There may be many more that never even make it to the claim stage.

scheme is woefully lacking, there are potentially other mental disorders that could be captured by using “pain” as an imputed catchall provision.

2. Argument for Parity from the Saunders Court

The Saunders court said that “pain need not be diagnosed as connected to a current underlying condition to function as an impairment.”273 It went on to assert:

The VA’s disability rating regulations also treat pain as a form of functional impairment. For example, 38 C.F.R. § 4.10 reads that “[t]he basis of disability evaluations is the ability of the body as a whole, or of the psyche, or of a system or organ of the body to function under the ordinary conditions of daily life including employment.” We have explained that the “functional loss” regulation, 38 C.F.R. § 4.40, “makes clear that functional loss may be due to pain and that pain may render a part seriously disabled.”274

Furthermore, the Saunders court explicitly points to PTSD as one disorder that we do not fully understand and that medical science might be slow to catch up on, saying that in “some situations, such as for post-traumatic stress disorder, herbicide exposure in Vietnam, and unexplained illnesses affecting Middle East veterans, medical science simply has been unable, as of yet, to diagnose the disabling impact of service for veterans affected by these conditions.”275

If science has not yet been able to “diagnose the disabling impact,” then it seems that over-reliance and strict adherence even to the DSM would not always be appropriate, and certainly not to the regulations which treat every single mental disorder on the same ratings scale.

The Regulatory scheme for “mental disorders” largely utilizes symptoms and terminology that may be appropriate

273. Saunders, 886 F.3d at 1364.
274. Id. (quoting Thompson v. McDonald, 815 F.3d 781, 785–86 (Fed. Cir. 2016)) (internal citations omitted).
275. Id. at 1367 (emphasis added).
for mood disorders and schizophrenia, but not for anxiety disorders and PTSD.\footnote{Bryan A. Liang & Mark S. Boyd, PTSD in Returning Wounded Warriors: Ensuring Medically Appropriate Evaluation and Legal Representation Through Legislative Reform, 22 STAN. L. & POL’Y REV. 177, 193 (2011).} Certainly, the regulations need to change dramatically. However, in lieu of sweeping regulatory change which is unlikely to happen in short order, the Veterans Court or a subsequent appellate court should use the broadness of the \textit{Saunders} case to remedy some of these issues.

\textit{Saunders} opened the door for disabilities to be examined not just on the basis of diagnosis as it relates to the ratings schedule, but also along the axis of functional impairment. If courts use functional impairment as the criteria for assessing whether mental disorders are disabilities, then cases involving mental disorders would be much more likely to be found disabling and thus eligible for compensation.

\textbf{CONCLUSION}

The disability status of pain, and chronic pain in particular, is fraught. The \textit{Saunders} case is an important first step in recognizing pain as a disability. When the causes of disability are uncertain, the experience subjective, and the mechanisms complex,\footnote{IPRCC Pain Strategy Report, \textit{supra} note 27, at 23.} there should be a nuanced legal response to that complexity.