Social Security Disability Insurance: The Compounding Limitations of Medical Evidence Through the Lens of Stroke Medicine

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INTRODUCTION

As part of training, I had the opportunity to be involved in the treatment of a patient in our local community-centered San Juan Bosco Clinic, which accepts uninsured patients 200% of the federal poverty level or less.¹ He was 57 years old, coming to be evaluated for progressively worsening memory loss. Previous clinic and psychiatric visits noted a magnetic resonance image (MRI) scan suggesting possible mild small vessel ischemic disease, a potential source for microscopic stroke², and a Mini-mental state examination of 12 out of 30, a screening result that can be interpreted as severe and impairing dementia. Yet during our evaluation, he responded to our questions appropriately and displayed no deficits that would immediately suggest cognitive impairment.

A complete physical examination did not produce remarkable results. Despite the MRI result, the patient had blood pressure within normal limits and was not on any antihypertensive medications. Additionally, he did not have any risk factors for stroke such as smoking, alcohol use, diabetes, and hyperlipidemia. Psychological assessment could not conclude any active depressive disorders. To simply put, we could not pinpoint any particular cause for his memory loss. Though our patient was previously employed as an engineer, he lost his job after becoming divorced and subsequently moved in with his mother, who accompanied him to the clinic. Our best diagnosis at the time was memory loss secondary to severe anxiety, but we recommended continued follow-up. It was later

¹ For more information on the University of Miami Miller School of Medicine student-run clinics and health fairs in Miami, Florida, please, visit http://umdocs.med.edu/miami.edu/
noted that he continued to be seen for disability determination for Social Security Disability Insurance (SSDI). Medical professionals may conclude a diagnosis and evaluate functionality parameters called activities of daily living (ADLs) at the time of examination, but it is unclear how these translate to long-term disability. This case, and many others encountered in San Juan Bosco Clinic, raises implications on the impact of the limitations in medical evidence with respect to fair disability determination for SSDI.

Growing fiscal and administrative challenges elevate the urgency for significant reform with SSDI. A 2014 annual report by the Social Security and Medicare Board of Trustees project an alarming estimate that funds for SSDI will deplete by 2016. Moreover, a backlog on initial disability claims and administrative hearings has reached dismal levels. Commissioner Michael Astrue of the Social Security Administration (SSA) reported these challenges could not be solved by simply increasing funding of the Social Security Trust Fund, but required efforts to improve all levels of the SSA from basic field employees to administrative law judges (ALJs). In keeping with the medical basis that Congress originally intended, the SSA has placed emphasis on improving medical criteria in order to cut down on delays and introduce better accuracy to disability

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determination. An attempt to improve medical criteria may benefit the claims process, but to determine disability fairly the SSA should not lose sight that medicine is limited in its ability to provide long-term prognosis and physicians can only attest to the medical status of a patient at the time of exam.

When Congress decided to make people with disabilities eligible for federal social insurance with the SSA, they required that the disability be sufficiently severe to prevent the person from working. The SSA administers both SSDI and the Supplemental Security Income (SSI) program, which provides benefits to those with limited income and who are disabled, blind, or age 65 or older. The medical standards to qualify for SSI are similar to SSDI, but the two programs do not come from the same source of funding. The U.S. Treasury finances SSI, while SSDI is supported by the Social Security Trust Fund. This discussion will focus on SSDI.

This Note addresses the limitations of medicine in identifying impairment prognosis as outlined by the SSA’s definition of disability and examines this premise through stroke research. Stroke medicine has benefitted from recent decades of research and progress in care but is still a leading cause of long-term adult disability in the United States. Given its increasing prevalence, advances in medical research, and large variety of post-stroke deficits, stroke is an important consideration for the future of SSDI in an

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7 For information provided on the SSA management issues and ongoing efforts to reduce backlog and delays, please, visit http://oig.ssa.gov/audits-and-investigations/top-ssa-management-issues/social-security-disability-hearings-backlog
aging population. Part I documents the burden of stroke disability and current rehabilitation guidelines to better understand current research and gaps in knowledge. Part II discusses SSA disability claim and administrative court procedure through the scope of Richardson v. Perales and the Administrative Procedure Act of 1964 (APA). In the context of a growing claims and hearings backlog, this part argues that limitations of medical evidence must be recognized to reach fair and accurate disability determination. Together with a non-adversarial disability court procedure and an outdated criteria system, the SSA has lost a crucial ability to distinguish disability, which not only adds to expenditure woes for the SSA, but also presents challenges in fair determination of disability. Part III analyzes current, ongoing solutions and potential strategies to reconcile medical limitations in hopes for long-term reformation to ensure an ability to meet a growing burden of disability.

I: GROWING BURDEN OF STROKE DISABILITY AND ISSUES WITH PREDICTING PROGNOSIS

A stroke is a sudden neurologic injury characterized by compromised cerebrovascular blood flow. It is divided into two broad categories – ischemic or hemorrhagic – that must be distinguished in an emergency setting for treatment purposes. Approximately 80% of stroke patients experience an ischemic stroke where the brain receives too little blood that supplies oxygen and nutrients needed for proper function.

Hemorrhagic stroke patients present oppositely with bleeding and excess blood in the

15 Id. at Definitions.
closed cranial cavity.\textsuperscript{16} Therefore, clinicians face a significant challenge in quickly and accurately assessing onset and type of stroke because the standard treatment for ischemic stroke is to encourage better blood flow, while this could likely cause death from excessive bleeding in hemorrhagic events.\textsuperscript{17}

In 2001, the Senate recognized the need for and granted further state funding towards both acute care and long-term rehabilitation in specialized hospital stroke units.\textsuperscript{18} These units can provide a patient with coordinated and multidisciplinary evaluation to more effectively treat and assess stroke patients.\textsuperscript{19} Aside from efforts in governmental, research, and clinical sectors, campaigns such as the Stroke Heroes Act FAST initiative promoted “time lost is brain lost” to increase public awareness for identifying stroke onset and seeking medical attention as soon as possible.\textsuperscript{20} Analysis at the end of 2014 indicates stroke has fallen from fourth to the fifth leading cause of death.\textsuperscript{21} Overall, an improvement in public health policy has reduced stroke mortality and continues to decline.\textsuperscript{22}

Despite these efforts, the number of stroke patients in the United States continues to increase. According to 2013 estimates, 6.8 million Americans above the age of 20 have had a stroke and about 795,000 people per year experience a stroke. Projections report a

\begin{thebibliography}{99}
\item Id. at Brain Hemorrhage.
\item Pamela W. Duncan et al., Management of Adult Stroke Rehabilitation Care: a Clinical Practice Guideline, 36 STROKE 104 (2005).
\item Alan S. Go et al., Heart Disease and Stroke Statistics – 2014 Update: A Report From the American Heart Association, 128 CIRCULATION 140 (2014).
\end{thebibliography}
20% increase of stroke prevalence from 2012 to 2030, which consists of over 3 million individuals. With increased survival of stroke, more patients experience functional and cognitive deficits. Patients may continue to suffer from limb paralysis, inability to walk independently, cognitive deficits, depression, aphasia, visual impairments, or dependency in ADLs as a result of stroke.23 Many of these patients can receive SSDI benefits if found unable to sustain work.24

Among 18 diseases contributing to long-term disability in the United States, only age-adjusted rates for stroke disability increased significantly in the last decade. In parallel, hosts of studies have identified risk factors and co-morbidities that are widespread public health concerns, including high blood pressure, diabetes, high blood cholesterol, and physical inactivity.25 Self-reported prevalence of cardiovascular disease, obesity, diabetes, and lung disease have increased for the Baby Boomer generation as they approach 60 years of age.26 Predictions over a 30-year span from the Institute of Medicine (IOM) project not only a 14 million increase in Americans with late life impairments that is partly driven by chronic medical conditions, but also a 4 million increase in SSDI caseloads from 2000 to 2015.27

While prevention of stroke, stroke care in an acute, or emergency, setting, and the growing burden of stroke disability are well documented, understanding in stroke recovery is variable. Immediately following stabilization of the patient, stroke

23 Id. at 146.
25 Go et al., supra note 22 at 142–6.
26 Linda G. Martin et al., Health and Functioning Among Baby Boomers Approaching 60, 64B GERONTOL. B. PSYCHOL. SCI. SOC. SCI. 374 (2009).
rehabilitation begins with initial assessment of stroke severity and functional deficits.\textsuperscript{28} Among the large variety of deficits possible from stroke, motor deficits are the most common.\textsuperscript{29} Current trends lean towards shortening the length of acute hospital stay\textsuperscript{30} and transferring to rehabilitation as soon as possible.\textsuperscript{31} The Agency for Health Care Policy and Research (AHCPR) recommends use of disability screening tools by a stroke team within the first 24 hours in the hospital.\textsuperscript{32}

There are several scaling systems designed to measure impairments and predict prognosis. Some of the most commonly used are the National Institutes of Health Stroke Scale (NIHSS), Barthel Index, and Modified Rankin Scale (mRS).\textsuperscript{33} These scales have been reliable in a clinical and research setting for assessing severity of individual deficits such as limb paralysis, aphasia, and ability to walk independently, but cannot fully describe all dimensions of stroke recovery.\textsuperscript{34} The NIHSS does not assess social functioning after stroke. The Barthel Index does not capture a patient’s high-level cognition such as processing of language and emotion. The mRS does not account for the source of impairment and does not directly measure cognition. Other tests look directly at aphasia, mobility, and depression individually, but their accuracies have not been completely validated.\textsuperscript{35}

\begin{thebibliography}{99}
\bibitem{28} Duncan et al., supra note 19.
\bibitem{31} Elliot J. Roth et al., \textit{Delay in Transfer to Inpatient Stroke Rehabilitation: the Role of Acute Hospital Medical Complications and Stroke Characteristics}, 14 TOP STROKE REHABIL 57 (2007).
\bibitem{32} Duncan et al., supra note 19 at e106.
\bibitem{35} Brewer et al., supra note 33.
\end{thebibliography}
Clinical practices have not readily accepted prognostic models due to issues with predictive accuracy and generalizations to standard populations. The hallmark for medicine in determining functional deficits lies in evaluation of the ability to perform ADLs, which are characteristic activities of independent living that includes bathing, dressing, toileting, maintaining continence, grooming, feeding, and mobility. Several variables have been named to play a role in stroke’s affect on a patient’s ADLs. These can be as directly observable as extremity paralysis to a factor as subtle as “adequacy of home and neighborhood”. Unfortunately, only age and arm paralysis have strong evidence suggesting their valid application towards evaluating ADLs. Regardless of ambiguity in validating these variables, the great number of factors involved in stroke disability alone underscores the challenge a physician faces in assessing a patient.

Additionally, advances in neuroimaging have helped clinicians in acute stroke diagnosis and management, but their usefulness in assessing functional limitations and disability is unclear. Some propose neuroimaging techniques may bring a novel level of objectivity to disability determination. This may be true for certain conditions, but many unclear cases will be left up to the interpretation of the examining physician. Though computed tomography (CT) and MRI techniques are well-established methods to identify patients who will benefit from thrombolytic therapy, rehabilitation clinics do not routinely consider imaging evidence and focus their evaluation on ADLs. Regarding

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36 Ward and Reuben, supra note 3.
37 Veerbeek et al., supra note 30 at 1485. (Strong evidence is qualified as “generally consistent findings” in two or more studies with low risk of bias).
our patient in San Juan Bosco Clinic, we could not conclude with absolute certainty his MRI results were conclusive for a cerebrovascular cause for memory loss because of the difficult nature in assessing the patient during a single visit. Despite his lack of risk factors and normal physical examination, we requested continued follow-up to ensure diagnosis of a potentially serious multi-infarct dementia, which would worsen over time in a step-wise fashion.

Although researchers and clinicians seek to create models to evaluate populations as a whole, disease is inherently a personal experience. The consequences for a stroke in a large metropolis differ than one in a rural setting. An older patient faces different challenges than does a young one. Race, gender, previous employment, education, neighborhood, family support and other social identification affect the extent to which a stroke survivor is limited. Recent studies highlight the importance of emotion regulation with social participation and quality of life and the need for stroke disability to consider an individual’s changed perception of self, body, and their homes and communities. In a clinical landscape where objectivity is valued, these subjective qualities are also important considerations in a patient’s functional limitations that are not assessed by physicians.

These studies and reports highlight the increasing obstacles SSDI will face with growing stroke disability. Medicine has benefited from research that continues to improve care, but gaps in knowledge with post-acute stroke care remain. Functional

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40 Grau-Olivares and Arboix, supra note 2.
42 Christa S. Nanninga et al., Place Attachment in Stroke Rehabilitation: A Transdisciplinary Encounter Between Cultural Geography, Environmental Psychology and Rehabilitation Medicine, DISABIL. REHABIL. 1–10 (2014.)
limitations may be effectively measurable at one point in time, but generalized models
cannot evaluate prognosis and duration of impairments entirely. Moreover, the individual
experience of disease that is shaped in the context of social and cultural factors is not
documented in a clinical assessment, but can be important in considering disability.
Imaging, scales, and models are frequently left for interpretation. This limit of medicine
in determining prognosis has been well understood by original SSDI policymakers and
should be reflected in SSA disability evaluation during efforts to improve the disability
claims process.

II: SSDI Disability Claims, ALJs, and Limitations of Medical Evidence

Social Security did not include disability insurance until 1956 after years of
discussion that began after the Great Depression. Early considerations recognized the
difficulty in making disability determinations and anticipated that the cost of these
insurance programs would depend on the definition of disability. They sought a strict and
cautious definition to limit abuse, which could be relaxed if socially warranted.43 By the
1950s, Congress recommended that disability benefits be granted to the permanently
disabled. Proof of lifetime impairment rested in a medical prognosis of permanency, but
added that benefits would not be paid until demonstrating an inability to work after 6
months. Further, they drew focus on the intention to support these disabled patients with
vocational rehabilitation in order to return them to productive lives.44

www.ssa.gov/history/pdf/dibreport.pdf, accessed 12/22/14; Jeffrey S. Wolfe and David W. Engel,
Restoring Social Security Disability’s Purpose: Does the Decisionmaking Process Serve the
44 SSA, Committee Staff Report on the Disability Insurance Program at 116–8.
Disability is an elastic concept that Professor Berkowitz stated in his address to the Subcommittee on Social Security of the Committee on Ways and Means required a “historical eye…to [see] which aspects of the system are worth changing…and spot emerging trends.”\footnote{Edward D. Berkowitz. Statement to the House, Subcommittee on Social Security on Ways and Means. *Disability Policy and History*, Hearing, July 13, 2000, available at http://www.ssa.gov/history/edberkdib.html, accessed 12/22/14.} Shortly following 1956, the criteria to qualify as disabled quickly expanded, but the medical-vocational standard remained fundamentally unchanged. In just over a decade, the age requirement to qualify for disability benefits was removed and benefits could be granted to those who were predicted to be functionally impaired for at least a year.\footnote{Jeffrey S. Wolfe and David W. Engel, supra note 43 at 49.} This led to a higher number of disability determinations than expected, causing concern in court interpretation of the definition of disability. In response, Congress refined their definition in 1967 amendments:

An individual shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but considering his age, education, and work experience, engage in any kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area, in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work.\footnote{Social Security Amendments of 1967, Social Security Act, 42 U.S.C. §§ 202(t), 216(i), 1814(b), 1866(a), 1875(b), 1877(b) and 1886(c) (1967).}

This came with a reemphasis on the “predominant importance” of medical evidence in objectively supporting the nature and extent of physical and mental impairments.\footnote{SSA, *Committee Staff Report on the Disability Insurance Program*, supra note 43 at 117.} Though intended to slow growth of allowances, SSDI experienced a rise in rolls that continues into the present day.\footnote{Berkowitz, *supra* note 45.} In many ways, Professor Berkowitz and
Social Security policy researchers are correct to look to original intentions of federal disability programs – Congress cautiously understood the fact that medical prognoses would be insufficient to accurately determine a social definition of disability. Half a century later, the SSA continues to shift and clarify qualifications of disability and has done so in part by further refining medical criteria. With noted gaps in knowledge, how capable is medicine with keeping the current criteria?

This section will analyze legal evaluation of disability by the SSA. Part IIA will discuss the initial disability claim and the sequential steps to qualify as disabled. It finds that current diagnostic tools may not be sufficient to meet medical criteria listed by the SSA. Part IIB examines the administrative courts and ALJs to show how an overemphasis on the capabilities of medicine can detract from the goal of fair disability rulings. Especially with ongoing fiscal and bureaucratic pressures of the SSA, medical evidence may not be scrutinized carefully enough. Part IIC looks at the role of non-medical considerations and the vocational expert program. Expert testimony may be confounded by imperfect medical evidence.

A. Initial Disability Claims

The SSA evaluates disability through a sequential five-step process that includes determining a claimant’s occupational status, severity of medical impairment, and ability to work based on medical condition.50 The first two steps look to identifying vocational and medical parameters separately: (1) whether one is working and (2) whether one has a medically diagnosed impairment. The third step details that certain severe medical conditions are categorized as generally sufficient qualifiers for SSDI under Listings of

Impairments. Stroke can be classified under “central nervous system vascular accident” if the patient has experienced ineffective communication and speech from aphasia or significant and persistent impairment of motor function in two extremities. These deficits must be present three months after stroke onset and be expected to cause death or persist for at least a year.

The rationale behind deferring cases until three months post-stroke is to better judge limitations. As already seen with current research in predicting ADLs after stroke, most variables including speech deficits, limb paralysis, ability to walk independently, and gait are questionably accurate prognostic indicators of future functionality. Moreover, prospective studies of factors that affected prognosis of post-stroke functionality indicated that domains as subjective as pain and emotional reaction to rehabilitation played roles in outcomes, whereas the Barthel Index, a general clinical measure of ADLs, did not conclusively predict functional outcome at time of discharge. At this stage in research, there is little definitive proof that clinicians possess accurate and valid tools that would be able to predict chronic impairments in stroke patients. Subjective factors that may also have important implications in long-term disability are not assessed in medical reports and difficult to characterize in a way that would be consistent with disability claims.

Additionally, observational studies indicate maximal functional gains in recovery

51 Id.
53 Id.
54 Veerbeek et al., supra note 30 at 1485.
are made by three months post-onset.\textsuperscript{56} The AHCPR lists several studies as early as 1965 that recovery initiation as soon as a few days post-stroke is strongly associated with better functional outcomes.\textsuperscript{57} Large-scale trials find that structured rehabilitation may promote improvement in motor function as early as two months post-stroke.\textsuperscript{58} Importantly, interventions in mobility are a progressive practice that may produce gains at any time after stroke onset.\textsuperscript{59} The earliest starters, however, in a structured rehabilitation program had significantly higher effectiveness of treatment than did medium or latest groups. Early is defined as initiation of therapy within 20 days and later categories are an additional 20 days.\textsuperscript{60} The fundamental principle of neurologic rehabilitation is that the brain is plastic and adapts.\textsuperscript{61} Therefore, medical evaluations can be a dynamic process. An evaluation at three months may not be an accurate indication of a patient’s limitations a year from now.

To increase complexity, stroke is a multi-faceted disability. Patients who do not present with aphasia or paresis may manifest with criteria in other listing categories such as “Special Senses and Speech” and “Mental Disorders”.\textsuperscript{62} Those who do not meet any listed impairments must present evidence that their “Residual Functional Capacity” is enough to prevent meaningful employment, after full consideration of non-medical characteristics.\textsuperscript{63} The claimant’s residual capacity can be challenging to assess even

\textsuperscript{57} Duncan et al., \textit{supra note} 17 at 107–8.
\textsuperscript{58} Dobkin and Dorsch, \textit{supra note} 55 at 2.
\textsuperscript{59} \textit{Id.}
\textsuperscript{60} Duncan et al., \textit{supra note} 17 at e108.
\textsuperscript{61} Dobkin and Dorsch, \textit{supra note} 56 at 3.
\textsuperscript{62} SSA, \textit{Blue Book}. Part A §§ 2.02, 2.09, 12.02, and 12.04. These conditions may be qualified by any disorder or cause.
\textsuperscript{63} 20 CFR § 416.945.
among medical professionals experienced in disability determination. Aside from adequacy of prognostic models, factors contributing to these hurdles stem from variability in clinicians: availability of time to properly assess a patient in a demanding clinical setting, hesitancy in reducing a doctor-patient relationship by assessing a patient against his or her preference to qualify for disability programs, and lack of training in proper interactions with administrative agencies and legal entities.64

The last steps combine the medical and vocational parameters: is your medical condition severe enough to prevent you from continuing your previous employment and preclude you from any substantial and gainful activity?65 Claimants over the retirement age of 65 who desire to continue working but cannot because of medical impairments may qualify for SSDI through special rules that consider vocational criteria. This step is the synthesis of clinical and nonclinical judgment, thereby carrying out Congress’s intent as expressed in the Social Security Amendments of 1967. Further, the amendment explicitly states employment may qualify as any found in this country’s economy regardless of geography, availability, or whether or not the applicant would be hired.66 As written, medicine serves as a threshold for severity, but at times this can be a difficult distinction between functional and disabled or a hazy boundary between short-term and long-term.

B. Appeals and the ALJ

The APA organizes formal due process in federal administrative agencies in order

65 SSA. Disability Benefits, supra note 50 at 12.
66 Social Security Amendments of 1967, 42 U.S.C.
to regulate their roles. To this end, claimants are afforded the opportunity to present their case from anew in court. Among the four levels of appealing an unfavorable initial disabilities claim, the ALJ serves to conduct hearings and consider all evidence in re-determining disability as defined by the SSA. Though distinct and separate in power from trial judges in the judicial branch, they function similarly and their decisions can impact individuals greatly. Like clinical evaluations, medical experts are not asked to make an opinion on disability when called to testify, but only add to the body of evidence with a justifiable description of the claimant’s functional limitations. It is up to the ALJ to decide disability after considering the weight of the medical experts opinion and nonclinical evidence, which may constitute vocational considerations such as past work experience.

In 1971, the Supreme Court decision in Richardson v Perales carried pivotal delineations on administrative court procedure with admissibility of medical evidence and the extent of due process in SSA disability hearings. This began with a SSDI claim filed by Mr. Perales in 1966 due to a sustained back injury. The state agency initially denied his claim for lack of substantial medical evidence provided by his physicians, which was later unfavorably reviewed through medical reports by an independent medical advisor. Conflicting medical opinions were presented at the hearing and the issue became whether physicians’ written reports of medical examinations may constitute

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70 OFFICE OF HEARINGS AND APPEALS, SOCIAL SECURITY ADMINISTRATION, HEARINGS APPEALS AND LITIGATION LAW MANUAL (1992)
71 Perales, 402 U.S. at 390.
“substantial evidence”.72

When Mr. Perales was found ineligible for SSDI, he appealed on the basis that the court denied him a fair hearing and violated his constitutional right to due process by not subpoenaing doctors who gave conflicting reports for cross-examination. The Supreme Court held that relevant and authenticated written medical reports may constitute substantial evidence in SSA disability hearings, despite their nature as uncorroborated hearsay.73 Substantial evidence is defined as “more than a mere scintilla”, such that a reasonable mind may accept as relevantly supportive of a conclusion.74

Moreover, the Supreme Court held that the nature of Social Security benefits determines the necessary due process. The “precise nature of the government function involved as well as of the private interest that has been affected by governmental action” must be taken into account.75 Unlike other welfare entitlements, Social Security disabilities are essentially an “earned” benefit. In contrast to Goldberg v. Kelly, the court emphasized that SSDI is not a termination of welfare where the recipient may be “condemned to suffer grievous loss”, and therefore, not subject to the same level of due process.76 Claimants still hold the right to request subpoena and cross-examination of adverse medical testimony, but the ALJ may determine validity and weight of medical reports without necessary oral testimony or direct physical and mental examination.77

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72 Id. at 391–398.
73 Id. at 398–401.
74 Consolidated Edison Co. v. NLRB, 305 U.S. 197, 229 (1938).
76 Id
77 Perales, 402 U.S. at 402.
Justice Blackmun’s majority opinion notes that the Social Security Act emphasizes the informal over formal so as to include the “layman claimant”.78 Indeed, the APA sought to include the public in agency policy and rulemaking with transparency and formal adjudication.79 ALJs, therefore, are responsible for a unique representation of interests. On one hand, the ALJ acts in favor of the patient, while on the other, the ALJ represents the public and taxpayers to safeguard SSDI to those who truly qualify.80 These seats must be filled simultaneously in an administrative court. Given the admissibility of medical reports and relaxed due process requirements, “SSDI adjudication impedes the determination of SSDI awards based on a comprehensive and fair review of the claimant’s record.”81 This procedure of SSA administrative courts opens the door for system abuse if inappropriate weight is given to medical evidence and if interests between safeguarding Social Security funds and awarding benefits are not appropriately represented in the courtroom.82

Certainly with stroke, patients can experience conditions that are often described in subjective terms, such as chronic pain, migraine and headache, and depression.83 The levels to which these are debilitating are up for interpretation and may vary with each involved individual, including physicians, vocational experts, and the ALJ. Functional and structural neuroimaging may provide some insight into a patient’s condition that cannot be easily described in objective terms, but their results can still come down to

78 Id. at 400–401.
81 Id. at 11.
82 Id. at 12.
83 Lawrence et al., supra note 29 at 1281.
individual interpretation as with many objective tests.\textsuperscript{84} Other conditions, not necessarily related to stroke care, have been subjects for debate on their merits in an administrative court disability hearing: chronic pain\textsuperscript{85}, obesity\textsuperscript{86}, and alcoholism\textsuperscript{87} to name a few. They share a characteristic of difficulty in objectively characterizing through medical examination.

While the Supreme Court’s decision in \textit{Perales} can be interpreted to favor patients, they may be overstating the weight of medical reports, especially if treating physicians are not required to testify. Justice Douglas, in his dissenting opinion, emphasized the troubling nature of admitting hearsay evidence without complete due process. Out of six doctors who had personally examined Mr. Perales, only one testified at his disability hearing. Justice Douglas goes on to state that cross-examination is necessary for a “full and fair disclosure of facts.”\textsuperscript{88} Problematically, Social Security disability hearings without cross-examination lends to the possibility that medical reports can be

\[\ldots\text{controlling}\ldots\] This permits easy solicitation of reports from treating physicians, who are already naturally in sympathy with their patients\ldots The treating physician is never subjected to cross-examination, let alone prosecution for misrepresentation\ldots Thus an Administrative Law

\begin{footnotes}
\item[84] Stinear and Ward, \textit{supra} note 39; and Pustilnik, \textit{supra} note 38.
\item[85] Pustilnik, \textit{supra} note 38.
\item[86] Christopher E. Pashler, \textit{Smithers, What’s the Name of This Gastropod? King-Size Homer and the Social Security Administration’s Subjective Evaluation of Fatness}, GA. ST. U. L. REV. (forthcoming); \textit{BUFFALO LEGAL STUDIES RESEARCH PAPER SERIES PAPER No. 2012 – 043} (2012) (analyzing the termination of obesity as a qualifier for SSDI).
\item[88] Perales, 402 U.S., \textit{supra} note 12 at 411–412.
\end{footnotes}
Judge is boxed into a corner, and forced to grant benefits, even when knowing the individual is not truly disabled.\textsuperscript{89}

This process is further complicated in the context of a huge case backlog, where the SSA places pressure on ALJs to meet a high volume of cases within a year.\textsuperscript{90} The SSA entered 2013’s fiscal year with over 700,000 pending disability claims and ended with just under 700,000 pending claims, with an average processing time of 107 days.\textsuperscript{91} Estimates into the next few years by the SSA and Office of the Inspector General (OIG) do not boast a reduction in processing time or delay to hearing.\textsuperscript{92}

Data shows a positive association between annual case dispositions and annual award rate.\textsuperscript{93} In other words, the data suggests that a judge with higher caseload will award more benefits. This may simply be a reflection that if a judge hears more cases, more claimants will exhibit qualified disability. Unfortunately, a recent OIG report reveals that 13.8\% of sample cases from outlier ALJs, who had both the highest deposition load and allowance rates over two fiscal years, would have been denied or dismissed if under proper review.\textsuperscript{94} These disability benefits were extrapolated over a 7-year period to estimate that improper benefits would be allowed on over 24,000 cases that

\textsuperscript{89} Gokhale, supra note 80 at 12.
\textsuperscript{90} Id.
\textsuperscript{92} Id.
\textsuperscript{93} Gokhale, supra note 80 at 15
\textsuperscript{94} OIG, Administrative Law Judges with Both High Dispositions and High Allowance Rates. Baltimore, MD: Office of Audit, November 2014 (Report A-12-14-24092). (“In a January 2014 letter, the Chairmen of the House Committee on Oversight and Government Reform and the Subcommittee on Energy Policy, Health Care, and Entitlements asked [the OIG] to identify ALJs who had 700 or more dispositions and allowance rates of 85 percent or higher in any 2 fiscal years (FY) from FYs 2007 through 2013.”)
would amount to $2 billion in questionable costs, a small expense compared to all $200 billion SSDI costs, but excessive nonetheless.\textsuperscript{95}

Additionally, the SSA and OIG explicitly state that they are aware some individuals will withhold, exaggerate, or fabricate medical information to improve their chances of collecting benefits they are not eligible to receive.\textsuperscript{96} Hundreds of thousands of cases are reported to have incomplete medical information that was not obtained at the initial claims process for varying reasons, resulting in determination without all sources of evidence. Overall, it is unclear if this affected claim outcomes in one way or another, as the hearing allowance rate for these cases without complete information is similar to those of national averages.\textsuperscript{97} On a different perspective, however, some medical conditions with high denial rates at initial claims process are subsequently allowed at high rates before a court hearing.\textsuperscript{98} The overwhelming majority of these claims acquired legal representation at court and a large proportion were decided on impairments other than one initially presented, with up to 12\% of these cases changed to affective or mood disorders. The OIG speculates these changes were due to impairments not evident at initial claim, assistance by legal aid in developing medical proof, or progression of disease or mental impairment.\textsuperscript{99}

\begin{footnotesize}
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\item \textsuperscript{98} OIG, Disability Impairments on Cases Most Frequently Denied by Disability Determination Services and Subsequently Allowed by Administrative Law Judges. Baltimore, MD: Office of Audit, August 2010 (Report A-07-09-19083).
\item \textsuperscript{99} Id.
\end{itemize}
\end{footnotesize}
Together, these reports overwhelmingly bring attention to the fallibility of medical evidence in an administrative court. Not only is there questionable completeness of medical evidence throughout the disability claims process, but also questionable accuracy of medical reports without proper examination and consideration of all facts. As stated before, physicians are ill equipped to give a conclusive medical prognosis in many cases, making it more difficult to translate this to disability as defined by the SSA.

C. Vocational Experts and the Daubert Standard

Since early discussions into federal disability insurance, Congress was not completely satisfied by only a medical prognosis and therefore chose to pay disability benefits until six months after the date of disability onset. This maintained a vocational requirement that would be reaffirmed in 1960 by the landmark case, *Kerner v Flemming.* Known as Kerner criteria, the case established the requirement of the SSA to demonstrate that the claimant was capable of any other work. In this manner, the SSA holds the burden to safeguard funds for patients who truly qualify as deemed by the definition of disability.

The *Kerner* decision paved the way to the inception of the vocational expert and consulting programs that would independently consider the non-medical, vocational factors relevant to a disability claim. The vocational consultant is charged with providing guidance in hearings by considering employment criteria including age,

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100 SSA, *Disability Benefits, supra* note 50 at 12.
101 *Kerner v Flemming,* 283 F.2d 916 (1960)
103 *Id.*
education, training and work experience, as detailed in 1967 amendments. A vocational testimony may be required if a claimants medical condition did not fall under the Listing of Impairments and additional evidence is needed to determine the extent of severity and work capabilities. This can be especially crucial for claimants over the age of 65 where special rules are in place to consider vocational criteria. Here as the last pieces of evidence to present, the claimant bears the burden of proving an inability to hold gainful employment due to his medical condition, and the ALJ must specify jobs that the claimant is able to perform with substantial supporting evidence. Given a claimant’s residual functional capacity, age, education and previous work experience, medical-vocational guideline grids may be used to determine appropriate sedentary, light, or medium employment that exists in the national economy. These grids act like a flowchart to assist the ALJ in determining disability and often follow a pattern that makes vocational testimony unnecessary, but “the preferred method of demonstrating job availability when the grids are not controlling is through expert vocational testimony.”

In hearings, a judge derives a reliable opinion from a vocational expert by asking hypothetical questions that account for the claimant’s physical or mental impairments. In order for the opinion to constitute substantial evidence, the hypothetical question must comprehensively include all impairments, deficits, and restrictions. Further, it must adequately and accurately present these facts for the vocational expert’s response to be

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104 Social Security Amendments of 1967, 42 U.S.C.
106 Id.
108 20 CFR Appendix 2 to Subpart P of Part 404.
reliable.\textsuperscript{111} This requires complete medical information, a reliable medical report, and an understanding of the medical evidence by the ALJ that allows articulation of inquiries to clearly portray medical impairments to their full extent. Without such, a disability determination may be reached erroneously.\textsuperscript{112}

To place checks on vocational expert testimony, the ALJ is required to ensure that the expert opinion adheres to data found in the \textit{Dictionary of Occupational Titles (DOT)} or more recently replaced online database, the \textit{Occupational Information Network (ONET)}, which provides reference to existing employment in the United States economy.\textsuperscript{113} There are many issues with the \textit{DOT} and \textit{ONET} that add to the list of doubts with vocational expert reliability. For example, the \textit{ONET} has not been revised since 1998 and contains many outdated entries of employment such as “telegrapher”.\textsuperscript{114} Changes in the national economy and work force have “eroded SSDI’s ability to link medical conditions with (in)ability to work.”\textsuperscript{115}

Further, medical assistive devices and rehabilitation medicine have added significant restorative capacity that changes the extent of functionality. Thus, another component must be accounted for in an already challenging assessment of impairment by clinicians that vocational criteria may not have appropriately incorporated. This erosion is evident in an analysis of disability determination trends. Allowances based on medical evidence alone appear less frequently than a quarter of a century ago. This may be the result of an increasingly noticeable and prevalent difficulty in clinical establishment of

\textsuperscript{111} \textit{Id.} at 209.
\textsuperscript{115} \textit{Gokhale, supra} note 80 at 6.
functional and work limitations causing a shift towards more consideration of vocational and nonclinical factors.\textsuperscript{116} OIG data reports a steady increase in serious assessment of nonmedical criteria, with up to 76% of dispositions in 2010 included testimony by vocational experts.\textsuperscript{117}

There has been extensive controversy over the reliability of vocational experts in court due to either lack of education and experiential qualifications or accuracy of medical evidence.\textsuperscript{118} Vocational experts often face cross-examination by claimant counsel. Common avenues of dispute, aside from an expert’s qualifications, are arguments into competing schools of thought in medicine on the subject at hand and the idea that medicine and rehabilitation is not an exact science.\textsuperscript{119} As explained, stroke rehabilitation is an ongoing field of research and clinicians experience significant challenges in accurately and reliably assessing impairments left by stroke. If a vocational expert offers a testimony that is not founded on accurate medical science, then their opinions cannot be made reliably.\textsuperscript{120}

Under the \textit{Daubert} standard, federal judges are to be “gatekeepers” in assuring that expert testimony is based on reliable and relevant scientific evidence. Deferring to an expert only based on credentials within a field invites unwarranted speculation instead of actual knowledge.\textsuperscript{121} The Court set out general guidelines to consider validity of scientific evidence. First the key question must be that proper scientific method and

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\textsuperscript{116} Id at 7–8.
\textsuperscript{117} OIG, Availability and Use of Vocational Experts. Baltimore, MD: Office of Audit, May 2012 (Report A-12-11-11124).
\textsuperscript{118} McKinnie v Barnhart, 368 F.3d (2003) at 910.
\textsuperscript{119} Solomon, supra note 120 at 214.
\textsuperscript{121} Daubert v. Merrell Dow Pharmaceuticals, 509 U.S. 579 (1993).
empirical testing established the evidence. Second, the judge should consider whether the evidence has been subject to peer review. Third, known or potential error rates are relevant factors to determine. Finally, minimal support of evidence or technique within the scientific community may promote skepticism on validity or admissibility.\footnote{Id. at Part C.}

Through these standards, the ALJ should carefully scrutinize the proffered medical evidence before turning to vocational criteria. This may call into question some prognostic models to assess severity and outcome of stroke impairments, which possess the potential for large error, have not been readily accepted in clinical practices, or simply lack enough evidence to support their validity. Under Perales, the emphasis on the informal over the formal, relaxed standards for due process and cross-examination, and admissibility of substantial evidence otherwise inadmissible in federal court proceedings, sets SSA disability hearings apart.\footnote{Perales, 402 U.S.} Scrutiny of evidence and validity of expert testimony “should be liberal and not strict in tone and operation.”\footnote{Id. at 400–401.} It is unrealistic to expect an ALJ to stay current on all medical and vocational aspects of disability. Therefore, to maintain standards of evidence and prevent overemphasis of medical reports, SSA disability hearings need counsel on both sides of the disability argument.

III: Addressing Administrative Challenges Without Compromising Fair and Accurate Disability Determination

In 2008, an investigation by the OIG reported that, among surveyed individuals, almost 80\% of claimants believed their finances were impacted by the delays in claims

\footnote{Id. at Part C.} \footnote{Perales, 402 U.S.} \footnote{Id. at 400–401.}
processing and 30% of patients felt that their access to medical care was affected.\textsuperscript{125} The SSA is the largest adjudicatory agency in the world that faces growing need to re-evaluate and reform its procedure.\textsuperscript{126} If not for the sake of fiscal solvency, then for the moral and ethical imperative to maintain and improve fairness and consistency to patients who often rely on benefits from disability insurance. To address these concerns, the SSA must base their efforts on not only what medical and social research can conclude, but also an understanding on their limitations.

If properly understood, medicine acts as a threshold for disability evaluation. From opening an initial claim with a local field office to a hearing before an ALJ, validity and accuracy of medical reports must be considered appropriately to prevent a compounding of unreliable evidence, testimony, and judgment. This final part discusses the strategies that the SSA uses to tackle current performance challenges and recommendations towards improving standards of evidence and updating clinical and nonclinical criteria.

\textit{A. Current Measures}

Some of the top issues recognized by the SSA and OIG include reducing claim backlogs and delays and minimizing inaccurate payments. These issues are intricately tied to fiscal projections and the economic challenge of encouraging return to work through rehabilitation.\textsuperscript{127} In 2007, the SSA commissioned the IOM to address some of

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\textsuperscript{125} Astrue, Michael J. \textit{Hearing on Clearing the Disability Backlog: Giving the Social Security Administration the Resources It Needs to Provide the Benefits Workers Have Earned}, supra note 8.
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\textsuperscript{126} Hubley, \textit{supra} note 120 at 345.
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\textsuperscript{127} Gokhale, \textit{supra} note 80 at 3–6.
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these pressing management issues.\textsuperscript{128}

As stipulated by the APA, the SSA is charged with accommodating to public comment before final publication of new rules.\textsuperscript{129} The Listing of Impairments has been in use since 1955 and has been continually revised with input and involvement from clinicians, advocates, adjudicators, and disabled individuals.\textsuperscript{130} Until 2007, however, the SSA rarely revised the Listings in a comprehensive manner. The shift towards disability allowances decided on vocational and nonclinical evidence instead of medical evidence alone caused concern in the validity of the Listings.\textsuperscript{131} The IOM was commissioned to review medical aspects of disability determination due to a substantial drop in percentage of claims referring to the Listings.\textsuperscript{132}

The SSA began an effort to comprehensively update the Listings in 2001, but discontinued the attempt because the SSA could not find any gold standard with which to evaluate their medical criteria. Logically, the Listing severities should correlate well with a status of inability to engage in gainful employment. Despite the absence of an objective foundation, the IOM suggested that the SSA continue using the Listings as a decision-making model because there are no better alternatives. To improve upon the medical criteria, they stressed beginning the collection of empirical data from disability cases and constant observation of new medical technologies and rehabilitation research.\textsuperscript{133} This

\textsuperscript{129} APA, 5 U.S.C. § 556.
\textsuperscript{131} Gokhale, \textit{supra} 80 at 3.
\textsuperscript{132} INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, \textit{supra} note 129 at 15.
\textsuperscript{133} \textit{Id.} at 7–9.
should also include an understanding of areas without clear research to correctly frame the weight of medical evidence.

The IOM added that though the Listings were introduced to increase speed of the process, it came at the price of reduced accuracy. The “accuracy problem is mitigated, because the SSA uses a stricter standard (i.e., any gainful activity)…. Although this diminishes sensitivity, SSA can tolerate having more truly disabled claimants fail the screen, because…they are considered in the next phase of the process (steps 4 and 5).”134 The IOM did not evaluate the medical-vocational standards set out in the last two steps and explicitly added that the accuracy problem would be mitigated unless the Steps 4 and 5 functioned correctly, which are up for debate.135

Further, the committee recommended expansion of the Listings to consider variable access to healthcare. Though difficult to incorporate into the Listings, “medical evaluation is involved in gauging the severity and functional impacts of an untreated condition, [thus] the circumstances limiting access to health care and assistive technology should be considered separately.”136 This brings out socioeconomic implications in disability that may require consideration when evaluating for medical severity and possibly extends into nonclinical assessment. The United States can expect a rise in healthcare costs associated with stroke and, problematically, patients of minority races and lower socioeconomic background shoulder a larger proportion of this increased cost than their non-minority counterparts.137 The per capita cost of stroke from 2005 to

134 Id. at 91.
135 Id.
136 Id. at 9.
2050 is estimated to be over $25782 in blacks, $17201 in Hispanics, and $15597 in non-Hispanic whites, with loss of earnings and employment as expected to be the highest cost contributor for each race-ethnicity.\textsuperscript{138} 

The IOM also recognized reports that detail variability in decisions by region and a high rate of overturned decisions during hearings. This may be regional variability among claimants or differences in court interpretation of hearings. Since 2007, the SSA has taken some steps towards greater oversight of hearings by periodically reviewing ALJs with outlier caseloads, limiting disposition volume, and creating tools to allow judges to track their performance.\textsuperscript{139} The APA expressly insulates and establishes independence of ALJs from the SSA, thus limiting the extent to which SSA, or any federal agency, can influence ALJ performance.\textsuperscript{140} Though theoretically immune, the high case volume and hearings delays poses interesting questions on the existence of confounding factors that may sway judge performance. Regardless, judge variance should be ironed out in final appeals and by a consistent and accurate interpretation on the definition of disability.

Aside from updating the Listings, the SSA has taken measures to train field staff, increase availability of medical and vocational experts, and continued reevaluation of disability allowances.\textsuperscript{141} These efforts, while increasing productivity modestly, seem to be inadequate against the magnitude of the SSA’s fiscal spiral. Some would argue that

\textsuperscript{138} Go et al., supra note 23 at 148–9.
\textsuperscript{139} OIG, Administrative Law Judges with Both High Dispositions and High Allowance Rates. Baltimore, MD: Office of Audit, November 2014 (Report A-12-14-24092).
\textsuperscript{140} APA, 5 U.S.C. § 554(d).
these “front-end” initiatives are halting the delays, but not solving the underlying problem that the SSA has lost its ability to draw the line between functional and nonfunctional.\textsuperscript{142} The more overarching solution may therefore lie in fine-tuning the definition of disability to meet our modern medical knowledge and national economy.

\textit{B. The Line Between Medicine and Vocation: Jurisprudence in Disability Hearings}

While perhaps out of the scope for a medical student to propose new rulings or policy statutes, tracing out areas within SSDI policy that can benefit from reform reveals better approaches to disability determination may lie in recalling the original foundations of SSDI.\textsuperscript{143} Analysts and lawmakers propose changing fee structures to benefit an incentive of rejoining the workforce, thereby cutting payments and increasing revenue.\textsuperscript{144} These economic solutions are beyond this discussion, but as Congress initially predicted, the cost of federal disability insurance is linked with the definition of disability.\textsuperscript{145}

With expansions in the eligibility of disability benefits and weakening medical and vocational criteria in our modern economy, revising the criteria to meet a fundamental definition of disability would improve the process greatly by increasing sensitivity to screen those who truly cannot sustain gainful activity. Strengthening medical criteria is a step in the right direction, but efforts will need to be made on all fronts to ensure more accurate determination because the definition is rooted in medical and nonmedical factors. Several ideas have been proposed to remove the vocational grid system for one that is matched with typical age-related functional decline, mandating the use of a modern occupational database, and applying \textit{Daubert} standards to SSDI.

\textsuperscript{142} Gokhale, \textit{supra} 80 at 3.
\textsuperscript{143} Wolfe and Engel, \textit{supra} note 43 at 50.
\textsuperscript{144} Gokhale, \textit{supra} 80 at 3.
\textsuperscript{145} SSA, \textit{Committee Staff Report on the Disability Insurance Program}, \textit{supra} note 43 at 107.
hearings.\textsuperscript{146} For this to work, this Note recognizes the need to change the non-adversarial disability court procedure.

As discussed, government interests are not properly represented in SSDI court proceedings. The ALJ carries a “three-hat jurisprudence” and it becomes difficult to maintain balance as a neutral decision maker.\textsuperscript{147} A government representative is not a new idea and has been examined in court before.\textsuperscript{148} It was thought they would simply act as an extension of the ALJ, but if properly considered, a government representative should ensure that evidence is appropriately scrutinized so that limitations and interpretations of clinical and nonclinical evidence are understood, and that justice is reached either for or against awarding benefits after full development of the record.\textsuperscript{149}

A government representative could potentially address all shortcomings of medical and vocational evidence and place checks on expert testimony. They would represent the public interest in ensuring correct determination of disability by upholding the fundamental definition of disability. Though costly, the savings associated with increasing efficiency in the process and better preventing overpayments or incorrect awards would likely outweigh their expense. Some beneficiaries undergo Continuing Medical Reviews to re-determine if an individual is still disabled and receiving the correct amounts for payment.\textsuperscript{150} These have been effective in reducing improper payments, but do not detract the need to reform initial disability determination. Once awarded, it becomes difficult to terminate SSDI benefits. Not only can this be contended

\textsuperscript{146} Wolfe and Engel, \textit{supra} note 43 at 51–2; and Hubley, \textit{supra} note 120 at 399–404.
\textsuperscript{147} Wolfe and Engel, \textit{supra} note 43 at 52.
\textsuperscript{149} Wolfe and Engel, \textit{supra} note 43 at 52.
as a loss of private interests\textsuperscript{151}, but also “administrative finality dictates that
determinations for payments and payment amounts become binding and final, unless they
are timely appealed…. Consequently, if conditions to reopen a determination do not
exist, or time limits expire, SSA generally will not revise the determination, and will
continue to pay the erroneous benefits throughout a beneficiary’s lifetime.”\textsuperscript{152}

Overall, the representatives could restore balance to the disability court system
and add expertise to recognize limitations in evidence. The ALJ would remain as the
decider of disability but maintain a truly neutral position. Evidence and testimony would
be more carefully scrutinized and their limitations made aware. Further, a government
representative would serve as an early communicative channel between the claimant’s
counsel and the government, allowing many cases to be made in early disposition as
opposed to all cases requiring the hearing of a federal judge.\textsuperscript{153}

\textbf{CONCLUSION}

As the population ages, administrative courts, Social Security, and the nation’s
healthcare system will face an increased burden of disability, thus bolstering the urgency
to introduce significant reform in SSDI that maintains fair and accurate determination of
disability. Medicine is a continually changing landscape that is molded by research.
Professors of medicine will often quote in their lectures that the information and
treatments they present will likely be outdated by the time students finish their training.\textsuperscript{154}

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\textsuperscript{151} Kelly, 397 U.S. \\
\textsuperscript{152} Astrue, Michael J. \textit{Challenges of Achieving Fair and Consistent Disability Decisions}, \textit{supra} note 98. \\
\textsuperscript{153} Wolfe and Engel, \textit{supra} note 43 at 52–3. \\
\textsuperscript{154} Paul J. Gorman et al., \textit{The Future of Medical Education is No Longer Blood and Guts, It is Bits and Bytes}, 180 \textit{AM J SURG} 353–356 (2000). (Referring to commonly understood idea that facts taught a medical
education have a short half-life, or high rate of decay, and are often declared obsolete by the time of
completed training.)
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Likewise, SSA must initiate significant reform and appropriate updates to preserve its ability to provide relief and assistance to often the most vulnerable American citizens.

As Congress envisioned, physicians are limited in their ability to meet medical criteria in disability determination. If medicine is to be a threshold of severity, there must be an understanding that predictions in prognosis may be variable. Comprehensively revising criteria is commendable action, but there will always be cases that are left up for interpretation. To correctly and accurately interpret evidence, the administrative court procedure must seek to carefully scrutinize expert testimony, medical reports, and vocational criteria.