Lessons the Veterans Benefits System Must Learn on Gathering Expert Witness Evidence

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Introduction

“The most savage controversies are those about matters as to which there is no good evidence either way.”

A sense of crisis in veterans benefits adjudication has been building for many years. One leading authority on veterans law recently wrote that “[t]here are few persons who believe that the current system for administering these benefits is working properly.” In fact, both Congress and the President recently commissioned studies to examine the delivery of benefits to veterans and to offer recommendations for improving the process. These studies documented the current problems well, but failed to appreciate that the fundamental cause of the crisis is the failure of the Department of Veterans Affairs (“VA”) to react to two decades of change with new, robust evidence-gathering procedures. Until that cause is addressed, increasing the number of adjudicators and

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1 Bertrand Russell, Unpopular Essays 116 (1950).


3 Fox, supra note 2, at 339.

revising the appellate review process for benefits claims will achieve nothing more than “simply to ‘do the wrong thing’ faster.”

Though Bertrand Russell was describing matters of faith in the quotation cited at the introduction to this Article, the sentiment remains true in the legal arena. An adjudication system that lacks adequate evidence-gathering tools is destined to breed both inefficiency and resentment. Accordingly, the time has come to examine how Congress can overhaul the evidence-gathering procedures for veterans benefits claims to conform to the modern process of claims adjudication. Part I of this Article reviews the essential elements of compensation claims and the development of the current system for gathering medical evidence. Essentially, the system has transformed from panels with medical professionals deciding claims for which a veteran’s evidence was insufficient as a matter of law, to groups of individual lay adjudicators weighing private and VA medical evidence on equal terms. Part II focuses on why the current evidence-gathering procedures are insufficient to clarify the complex questions that arise in veterans benefits cases and result in needless delay while claims languish, waiting for information that a proper system would solicit at the beginning. Finally, Part III proposes how VA can use lessons from the adversarial arena to reshape the Secretary’s duties to notify and assist claimants to obtain adequate evidence as quickly and efficiently as possible. Once Congress adopts these changes, VA will decide claims faster, tremendous resources will be freed at VA that are currently devoted to inefficient procedures, and—most importantly—veterans can be assured that their claims are being decided fairly.

5 Examining the Backlog and the U.S. Department of Veterans Affairs’ Claims Processing System: Hearing Before the Subcomm. on Disability Assistance and Memorial Affairs of the H. Comm. on Veterans’ Affairs, 110th Cong. 112 (2008) (statement of Linda J. Bilmes, Professor at the Kennedy School of Government), available at http://veterans.house.gov/hearings/hearing.aspx?newsid=189. Professor Bilmes’ suggestion that VA look to the insurance industry for a claims processing model identifies the need for VA to deal directly with private doctors, but fails to focus on procedures for developing evidence adequate for adjudication. See infra Part III.

6 Notably, within administrative law, there is little data about how judicial review affects agency decision making, and “[d]espite (or perhaps because of) the lack of data, strong opinions on this question are common.” Peter H. Schuck & E. Donald Elliott, Studying Administrative Law: A Methodology for, and Report on, New Empirical Research, 42 Admin. L. Rev. 519, 520 (1990).

7 See Holding, supra note 2, at 26–29.
I. The Current System and Its Origins

A. The Elements of a Compensation Claim

VA receives and decides hundreds of thousands of claims for benefits every year, and the great majority of these are claims for compensation.\(^8\) When a claim is filed, the Secretary obtains the veteran’s service medical records\(^9\) and the veteran may provide testimony as to symptoms that a layperson is capable of observing.\(^10\) However, the overwhelming majority of claims require the veteran to provide evidence linking the veteran’s current disability to an injury or disease that occurred during service.\(^11\) In most cases, this requires medical evidence diagnosing the current disability and providing the requisite “nexus” to a specific disease or injury received during service.\(^12\) Once the connection is established, the evidence must further demonstrate the veteran’s level of disability, based on specific criteria set forth in Chapter 4 of Title 38 of the Code of Federal Regulations. Chapter 4 contains hundreds of diagnostic codes that are used to parse any condition into levels of disability, ranging from non-compensable to 100% disabled, in 10% increments.\(^13\)

The nexus prong of a claim is usually the most difficult to establish, although there are numerous theories that may be used.\(^15\) A suitable medical professional\(^16\) may opine that there is a direct etiological link, or a direct service connection.\(^17\) VA may presume a nexus for certain conditions, depending on how soon after service it manifested and what experiences the veteran had

\(^8\) In Fiscal Year 2006, 654,000 of the 806,000 claims received by VA were claims for compensation. INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, A 21ST CENTURY SYSTEM FOR EVALUATING VETERANS FOR DISABILITY BENEFITS 169 (2007), available at http://www.iom.edu/CMS/26761/34247/43423.aspx.


\(^11\) A few exceptions have recently been carved out. See Barr v. Nicholson, 21 Vet. App. 303, 310–11 (2007) (holding that a veteran is competent to diagnose his own varicose veins); cf. Jandreau v. Nicholson, 492 F.3d 1372, 1376–77 (Fed. Cir. 2007) (holding that a veteran is competent to diagnose his own broken leg in service).

\(^12\) Caluza v. Brown, 7 Vet. App. 498, 506 (1995). A veteran’s next of kin can also apply for compensation if his or her death is related to service. 38 U.S.C. § 1310(a) (2006). For simplicity, this article speaks only in terms of disability compensation claims.


\(^15\) See, e.g., Hickson, 12 Vet. App. at 252–53.

\(^16\) In appropriate cases an opinion can be supplied by another type of professional such as a registered nurse or a psychologist. See Cox v. Nicholson, 20 Vet. App. 563, 566 (2007).

A veteran may also demonstrate a nexus if the symptoms of the current condition have existed continuously since service or if the current condition is chronic and manifested during service, which demonstrates that it was chronic at that time. If one condition is caused by a condition already found to be service connected, then VA may find a “secondary” service connection. Moreover, there also may be a medical question as to whether a condition existed prior to service and, if so, whether service permanently aggravated the condition.

Even after a veteran establishes entitlement to compensation, the appropriate effective date and disability rating for benefits often require additional medical evidence demonstrating what symptoms are associated with the condition and when they first manifested. Accordingly, the numerous theories of entitlement to compensation and levels of disability make obtaining adequate medical evidence both difficult and vitally important.

**B. The Requirements for an Adequate Medical Opinion**

At the most basic level, an adequate medical opinion is one that allows the VA adjudicator’s “evaluation of the claimed disability [to] be a fully informed one.” The standard is only understood by looking at how the evidence will be evaluated. A defining characteristic of the VA adjudication system is that the initial decision-makers at the fifty-seven regional offices (“ROs”) are neither medical professionals nor attorneys. Because VA adjudicators are not medical professionals, an adequate opinion is one that can be weighed and evaluated by a layperson. The standard of proof that these adjudicators apply

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18 38 C.F.R. §§ 3.307, 3.309(a). The presumptions available vary by type of service including special presumptions for veterans who were prisoners of war, see 38 C.F.R. § 3.309(c), exposed to Agent Orange, see 38 C.F.R. §§ 3.309(e), 3.313, exposed to certain chemical weapons, see 38 C.F.R. § 3.316, exposed to radiation from atomic weapon use or testing, see 38 C.F.R. §§ 309(d), 3.311, or suffering from an undiagnosed illness after service in the Persian Gulf, see 38 C.F.R. § 3.317.
24 Although a plurality of rating official (“RO”) adjudicators have college degrees, a quarter do not. See Daniel Harris, Findings from Raters and VSOs Surveys 14 (CNA 2007), available at https://www.1888932-2946.ws/vetscommission/e-documentmanager/gallery/Documents/2007_July/CNA_Raters&NVSO-Survey_FinalReport.pdf. This survey was taken in concert with a report prepared by CNA Corporation for the Veterans’ Disability Benefits Commission mentioned supra, note 4, with the full cooperation of VA.
is generous to veterans, but still requires some competent evidence to support all essential elements.\textsuperscript{26} Although a veteran enjoys the benefit of the doubt,\textsuperscript{27} the adjudicator may not be willing to grant benefits based upon speculation that a current condition is related to service.\textsuperscript{28}

In practice, this means that a letter from the veteran’s doctor stating merely that he or she believes that the veteran’s current condition is related to some in-service injury or disease will not be sufficient to grant benefits.\textsuperscript{29} An adjudicator cannot simply rely on the assertion of a veteran’s treating physician.\textsuperscript{30} Rather, the medical opinion must provide sufficient detail to make clear its factual basis and the theory of causation, and thereby convince the adjudicator that there is a basis for granting the claim.\textsuperscript{31}

An adequate medical opinion must meet numerous criteria. First, the opinion should state its factual premise in detail, including the precise nature of the in-service disease or injury and whether there have been any intervening post-service injuries or diseases.\textsuperscript{32} This statement of facts should indicate its sources, including to what extent the facts are taken from available medical records, versus history supplied by the veteran.\textsuperscript{33} The degree to which an opinion discusses and accounts for the veteran’s documented medical history is a relevant factor.\textsuperscript{34} VA may reject a medical opinion as having no value because of an inaccurate factual premise, and an incomplete factual premise diminishes the weight that the opinion might otherwise be assigned.\textsuperscript{35}

\begin{itemize}
\item \textsuperscript{26} See 38 U.S.C. § 5107(a) (2006) (stating that a claimant “has the responsibility to present and support a claim for benefits”).
\item \textsuperscript{27} 38 U.S.C. § 5107(b) (“When there is an approximate balance of positive and negative evidence regarding any issue material to the determination of a matter, the Secretary shall give the benefit of the doubt to the claimant.”); see 38 C.F.R. § 3.102 (2008) (stating that reasonable doubt will be resolved in favor of the claimant).
\item \textsuperscript{28} Tirpak v. Derwinski, 2 Vet. App. 609, 611 (1992).
\item \textsuperscript{29} See id.
\item \textsuperscript{30} In fact, the Federal Circuit has rejected the argument that the opinion of a veteran’s personal physicians should be accorded special deference. See White v. Principi, 243 F.3d 1378, 1380–81 (Fed. Cir. 2001).
\item \textsuperscript{31} Tirpak, 2 Vet. App. at 611.
\item \textsuperscript{32} See Miller v. West, 11 Vet. App. 345, 348 (1998) (holding that a veteran’s burden cannot be carried by “[a] bare conclusion, even one written by a medical professional, without a factual predicate”).
\item \textsuperscript{33} A veteran’s account of injuries and symptoms that a layperson is competent to observe should not be rejected merely for lack of corroboration. Buchanan v. Nicholson, 451 F.3d 1331, 1335 (Fed. Cir. 2006).
\item \textsuperscript{34} See Guerrieri v. Brown, 4 Vet. App. 467, 470–71 (1993) (holding that the probative value of an opinion is based, in part, upon “physician’s knowledge and skill in analyzing the data”).
\end{itemize}
Second, the opinion should state the diagnosis of the veteran’s current condition. The opinion should list each symptom attributable to the veteran’s current condition and when the condition first manifested. The physician should also document any objective test results supporting the existence, severity, or duration of any symptom. If applicable, the opinion should note specifically whether the veteran’s symptoms have been continuous since service. If the condition is chronic, the opinion should discuss whether the available evidence is sufficient to determine that the condition first manifested as chronic during service. If appropriate, it should also address prior conflicting diagnoses and the possibility that some symptoms may be attributable to a different condition.

Third, the medical opinion should state why the physician believes that the veteran’s condition relates to service. The physician must state this opinion in terms that make clear that the expert believes that it is at least as likely as not that a relationship exists. If the theory of causation is not generally accepted in the medical community, then it may be necessary for the doctor to note any research that was conducted and what authorities support the stated theory of causation. A medical opinion should address prior negative opinions, and the rationale for rejecting a contrary opinion is an important

37 See Massey v. Brown, 7 Vet. App. 204, 207–08 (1994) (holding that an examination must contain reference to the pertinent scheduler rating criteria found in 38 C.F.R. pt. 4 to be adequate).
39 See Claiborne v. Nicholson, 19 Vet. App. 181, 186 (2005) (rejecting medical opinions that did not indicate whether the physicians actually examined the veteran, did not provide the extent of any examination, and did not provide any supporting clinical data).
40 38 C.F.R. § 3.303(b) (2008).
41 Id.
42 See Wells v. Principi, 326 F.3d 1381, 1382 (Fed. Cir. 2003).
43 See id.
44 Doctors are trained to use terms such as “possible” and “history of” unless they are absolutely certain their opinion is correct. See Dr. Lewis R. Coulson, Dir. of VA’s Comp. and Pension Examination Program, Remarks at the Court of Appeals for Veterans Claims Bar Ass’n Continuing Legal Educ. Program: Determining What Constitutes an Adequate VA Examination (Apr. 15, 2008). However, opinions phrased in these terms are considered too speculative to support an award of benefits. See Obert v. Brown, 5 Vet. App. 30, 33 (1993) (holding that a medical opinion expressed in terms of “may,” implies “may or may not” and is too speculative to establish a plausible claim).
46 See Green v. Derwinski, 1 Vet. App. 121, 124 (1991); cf. 38 C.F.R. § 4.2 (2008) (“It is the responsibility of the rating specialist to . . . reconcile[e] the various reports into a consistent picture . . . ”).
factor when a lay adjudicator is weighing the evidence. Additionally, the Secretary’s duty to assist requires that he obtain an opinion that discusses every theory of causation raised by the record. Therefore, one of the most frequent reasons that VA rejects an opinion is that the opinion addresses only direct service connection without analyzing whether there was continuity of symptomatology, secondary service connection, or another alternative theory.

It may seem at first blush that the requirements are somewhat onerous, but it is important to remember that they are neutral. Although they may make it difficult for a private physician to provide an opinion in support of a claim, these requirements also make it difficult for VA to deny a claim based upon a less than thorough opinion. Ultimately, the purpose of the requirements is to make sure the decision is reliable regardless of outcome. However, it is easy to see why it may be difficult for a private physician to provide a medical opinion that is adequate to support an award of benefits. Unless a doctor has experience testifying as an expert, he or she may not understand how much detail is necessary to provide a medical opinion that is adequate and persuasive to a lay VA adjudicator. What is more difficult to understand is how VA has reached the 21st century without developing procedures for assisting private physicians to render adequate opinions for the veterans that they treat. In order to understand this anomaly, it is necessary to review how the current system came into existence.

C. A Brief History of the Adjudication System

1. VA’s Decision Process and the VJRA

The veterans benefits system in the United States began as intentionally non-adversarial and paternalistic. Two aspects of the system’s history are

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48 Robinson v. Mansfield, 21 Vet. App. 545, 553 (2008). Technically, it is the Board's obligation to discuss every theory, not the doctor's. However, because the adjudicator is not competent to provide a medical opinion, in practice a medical opinion must be obtained in order for the Board to fulfill its duty.
49 See, e.g., Nicholson, 21 Vet. App. at 124–25 (holding that a medical opinion must consider not only direct service connections, but also other factors such as contrary opinions, studies, and whether the veteran has certain risk factors).
particularly relevant to the current problem: the development of the decision-making process and the evolution of the Secretary’s duty to assist claimants. Prior to the enactment of the Veterans Judicial Review Act\(^52\) (“VJRA”) in 1988, there was no independent review of benefits decisions.\(^53\) Before Congress created the United States Court of Appeals for Veterans Claims (“CAVC”), medical specialists were directly involved in making benefits decisions.\(^54\) At that time, initial decisions on disability claims were made at the locally a three-person rating board.\(^55\) This board consisted of a medical specialist, a legal specialist, and an occupational specialist.\(^56\) These individuals used their expertise to evaluate claims, rather than relying exclusively on a detached evaluation of any expert opinion contained in the record.\(^57\)

Similarly, appeals to the Board of Veterans Appeals (“Board”) were heard by three-member panels, consisting of two attorneys and a licensed physician who “were expected to use the additional resources provided by their own training and their informed legal and medical judgment” in deciding the claims presented.\(^58\) Because of these structures, it was not necessary to obtain an expert medical opinion prior to adjudication.\(^59\) So long as the complete medical history was in the record, the panel could reach a decision that applied expert medical knowledge to the correct legal standards.\(^60\) Moreover, there was direct dialogue between the legal and medical experts so that if the legal experts had any medical questions, they could receive an immediate answer and follow up with additional questions until they were satisfied that they understood every aspect of the claim.\(^61\)

Once Congress added independent judicial review to the system, it became necessary to remove the medical specialists from direct participation in the adjudication of claims.\(^62\) VA decisions had to be made strictly by lay adjudicators in order to have a clear separation between the evidence of record and


\(^{54}\) Id. at 24–25.

\(^{55}\) Id. at 24 (internal quotations omitted).

\(^{56}\) Id. (citing Walters v. Nat’l Ass’n of Radiation Survivors, 473 U.S. 305, 309 (1985)).

\(^{57}\) Id.; see also Walters, 473 U.S. at 309.

\(^{58}\) See Cragin, supra note 53, at 24–25.

\(^{59}\) Id.

\(^{60}\) See id.

\(^{61}\) Of course, the process was not perfect. At the very least, the fact that the crucial interactions between the legal and medical specialists was off the record certainly contributed to the dissatisfaction within the veterans community that led to the VJRA. See id. at 25.

\(^{62}\) See id. at 25–26.
the decision being reviewed. The Board initially resisted, but the CAVC ruled in one of its earliest decisions, Colvin v. Derwinski, that doctors could not participate directly in Board decisions, but rather that such decisions had to be based on “independent medical evidence.” Shortly after Colvin, the Board Chairman allowed the appointments of the doctors on the Board to lapse and announced that the Board would not appoint any additional doctors. Unfortunately, after the VJRA and Colvin, VA failed to make any changes to compensate for the loss of medical expertise previously inherent in VA decisions.

2. The Duty to Assist Prior to the VCAA

When Congress created the CAVC, it also provided that any veteran submitting a “well[-]grounded” claim should receive assistance in substantiating that claim. However, with minor exceptions, a VA regulation from 1961 required that private medical opinions “be verified by official examination prior to [the] granting [of] benefits.” The CAVC interpreted a well-grounded claim to be one for which the veteran had submitted at least prima facie evidence on each element. This meant that a veteran without competent medical nexus evidence was not entitled to assistance, while a veteran with an opinion from a private physician would receive a second opinion from a VA doctor.

As part of the Veterans Benefits Improvements Act of 1994, Congress superseded the 1961 regulation with a statute allowing benefits to be granted based on private medical evidence “if the report is sufficiently complete to be adequate for the purpose of adjudicating such claim.” The legislative history declares, in no uncertain terms, that:

[i]t is the express intention of the House and Senate Committees on Veterans’ Affairs that, to the maximum extent feasible, the Secretary exercise the authority provided under this section as being in the best interest of veterans in furthering the timely adjudication of their claims for compensation by reducing the need for duplicative medical examinations by VA physicians.

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63 See id. at 26.
65 Id. at 172.
70 See id. at 82–83.
Unfortunately, the Act made no provision for assisting veterans in obtaining private opinions that would be adequate for granting benefits.

Five years later, in *Morton v. West*, the CAVC hampered the ability of veterans to obtain adequate medical evidence by holding that the Secretary did not have statutory authority to provide a medical opinion for a claim that did not meet the threshold of being well-grounded. *Morton* was the subject of immediate and strenuous objection in the veteran community. Congress quickly reacted with the Veterans Claims Assistance Act of 2000 (“VCAA”). Unfortunately, the VCAA did not focus on the root problem of soliciting adequate medical opinions.

**D. The VCAA and the Secretary’s Current Duties**

The VCAA enacted two major changes in the Secretary’s duty to assist. First, it created a new duty to notify claimants about how to prove their claims. This notification duty was largely a congressional response to the perception that VA frequently denied benefits because the veterans simply did not understand how to prove their claims. The VCAA requires that, upon receipt of a substantially complete claim, the Secretary must provide notice to the claimant of the evidence and information necessary to substantiate the claim. This notice duty does not require the Secretary to pre-adjudicate the evidence submitted with a claim. However, the Secretary must tailor the notice to the nature of the claim, and, if the claim is an attempt to seek a previously denied benefit, the Secretary must tailor it to any findings made in the prior adjudication. Although this notice requirement sounds helpful, it has not succeeded in producing adequate evidence. Nonetheless, this notice duty completed the transformation from a system in which private physician evidence was insufficient as a matter of law to one in which it was intended to be the evidence of first resort.

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75 *Id.* at 486.
83 See infra Part III.A.
The VCAA’s second major change was to give the Secretary unrestricted authority to provide medical opinions in support of claims.\textsuperscript{84} Congress intended this change to address the CAVC’s holding in \textit{Morton}.\textsuperscript{85} In addition, the VCAA mandates that if a claim contains evidence indicating that there may be a nexus between the veteran’s current condition and service, but the evidence is insufficient to grant the claim, the Secretary must obtain a medical opinion to resolve the issue.\textsuperscript{86}

\textbf{E. Proof that the Evidence-Gathering Process is Dysfunctional}

Despite the lofty goals of the VCAA, all available evidence indicates that the current VA evidence-gathering process remains deeply flawed. First, VCAA notice letters have not succeeded in enabling veterans to support their claims with adequate medical evidence. VA does not publish statistics on how many claims it grants each year at the initial adjudication stage based upon private medical opinions, or how many it denies at that stage based upon a determination that there is not sufficient evidence to trigger the duty to assist. However, given that there are approximately 650,000 compensation claims filed each year\textsuperscript{87} and the Secretary obtains more than 500,000 medical opinions pursuant to the duty to assist,\textsuperscript{88} one may reasonably infer that it is relatively infrequent for a veteran to submit a private medical opinion that is sufficient to grant benefits. Instead, the high ratio of VA medical examinations to claims suggests that veterans routinely submit private medical evidence that VA deems to indicate that a claim might have merit, but which is ultimately not adequate to grant benefits.

Second, and perhaps more importantly, the evidence suggests that VCAA notice letters have not improved veterans’ understanding of, or faith in, the benefits adjudication system. In a recent survey conducted for Congress’ Veterans’ Disability Benefits Commission, 70\% of veterans service officers (“VSOs”)\textsuperscript{89} reported that they believed that most of their clients did not understand the system, and a majority reported that their clients found the

\textsuperscript{84} 38 U.S.C. § 5103A(a).


\textsuperscript{87} \textit{Institute of Medicine}, supra note 8, at 169.

\textsuperscript{88} \textit{Id.} at 149.

\textsuperscript{89} VSOs are employees of national and state veterans service organizations—generally lay advocates—who provide free assistance to individuals pursing veterans benefits claims. \textit{See Barton F. Stichman et al., Veterans Benefits Manual} § 17.1.4, at 1394–95 (2007).
Moreover, 77% of rating official (“RO”) adjudicators and 68% of VSOs reported that they believed that claimants had unrealistic expectations of the veterans benefits system. Beyond these survey results, there are many reports that claimants routinely do not understand the VCAA notice letters they receive.

As to the half million medical opinions that VA seeks each year, it is clear that the current system does a poor job of producing adequate evidence. The need for an adequate medical examination has been the leading cause of remand from the Board. Both internal and independent reviews of RO decisions have found that more than half of all evidence development errors were due to not obtaining VA medical opinions and relying on inadequate medical examinations.

See Harris, supra note 24, at 43. This perception contrasts markedly with the result showing that nearly 80% of VSOs believe that the benefits adjudication most often produces fair results. See id. at 41.

In response to an open-ended question on how to overcome the current problems in adjudicating veterans claims, a significant number of VSOs stated that a better job needs to be done in educating veterans on how the claims process works. See id. at 26.

See, e.g., Holding, supra note 2, at 28 (quoting one veteran as saying, “I would start reading these letters with five pages of legal garbage and just give up”).


Data from VA’s Systematic Technical Accuracy Review program, which reviews samples of RO decisions, found that during the first half of 2006 over half of all evidence development errors were due to not obtaining VA medical opinions and relying on inadequate medical examinations. GAO-07-98, supra note 93, at 5.

Two of the most commonly cited errors in the random samples of claims reviewed by the American Legion and the National Veterans Legal Services Program are inadequate claim development and decision making based upon inadequate VA medical opinions. See Examining the U.S. Department of Veterans Affairs’ Claims Processing System: Hearing Before the H. Subcomm. on Disability Assistance and Memorial Affairs of the H. Comm. on Veterans’ Affairs, 110th Cong. (2008) (statement of Steve Smithson, Deputy Director Veterans Affairs
decisions find the same problem. Beyond the error rates, there is an entrenched perception that obtaining adequate evidence is a problem. Fifty-six percent of surveyed RO adjudicators responded that inadequate examinations were a problem that made it difficult to make accurate decisions. Part of the problem is undoubtedly due to the limited resources available to ROs. Of course, insufficient time and inadequate tools for obtaining satisfactory evidence are certainly related problems.

Furthermore, there is a fundamental disconnect in how RO adjudicators and VSOs view medical evidence. Almost half of RO adjudicators indicated that it was difficult to rate a case based upon a private medical opinion, but only a quarter indicated this was true for opinions obtained through the duty to assist. Among VSOs, these numbers are almost exactly reversed. Regardless of whether either group might be objectively correct, this perception gap is certain to be a source of friction between VA and veterans if it continues.

**F. The Consequences of Deciding Claims Without Adequate Evidence**

Inadequate opinions heavily contribute to the backlog of claims in the system. As the Chief Counsel for Policy at the Board has observed, because the RO must review all evidence in the first instance, “a problem at the early stage in the development of [a] claim” will often lead to “a cascading effect
with respect to other problems in the case.\textsuperscript{102} Moreover, because the CAVC does not have the power to find facts de novo or to consider new evidence, appeals frequently result in remands back to the RO level for a new medical opinion,\textsuperscript{103} which begins the process anew and often results in claims lingering for a decade or more before being decided.\textsuperscript{104} Finally, and perhaps most importantly, the ability of veterans to make unlimited attempts to reopen claims means that a majority of the claims filed each year are not new.\textsuperscript{105} It is not uncommon for an unsuccessful claimant to seek the reopening of a claim a dozen or more times.\textsuperscript{106} Each time a veteran litigates a claim, the claim is further removed from the events in service and most likely becomes more difficult to prove. Even if VA grants the claim, a veteran dissatisfied with the disability rating may file an unlimited number of claims for a higher disability rating.\textsuperscript{107} Accordingly, each denied claim has the potential to multiply exponentially the adjudication resources consumed over the course of years of refilings.

II. The Deficiencies in the Current System

The first step in breaking out of the cycle of denials, appeals, remands, and refilings is to identify the two-fold problem with the current system: (1) VA makes no effort to work with private physicians, and (2) its procedures for obtaining internal opinions prevent decision makers from communicating directly with VA doctors.

A. VA’s System for Gathering Evidence from Veterans

The first flaw in VA’s process is that its procedures for gathering evidence from veterans are remarkably weak. The form used to apply for disability benefits is twenty-three pages long,\textsuperscript{108} yet it is woefully unhelpful in explaining how to prove the crucial issue—that a current disability relates to service. The

\textsuperscript{102} Brian Thrasher, Remarks at the Ninth Judicial Conference of the United States Court of Appeals for Veterans Claims (Apr. 24, 2006), in 21 Vet. App. LI, CLXXI.

\textsuperscript{103} See Gary E. O’Connor, Rendering to Caesar: A Response to Professor O’Reilly, 53 ADMIN. L. REV. 343, 383 (2001).


\textsuperscript{106} Stichman et al., supra note 89, § 12.2.2.1, at 866.

\textsuperscript{107} Id. § 12.2.1.1.2, at 860.

\textsuperscript{108} Dep’t of Veterans Affairs, General Instructions for Veteran’s Application for Compensation and/or Pension, VA Form 21-526 23 (2004), http://www.vba.va.gov/pubs/forms/VBA-21-526-ARE.pdf.
instructions state that a claimant will need “[m]edical records . . . indicating that the disability was caused by or happened during . . . active service.” 109 In the body of the application, there is an instruction to “tell us more about your . . . disabilities . . . [Y]ou believe are related to military service,” next to a box labeled “[t]ell us about your disability” 110 Nothing in the form, however, explains what a medical opinion that is adequate to grant a claim requires.

After a veteran submits a claim, VA must respond with a VCAA notice letter. 111 The language in that letter, which is usually similar to one published as an appendix to the CAVC’s decision in Mayfield v. Nicholson, 112 states that the evidence must show

[a] relationship between the cause of death and the injury, disease, or event in service. (This is usually shown by the death certificate, or in other medical records or medical opinions. We will request this medical evidence for you if you tell us about it. If appropriate, we may also try to get this evidence for you by requesting a medical opinion from a VA doctor, or you can give us a medical opinion from your own doctor.) 113

As with the application, the need for medical evidence is clear, but the elements of an adequate medical opinion are absent.

Furthermore, even if VA adequately communicated all the elements to the veteran, the veteran would not be the person writing the opinion. Instead, the veteran’s treating physician needs to understand how to write an adequate medical opinion. 114 Unfortunately, VA has no procedure for communicating directly with private physicians or eliciting adequate opinions from them. 115

### B. VA’s System for Providing Medical Opinions

In the likely event that a veteran fails to submit an adequate medical opinion, VA’s mechanism for providing an opinion stifles communication between physicians and decision makers. The mechanics of making the ultimate determination at an RO is governed by the claims process improvement model (“CPI”), adopted in 2001. 116 Once a claim is submitted, the RO’s “predetermination team” evaluates the claim and obtains a medical opinion from the

109 Id. at 3.
110 Id. at 13.
111 See 38 C.F.R. § 3.159(b) (2008).
112 19 Vet. App. 103 (2005), rev’d on other grounds, 444 F.3d 1328 (Fed. Cir. 2006).
113 Id. at 131. Mayfield involved a claim for compensation asserting the veteran’s death was connected to service. Id. at 107. The language for disability compensation is comparable.
114 See id. at 131.
115 Technically, ROs have the authority to subpoena a veteran’s physician to testify at a hearing, 38 U.S.C. § 5711 (2006); 38 C.F.R. §§ 2.2(a), 2.3(a). However, “[c]laimants and advocates have rarely asked the VA to issue subpoenas, and it is an authority that has been rarely exercised by the VA.” STICHEMAN ET AL., supra note 89, § 12.9.4, at 932 (2007).
116 INSTITUTE OF MEDICINE, supra note 8, at 141.
Veterans Health Administration (“VHA”), the medical division of VA, if it believes one is necessary to decide the claim.\(^{117}\) To do this, the team evaluates the available records and uses one or more of fifty-eight different Automated Medical Information Exchange system (“AMIE”) examination worksheets to prepare a request detailing for the VA physician the specific requirements of the opinion needed.\(^{118}\) Unfortunately, these forms were developed more than a decade ago and VA has no program for evaluating how successfully they produce adequate opinions, or for regularly reviewing and updating them.\(^{119}\)

In addition to problems with accuracy and completeness, claimants often assert that requests for opinions suffer from bias as well.\(^{120}\) However, VA prohibits leading questions to solicit an opinion,\(^{121}\) and at least one senior VHA physician has stated that, if anything, opinion requests are overly neutral and sterile.\(^{122}\) Accordingly, it is possible that a problem exists, but that it is not one of bias. While prohibiting leading questions makes sense, it is likely that in some cases it has the perverse effect of discouraging adjudicators from clearly explaining exactly what appears inconsistent or confusing about the evidence of record. In such circumstance, the opportunity to shore up the claimant’s case is lost due to the fear that focusing on the problems in the current evidence will be seen as bias.

VA’s record-keeping practices further complicate the process of obtaining an adequate medical opinion.

Claim files are currently and historically maintained by [VA] in a single and unmanageable file containing information concerning every claim ever made by the claimant. Claim files also include paperwork and evidence of not only the pending claim but also of any other prior unrelated claims, claims for dependent benefits, apportionment of benefits, overpayment of benefits issues, as well as educational benefits. Claim files are not organized chronologically, nor are their contents paginated. Claim files do not contain a table of contents or in any way provide a description of the contents of the file. There are no means of determining or even ascertaining the chronological order in which the contents of the claims file were received by [VA]. Documents are not uniformly date stamped; there are no mandatory or uniform procedures utilized for

\(^{117}\) See id. at 142–43. Sixteen percent of opinions are obtained from an outside contractor. Id. at 149.

\(^{118}\) Id. at 149.

\(^{119}\) See id.

\(^{120}\) See, e.g., Tablazon v. Nicholson, No. 05-2462, 2007 U.S. App. Vet. Claims LEXIS 1208, at *8–9 (July 31, 2007) (finding that appellant’s argument that the RO was biased in requesting an opinion was unfounded).


identifying the date of receipt of evidence placed in the claims file. There are no means for VA claimants or the claimant’s representative to ascertain at any discrete point in time, including the date of the Board’s decision, the precise contents of the claims file. As a consequence, claim files, which can range from several hundred to several thousand pages, are without any form of organization, making the task of reviewing and understanding a claims file’s contents increasingly problematic as the number of pages contained in the claims file increases.\textsuperscript{123}

Rather than require VA physicians to read the entire file, the predetermination team attaches tabs to the relevant medical evidence in a veteran’s claims file.\textsuperscript{124} Veterans’ representatives complain that the tabs often omit evidence that is favorable to the veteran, particularly lay statements made outside of prior medical examinations.\textsuperscript{125} Regardless of whether this occurs, there is no system for recording which portions of the claims file were tabbed to ensure that a medical examiner was directed to all relevant evidence.\textsuperscript{126}

Assuming that a VA physician receives a comprehensive request for a medical opinion and is directed to all relevant evidence in the claims file, there are additional flaws in the system for producing opinions. First, although VA has converted the AMIE worksheets used by RO staff into online templates that physicians could fill out using a point-and-click graphical user interface, as of February 2007, only 28\% of VA medical opinions were being prepared using these templates.\textsuperscript{127} Second, although VA provides a handbook to physicians, it does not clearly explain the requirements for an adequate medical examination or the most common reasons why VA might reject an opinion.\textsuperscript{128} Third,

\begin{itemize}
  \item \textsuperscript{123} Carpenter, \textit{supra} note 51, at 294–95. VA is aware of the need to replace its antiquated claims file system with modern, computerized records. However, converting the records of tens of millions of veterans is an enormous undertaking and, after several years of study and effort, VA is still some time away from making the conversion. See \textsc{Paralyzed Veterans of American et al., The Independent Budget for the Department of Veterans Affairs Fiscal Year 2009} 27–28 (2008), http://es3.pva.org/independentbudget/pdf/IB_09.pdf.
  \item \textsuperscript{124} See Thrasher, \textit{supra} note 102, at CLXXXVIII.
  \item \textsuperscript{125} See, e.g., Ted Jarvi, Remarks at the Ninth Judicial Conference of the Court of Appeals for Veterans Claims (Apr. 24, 2006), \textit{in} 21 Vet. App. LI, CLXXXIX.
  \item \textsuperscript{126} See id.
  \item \textsuperscript{127} See \textsc{Institute of Medicine}, \textit{supra} note 8, at 150.
  \item \textsuperscript{128} The VA clinician’s guide explains to physicians that “[t]he purpose of the C&P exam is to provide very specific information in order to ensure a proper evaluation of the claimed disability rather than to provide medical treatment. A treatment examination is written for clinicians to understand, but a compensation and pension examination is written for [RO adjudicators], lawyers, and judges to understand.” \textsc{C&P Service Clinician’s Guide} \textsection 1.9 (Lewis R. Coulson ed., 2002), \textit{available at} http://www.warms.vba.va.gov/21guides.html. The section titled “How much information should be included in the report?” is only six sentences long, \textit{id.} at \textsection 1.11. The section on how to provide a nexus opinion explains only what language to use to express various levels of certainty. See \textit{id.} at \textsection 1.16.
\end{itemize}
VA gives feedback to VA doctors through the Compensation and Pension Examination Project ("CPEP"). Rather than contacting the adjudicators and determining what issues they have had with opinions from specific physicians, CPEP establishes "quality indicators" for opinions for different conditions. Then CPEP monitors performance and provides feedback based on those elements. Regardless of how well designed such a program may be, there is little reason to believe that CPEP feedback can be of as much value as the actual adjudicator explaining how an opinion was unsatisfactory.

Eventually, once the predetermination team has certified that a claim is "ready to rate," the claim is turned over to the "rating team" for a decision. However, there is simply no guarantee that the adjudicator on the rating team will view the evidence in the same way as the predetermination team, or agree that the appropriate questions were asked of the VA physician. In such cases, an adjudicator may well be tempted to decide a case based upon a problematic opinion rather than delay the matter further for clarification. A 2005 survey by VA's Office of Inspector General strongly suggests that this frequently happens.

Ultimately, the current VA process resembles one tried in the 1850s in the English Courts of Chancery. Those courts experimented with having evidence gathered by one official and then presented to a judge for a decision. The system was a failure and the commission that recommended its revision observed: "The evil arising from having the evidence taken before one functionary, and its weight and effect decided on by another, is an evil of principle, and not of detail." That observation is equally true today. Much time and effort is wasted in veterans benefits cases by dividing up the evidence-gathering and adjudication processes and creating excessive separa-

129 See Institute of Medicine, supra note 8, at 152.
130 See id.
131 Id. at 143.
132 This problem has been observed by practitioners. See Stichman et al., supra note 89, § 12.6.2.2.2, at 906–07.
133 In that survey, VA adjudicators estimated that medical opinions are inadequate at a rate substantially higher than the rate at which they are actually returned. See VA Office of Inspector General Report, supra note 98, at 59.
134 Compare id. at 58–62, with Report of Her Majesty's Commissioners Appointed to Inquire into the Mode of Taking Evidence in Chancery, and Its Effects, 6 Jurist 261, 266 (1860) [hereinafter Report on Evidence in Chancery].
135 See Report on Evidence in Chancery, supra note 149, at 266.
136 Id.
Lessons on Gathering Expert Witness Evidence

III. An Improved Evidence-Gathering Model

Fixing the current system requires a return to basic legal skills. The veterans benefits system should stay non-adversarial. However, now that it is based upon lay adjudicators considering independent medical opinions, there is much that the system can learn from the long history of the use of expert evidence in the adversarial arena of the courtroom. On a basic level, adequate expert evidence is obtained in court by asking numerous, precise questions that cover all relevant information and that are phrased to reflect the appropriate legal standards.

A. Improving Private Medical Opinions

Applying this lesson from courtrooms to the beginning of the veterans claims process, the fundamental problem with private medical opinions is that they tend to lack detail because the doctors are not aware of the relevant legal standards or of all the information that should be included. In order to obtain the requisite level of detail, VA cannot tell claimants simply to provide medical opinions. Instead, VA needs a tool to work directly with veterans’ doctors. Given the volume of veterans benefits cases, the most practical tool would be opinion forms that—if properly completed by a physician—will answer all the questions necessary to adjudicate the claim.

VA should model these opinion forms on a direct courtroom examination that would be appropriate if the physician were testifying as a witness.

137 The Institute of Medicine has commented that “[t]he separation between medical examiners and rating specialists at VA is an artificial one and based on a misunderstanding of the role of physicians in adjudication.” Institute of Medicine, supra note 8, at 194. However, while the comment recognizes part of the problem, the criticism misunderstands the ruling of the CAVC. Colvin does not prohibit VA adjudicators from consulting with physicians. Rather, Colvin merely requires that any input from physicians, which would be a form of evidence, must be provided on the record so that the process is transparent and capable of appellate review. 1 Vet. App. 171, 175 (1991).


139 See supra Part 1.B.

140 It may also be helpful to consider other forms that doctors must frequently fill out, such as insurance forms, so as to find a format that is consistent with doctors’ intuitive expectations. See Bilmes, supra note 5.
The forms should have the physician clearly state all relevant information, including his or her credentials, the factual predicate upon which the opinion is based, the sources of information used to determine the factual predicate, the claimant’s current symptoms and diagnosis, and all authorities that were consulted in reaching the opinion. Based on this information, the forms should guide the physician in addressing all potential theories of entitlement, using language that reflects the appropriate standards of proof. Different forms would be required for different types of claims. For example, claims for an increased rating would focus on the claimant’s current condition and explicitly address all symptoms relevant to the applicable diagnostic code. In all cases, VA should provide the claimant with the relevant forms along with the VCAA notice letter so that claimants have a realistic opportunity to prevail without requiring further assistance from the Secretary.

Although developing and distributing such forms should be relatively straightforward, it still leaves one significant complaint unaddressed: private physicians’ access to the evidence in the claims file. Giving private physicians an opportunity to address all the evidence is essential to show veterans that the process is fair. Accordingly, if an RO decides that a private physician’s initial opinion is inadequate, particularly if the opinion failed to address important evidence in the claims file, then the RO should copy all of the relevant evidence in the file—including lay statements of symptoms—and provide the physician with an opportunity to modify or clarify the original opinion. Without such an opportunity, it is doubtful that the Secretary would effectively be able to counter criticism from veterans that the process is biased against private evidence.

Altering the way VA obtains medical opinions in this manner would be a major paradigm shift for processing veterans benefits claims and would reduce the number of VA-generated opinions dramatically. To achieve this goal fully, there are a number of current and proposed programs that can be integrated into this change. The examination worksheets for VA physicians developed through the AMIE program should serve as a starting point for developing comprehensive opinion forms.142 However, VA would have to expand these forms to cover all relevant information comprehensively. VA has also been experimenting with computer programs to assist some adjudicators in discussing evidence and making decisions in complex cases.143 VA should update such tools to reflect the sections where relevant evidence will

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142 See Institute of Medicine, supra note 8, at 189. One of the recommendations was that there should be a process for periodically reviewing and updating these worksheets. Id.
143 See Board of Veterans Appeals, supra note 101, at 6. However, most RO adjudicators doubt such a tool would be useful. See Harris, supra note 24, at 49.
be found in the new opinion forms. Both tools should be subject to a process of regular review and updating.

The Secretary can also improve the likelihood that private physicians would use such forms by expanding upon one of the major recommendations of the Dole-Shalala report.\(^\text{144}\) The President’s Commission recommended reaching out to veterans through “a consumer-friendly, interactive, evolving, fully customizable and personalized information portal,” which the report referred to as “My eBenefits.”\(^\text{145}\) This outreach needs to be taken a step further. The Secretary needs to create an online portal to assist private physicians in producing adequate medical opinions. This portal should have all the forms that a physician might need, along with general advice for providing opinions and avoiding common problems. Eventually, once veterans’ records have been securely digitized,\(^\text{146}\) the two portals should be linked so that a veteran can use the Internet to provide his or her physician full access to all relevant records and the physician can fill out and update the opinion form online to provide evidence in support of claims as fast and as accurately as possible.

**B. Improving VA Medical Opinions**

Of course, even if such changes were made, there would be veterans who would need medical opinions provided by VA.\(^\text{147}\) VA must ensure that these opinions are adequate the first time they are given. This must be done in such a way that veterans believe that the system is not biased against private evidence.

The first step towards both of these goals is that VA physicians should be required to provide their opinions on the same forms provided to private physicians.\(^\text{148}\) Using the same forms ensures that all feedback and improvements made over time will improve both private and VA opinions equally. Furthermore, by using the same forms, all opinions—regardless of source—can

\(^{144}\) See Dole-Shalala, supra note 4, at 5–11.

\(^{145}\) Id. at 26–27.

\(^{146}\) Although not imminently available, Google has begun a pilot project to digitize medical records for secure and easy access. See Michael Liedtke, *Google to Test Medical-Record Service*, Wash. Post, Feb. 22, 2008, at D4.

\(^{147}\) For example, some private physicians will not be comfortable providing medical opinions for fear that it would interfere with the therapeutic relationship. See Joyce, *supra* note 122, at CLXXXVII (“[T]he primary function of the treating physician is to take good care of the veteran and that comes first.”).

\(^{148}\) Currently, VA examiners are not required to use the worksheets developed by VA. This was a concern raised by VA’s Inspector General in 2005, and the IOM has recommended that use of these templates should be mandatory. See Institute of Medicine, *supra* note 8, at 190–91.
be compared side-by-side on an apples-to-apples basis. This will make fact finding much easier for ROs and facilitate review by the Board and the CAVC.

Another key step in obtaining adequate VA medical opinions is abolishing the barrier between evidence development and adjudication. Although there is certainly some value in specializing functions within ROs, the special relationship between evidence development and claims adjudication requires that VA unify these functions.

Even if VA adopted both of these changes, there would still be many difficult cases in which the Board or the CAVC decides upon review that the opinions in the record are inadequate. At such a point, the issues are likely to be complicated, and the veteran’s interest in a speedy resolution merits a more robust procedure than simply another written request for an opinion. Instead, the adjudicator should interview the VA physician to clarify every issue in doubt. Although this would be akin to having the physician testify at trial, the process should not be adversarial.

Such a procedure would be a radical change for VA and would require certain safeguards. Perhaps surprisingly, the recent trend towards recording custodial interrogations by police should provide a roadmap for VA physician interviews.¹⁴⁹ The mistrust that veterans have for VA opinions resembles that which defense attorneys have for confessions obtained by interrogation. Accordingly, the benefits of transparency reaped by law enforcement are available to VA if it follows suit.

First, VA should record the interview so that there is a record for review. The Board already conducts hearings by video conference¹⁵⁰ and prepares transcripts for all Board hearings.¹⁵¹ Accordingly, VA has the technological expertise to conduct and record such interviews. Second, and perhaps more difficult, the interview process must be neutral. VA may not solicit a medical opinion in a manner that suggests a desired result.¹⁵² Accordingly, VA must train adjudicators to conduct the interviews in a way that is consistent with

¹⁴⁹ See generally Thomas P. Sullivan, Electronic Recording of Custodial Interrogations: Everybody Wins, 95 J. Crim. L. & Criminology 1127 (2005) (discussing the Minnesota practice of electronically recording all custodial interrogations in felony investigations from the time that Miranda warnings are given until the end of the interviews, and how the practice is popular among both defense attorneys and law enforcement officials).
a veteran’s right to an unbiased opinion. As with the opinion forms, direct examinations in the trial setting would be an appropriate model.153

Reviewing these interviews will require some sensitivity on the part of the Board and the CAVC as to the difference between thorough questioning and adversarial questioning. In order to obtain an adequate opinion in a complicated case, it is necessary to explore the weaknesses and conflicts in the evidence supporting the claim. Asking the physician about those problems should not be considered improper, so long as the adjudicator does not suggest what answer is desired.

Ultimately, such a program would provide the veterans benefits system with the same advantages that recording interrogations provides to the criminal justice system. For example, recording interrogations strongly discourages improper actions by police officers, eliminates unfounded accusations of misconduct, and promotes easy and reliable review of any disputes as to the propriety of the interview.154 Similarly, recording medical opinion interviews would promote professionalism, transparency, and easy appellate review of the adequacy of opinions rendered. Recording police interrogations also allows officers to concentrate on questioning rather than note taking, and to review the whole interview later to retrieve additional leads and inconsistent statements that may have been overlooked or not apparent originally.155 Obtaining medical opinions through an interview would allow all of the adjudicator’s questions to be answered at one time rather than through repeated inquiries, which may decline in value as the physician tries to recall how he or she reached the previous conclusion. Interviews would also allow physicians to elaborate the details of such an opinion rather than be constrained by the often more limited information contained in a written summary opinion. Additionally, recordings of well-done interviews would be an excellent training tool for VA, as they are for police officers.156 As with the recording of police interrogations, the front-end expenses for setting up such a system would be offset by fewer appeals and fewer additional opinions being required upon remand.157

The most important gain from obtaining opinions through recorded interviews, however, is likely to be intangible. Jurisdictions that now record custodial

153 Another useful model would be the investigatory model of hearings used in the Social Security hearings conducted by ALJs. See Verkuil & Lubbers, supra note 105, at 771 (“At the SSA, the more formal ALJ process and the more prevalent participation of attorneys (in 70 percent of cases) produce[s] a better record.”); Carpenter, supra note 51, at 288–90 (comparing SSA procedures to VA procedures).
154 See Sullivan, supra note 149, at 1129.
155 Id.
156 See id. at 1130.
157 See id.
interrogations have found that “[p]ublic confidence in police practices increases, because recordings demonstrate that officers conducting closed custodial inter-
views have nothing to hide from public review.” 158 As demonstrated above, con-
fidence in VA among veterans and veterans’ representatives is currently very low. 159 Therefore, if recording interviews with physicians were to prove to veterans that VA has nothing to hide, then it would be much easier for VA to work with them towards improving the system, rather than spending time countering accusations that the process is biased against veterans. Whatever problems persist after the evidence-gathering process is repaired will be much easier to solve in an atmosphere of cooperation, rather than one of acrimony.

Conclusion

The current backlog of cases at the Board and the CAVC is clearly a symptom of a very serious problem with the system for adjudicating veterans benefits claims. However, a good doctor will tell you that the organs display-
ing symptoms of an illness may not harbor the true cause of the disease. Any cure for what ails the veterans claims system must begin with overhauling the ways in which VA gathers medical evidence. These new procedures must incorporate the lessons learned from other arenas about how to obtain ade-
quate expert evidence from medical professionals. Regardless of details, these new changes must focus on asking both private and VA doctors numerous, detailed questions designed to clearly elicit all relevant information the first time an opinion is provided.

The Secretary could adopt most—if not all—of these changes through regulation. 160 The current distrust of the Secretary within the veteran community, however, could complicate and delay such a change through the rulemaking process. At this point, it makes more sense for Congress to adopt these new procedures through legislation. This would ensure swift adoption by the Secretary and guarantee that the procedures become a permanent part of an enhanced and truly non-adversarial system of adjudicating veterans benefits claims.

158 Id.
159 See supra Part II.