



April 3, 2012

The Honorable Sam Johnson, Chairman
House Committee on Ways and Means
Subcommittee on Social Security
United States House of Representatives

Re: Hearing, "Securing the Future of the Social Security Disability Insurance Program,"
March 20, 2012.

Dear Mr. Johnson:

Variations in disability determinations for Title II or Title XVI benefits at both the state and federal level are very problematic because the statutory and regulatory framework for decision making is based on a stable definition of disability that is intended to operate uniformly.¹ These variations raise several important questions about the fairness of the Social Security Administration's ("Agency") administrative decision-making process. One question raised is whether variations in allowance rates between decision makers at the state level and within the ALJ corps indicate that different decision makers apply the uniform definition of disability differently. One possible explanation, of course, is that there are a considerable number of decision makers at both the state level and within the ALJ corps that make decisions based on idiosyncratic preferences, rather than the underlying merits of the claim.

Consistent evaluation of disability applications filed by similarly situated claimants assumes that the protocols used to evaluate disability provide sufficient guidance to decision makers to ensure these individuals are treated uniformly.² Thus, this commentary will consider whether the Agency's repeal of Medical Listing 9.09 for use in its evaluation of obesity as a severe impairment has led to variations in decisions concerning similarly situated obese individuals. After reviewing the relevant case law following the repeal of Medical Listing 9.09, my article concluded that the repeal of the Listing and the inadequate methodology utilized in SSR 02-1p ("Ruling") has had a negative impact on the Agency's ability to provide consistent and fair adjudication of claims involving obesity.

¹ My comments are based on my forthcoming article, "SMITHERS, WHAT'S THE NAME OF THIS GASTROPOD? KING-SIZE HOMER AND THE SOCIAL SECURITY ADMINISTRATION'S SUBJECTIVE EVALUATION OF FATNESS," 29 GA. ST. L. REV. ____ (2012), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2016396.

² I chose to look at obesity for two reasons. First, obesity can invoke strong negative reactions among reasonable individuals: slothfulness, gluttony, and pitiful are all adjectives associated with high body weight. In spite of the stigma associated with obesity, other reasonable individuals might decry the moral panic associated with obesity. These opinions make the obese potentially vulnerable to inconsistent decision making. Second, I thought identifying similarly situated claimants would be possible by looking at the claimant's Body Mass Index ("BMI"). With these two reasons in mind, I began to review all district and circuit court decisions following the repeal of Medical Listing 9.09. Out of these cases involving obese claimants, I only reviewed cases where the claimant's BMI could be ascertained. These cases were reviewed for a number of factors: age, gender, BMI, type of claim, and presence of additional impairments. Upon completion of the first review, it became apparent that my search had also included cases where the claimant did not identify obesity as a severe impairment. Thus, I added a category to consider whether the claimant alleged obesity as a severe impairment, or whether the ALJ determined that the claimant's obesity was a severe impairment.

Several key themes emerged from my review. First, the lack of consistent results for seemingly similarly situated individuals, particularly for individuals with a higher BMI became apparent. This finding was surprising because of the assumption that the claimant's size would be sufficient to put the ALJ on notice that obesity could be a potentially limiting factor.³ Second, a seemingly low BMI might place a claimant at risk for an adverse decision when in fact the low BMI masks significant (and disabling) health problems.⁴ This is problematic given the debate concerning the accuracy with which BMI can be used to evaluate the epidemiological link between fatness and health. For example, for women the waist-to-hip circumference provides a more accurate way to consider how a patient's obesity impacts other bodily systems. A third, and potentially more significant problem, is that the Agency's evaluation of obesity might be under-inclusive. Again, the Ruling provides little guidance. Terms in the claimant's medical records (e.g., "severe," "extreme," or "morbid") cannot be used to establish BMI as a severe impairment. Accordingly, establishing obesity as a severe impairment through the use of objective medical records and specific evidence of functional impairments should be an area of significant concern in a practitioner's case preparation.⁵

PART I: THE AGENCY'S CURRENT RULING FOR THE EVALUATION OF OBESITY

After the Agency repealed Medical Listing 9.09, the Agency enacted SSR Ruling 02-01p to provide guidance as to the evaluation of obesity. A background on the Ruling is necessary because the Ruling itself may be a source of potential points of vulnerability for obese claimants. At least one district court has complained about the Ruling's lack of guidance.⁶ The Ruling correctly acknowledges that obesity is a "complex, chronic disease characterized by excessive accumulation of body fat," and concludes that obesity is generally the result of a combination of factors (e.g., genetic, environmental, and behavioral). Like other Agency protocols, the Ruling seemingly puts great emphasis on objective evidence of disability. Here, the Ruling utilizes BMI as a means for the ALJ to determine the presence of obesity. However, the utility of using BMI as an accurate predictor of the impact of weight on health is somewhat questionable for certain

³ For instance, in *Rockwood v. Astrue*, a female claimant had a BMI of 38.8, yet the ALJ did not mention the claimant's obesity anywhere in his decision. On appeal, the Agency, despite the fact the claimant's treating physician had diagnosed her as being obese, argued the claimant's weight was "in the range of her normal weight." *Barr v. Astrue* provides another example of why practitioners need to aggressively be prepared to develop the record concerning the claimant's obesity. In *Barr*, while the claimant did have a BMI of 40.6, the ALJ only mentioned in passing that the claimant's obesity "probably exacerbat[ed]" the claimant's sleep apnea and back pain. In remanding the case the district court, however, perhaps offered a slight criticism of the claimant's representative. Specifically, the court noted the claimant had only submitted records to the Appeals Council concerning the claimant's obesity from a nurse practitioner and physical therapist, which raised questions of whether the record had been sufficiently developed at the ALJ hearing level. *Rockwood* and *Barr* illustrate the need the need for a claimant's representative to prepare to address the impact of the claimant's weight on the claim, even where such impact may seem obvious because of the claimant's size.

⁴ Some courts have noted that an ALJ should take note where a claimant a BMI that would place her at either Level II or Level III obesity. Compare *Skarbek v. Barnhart*, 390 F. 3d 500 (7th Cir. 2004)(claimant's BMI was 32.3) with *Norris v. Astrue*, 776 F. Supp. 2d 616 (N.D. Ill. 2011)(claimant's BMI was 46.1 and the court noted this difference to distinguish *Skarbek*).

⁵ See e.g., *Rockwood*, 614 F. Supp. at 278 (acknowledging Agency's contention that medical evidence of claimant's obesity was "scant").

⁶ *Norman v. Astrue*, 694 F. Supp. 2d 738, 748 (N.D. Ohio 2010)("This Court concedes that SSR 02-01p does not identify a specific level of analysis.").

groups (e.g., women and African-Americans). Even the Agency acknowledges that using BMI to determine whether an individual is obese can result in both false positives and false negatives.⁷ Despite this concession that measurements of obesity other than BMI exist, such as hip-to-waist ratio, the Ruling states the Agency will not purchase these additional tests on behalf of the claimant because the Agency believes the medical or other evidence in the case file will be sufficient to establish whether the claimant is obese. However, my review of case law suggested that the Agency (and reviewing) courts struggled with the question of how much evidence would be sufficient to establish the presence of obesity and whether obesity was in fact a severe impairment.

The guidelines for Step 3 are troublesome because the Ruling does not make it readily apparent how the adjudicator should consider the accumulation of related impairments. While the Ruling does acknowledge that obesity can impact both physical and mental health, the Ruling's inability to articulate how obesity impacts related impairments reflects the Agency's difficulty in evaluating how the combination of impairments associated with obesity impact different bodily systems. When the Agency rescinded Medical Listing 9.09, the Agency noted it would take steps to provide adequate guidance as to the impact of obesity on health. To this end, the Ruling added prefaces to three Listings - musculoskeletal, respiratory, and cardiovascular - to provide guidance about the potential effects of obesity. For example, Medical Listing 1.00 Q (musculoskeletal) provides:

Effects of obesity. Obesity is a medically determinable impairment that is often associated with disturbance of the musculoskeletal system, and disturbance of this system can be a major cause of disability in individuals with obesity. The combined effects of obesity with musculoskeletal impairments can be greater than the effects of each of the impairments considered separately. Therefore, when determining whether an individual with obesity has a listing-level impairment or combination of impairments, and when assessing a claim at other steps of the sequential evaluation process, including when assessing an individual's residual functional capacity, adjudicators must consider any additional and cumulative effects of obesity.

However, the Medical Listing does not provide further guidance as to how obesity can impact musculoskeletal impairments. Additionally, the prefaces to Medical Listings 3.00I and 4.00F are almost identical and also do not provide any instruction to evaluate the impact of obesity on each respective bodily system.

In my review of the case law only a small number of cases were decided at Step 3. In part, equivalence is a difficult concept because there are a number of plausible explanations as to what equivalence means.⁸

Like the criteria outlined for the evaluation of obesity at Step 3, the criteria utilized for

⁷ A true positive would refer to an individual who does meet the statutory definition of disability. A false negative would refer to an individual who does meet the statutory definition of disability but whose claim was erroneously denied by an ALJ.

⁸ See e.g., *Diaz v. Comm. of Soc. Sec.*, 57 F. 3d 500, 504 (3d Cir. 2009)(ALJ erred in failing to discuss the interaction between the claimant's obesity and other severe impairments).

determining the functional impact of obesity at later steps in the evaluation process is sufficiently vague enough to pose a considerable challenge for claimants. The Ruling notes that obesity can cause limitation of function and limitations in exertional ability, postural requirements, gross and fine motor skills, and the ability to be exposed to certain elements, such as heat or humidity.

Additionally, the Ruling notes the combined effects of obesity with other impairments may be greater than might be expected without obesity.

The challenge for claimants, however, is how much evidence is needed to prove that the claimant's obesity has impacted the claimant's ability to perform the functional requirements of work. Two cases illustrate this point: *Rutherford v. Barnhart* and *Skarbek*.⁹ The claimant in *Rutherford* indicated her obesity made it more difficult to manipulate objects with her fingers, in addition to her ability to walk and stand. In *Skarbek*, the claimant alleged his obesity limited his ability to walk and stand. Both courts, however, rejected these allegations as being too generalized.

Another problem with the Ruling's guidance is its lack of predictive power. For example, the Ruling suggested that someone with obesity and arthritis affecting a weight-bearing joint might have more pain and limitation than might be expected from the arthritis alone. Despite the Ruling's attempt to point out how obesity can impact other impairments such as arthritis, there are numerous examples of where seemingly similarly situated claimants experience different results.¹⁰ For example, in *Barrett*, the claimant was 5'1" tall, 301 pounds, and the alleged disability was a result of her arthritis and obesity. In *Heino*, the claimant was 5'1" tall, with a weight range of 230 to 325 pounds, and alleged disability as a result of her osteoarthritis and obesity. In *Barrett*, the court rejected the ALJ's conclusion that the claimant could stand for two hours a day because, in the opinion of the reviewing court, the ALJ did not adequately consider the impact of the claimant's obesity on her arthritis. In contrast, the court in *Heino* accepted the ALJ's conclusion that despite the claimant's obesity and arthritis, she retained the functional ability to stand for six hours (with breaks) in an eight-hour workday.

The results in *Barrett* and *Heino* provide a cautionary tale for claimants because it may be impossible to predict how decision makers will apply SSR-02-1p. The result in *Barrett* seems to logically follow SSR-02-1p's guidance on the functional limitations of obesity,¹¹ whereas the ALJ in *Heino* did not address how the claimant's obesity impacted her arthritis.¹² These cases suggest claimants need to specifically address how the claimant's obesity exacerbates existing impairments.

PART II: THE LIMITS OF THE COMMON SENSE APPROACH

It is a matter of common sense that obesity can exacerbate other impairments, right? Consider *Diaz*, where the Third Circuit observed the claimant's morbid obesity would seem to have

⁹ *Rutherford v. Barnhart*, 399 F. 3d at 553.

¹⁰ See e.g., *Heino v. Astrue*, 578 F. 3d 873 (8th Cir. 2009) and *Barrett v. Barnhart*, 355 F. 3d 1065 (7th Cir. 2004).

¹¹ *Barrett*, 355 F. 3d at 1068 ("A great many people who are not grossly obese and do not have arthritic knees find it distinctly uncomfortable to stand for two hours at a time. To suppose that Barrett could do so day after day on a factory floor borders on the fantastic, but in any event has no evidentiary basis that we can find.")

¹² *Heino*, 578 F. 3d at 881 (in his hypothetical to the Vocation Expert, the ALJ referenced the claimant's history of obesity).

exacerbated her joint dysfunction as a matter of “common sense, if not medical diagnosis.”¹³ The problem with this common sense approach, however, is that this standard is sufficiently vague that opposite conclusions could be drawn by decision makers who may be disinclined to grant benefits. For instance, in *Santini v. Commissioner of Social Security*, the court noted there was no “common sense expectation that the obesity would exacerbate the impairing effects of either the seizure disorder or diabetes.”¹⁴ This conclusion is, in fact, contrary to medical literature on the subject.

My review of the case law highlights the degree of randomness that exists in the disability certification process. An understanding of case law involving obesity is important for claimants because despite the clear articulation by the Seventh and Third Circuits in *Skarbek* and *Rutherford* of how obesity is to be addressed by the ALJ, there appears to be some variation at the district court level in what will be expected from the ALJ.¹⁵ Yet, despite the uncertainties about positive outcomes, there are lessons from past cases that can help practitioners prepare to represent obese claimants and avoid points of vulnerability.

A. DO NOT ASSUME ABNORMAL BODY MASS WILL PROVIDE SUFFICIENT NOTICE FOR THE DECISION MAKER TO CONSIDER OBESITY

The Ninth Circuit’s decision in *Celaya v. Hunter* illustrates how an ALJ may choose to ignore a claimant’s obvious high BMI, especially when the claimant does not allege obesity as a severe impairment.¹⁶ The record did contain some inconsistencies as to Celaya’s height, ranging from 4’9” to 5’7”.¹⁷ Additionally, during the period Celaya asserted she was eligible for benefits, Celaya’s weight fluctuated between 205 and 213 pounds.¹⁸ Depending on the estimate of height and weight used, Celaya’s BMI would have ranged from either the lowest classification of BMI, Level 1, to the highest classification, Level III.¹⁹ However, despite this obvious level of disability, the dissent expressed concern that the ALJ, despite visually observing an obese claimant, did not have to explore the claimant’s obesity in a multiple impairment analysis:

This approach would transform Social Security administrative hearings into seance-like

¹³ Diaz, 57 F. 3d at 504.

¹⁴ *Santini v. Comm. of Soc. Sec.*, 2009 WL 3390319 No. 08-5348 at *5 (Oct. 15, 2009) *aff’d* 413 Fed. Appx. 517 (3d Cir. 2011).

¹⁵ *Rockwood*, 614 F. Supp 2d at 278 (reviewing various district court decisions that follow and decline to follow the approach utilized in *Skarbek*); *see also*, *Sotack v. Astrue*, No. 07-CV-0382, 2009 WL 3734869 (Nov. 4, 2009)(observing district courts vary in their interpretation of the extent and explicitness of the ALJ’s explanation of how the ALJ considered the claimant’s obesity at Steps 4 and 5) *cf.* *Cruz v. Barnhart*, No. 04 CV-9011, 2006 WL 1228581 (S.D.N.Y 2006)(claimant did not claim obesity as a severe impairment, but remand was not needed as ALJ’s acknowledgment of the claimant’s obesity in the statement of facts was sufficient consideration of the impairment).

¹⁶ *Celaya v. Hunter*, 332 F. 3d 1177 (9th Cir. 2003). Celaya applied for benefits when Medical Listing 9.09 was still in effect. While the case was analyzed under this Listing, this decision is a good example of the difficulties claimants will have in establishing the impact of obesity on functional limitation.

¹⁷ *Id.* at 1179, 1183 n. 3.

¹⁸ *Id.*

¹⁹ BMI describes the relationship between height and weight and is significantly correlated with total body fat content. Obese individuals are placed into one of three classes depending on their BMI. Class I includes individuals with a BMI between 30.0-34.9; Class II includes individuals between 35.0-39.9; and Class III includes those whose BMI is greater than 40.

proceedings where the ALJ must divine implicit impairments, diagnose disabilities lying close to the listing criterion and detect any aura compelling further development of the record. Nothing in our precedent condones such wholesale disregard of the ALJ's adjudicatory role.²⁰

The majority disagreed and argued the ALJ had an obligation where viewing the claimant in-person should have alerted the ALJ that he needed to facilitate a multi-impairment analysis, even though the non-asserted condition (obesity) was not noted in the record.²¹

Two problems emerge from *Celaya*. First, my review of cases indicates that even in instances of claims filed by individuals with a BMI greater than 40, there are multiple decisions where the ALJ did not list obesity as a severe impairment.²² These cases illustrate that practitioners need to be aware that further development of the record concerning the impact of weight on health or functional limitation may be necessary, even for individuals whose weight would constitute Level III, or morbid obesity.²³ This potential pitfall leads to a second problem with *Celaya*, which concerns the level of detail about the impact of obesity on health and functional limitation the medical records will need to establish.

Another area of concern regarding the Agency's use of BMI to evaluate obesity concerns claimants with lower BMIs. These relatively lower levels of obesity may mask the fact that the claimant's obesity has in fact greatly exacerbated other health concerns.²⁴ As previously discussed, the Agency's current protocols for the evaluation of obesity place heavy emphasis on

²⁰ *Id.* at 1186 (J. Rawlinson, dissenting).

²¹ *Id.*, at 1183 n. 3.

²² See e.g., *Warner v. Astrue*, 2011 WL 1135810 No. 1:09-cv-01112 (Mar. 25, 2011)(claimant's BMI was greater than 40, but the ALJ declined to find obesity was a severe impairment because medical records did not indicate claimant's obesity caused functional limitations); *Norton v. Astrue*, 2010 WL 4273108 No. 4:09CV3100 (Oct. 21, 2010)(despite BMI of 43.3, the claimant's obesity was not determined to be a severe impairment); *Deaver v. Astrue*, 2008 WL 4619823 No. 7:07-CV-158 (Oct. 20, 2008)(ALJ did not find that obesity was a severe impairment despite multiple references in the medical records to the claimant's morbid obesity and her BMI of 51.6); *Adkins v. Astrue*, 2010 WL 5825428 No. 3:10CV60 (Sept. 28, 2010)(despite claimant's BMI of 50, condition non-severe where the claimant did not allege obesity as a severe impairment, nor did he testify as to any physical limitations caused by obesity); *Bassett v. Astrue*, 2010 WL 2891149 No. 4:09-CV-142-A (June 25, 2010)(ALJ did not mention claimant's obesity despite BMI of 40.6); *Radford v. Astrue*, 2010 WL 2891149 No. 5:10-CV-00022-J (May 28, 2010)(claimant's BMI was 40 but ALJ did not determine that obesity was a severe impairment because the claimant did not testify as to the limiting aspects of her obesity at the hearing); *Bogans v. Astrue*, 2010 WL 2927486 No. 8:09-CV-0682-T-27 (June 22, 2010)(claimant's BMI was as low as 32 when he left employment but had ballooned to 40); *Callicoatt v. Astrue*, 296 Fed. Appx. 700 (10th Cir. 2008)(harmless error where ALJ did not consider claimant's obesity (BMI 40.7)); cf. *Early v. Astrue*, 481 F. Supp. 2d 1233 (N.D. Ala. 2007)(claimant had a BMI greater than 40 and ALJ erred when he did not consider claimant's obesity to be a severe impairment).

²³ See also *Zonak v. Comm. of Soc. Sec.*, 290 Fed. Appx. 493 (3rd Cir. 2008)(suggesting claimant could not rely on high BMI as "obvious" indicator of limitations).

²⁴ See e.g., *Heflick v. Astrue*, 2009 WL 1417913 No. 08-C-996 (May 20, 2009)(claimant's BMI was only 31.5 but ALJ failed to consider whether the claimant's obesity, in combination with her knee problem, limited her ability to walk); *Parks v. Astrue*, 2008 WL 4147559 No. CIV-07-1229-D (Sept. 2, 2008)(ALJ erred by failing to consider how claimant's obesity (BMI 33) affected his chronic obstructive pulmonary disorder); *Eskridge v. Astrue*, 569 F.Supp.2d 424 (D. Del. 2008)(BMI 33.9 and the ALJ failed to identify obesity as severe impairment); *Thomason v. Barnhart*, 344 F. Supp. 1326 (N.D. Ala. 2004)(ALJ did not consider the claimant's obesity (BMI 33.7) in addition to her other impairments, including arthritis); *Segal v. Barnhart*, 342 F. Supp. 2d 338 (E.D. Penn. 2004)(claimant's BMI was 32 and the ALJ determined her severe impairments included chronic ulcerative colitis, spastic colon and migraines, but failed to consider whether obesity impacted exertional and non-exertional functioning).

use of an applicant's BMI. While the Agency does acknowledge in the Ruling that there are alternative means of establishing that a claimant is obese, the Ruling's suggestion that BMI can be an appropriate tool used to establish that the claimant is obese causes two problems during the disability certification process. First, while BMI measures the presence of fat, it might not be the best measurement to identify true positives. To this end, some researchers have stated BMI is a "noisy" measurement of obesity because it does not distinguish fat from muscle, bone, or other lean body mass. Richard Burkhauser of Cornell University compared two definitions of obesity, BMI and percent of body fat. His research suggests that BMI might be a more useful predictor of the impact of obesity on health and functional limitation for men but not women. Professor Burkhauser concluded that among men, BMI produced 14.20% false positives and 33.50% false negatives. Among women, Professor Burkhauser concluded that BMI did not produce any false positives, but 61.25% classified as non-obese were false negatives. Second, the high number of women erroneously classified as non-obese is particularly disturbing because of the fact that of the district and appellate court decisions surveyed, over 70 percent of the claimants were women, and BMI is not the best measurement of the impact of fatness on health for women.

B. A MOST DANGEROUS STEP: IS OBESITY A SEVERE IMPAIRMENT?

The decisions in *Rutherford v. Barnhart* and *Diaz* illustrate the importance of the claimant's allegation that obesity is a severe impairment on the initial application for benefits or at the hearing.²⁵ Both *Rutherford* and *Diaz* involved two morbidly obese claimants: the claimant in *Rutherford* had a BMI of 44.8 whereas the claimant in *Diaz* had a BMI of 50.9. In *Rutherford*, the claimant did not allege that her obesity was a severe impairment; but rather, argued that references to her obesity in the medical record were sufficient to put the ALJ on notice that the claimant's weight could be a factor in the decision. Despite these obvious signals of the claimant's obesity, the *Rutherford* court reasoned the ALJ did not specifically have to address the claimant's obesity in his decision because the claimant's doctors were likely aware of her "obvious" disability, so it was appropriate for the ALJ to consider and adopt their opinions concerning her functional limitations and impairments.

In *Diaz*, which followed *Rutherford*, the court reached a different result. While *Diaz* did not allege obesity as a severe impairment, the difference is attributable to the ALJ's acknowledgment at Step 2 that the claimant's obesity was a severe impairment. This determination triggered the ALJ's obligation to consider her obesity at the other steps as required by SSR 02-01p.

These cases illustrate points of vulnerability in the process for a claimant. For example, *Diaz* and *Rutherford* show that it is important for claimants to establish obesity as a severe impairment. If the claimant alleges obesity as a disabling condition or the ALJ determines that obesity is a severe impairment, reviewing courts potentially expect the ALJ to provide a more substantive discussion of how a claimant's obesity may impact other impairments or functional

²⁵ See also, *Halsell v. Astrue*, 357 Fed. Appx. 717, 723 (7th Cir. 2009)(court rejected claimant's argument that ALJ erred by failing to consider her obesity based on inferences from the reports of the state-agency physician where claimant did not allege obesity as severe impairment); *Briggs v. Astrue*, 221 Fed. Appx 767, 771 (10th Cir. 2007)(ALJ correctly determined obesity was not a severe impairment where the claimant did not allege it); *Wind v. Barnhart*, 133 Fed. Appx. 684, 690-91 (11th Cir. 2005)(claimant did not allege obesity as a severe impairment, so ALJ did not have to list obesity as a severe impairment where there was no medical evidence the claimant's obesity impacted her ability to perform medium level work).

limitations.

For example, in *Ellis v. Astrue*, the claimant applied for SSI alleging disability on the basis of arthritis in the knees, hands, and wrists, diabetes, and high cholesterol; obesity was not identified.²⁶ At the hearing, the claimant testified that her current weight was 268 pounds but fluctuated to as high as 298 pounds.²⁷ At Step 2 of the decision, the ALJ found that the claimant's obesity was a severe impairment.²⁸ The only other reference to the claimant's obesity came during the discussion of Step 3, where the ALJ acknowledged his legal obligation to discuss the impact of the claimant's obesity on other impairments.²⁹ The court, however, found this discussion inadequate and remanded the case for further development of how the claimant's obesity impacted her bilateral knee disorder and her ability to walk and/or stand.³⁰ Where obesity has been determined to be a severe impairment, the ALJ will have to explain in her decision how obesity figured into her determination at any point in the five step sequential evaluation process, or adopt the recommendations of doctors who were aware of plaintiff's obesity.³¹

A review of case law suggests reviewing courts vary widely in their expectations of how ALJs evaluate obesity during the five-step sequential evaluation process. In part, the differing results are a product of tension between the Act, regulations, and SSR 02-1p.³² However, the idea that an ALJ has virtually no obligation to further develop generalized points of evidence or testimony is somewhat at odds with other regulations and SSR 02-1p. Specifically, 20 C.F.R. § 404.1545(a)(3) provides that before making a determination the claimant is not disabled, the ALJ has an obligation to assist the claimant in developing the record. Additionally, SSR 02-1p at ¶ 5 suggests the ALJ has the power to seek additional guidance from a medical source to clarify whether the individual has obesity in situations where the clinical records only contain references to the claimant's high body weight.³³

Notwithstanding the ALJ's obligations, the review of case law indicates claimants should take steps to develop the record with respect to the limitations caused by obesity on the claimant's functional capacity and the effect of the claimant's obesity in combination with other medical impairments.³⁴ This can be a difficult hurdle for two reasons. First, it is not necessarily clear to

²⁶ See e.g., *Ellis v. Astrue*, 2010 WL 1817246 * 1 (E.D. Penn. 2010).

²⁷ *Id.* at *2.

²⁸ *Id.*

²⁹ *Id.*

³⁰ *Id.* at *5.

³¹ *Eskridge v. Astrue*, 569 F. Supp. 2d 424, 439 (D. Del. 2008).

³² See C.F.R. § 404.1521(b). Basic work activities include physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; capacities for seeing, hearing, and speaking; understanding, carrying out, and remembering simple instructions; use of judgment; responding appropriately to supervision, co-workers and usual work situations; and dealing with changes in a routine work setting.

³³ The Ruling, however, contains conflicting guidance because the next sentence in Paragraph 4 states, “[h]owever, in most such cases we will use our judgment to establish the presence of obesity based on the medical findings and other evidence in the case record, even if a treating or examining source has not indicated a diagnosis.” This is perhaps an example of a communications problem that can impede the furtherance of Agency goals.

³⁴ See e.g., *Castel v. Astrue*, 355 Fed. Appx. 260, 264 (11th Cir. 2009)(record did not establish claimant's obesity resulted in any functional limitations). My review did find several instances of poor development of the medical record. For example, in *Rutherford*, the ALJ held the record open for thirty days after the hearing to receive additional records regarding a pulmonary function test, but the claimant never provided further documentation that

what extent the medical records have to discuss the claimant's obesity. For instance, single references in the claimant's file to his or her obesity may be insufficient to establish obesity as a severe impairment.³⁵ Additionally, in *Guadalupe v. Barnhart*, the ALJ did not have to consider the claimant's obesity where the claimant's medical records described her as obese, but she was not diagnosed as obese nor did the claimant's doctors suggest her obesity contributed to her other impairments.³⁶ The second problem is that the ALJ may also expect the medical records to not only diagnose the claimant with obesity, but also to discuss the impact of the claimant's obesity on health or functional limitation.³⁷ More specifically, the claimant may have to produce medical records that explicitly discuss how the claimant's obesity affects her ability to work.³⁸

CONCLUSION

Two reforms are necessary. First, the Agency should revise its protocols for the evaluation of obesity so that greater accuracy and consistency in decision making can be achieved. My second conclusion is that the Agency should develop other criteria in addition to BMI that can be used to evaluate the epidemiological link between fatness and health.

Please let me know if I may provide you with any further information regarding my research.

Regards,

Chris Pashler

could have established the connection between her obesity and her work-related limitations. *Rutherford*, 399 F. 3d at 554. See also *Rickabaugh v. Astrue*, 2010 WL 1142041 (2010)(physician concluded severe reduction in maximal ventilatory volume on pulmonary function test but the claimant dialed to submit additional evidence).

³⁵ See e.g., *Bowser v. Commissioner of Social Security*, 121 Fed. Appx. 231, 236 (9th Cir. 2005)(medical record contained one reference from the treating physician that the claimant was obese); *Prochaska v. Barnhart*, 454 F.3d 731, 737 (7th Cir. 2006)(one treating physician diagnosed claimant as obese, and other medical reports relied upon by ALJ noted claimant's height and weight).

³⁶ *Guadalupe v. Barnhart*, 2005 WL 203380 No. 04-CV-7644 (S.D.N.Y. Aug. 24, 2005).

³⁷ See *Wiese v. Astrue*, 552 F. 3d 728, 732-33 (8th Cir. 2009)(claimant's medical records indicated she had been diagnosed with obesity, but records did not suggest what the impact was on other impairments or what the limiting effect of her obesity was).

³⁸ *Cranfield v. Comm. of Soc. Sec.*, 57 F. 3d 500, 504 (3d Cir. 2009).

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