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## Pigeonholing Illness: Medical Diagnosis as a Legal Construct

Lars Noah

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## Articles

# Pigeonholing Illness: Medical Diagnosis as a Legal Construct

by  
LARS NOAH\*

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There was the usual waiting and the important air assumed by the doctor, with which he was so familiar (resembling that which he himself assumed in court), and the sounding and listening, and the questions which called for answers that were foregone conclusions . . . . It was all just as it was in the law courts. . . . It was not a question of Ivan Ilyich's life or death, but one between a floating kidney and appendicitis.<sup>1</sup>

### Introduction

The concept of disease, which is so fundamental to medical practice, has numerous important applications in the law. It helps to inform or delineate reimbursable illnesses covered by health insurance, risk-benefit calculations performed by regulatory agencies charged with licensing therapeutic products, the scope of compensable injuries in tort actions, the potential relevance of psychiatric evidence in criminal trials, and impairments subject to antidiscrimination laws and disability benefit programs. Diagnostic judgments have become so pervasive and readily accepted in these varied contexts that we may lose sight of their overall significance. Novel diseases occasionally attract critical scrutiny, as has happened recently with the perceived proliferation of psychiatric syndrome evidence in criminal trials, but commentators invariably advocate doctrinal responses designed to assist decisionmakers in properly assimilating such information. Little or no attention is paid to the ways in which medical professionals react to the external pressures emanating from, or mediated by, legal institutions with regard to defining and diagnosing disease conditions. This Article focuses on that point of interface between the disciplines of medicine and law.

Traditionally, medical professionals defined categories of diseases (nosology) and identified such conditions in particular patients (diagnosis) for purposes of selecting appropriate treatments and predicting the likely course of the patient's illness (prognosis). Increasingly, however, diagnostic judgments have come to serve other purposes. Perhaps such a development is neither surprising nor worrisome, at least so long as these diagnoses do not interfere with therapeutic purposes. But once the definition and identification of illness begin primarily to serve the needs of non-medical decisionmakers such as insurers, regulatory agencies, and litigants, closer scrutiny of the diagnostic process is warranted. In at least some situations, researchers apparently cater to patient demands for useful new disease

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1. Leo Tolstoy, *The Death of Ivan Ilyich*, in TOLSTOY'S SHORT FICTION 142 (Aylmer Maude trans., Michael R. Katz ed., W.W. Norton & Co. 1991) (1886).

categories, and physicians authenticate complaints, certifying to bureaucrats that particular patients suffer from a qualifying illness. To the extent that non-medical decisionmakers influence or drive the diagnostic process, legitimate concerns arise about patient health, the integrity of the medical profession, and larger costs to society. This Article evaluates these concerns, using medical diagnosis as an organizing principle and suggesting possible responses.

Part I examines both historical and contemporary accounts of the diagnostic process. "Diseases" are not things awaiting discovery by researchers and physicians. Instead, they are convenient short-hand descriptions of illnesses experienced by patients that facilitate investigating and selecting possible courses of treatment. But conceptions of illness do not serve only medical purposes; scholars and physicians alike have recognized that diseases are socially constructed and mutable. Nosology and diagnosis can describe a patient's health or illness experience only imperfectly. As with language and other systems of classification, disease categories are context-dependent and subject to manipulation.

Part II takes these insights about the social construction of disease one step further, inquiring about the legal construction of illness.<sup>2</sup> Although in some respects subsumed within the broad contours of arguments made by those describing the social construction of illness, the extent to which legal institutions influence and perhaps distort the diagnostic process has received essentially no consideration and presents sufficiently distinct questions that deserve separate treatment. Part II considers the many different pressures exerted by public and private insurers, regulatory agencies, litigants in tort and criminal cases, beneficiaries of disability programs, and workers' compensation claimants. In each setting, legal institutions sometimes rely heavily on clinical judgments but at the same time may unwittingly distort the diagnostic process.

Part III evaluates the possible consequences for the health care system of such exogenous pressures and examines the extent to which legal rules might be reoriented to minimize any distorting effects that they currently have on the diagnostic process. To some degree, pressures mediated by legal institutions have shaped both nosology and diagnosis, so much so that these decisionmakers may wish to rethink their traditional reliance on judgments by biomedical researchers and health care providers. This Article, however, concerns itself less with

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2. Cf. Gerald E. Frug, *The City as a Legal Concept*, 93 HARV. L. REV. 1057, 1081 (1980) ("[T]he best way of understanding a legal concept is to analyze it the way a geologist looks at the landscape. . . . Our current legal conception of cities is similarly the remnant of an historical process, so that its meaning cannot be grasped until the elements of that process, and their relationships, are understood.").

the consequences for legal institutions than the possible effects on the medical profession. Although these influences are by no means the only cause of diagnostic distortion, researchers and physicians have responded to pressures from legal institutions in ways that do not promote, and may even undermine, patient care and public health. Beyond exposing these problems, this Article suggests that legal institutions should better insulate the diagnostic enterprise by delinking their decisions from clinical judgments, and that researchers and physicians should reevaluate their role as patient advocates.

## I. Differential Diagnosis and Nosology

One cannot meaningfully discuss questions about the health care system without first having some conception of what it means to be sick,<sup>3</sup> and physicians obviously play a central role in identifying and treating illness.<sup>4</sup> Although not synonymous, disease and illness both connote some sort of departure from normal physiological or psychological functioning.<sup>5</sup> According to one popular medical dictionary, "disease" means "any deviation from or interruption of the normal structure or function of any part, organ, or system (or combination thereof) of the body that is manifested by a characteristic set of symptoms and signs and whose etiology, pathology, and prognosis may be known or unknown."<sup>6</sup> Such definitions assume that

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3. See BARRY R. FURROW ET AL., *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* 1 (3d ed. 1997) ("We need some definition of health in order to assess the quality of care needed to promote or restore it. A malpractice suit or medical quality audit depends on an ability to distinguish a bad from a good medical outcome.").

4. See *id.* at 2-3 ("A sick person can be assisted by treatment defined by the medical model. He becomes a patient, an object of medical attention by a doctor. The doctor has the right and the ability to label someone ill . . ."). This power to identify illness has "many ramifications" for the individual patient as well as society. See *id.* at 3; see also MICHAEL L. GLENN, *ON DIAGNOSIS: A SYSTEMIC APPROACH* xvii (1984) ("Establishing a diagnosis is one of the physician's most basic tasks. . . . It is a vital criterion which affects the organization and functioning of the entire health care system.").

5. See ARTHUR KLEINMAN, *THE ILLNESS NARRATIVES: SUFFERING, HEALING, AND THE HUMAN CONDITION* 3-5 (1988) (distinguishing between illness, "the innately human experience of symptoms and suffering," and disease, which is "what the practitioner creates in the recasting of illness in terms of theories of disorder"); Christopher Boorse, *On the Distinction Between Disease and Illness*, 5 *PHIL. & PUB. AFF.* 49, 61 (1975); Christopher Boorse, *A Rebuttal on Health*, in *WHAT IS DISEASE?* 3, 45-50 (James M. Humber & Robert F. Almeder eds., 1997) (explaining that a disease, which is a descriptive and non-normative concept, rises to the level of illness, which is context- and culture-relative, only when it is serious and incapacitating).

6. *DORLAND'S ILLUSTRATED MEDICAL DICTIONARY* 481 (27th ed. 1988); see also *THE OXFORD MEDICAL COMPANION* 207 (1994) ("Any sickness, ailment, or departure from the generally accepted norm of good health . . ."); *STEDMAN'S MEDICAL DICTIONARY* 492 (26th ed. 1995) ("An interruption, cessation, or disorder of body functions, systems, or organs.").

one can settle on a shared understanding of what constitutes a "normal" condition or "healthy" status. Philosophers reject an exclusively medical conception of the term and argue that disease means different things depending on the context in which one asks the question.<sup>7</sup>

Before more fully elaborating on this point, let us consider an overly simplified and perhaps nostalgic picture of the physician-patient encounter.<sup>8</sup> Typically, an individual prompts the intervention of a health care professional by complaining of some physical injury or symptom. The physician then must determine the nature of the patient's condition with enough confidence to choose an appropriate course of treatment. He or she usually will do so by taking a medical history, seeking detailed information about the specific complaint, and then physically examining the patient and perhaps ordering laboratory or other diagnostic tests.<sup>9</sup>

Once the fact gathering process concludes, the health care professional will attempt to diagnose the patient's condition.<sup>10</sup> Through a process of differential diagnosis, which involves a consideration of a

7. See LAWRIE REZNEK, *THE NATURE OF DISEASE* 1, 211-13 (1987); Lester S. King, *What Is Disease?*, 21 *PHIL. SCI.* 193, 197 (1954); Harold Merskey, *Variable Meanings for the Definition of Disease*, 11 *J. MED. & PHIL.* 215 (1986).

Disease is a state of malfunction of body or mind that is a matter of concern to the patient, his doctors, and other relevant persons, subject to the qualifications that the malfunction has to be defined from case to case and that the consequences of the disease for the patient's obligations to others (and theirs to him) will be determined by the patient and his doctors with the consent of other relevant persons.

*Id.* at 229-30 (emphasis omitted). Professor Merskey identified insurers and courts as among the other relevant actors that may have differing conceptions of disease. See *id.* at 225-29. He hastened to add that courts are not "the final arbiter[s] of a medical diagnosis" but can only decide whether or not to accept a diagnosis for legal purposes. *Id.* at 227-28.

8. For significantly more comprehensive and sophisticated accounts, see EDMUND D. PELLEGRINO & DAVID C. THOMASMA, *A PHILOSOPHICAL BASIS OF MEDICAL PRACTICE* (1981); Ezekiel J. Emanuel & Linda L. Emanuel, *Four Models of the Physician-Patient Relationship*, 267 *JAMA* 2221 (1992). For an account that emphasizes the patient's perspective, see S. KAY TOOMBS, *THE MEANING OF ILLNESS: A PHENOMENOLOGICAL ACCOUNT OF THE DIFFERENT PERSPECTIVES OF PHYSICIAN AND PATIENT* 89 (1992) (arguing that illness "mean[s] something significantly and qualitatively different to the patient and to the physician," reflecting "the fundamental and decisive distinction between the lived experience of illness and the naturalistic account of such experience").

9. See PAUL CUTLER, *PROBLEM SOLVING IN CLINICAL MEDICINE: FROM DATA TO DIAGNOSIS* (3d ed. 1998); 2 ERIC J. CASSELL, *TALKING WITH PATIENTS: CLINICAL TECHNIQUE* 86-90 (1985) (discussing the importance of care in constructing a patient's medical history).

10. See Ralph L. Engel, Jr. & B.J. Davis, *Medical Diagnosis: Present, Past, and Future*, 112 *ARCHIVES INTERNAL MED.* 512 (1963); Lester S. King, *What Is a Diagnosis?*, 202 *JAMA* 714 (1967); Robert G. Miceli, *Deprivation of Due Process for Physicians: The "Failure to Diagnose" Cause of Action*, 33 *ST. LOUIS U. L.J.* 859, 871-85 (1989) (summarizing the diagnostic process).

hierarchy of different possible explanations for the results of the initial examination,<sup>11</sup> the physician tries to determine the most likely source of the complaint. This essentially probabilistic exercise requires reference to a catalog of diseases and their diagnostic criteria, as developed by clinical researchers and learned by the health care professional. Often the nature of the injury or disease will be obvious, such as a fractured limb, but some ambiguity exists in many situations. If the physician cannot reasonably settle upon a diagnosis, he or she may refer the patient to another physician, often a specialist in a particular field, for a consultation.

Patients seek out medical care in hopes of finding a treatment for some bothersome condition.<sup>12</sup> They usually care little about the name of their affliction. Similarly, physicians diagnose patients as a means to the end of identifying the most appropriate therapy.<sup>13</sup> It may be that, if there are several plausible diagnoses for a condition but further specification would serve no purpose given the nature of available treatments, the health care professional will not pursue additional diagnostic inquiries for their own sake.<sup>14</sup> Similarly, physicians

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11. See ARTHUR S. ELSTEIN ET AL., *MEDICAL PROBLEM SOLVING: AN ANALYSIS OF CLINICAL REASONING* 277 (1978) ("Ill-defined problems must be progressively better defined so that rational action can be taken. Alternative interpretations of probabilistic data must be generated and compared. . . . As in other domains of problem solving, the potential size of the problem space is enormous."); Jerome P. Kassirer, *Clinical Problem-Solving—A New Feature in the Journal*, 326 *NEW ENG. J. MED.* 60, 60 (1992) ("In many ways the diagnostic process resembles the start of a chess game: after one or two moves (one or two symptoms), the number of possible moves (diagnostic possibilities) is usually enormous; . . . the challenge is to make the right move in the right direction at the right time.").

12. See PELLEGRINO & THOMASMA, *supra* note 8, at 211.

13. See *id.* at 136-38.

14. See, e.g., JOHN I. BALLA, *THE DIAGNOSTIC PROCESS: A MODEL FOR CLINICAL TEACHERS* 54 (1985) ("[D]iagnostic perfectionism differed a great deal from one disease to another. . . . [I]n situations where no reasonable treatment was available and where the condition had little effect on life, diagnostic utility would be low and accuracy would be relatively unimportant."); *id.* at 95 ("[I]ncreased precision for its own sake is of no benefit in any scientific endeavour. . . . In the days when tuberculosis and carcinoma of the lung were untreatable, a vague diagnosis of chest disease may have been satisfactory."); Ernan McMullin, *Diagnosis by Computer*, in *LOGIC OF DISCOVERY AND DIAGNOSIS IN MEDICINE* 199, 218 (Kenneth F. Schaffner ed., 1985) ("Clinical medicine . . . does not aim at theoretical understanding. It aims at the practical goal of therapy, though it uses whatever theoretical science is available."); Herbert A. Simon, *Artificial-Intelligence Approaches to Problem Solving and Clinical Diagnosis*, in *LOGIC OF DISCOVERY*, *supra*, at 72, 87 ("From the therapeutic or 'troubleshooting' standpoint we want to follow the causal stream up to a point where intervention is possible."); King, *supra* note 10, at 716 ("[M]erely because the diagnostic categories exist, does not mean that they must be used. . . . A diagnostic framework suitable for a research scientist may be quite unnecessary for a practicing physician." (emphasis omitted)); see also Jerome P. Kassirer & Stephen G. Pauker, Editorial, *The Toss-Up*, 305 *NEW ENG. J. MED.* 1467 (1981).

may have to revisit their initial diagnosis in the event that the patient's condition does not improve with the prescribed therapy. Physicians view patient care as an iterative process designed to treat a condition to the best extent possible.<sup>15</sup> They do not care much about the disease's etiology—the theory of its origin or cause—unless understanding causation would assist in diagnosis and treatment. For instance, in treating appendicitis, physicians focus on the site and extent of inflammation rather than struggling in vain to establish its underlying cause.

Diagnoses may be inaccurate for any number of reasons.<sup>16</sup> First, the manner of taking a medical history or eliciting details about the patient's present complaints may adversely influence the process of gathering information. Second, errors may occur in conducting or interpreting laboratory tests. Third, physicians may inappropriately cut short the process of engaging in a differential diagnosis or misjudge the probabilities of competing explanations. Finally, the presence of multiple medical conditions may confound the selection of the best treatment.

So far, the discussion has focused on the medical evaluation of physical injuries and organic diseases (pathophysiological conditions), but this obviously does not exhaust the range of possible symptoms or diagnoses. Estimates suggest that at least twenty percent of the population will suffer a significant mental disorder at some point during their lifetimes.<sup>17</sup> Indeed, the likely interaction between physical and mental illnesses further complicates any effort to single out the cause of, and best treatment for, a patient's complaint, but psychiatric diagnoses present a host of additional challenges.<sup>18</sup>

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15. See GLENN, *supra* note 4, at 83, 90 (describing the dialectical process in diagnosis and treatment); K. Danner Clouser, *Approaching the Logic of Diagnosis*, in LOGIC OF DISCOVERY, *supra* note 14, at 35, 39 ("In trying to arrive at a classification, that is, a disease or illness label, the processes of data gathering and diagnosis are in no set sequence. The physician goes back and forth; progress on one front gives rise to suggested possibilities on the other.")

16. See GLENN, *supra* note 4, at 65, 82-83; Jack D. Myers, *The Process of Clinical Diagnosis and Its Adaptation to the Computer*, in LOGIC OF DISCOVERY, *supra* note 14, at 155, 156-57; Nelda P. Wray & Joan A. Friedland, *Detection and Correction of House Staff Error in Physical Diagnosis*, 249 JAMA 1035 (1983).

17. See Laura Lee Hall, *The Biology of Mental Disorders*, 269 JAMA 844, 844 (1993); see also Ronald C. Kessler et al., *Lifetime and 12-Month Prevalence of DSM-III-R Psychiatric Disorders in the United States: Results from the National Comorbidity Survey*, 51 ARCHIVES GEN. PSYCHIATRY 8, 14 (1994) (finding that almost half of all respondents to a survey reported at least one psychiatric disorder during their lifetime).

18. See Henry Berry, *The Merits of an Opinion and the Diagnosis of Diagnosis*, 18 ADVOCS. Q. 330, 340-47 (1996) (distinguishing between medical, psychiatric, and psychological diagnoses). See generally GARY B. MELTON ET AL., PSYCHOLOGICAL EVALUATIONS FOR THE COURTS (2d ed. 1997).

First, mental health professionals typically take a patient's subjective complaints at face value, without any meaningful way of attempting to verify the nature or severity of their symptoms.<sup>19</sup> Second, mental health professionals often express greater disagreements about an appropriate diagnosis for a particular patient because the relevant symptoms tend to be non-specific, which means that any number of mental illnesses could account for the particular complaint.<sup>20</sup> Even for fairly well-accepted psychiatric disorders, diagnostic judgments are notoriously unreliable.<sup>21</sup> Third, differential diagnosis—the effort to arrive at the most probable single source of the patient's condition or symptom(s)—often serves little purpose in selecting among the more limited range of available treatment modalities. In fact, psychotherapy typically comes before the post hoc assignment of a diagnosis. Psychiatrists and psychologists still tailor their interventions to the particular patient,<sup>22</sup> but some would say that

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19. See *People v. Bledsoe*, 681 P.2d 291, 300 (Cal. 1984) ("Because their function is to help their clients deal with the trauma they are experiencing, the historical accuracy of the client's descriptions of the details of the traumatizing events is not vital in their task."); see also *Jaffee v. Redmond*, 518 U.S. 1, 10-11 (1996) (distinguishing, in the course of recognizing an evidentiary privilege for psychotherapist-patient communications, psychotherapy from the treatment of physical ailments by a physician based on "objective" information).

20. See, e.g., *Ake v. Oklahoma*, 470 U.S. 68, 81 (1985) ("Psychiatry is not . . . an exact science, and psychiatrists disagree widely and frequently on what constitutes mental illness, on the appropriate diagnosis to be attached to given behavior and symptoms, on cure and treatment, and on likelihood of future dangerousness."); *Addington v. Texas*, 441 U.S. 418, 430 (1979) ("The subtleties and nuances of psychiatric diagnosis render certainties virtually beyond reach in most situations."); Bruce J. Ennis & Thomas R. Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CAL. L. REV. 693, 719-32 (1974) (elaborating on the reasons for unreliability in psychiatric diagnoses); David Faust & Jay Ziskin, *The Expert Witness in Psychology and Psychiatry*, 241 SCIENCE 31, 34 (1988) ("Clinicians frequently cannot agree on psychiatric diagnoses of current states, much less provide trustworthy answers to less familiar and more difficult forensic questions, which often demand projections backward or forward in time."); accord Stephen J. Morse, *Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law*, 51 S. CAL. L. REV. 527, 554-60, 604-11 (1978). But see Jules B. Gerard, *The Usefulness of the Medical Model to the Legal System*, 39 RUTGERS L. REV. 377, 398-403, 418 (1987) (responding to criticisms of diagnostic unreliability but only by first excluding the majority of identified mental disorders as not diseases in the traditional sense and therefore not of interest for legal purposes).

21. See KENNETH MARK COLBY & JAMES E. SPAR, THE FUNDAMENTAL CRISIS IN PSYCHIATRY: UNRELIABILITY OF DIAGNOSIS 4-11, 21 (1983); James C. Anthony et al., *Comparison of the Lay Diagnostic Interview Schedule and a Standardized Psychiatric Diagnosis*, 42 ARCHIVES GEN. PSYCHIATRY 667, 672 (1985); Matthew P. Dumont, *The Non-specificity of Mental Illness*, 54 AM. J. ORTHOPSYCHIATRY 326, 327-28 (1984); Graham Mellsop et al., *The Reliability of Axis II of DSM-III*, 139 AM. J. PSYCHIATRY 1360, 1361 (1982).

22. See generally EILEEN GAMBRILL, CRITICAL THINKING IN CLINICAL PRACTICE: IMPROVING THE ACCURACY OF JUDGMENTS AND DECISIONS ABOUT CLIENTS (1990).

efforts at labeling a mental illness with any degree of specificity are largely beside the point.<sup>23</sup>

There remain important questions about the very nature of disease as distinct from the processes used to identify previously defined diseases in particular patients. Successful diagnosis and treatment depend, of course, on biomedical research into the nature of disease processes and various possible avenues for therapy. Scientists attempt, therefore, to denominate classes of persons suffering from certain symptoms in order to promote basic and applied research. Although a physician may enjoy the luxury of taking a particularistic view of each patient and customizing appropriate therapies,<sup>24</sup> clinical researchers depend on generalizations and some shared understanding so that results of studies can be cumulated and compared. This basically taxonomic process of identifying and classifying diseases is referred to as nosology. As with physicians, clinical researchers struggle to define diseases less for their own sake than in order to pursue applied research into appropriate treatments.<sup>25</sup> As with diagnoses, these definitions may evolve over time as additional scientific information accumulates. Disease concepts are not fixed and static.

Ever since the ancient Greeks,<sup>26</sup> physicians have struggled in their attempts to describe and classify diseases. Nosology developed

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23. See COLBY & SPAR, *supra* note 21, at 11 (“[E]xperienced clinicians do not use the official diagnostic system much, either in helping their patients or in informally communicating with one another. . . . Practitioners treat *clinical phenomena* more than diseases.”); *id.* at 211-12; ANDREW S. WATSON, *PSYCHIATRY FOR LAWYERS* 383-85, 437-38 (rev. ed. 1978). *But cf.* R.E. KENDELL, *THE ROLE OF DIAGNOSIS IN PSYCHIATRY* 2-8 (1975) (conceding weaknesses in psychiatric diagnoses, but disputing claims that they are entirely irrelevant). For instance, many psychoanalysts regard diagnostic labels as irrelevant to treatment. See Bernard L. Diamond & David W. Louisell, *The Psychiatrist as an Expert Witness: Some Ruminations and Speculations*, 63 *MICH. L. REV.* 1335, 1337-39 (1965); Paul Williams, *Deciding How to Treat—The Relevance of Psychiatric Diagnosis*, 9 *PSYCHOL. MED.* 179, 182-83 (1979). A few have gone so far as to assert that there is no such thing as mental illness. See THOMAS S. SZASZ, *THE MYTH OF MENTAL ILLNESS: FOUNDATIONS OF A THEORY OF PERSONAL CONDUCT* 294-97 (1961) (calling it a medical metaphor for behavioral problems).

24. See ERIC J. CASSELL, *THE NATURE OF SUFFERING AND THE GOALS OF MEDICINE* 179 (1991) (explaining that physicians “treat particular patients in particular circumstances at a particular moment in time, and thus they require information that particularizes the individual and the moment”).

25. See HENRIK R. WULFF, *RATIONAL DIAGNOSIS AND TREATMENT* (1976); H. Tristram Engelhardt, Jr., *Typologies of Disease: Nosologies Revisited*, in *LOGIC OF DISCOVERY*, *supra* note 14, at 56, 56 (“argu[ing] that for medicine, concepts of disease and typologies of disease are properly therapy-oriented”); *id.* at 63-64 (noting, however, that “one sees an ongoing attempt to standardize medical diagnoses and information gathering” for non-therapeutic purposes); *id.* at 67 (“One should develop classifications of disease with a view to maximizing the achievement of the goals of treatment and prevention.”).

26. See *GALEN ON THE AFFECTED PARTS* (Rudolph E. Siegel trans., S. Karger 1976).

during the seventeenth and eighteenth centuries, initially by defining diseases as observable symptom complexes.<sup>27</sup> Thus, patients with seemingly identical symptomology were classified together. During the nineteenth century, nosology shifted from a focus on shared non-specific symptoms to an appreciation of the specific etiology underlying a pattern of symptoms.<sup>28</sup> Technological advances played some role in this transformation, promoting improvements in clinical research and practice.<sup>29</sup> Eventually, however, critics challenged the emerging ontological conception of illness (the notion that disease amounts to a meaningful concept, abstracted from any one patient's experience, simply waiting to be discovered), superficially resembling the legal realist assault on nineteenth century classical legal orthodoxy.<sup>30</sup> Instead, these critics emphasized that physicians ultimately must treat individual patients complaining of particular ailments.<sup>31</sup> Nonetheless, nosological work and accompanying controversies about selecting appropriate diagnostic criteria persist to this day.

In a provocative new book, Robert Aronowitz discusses the "social construction" of illness,<sup>32</sup> elaborating on themes developed by a number of earlier scholars who denied that medical diagnosis simply represented a technical and value-neutral exercise.<sup>33</sup> He juxtaposes

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27. See KNUD FABER, *NOSOGRAPHY: THE EVOLUTION OF CLINICAL MEDICINE IN MODERN TIMES* 20-27, 208-09 (2d rev. ed. 1930). Indeed, the father of modern taxonomy in the biological sciences included diseases among his subjects for classification. See CAROLUS LINNAEUS, *GENERA MORBORUM* (1763).

28. See MICHEL FOUCAULT, *THE BIRTH OF THE CLINIC: AN ARCHAEOLOGY OF MEDICAL PERCEPTION 188-91* (A.M. Sheridan Smith trans., Pantheon Books 1973); LESTER S. KING, *TRANSFORMATIONS IN AMERICAN MEDICINE* 96, 138-40, 171, 239 (1991). "A continuity of problems bound the eighteenth to the nineteenth centuries. The same problems have persisted in the twentieth century . . . First, What is disease? And second, How do you identify it?" *Id.* at 232; see also *id.* at 233 ("When [symptoms] cohere and interact and form a temporal pattern, we can speak of a *disease*. A particular pattern will acquire a name as a sort of handle that makes discourse easier and facilitates diagnosis.").

29. See STANLEY JOEL REISER, *MEDICINE AND THE REIGN OF TECHNOLOGY* 18-19, 227-31 (1978).

30. See MORTON J. HORWITZ, *THE TRANSFORMATION OF AMERICAN LAW, 1870-1960: THE CRISIS OF LEGAL ORTHODOXY* 198-202 (1992).

31. See Charles E. Rosenberg, *Disease and Social Order in America: Perceptions and Expectations, in AIDS: THE BURDENS OF HISTORY* 12, 17-21 (Elizabeth Fee & Daniel M. Fox eds., 1988).

32. See ROBERT A. ARONOWITZ, *MAKING SENSE OF ILLNESS: SCIENCE, SOCIETY, AND DISEASE* 10-15, 171 (1998) ("[T]he acts of disease recognition, naming, and classification—whether one is conceptualizing fatigue or obstruction of the coronary arteries as disease—are always contingent on social factors."); see also Joseph S. Alpert, *Society and Disease*, 279 *JAMA* 1665 (1998) (book review).

33. See, e.g., *FRAMING DISEASE: STUDIES IN CULTURAL HISTORY* (Charles E. Rosenberg & Janet Golden eds., 1992); *THE PROBLEM OF MEDICAL KNOWLEDGE: EXAMINING THE SOCIAL CONSTRUCTION OF MEDICINE* (Peter Wright & Andrew

several recent case studies—chronic fatigue syndrome, ulcerative colitis, Lyme disease, and coronary heart disease—in order to explore the extent to which understandings about, and the diagnostic criteria for, these conditions have been framed by influences other than advances in biomedical science. Dr. Aronowitz criticizes the excessive biological reductionism fostered by overreliance on the medical model of disease, arguing that physicians should come to recognize more clearly the inevitable idiosyncracies of their patients, and urging a shift from an ontological (objective/anatomical) to a more holistic (subjective/experiential) conception of illness.<sup>34</sup> In a sense, disease categories and boundaries are not discovered but invented from among several competing choices, and he argues that one should measure nosologies by reference to non-epistemic purposes. Although by no means uncontroversial, the book provides important insights about the still fluid and increasingly contentious nature of nosology and diagnosis.<sup>35</sup>

Like others who have previously written in this vein, Aronowitz pays essentially no attention to the potentially influential role of legal proceedings and institutions in defining the contours of disease. He identifies patient groups as one of the primary sources of pressure in the process of negotiating over the boundaries of disease definitions,<sup>36</sup>

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Treacher eds., 1982); see also DAVID MECHANIC, *MEDICAL SOCIOLOGY* (2d ed. 1978); FREDRIC D. WOLINSKY, *THE SOCIOLOGY OF HEALTH: PRINCIPLES, PRACTITIONERS, AND ISSUES* (2d ed. 1988); *CONCEPTS OF HEALTH AND DISEASE: INTERDISCIPLINARY PERSPECTIVES* (Arthur L. Caplan et al. eds., 1981); *HEALTH, DISEASE, AND CAUSAL EXPLANATIONS IN MEDICINE 3-90* (Lennart Nordenfelt & B. Ingemar B. Lindahl eds., 1984). See generally PETER L. BERGER & THOMAS LUCKMANN, *THE SOCIAL CONSTRUCTION OF REALITY* (1966).

34. See ARONOWITZ, *supra* note 32, at 8-10 (distinguishing between ontological and holistic ideal-types of illness); *id.* at 174 (“One reason that we need to question our reliance on the ontological ideal is that it results in continuous pressure on both patients and physicians to create new and eventually controversial medical diagnoses such as chronic fatigue syndrome that have the appearance of specificity . . .”); *id.* at 175 (“While it is not unusual for doctors to bemoan the popularity of such diagnoses, little attention has been paid to biomedicine’s role in creating the market in the first place by its collective inability to accommodate suffering not understandable in such [mechanistic] terms.”); *id.* at 184-85, 189; see also GLENN, *supra* note 4, at xxv, 158-59, 176-79 (urging a systemic approach that takes into account psychosocial factors and the role of the patient’s family); James S. Goodwin, *Chaos, and the Limits of Modern Medicine*, 278 *JAMA* 1399, 1399-400 (1997).

35. See ARONOWITZ, *supra* note 32, at 185. For instance, he rejects the notion that “there is a right or true definition of Lyme disease. It is a matter of some choice—within biologically given limits—as to how we might define the disease. . . . Values will still need to be debated and interests balanced.” *Id.* at 180.

36. See *id.* at 168 (“Undoubtedly, sociocultural trends such as the increased questioning of biomedical authority and the rise of consumerism have emboldened patients to actively promote new, legitimizing diagnoses, in turn leading to an increased number of—and more strident—controversies over disease legitimacy.”).

If physicians would accept their patients’ self-report of suffering as legitimate,

but individual patients also look to lawyers to pursue goals that may place significant indirect pressures on physicians to define and identify diseases that have some valuable legal ramifications. Thus, legal institutions may mediate the demands of such patients, yet no one has systematically assessed the role that the law plays in the diagnostic enterprise.<sup>37</sup> As another commentator recently recognized: "One of the most neglected members of the cast . . . is the American legal profession; the law and lawyers have played a subtle, but often significant, role in 'framing' disease."<sup>38</sup>

## II. Legal Institutions and Illness

It should surprise no one to discover the numerous contexts in which nosological categories and particular diagnoses assume legal relevance. Disease definitions and clinical judgments routinely affect coverage and reimbursement decisions by health insurers, the licensing determinations of regulatory agencies that review new therapeutic technologies, evidentiary and substantive rulings by the judiciary in personal injury lawsuits and criminal trials, eligibility decisions in dis-

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rather than solely by the presence of an objective abnormality, the stakes for a specific diagnosis would be much lower. As a result, there would be less reason to fight tooth and nail for the acceptance of specific diseases to rationalize suffering.

*Id.* at 175. Aronowitz also argues that modifications in the definitions of disease may reflect turf battles among groups of physicians. *See id.* at 179 ("The shift from the experiential definition of angina pectoris to the more anatomically defined [coronary heart disease] allowed the emerging specialty of cardiology to focus its new techniques on patients who suffered from specific cardiac ailments, while taking patients and status away from general practitioners.").

37. A few of these commentators mention the role of legal institutions only to shunt such questions aside as beyond their focus on other societal influences on the diagnostic process. *See, e.g.*, GLENN, *supra* note 4, at 33, 102. "Another category of diagnosis includes occasions when physicians are asked to provide expert opinion about their patient to a third party. In this group are physicians' letters to welfare departments, the courts, insurance companies, employers, schools, disability, social security, and other public agencies." *Id.* at 148. The so-called "therapeutic jurisprudence" represents a very different research program, arguing that greater attention should be paid to the manner in which legal rules and procedures inevitably affect the mental health of individuals, and recommending various reforms designed to promote the therapeutic consequences of the law. *See* DAVID B. WEXLER & BRUCE J. WINICK, *LAW IN A THERAPEUTIC KEY: DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE* xvii (1996); BRUCE J. WINICK, *THERAPEUTIC JURISPRUDENCE APPLIED: ESSAYS ON MENTAL HEALTH LAW* 3-4 (1997); Christopher Slobogin, *Therapeutic Jurisprudence: Five Dilemmas to Ponder*, 1 *PSYCHOL., PUB. POL'Y & L.* 193 (1995).

38. Janet A. Tighe, *The Legal Art of Psychiatric Diagnosis: Searching for Reliability*, in *FRAMING DISEASE*, *supra* note 33, at 206, 207 (focusing only on forensic psychiatric testimony); *see also* Charles E. Rosenberg, *Framing Disease: Illness, Society, and History*, in *FRAMING DISEASE*, *supra* note 33, at xiii, xxi (noting in passing that negotiations about the definitions of disease may be played out in a variety of legal proceedings).

ability programs, and the resolution of claims brought before workers' compensation tribunals. The applications and influences of medical diagnoses vary among these diverse judicial and bureaucratic settings,<sup>39</sup> but each of the following examples illustrates how legal institutions do more than passively accept nosological categories and particular diagnoses designed to serve therapeutic purposes.

In order to appreciate these multifaceted influences, a broad but inevitably superficial exposition of each of these contexts provides the indispensable backdrop for an analysis of the legal construction of disease. As more fully elaborated in Part III, the ready legal acceptance of disease definitions may in turn shape or even distort nosology and diagnosis by medical professionals.

#### A. Public and Private Health Insurers

Federal agencies charged with administering public health insurance programs have imposed payment restrictions on medical treatments that depend on making particular diagnoses. For instance, the Health Care Financing Administration (HCFA) uses diagnosis-related groups (DRGs) to manage hospital reimbursement under the Medicare program. Private insurers have imposed comparable payment restrictions. Moreover, in both of these contexts, insurance coverage may depend in the first instance on how broadly one defines the terms disease and illness.

Originally, DRGs were designed as an internal management tool for hospitals.<sup>40</sup> DRGs classify hospital patients based upon their primary and secondary diagnoses, procedures performed, age, status at discharge, and any complications.<sup>41</sup> By assigning one of the almost 500 DRGs to each discharged patient, hospital administrators could better anticipate treatment costs and more efficiently manage their budgets. If the average cost for treating patients within any given DRG exceeded forecasts, the hospital might decide to adjust its treatment protocols or perhaps renegotiate contracts with suppliers and insurers. If certain physicians utilized greater resources than forecast, the administrators might choose to institute better cost con-

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39. The use here and elsewhere of the term "bureaucratic" distinguishes a variety of administrative agencies and other non-judicial institutions from the courts, and it also connotes a style of decision-making and concentration of power typical of large and complex organizations. See JAMES Q. WILSON, *BUREAUCRACY: WHAT GOVERNMENT AGENCIES DO AND WHY THEY DO IT* (1989); Gerald E. Frug, *The Ideology of Bureaucracy in American Law*, 97 HARV. L. REV. 1276 (1984).

40. For a comprehensive discussion of DRGs by the team of researchers who originally developed them, see *DRGS: THEIR DESIGN AND DEVELOPMENT* (Robert B. Fetter et al. eds., 1991).

41. See PAUL L. GRIMALDI & JULIE A. MICHELETTI, *DIAGNOSIS RELATED GROUPS: A PRACTITIONER'S GUIDE* 19-38 (2d ed. 1983).

trols. If the case-mix of patients treated at the hospital changed over time, the hospital might have to reallocate its resources or reconsider its patient population.

DRGs depend on a uniform classification system for diagnoses. Currently, most health providers use the ninth revision of the *International Classification of Diseases—Clinical Modification (ICD-9-CM)*,<sup>42</sup> a system designed for indexing medical records. Physicians reduce their patient diagnoses to one or more of the 10,000 *ICD-9-CM* codes.<sup>43</sup> For instance, Legionnaires' disease would be assigned code number 482.84.<sup>44</sup> Hospital administrators use these coded diagnoses to aggregate patients with similar conditions into DRGs in order to predict average treatment costs and plan hospital budgets. Legionnaires' disease would be included in DRGs 79-81 ("Respiratory Infections & Inflammations"), depending on the patient's age and the presence of any complications.<sup>45</sup> The entire system therefore depends on the physician's initial diagnosis, something which hospital administrators would rarely have any occasion to second-guess.

As an internal management tool, DRGs had fairly limited utility and virtually no effect on the diagnostic process, but they have become much more important now that public and private insurers use them as a basis for reimbursing treatment costs, in effect utilizing DRGs for external budgeting. Rather than indemnifying hospitals and physicians for the actual or reasonable costs expended in treating a covered patient, insurers now frequently base their payments on the average treatment costs forecast by the DRGs for each discharged patient covered by the insurer.

The Medicare program initially reimbursed hospitals and physicians for the reasonable costs of treating covered disabled and elderly patients. In 1983, however, Congress directed HCFA to use the

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42. See U.S. DEPT OF HEALTH & HUMAN SERVICES, THE INTERNATIONAL CLASSIFICATION OF DISEASES—CLINICAL MODIFICATION (5th ed. 9th rev. 1995); WORLD HEALTH ORGANIZATION, INTERNATIONAL CLASSIFICATION OF DISEASES, INJURIES, AND CAUSES OF DEATH (9th rev. ed. 1977). The tenth edition of the *ICD* was published in 1992 but has not yet come into official use in the United States.

43. See David Baldus et al., *Improving Judicial Oversight of Jury Damages Assessments*, 80 IOWA L. REV. 1109, 1163 (1995) (noting that *ICD-9* codes "are routinely used throughout American medical practice to classify injuries, illnesses, diseases, medical treatment, and rehabilitation," and urging courts to use this classification system in reviewing damage awards); see also Catherine Hoffman et al., *Persons with Chronic Conditions: Their Prevalence and Costs*, 276 JAMA 1473, 1474 (1996) (using *ICD-9* codes in public health research).

44. See 62 Fed. Reg. 29,902, 29,991 (1997). The federal government reprints and occasionally updates the *ICD-9-CM* codes. See 61 Fed. Reg. 27,444, 27,451 (1996) (describing the process). For a discussion of one update, see Christine K. Cassel & Bruce C. Vladeck, *ICD-9 Code for Palliative or Terminal Care*, 335 NEW ENG. J. MED. 1232, 1233 (1996).

45. See 62 Fed. Reg. at 29,983, 29,991.

DRGs as the basis for Medicare reimbursement of hospitals, establishing the Prospective Payment System (PPS).<sup>46</sup> The statute explicitly precludes judicial review of DRG definitions.<sup>47</sup> Even so, as one critic of the system has explained, this shift effectively transferred the power to define diseases from clinicians to legal institutions:

At the beginning of Medicare, the authority to attribute severity of illness lay largely in the hands of the medical profession. The very idea of prospective payment was to displace that authority to a great extent. The authority to define illness and severity of illness, however, did not simply disappear. . . . [PPS] moved much of this authority to Congress, HCFA, ProPAC [the Prospective Payment Assessment Commission], and the health services research community more generally.<sup>48</sup>

As explained later in this Article, DRG-based reimbursement has triggered diagnostic "upcoding" by some physicians in an effort to circumvent Medicare PPS payment restrictions.<sup>49</sup>

In 1989, Congress directed HCFA to pay physicians treating Medicare patients using a similar concept called the "resource-based relative value scale" (RBRVS), though it sets fees based on the

46. See Social Security Amendments of 1983, Pub. L. No. 98-21, § 601, 97 Stat. 65, 149 (codified as amended at 42 U.S.C. § 1395ww (1994)); see also 42 C.F.R. pt. 412 (1998) (HCFA's implementing regulations); Judith R. Lave, *The Impact of the Medicare Prospective Payment System and Recommendations for Change*, 7 YALE J. ON REG. 499 (1990); J. Timothy Phillips & Don E. Wineberg, *Medicare Prospective Payment: A Quiet Revolution*, 87 W. VA. L. REV. 13 (1984); Bruce C. Vladeck, *Medicare Hospital Payment by Diagnosis-Related Groups*, 100 ANNALS INTERNAL MED. 576 (1984). Congress recently decided to require a similar prospective payment system to replace cost-based Medicare reimbursement for outpatient services. See Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4523(a), 111 Stat. 330, 445 (to be codified at 42 U.S.C. § 1395l(i)).

47. See 42 U.S.C. § 1395ww(d)(7) (1994) ("There shall be no administrative or judicial review . . . [of] the establishment of diagnosis-related groups, of the methodology for the classification of discharges within such groups, and of the appropriate weighing of factors thereof . . .").

48. David M. Frankford, *The Complexity of Medicare's Hospital Reimbursement System: Paradoxes of Averaging*, 78 IOWA L. REV. 517, 665 (1993) (adding that "these actors are uncomfortable with that transfer" and "constantly look back to the medical profession"). Another commentator has made a similar point:

Under a system of retrospective reimbursement, research, driven solely by clinical concerns, results in a proliferation of categories and classifications of mental disorders that lose their utility for administrative and reimbursement concerns. Within the present framework of prospective payment, the interest of third-party payers is providing clear parameters for the clinical work, informing its questions, purposes, and outcomes, . . . accentuat[ing] the control of payers over providers.

Mary Ruggie, *Retrenchment or Realignment? U.S. Mental Health Policy and DRGs*, 15 J. HEALTH POL. POL'Y & L. 145, 157 (1990) ("[W]hen research speaks to developments that have implications for reimbursement, administrative efficiency and cost implications drive the process of further redefinition in diagnostic categories." (footnote omitted)).

49. See *infra* Part III.B.

course of treatment selected rather than the diagnosis.<sup>50</sup> For this purpose, physicians utilize the codes from the fourth edition of the AMA's *Current Procedural Terminology (CPT-4)*, which covers more than 7,000 medical procedures and services.<sup>51</sup> Although not identical to Medicare's PPS and RBRVS reimbursement methods, other health insurers also have linked their payments to the *ICD-9-CM* and *CPT-4* codes appearing in patient charts.<sup>52</sup>

Whatever the method used for reimbursement, questions sometimes also arise about coverage. For instance, Medicare only covers expenses for items or services which are "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."<sup>53</sup> The selection of a medical intervention traditionally had been left to the judgment of a physician, but nowadays both public and private insurers increasingly struggle when deciding whether a therapy should be considered necessary. Although disputes about medical necessity usually concern the selection or duration of treatments, especially when reimbursement is sought for "experimental" therapies,<sup>54</sup> diagnosis of a disease

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50. See Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6102, 103 Stat. 2106, 2169 (codified as amended at 42 U.S.C. § 1395w-4 (1994)); John K. Inglehart, *The New Law on Medicare's Payments to Physicians*, 322 NEW ENG. J. MED. 1247 (1990); see also Charles J. Dougherty, *The Resource-Based Relative Value Scale: An Ethical Assessment*, 34 ST. LOUIS U. L.J. 1061, 1067 (1990) ("It is only fair then that physician payments, one of the major sources of out-patient costs, should come under the same kind of scrutiny and constraint imposed on hospital payments by the DRG's."); Janet B. Mitchell, *Physician DRGs*, 313 NEW ENG. J. MED. 670 (1985) (identifying problems with a DRG-like approach to reimbursing physicians).

51. AMA, CURRENT PROCEDURAL TERMINOLOGY (4th rev. ed. 1998); see also KENNETH R. WING ET AL., THE LAW AND AMERICAN HEALTH CARE 538 (1998) ("[T]he CPT-4 code system is the preferred and most common method of describing physician services for reimbursement purposes."). Medicare now requires the use of *CPT-4* coding. See *id.* ("In 1983, CPT-4 was adopted by HCFA as part of the coding system used in billing for services rendered to Medicare beneficiaries.").

52. See Grace M. Carter et al., *Use of Diagnosis-Related Groups by Non-Medicare Payers*, HEALTH CARE FIN. REV., Winter 1994, at 127; see also *New York St. Conf. Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 649-50 (1995) (reviewing a state statute that mandated the use of DRGs for all hospital patient charges); David M. Eddy, *Oregon's Methods: Did Cost-Effectiveness Analysis Fail?*, 266 JAMA 2135, 2136 (1991) (describing one state's use of *ICD-9* and *CPT-4* codes to establish a system for rationing Medicaid services); David M. Eddy, *Oregon's Plan: Should It Be Approved?*, 266 JAMA 2439, 2444 (1991) (arguing that the *ICD-9* codes are too crude for Medicaid rationing).

53. 42 U.S.C. § 1395y(a)(1)(A) (1994); see also Timothy P. Blanchard, "Medical Necessity" Denials as a Medicare Part B Cost-Containment Strategy: Two Wrongs Don't Make It Right or Rational, 34 ST. LOUIS U. L.J. 939, 972-1021 (1990); Eleanor D. Kinney, *National Coverage Policy Under the Medicare Program: Problems and Proposals for Change*, 32 ST. LOUIS U. L.J. 869 (1988).

54. See Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical*

provides the essential predicate for coverage. In addition, the application of pre-existing condition exclusions depends on defining the point at which someone develops such a condition.<sup>55</sup>

Disputes about coverage denials sometimes find their way into court, forcing judges and jurors to assess claims that a particular condition qualifies as an illness.<sup>56</sup> In one recent decision, a court held that "breast-ovarian carcinoma syndrome" represented an illness under the terms of a health insurance policy and, therefore, that radical prophylactic surgery should have been covered as medically necessary.<sup>57</sup> The court rejected the insurer's argument that this syndrome amounted to nothing more than a genetic predisposition—diagnosed from nothing more than the patient's family history of breast and ovarian cancer—for the development of a disease at some indefinite point in the future.<sup>58</sup> Although not based on any detected chromosomal abnormality, the court noted that women with the plaintiff's family history had at least an even chance of eventually developing

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*Necessity*, 140 U. PA. L. REV. 1637 (1992); Richard S. Saver, Note, *Reimbursing New Technologies: Why Are the Courts Judging Experimental Medicine?*, 44 STAN. L. REV. 1095 (1992); Annotation, *What Services, Equipment, or Supplies Are "Medically Necessary" for Purposes of Coverage Under Medical Insurance*, 75 A.L.R.4th 763 (1990 & Supp. 1998).

55. See *Hardester v. Lincoln Nat'l Life Ins. Co.*, 841 F. Supp. 714, 715-16 (D. Md. 1994) (distinguishing previously detected fibrocystic breast disease from subsequently diagnosed breast cancer, and holding that treatment of the latter disease was not excluded from coverage by a pre-existing condition clause), *aff'd*, 52 F.3d 70, 71 (4th Cir. 1995) (en banc) (per curiam); *Pitcher v. Principal Mut. Life Ins. Co.*, 870 F. Supp. 903, 907-16 (S.D. Ind. 1994) (same), *aff'd*, 93 F.3d 407 (7th Cir. 1996); *Fuglsang v. Blue Cross*, 456 N.W.2d 281, 285 (Neb. 1990) ("A disease, condition, or illness exists within the meaning of a health insurance policy excluding preexisting conditions only at such time as the disease, condition, or illness is manifest or active or when there is a distinct symptom or condition from which one learned in medicine can with reasonable accuracy diagnose the disease."); see also *Hughes v. Boston Mut. Life Ins. Co.*, 26 F.3d 264, 269 (1st Cir. 1994) (interpreting pre-existing condition clause in a disability insurance policy).

56. See, e.g., *Silverstein v. Metropolitan Life Ins. Co.*, 171 N.E. 914, 915 (N.Y. 1930) (Cardozo, C.J.) ("[A] condition abnormal or unsound when tested by a standard of perfection, yet so remote in its potential mischief that common speech would call it not disease or infirmity, [is] at most a predisposing tendency."); J.A. Bryant, Jr., Annotation, *What Conditions Constitute "Disease" Within Terms of Life, Accident, Disability, or Hospitalization Insurance Policy*, 61 A.L.R.3d 822 (1975 & Supp. 1998); Cristine Nardi, Comment, *When Health Insurers Deny Coverage for Breast Reconstructive Surgery: Gender Meets Disability*, 1997 WIS. L. REV. 777.

57. See *Katskee v. Blue Cross/Blue Shield*, 515 N.W.2d 645, 651-53 (Neb. 1994).

58. See *id.* at 652 ("Although appellant's condition was not detectable by physical evidence or a physical examination, it does not necessarily follow that appellant does not suffer from an illness."); see also *id.* ("We are mindful that not every condition which itself constitutes a predisposition to another illness is necessarily an illness within the meaning of an insurance policy."); *Cheney v. Bell Nat'l Life Ins. Co.*, 556 A.2d 1135, 1138-40 (Md. 1989) (concluding that hemophilia is a "disease" rather than a genetic trait).

one of these cancers.<sup>59</sup> As genetic screening becomes more sophisticated in the future, issues of this sort will become even more complicated,<sup>60</sup> especially if insurers attempt to turn the tables on patients with a previously identified predisposition to a certain disease by denying coverage for the treatment of the actual manifestation of that disease as a pre-existing condition.

Even when an insured individual has clearly manifested a medically treatable condition, coverage may still depend on whether certain physical traits are somehow considered dysfunctional.<sup>61</sup> For instance, courts have struggled with insurers' arguments that infertility treatments are not covered by policies that reimburse expenses for treating an "illness."<sup>62</sup> Similar questions have arisen more recently

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59. See *Katskee*, 515 N.W.2d at 651-52 (adding that this significant risk would itself cause present "anxiety and stress"). The disaggregated probabilities that the plaintiff would develop ovarian cancer or breast cancer apparently were less than 50%. See *id.*; Andrea Eisen & Barbara L. Weber, Editorial, *Prophylactic Mastectomy—The Price of Fear*, 340 NEW ENG. J. MED. 137 (1999). Only by cumulating the two risks into a single syndrome did the probability surpass that threshold, but the radical prophylactic surgery only avoided ovarian cancer. It may well have been appropriate even though ovarian cancer alone was less probable than not, but the court should not have cloaked its deference to the medical judgment by reference to an exaggerated probability. Cf. Alexandra K. Glazier, *Genetic Predispositions, Prophylactic Treatments and Private Health Insurance: Nothing Is Better Than a Good Pair of Genes*, 23 AM. J.L. & MED. 45, 67-68 (1997) (arguing that insurers should cover treatments for patients with a genetic defect and a greater than 50% current risk of developing a serious disease).

60. See Rochelle Cooper Dreyfuss & Dorothy Nelkin, *The Jurisprudence of Genetics*, 45 VAND. L. REV. 313, 318 (1992) (noting that "expectations about the predictive possibilities of genetic tests have created a new category of person—the presymptomatically ill"); Ruth Hubbard, *Predictive Genetics and the Construction of the Healthy Ill*, 27 SUFFOLK U. L. REV. 1209, 1221 (1993) ("[G]enetic predictions of ill health create a new class of 'patients' who are coming to be referred to as the asymptomatic or healthy ill: people who have no symptoms, but are predicted to develop them at some undefined time in the future."); see also DOROTHY NELKIN & LAURENCE TANCREDI, *DANGEROUS DIAGNOSTICS: THE SOCIAL POWER OF BIOLOGICAL INFORMATION* (2d ed. 1994); John A. Robertson, *Genetic Selection of Offspring Characteristics*, 76 B.U. L. REV. 421, 432-34 (1996).

61. See Michael H. Shapiro, *The Technology of Perfection: Performance Enhancement and the Control of Attributes*, 65 S. CAL. L. REV. 11, 48-51 (1991) (distinguishing enhancements from treatments for disorder). For example, controversy has emerged over the use of human growth hormone in normal children of short stature. See Committee on Drugs and Committee on Bioethics, American Academy of Pediatrics, *Considerations Related to the Use of Recombinant Human Growth Hormone in Children*, 99 PEDIATRICS 122, 125-26 (1997); Patricia McLaughlin, *If Shortness Isn't a Disease, Why Are We Testing a Cure?*, HOUS. CHRON., Nov. 1, 1993, at 3; see also Alice Dreger, *When Medicine Goes Too Far in the Pursuit of Normality*, N.Y. TIMES, July 28, 1998, at F4 ("Instead of constantly enhancing the norm—forever upping the ante of the 'normal' with new technologies—we should work on enhancing the concept of normal by broadening appreciation of anatomical variation.").

62. See *Egert v. Connecticut Gen. Life Ins. Co.*, 900 F.2d 1032, 1037-38 (7th Cir. 1990) (covered); *Witcraft v. Sundstrand Health & Disability Group Benefit Plan*, 420 N.W.2d

over insurance coverage for the anti-impotence drug sildenafil citrate (Viagra<sup>®</sup>).<sup>63</sup> In addition, in the early 1980s, the American Society of Plastic and Reconstructive Surgeons argued that small breasts should be diagnosed as "micromastia," a physical deformity that could be "treated" with silicone-gel implants.<sup>64</sup> Although each of these examples poses coverage questions of differing complexity, they demonstrate how disputes about health insurance policies' references to disease or dysfunction may turn on controversial medical judgments that in turn may have been influenced by non-therapeutic considerations.

## B. Federal Regulatory Agencies

Federal agencies make numerous decisions that depend on how one defines a disease. For example, the status of a health condition as a disease potentially affects a number of regulatory decisions by the U.S. Food and Drug Administration (FDA). First, the classification of a product may depend on whether its intended use involves the treatment of a disease.<sup>65</sup> Drugs and medical devices face stiffer regu-

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785, 788-90 (Iowa 1988) (same); *Ralston v. Connecticut Gen. Life Ins. Co.*, 617 So. 2d 1379, 1381-82 (La. Ct. App.) (same), *rev'd in part on other grounds*, 625 So. 2d 156 (La. Ct. App. 1993); *Kinzie v. Physician's Liab. Ins. Co.*, 750 P.2d 1140, 1142 (Okla. Ct. App. 1987) (not covered); *see also* Pamela J. Prager, *Infertility: The Unrecognized Illness in the Health Insurance Industry*, 39 *DRAKE L. REV.* 617, 617 (1989-1990) ("Infertility can be a devastating illness, yet insurance companies generally refuse to pay for the treatment of this disease."); Edward L. Raymond, Jr., Annotation, *Coverage of Artificial Insemination Procedures or Other Infertility Treatments by Health, Sickness, or Hospitalization Insurance*, 80 *A.L.R.4th* 1059 (1990 & Supp. 1998).

63. *See* Victoria Slind-Flor & Bob Van Voris, *Viagra May Have Legal Downside: Next Fen-Phen?*, *NAT'L L.J.*, May 18, 1998, at A1; Milt Freudenheim, *Many Insurers Are Deciding Not to Cover Cost of Viagra*, *N.Y. TIMES*, June 20, 1998, at A6 ("The drug has been promoted as an important enhancement to the quality of life for many older men and their wives, but some health economists have raised questions about the medical necessity of a treatment for impotence . . ."); Laurie McGinley, *Medicaid Programs Are Told to Pay for Viagra but Monitoring Continues*, *WALL ST. J.*, July 2, 1998, at B5; Robert Pear, *White House Plans Medicaid Coverage of Viagra by States*, *N.Y. TIMES*, May 28, 1998, at A1 (According to one HHS official, "if Viagra is determined by a doctor to be medically necessary, Medicaid should pay for it.").

64. *See* BARBARA EHRENREICH, *THE SNARLING CITIZEN* 56-59 (1995); ELIZABETH HAIKEN, *VENUS ENVY: A HISTORY OF COSMETIC SURGERY* 271 (1997); Jan Gehorsam, *Women Feeling Pressured to Sculpt a Perfect Body: Implants a Response to Cultural Message*, *ATLANTA J. & CONST.*, Mar. 29, 1992, at A1.

65. *See* 21 U.S.C. § 321(g)(1)(B) (1994) (defining the term "drug" in part as "articles intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease"); *id.* § 321(h)(2) (defining the term "medical device" in a similar fashion); *see also* Lars Noah & Barbara A. Noah, *Nicotine Withdrawal: Assessing the FDA's Effort to Regulate Tobacco Products*, 48 *ALA. L. REV.* 1, 10 (1996) ("In the past, the FDA has asserted [drug] jurisdiction over tobacco products only when they were accompanied by therapeutic claims."); Gary E. Gamerman, Note, *Intended Use and Medical Devices: Distinguishing Nonmedical "Devices" from Medical "Devices" Under 21 U.S.C. § 321(h)*, 61 *GEO. WASH.*

latory requirements than do food products and cosmetics. Second, in the case of food products, the FDA has authorized the use of health claims in labeling only for a limited class of disease-prevention statements.<sup>66</sup> The FDA would not allow such a labeling claim for a nutrient positively associated with a health condition that was not regarded as either a disease or a recognized risk factor.

Third, in the case of drugs, the nature of the targeted condition might affect the availability of special review provisions. For instance, accelerated approval is available for certain drugs and biologics that are intended for use "in treating serious or life-threatening illnesses and that provide meaningful therapeutic benefit to patients over existing treatments."<sup>67</sup> The FDA will accept evidence of drug effectiveness in attaining surrogate markers or endpoints (such as reductions in CD4 cell counts) in lieu of more difficult to prove clinical endpoints (such as reductions in disease morbidity or mortality).<sup>68</sup> Even if they are not eligible for accelerated approval, new drugs to treat diseases for which no effective pharmaceutical therapies cur-

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L. REV. 806, 850 (1993) (explaining that courts "have restricted the [FDA's] medical device jurisdiction to products bearing claims of therapeutic use or effect").

66. See 21 U.S.C. § 343(r)(3)(B) (1994) (calling for the promulgation of regulations to authorize labeling claims about the relationship between a nutrient and a "disease or health-related condition"); 21 C.F.R. § 101.14(a)(6) (1998) ("*Disease or health-related condition* means damage to an organ, part, structure, or system of the body such that it does not function properly (e.g., cardiovascular disease), or a state of health leading to such dysfunctioning (e.g., hypertension)."); *id.* § 101.72-81 (approving health claims for certain nutrients associated with the prevention of osteoporosis, cancer, hypertension, coronary heart disease, neural tube defects, and dental caries); see also 58 Fed. Reg. 2478, 2481 (1993) ("Congress intended that claims about conditions other than diseases be regulated . . . [C]laims about risk factors related to disease, as well as claims about a disease, can be health claims."). For a summary of these restrictions, see Lars Noah & Barbara A. Noah, *Liberating Commercial Speech: Product Labeling Controls and the First Amendment*, 47 FLA. L. REV. 63, 67-70 (1995).

More recently, in the course of implementing statutory amendments that liberalize restrictions on the labeling of dietary supplements, see 21 U.S.C. § 343(r)(6), the FDA proposed rules designed to broaden the definition of the term "disease," arguably in an effort to limit the effect of the statutory amendments. See Regulations on Statements Made for Dietary Supplements Concerning the Effect of the Product on the Structure or Function of the Body, 63 Fed. Reg. 23,624, 23,626, 23,631-32 (1998) (amending 21 C.F.R. § 101.14(a)(6)) (proposed Apr. 29, 1998); David Brown, *New FDA Commissioner Enters War over Words*, WASH. POST, Mar. 26, 1999, at A31 (describing congressional hearing that focused on the Agency's proposed new definition of "disease").

67. 21 C.F.R. §§ 314.500, 601.40 (1998); see also *id.* § 312.34(b) (defining "serious" and "immediately life-threatening"); 57 Fed. Reg. 58,942, 58,945-46 (1992) (responding to objections that this category was vague).

68. See 21 C.F.R. §§ 314.510, 601.41; 57 Fed. Reg. at 58,944; see also FDA Modernization Act of 1997, Pub. L. No. 105-115, § 112, 111 Stat. 2296, 2309-10 (to be codified at 21 U.S.C. § 356) (codifying these special procedures for "fast track" approvals). The applicant generally must conduct postmarketing studies relating to the product's effectiveness in achieving the clinical endpoints presumably associated with the surrogate markers.

rently exist receive priority status by FDA reviewers.<sup>69</sup> In addition, products intended to treat a rare disease or condition may qualify for "orphan drug" designation, which entitles the sponsor to certain special research and development incentives.<sup>70</sup>

Finally, and most important, the FDA's decision to approve a new drug or other medical product will entail a risk-benefit calculation,<sup>71</sup> so the perceived importance of the therapeutic benefit naturally will influence the Agency's licensing judgments. In this manner, the FDA takes into account the significance of a targeted health condition, or the status of that condition as a treatable disease, when making product approval decisions. Moreover, even if a drug's benefits outweigh its potential risks, the Agency may demand prescription status if labeling cannot be designed to allow consumers to engage in safe self-diagnosis and treatment.<sup>72</sup>

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69. See Bruce N. Kuhlik, *Industry Funding of Improvements in the FDA's New Drug Approval Process: The Prescription Drug User Fee Act of 1992*, 47 FOOD & DRUG L.J. 483, 501 n.101 (1992).

70. See 21 U.S.C. § 360bb(a) (1994) (allowing special designation of a drug intended to treat "a rare disease or condition," defined as affecting less than 200,000 persons in the United States or for which there is no reasonable expectation of recovering research and development costs).

For the purpose of documenting that the number of people affected by the disease or condition for which the drug product is indicated is less than 200,000 persons, "prevalence" is defined as the number of persons in the United States who have been diagnosed as having the disease or condition at the time of the submission of the request for orphan-drug designation.

21 C.F.R. § 316.21(b) (1998); see 57 Fed. Reg. 62,076, 62,081 (1992) ("FDA has no way of determining the likely treatment population other than by relying on current diagnostic methods and treatment attitudes."); see also 21 C.F.R. § 316.20(b)(6) ("Where a drug is under development for only a subset of persons with a particular disease or condition, [a sponsor shall provide] a demonstration that the subset is medically plausible."); 57 Fed. Reg. at 62,081 ("FDA declines to provide examples of medical plausibility [of a subset of patients] or to further develop the definition of this term. Application of the concept is a matter of judgment based on the specific facts of each case."); David B. Clissold, *Prescription for the Orphan Drug Act: The Impact of the FDA's 1992 Regulations and the Latest Congressional Proposals for Reform*, 50 FOOD & DRUG L.J. 125, 133-37 (1995) (discussing these issues).

71. See Richard A. Merrill, *The Architecture of Government Regulation of Medical Products*, 82 VA. L. REV. 1753, 1765 n.37 (1996) ("The central question became whether the known risks of a drug were outweighed by its demonstrated clinical utility.").

72. See 21 U.S.C. § 353(b)(1)(B) (1994). A number of reasons may exist for prescription labeling, such as the difficulty with self-diagnosis, a product's margin of safety, and the extent to which dosages need to be carefully titrated for each patient. See *id.* (providing that a drug which, "because of its toxicity or other potentiality for harmful effect, or the method of its use, or the collateral measures necessary to its use, is not safe for use except under the supervision of a practitioner licensed by law to administer such drug . . . shall be dispensed only" upon a prescription); 21 C.F.R. § 330.10(a)(4)(vi) (1998) (same); Peter Barton Hutt, *A Legal Framework for Future Decisions on Transferring Drugs from Prescription to Nonprescription Status*, 37 FOOD DRUG COSM. L.J. 427, 433-39 (1982).

Asymptomatic conditions may pose difficult questions for the FDA when it reviews new drugs intended to manage these conditions. An asymptomatic condition does not really qualify as an "illness" because the patient cannot perceive any complaints, though it may still represent a disease condition detected by a physician. For example, hypertension, hypercholesterolemia, and hyperlipidemia generally do not manifest symptoms, but they are viewed as risk-factors in coronary heart disease and stroke. As previously mentioned, barring eligibility for accelerated approval, the Agency usually demands that an applicant demonstrate a drug's effectiveness in achieving clinical endpoints rather than surrogate markers associated with those clinical endpoints. By reconceptualizing hypertension as a freestanding disease entity, however, a pharmaceutical manufacturer would only have to demonstrate that its new drug product effectively reduced blood pressure without also having to show that this resulted in reduced morbidity or mortality.<sup>73</sup> Classifying asymptomatic conditions as diseases may, however, also undermine the prospects for approval of a drug whose side effects include one of these conditions—for instance, a drug intended to treat some other condition may fare less well in the Agency's risk-benefit calculus if it causes the "disease" of hypertension than if it merely causes elevated blood pressure.

The status of obesity as a condition or a disease has been a recurrent issue for the FDA. In approving the fat-substitute olestra, the Agency noted that it had received several comments supporting this novel food additive as a useful response to the adverse health effects of obesity.<sup>74</sup> The FDA also has approved prescription weight loss drugs in recent years based in part on the assumption that obesity represents a disease.<sup>75</sup> Indeed, historically, the FDA did not regard

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73. Cf. ARONOWITZ, *supra* note 32, at 127 ("Risk factors have been defined and treated as if they were straightforward diseases. This has been especially true of hypertension and hypercholesterolemia."); *id.* at 127-28 (noting that pharmaceutical companies helped launch a campaign to promote hypercholesterolemia screening and treatment, adding that, "for the physician, the carrot in the national cholesterol campaigns was the creation of new reimbursable medical diagnoses"); *id.* at 246 n.20 ("Defining blood pressure above 140/90 as a disease, for example, results in a large market for antihypertensive medications and an imperative for costly screening campaigns."); Denise Grady, *As Silent Killer Returns, Doctors Rethink Tactics to Lower Blood Pressure*, N.Y. TIMES, July 14, 1998, at F1 (reporting that "it is not known whether all drugs that lower blood pressure also protect against heart attack and stroke," adding that "[d]rug companies sold about \$9 billion in blood pressure medications in 1997").

74. See 61 Fed. Reg. 3118, 3163 (1996). In approving food additives, however, the FDA may not take purported benefits into account. See *id.* at 3166; see also Lars Noah & Richard A. Merrill, *Starting from Scratch?: Reinventing the Food Additive Approval Process*, 78 B.U. L. REV. 329, 392-94 (1998).

75. See Laura Johannes & Steve Stecklow, *Dire Warnings About Obesity Rely on Slippery Statistic*, WALL ST. J., Feb. 9, 1998, at B1 ("[T]he FDA's bar for approving new drugs

obesity as a disease, leading Congress to expand the drug definition so that the Agency could assert its regulatory authority over weight loss products.<sup>76</sup> Although obese individuals face a variety of health problems,<sup>77</sup> some scientists regard most types of obesity as a symptom of one among several possible underlying disorders rather than a disease process itself.<sup>78</sup> If only regarded as a symptom, proposed new obesity treatments will fare less well in the Agency's risk-benefit calculus and product approval decisions in the future.

Other federal agencies make decisions that depend on, and in turn influence, how one defines diseases. The Centers for Disease Control and Prevention (CDC) play an important role in both defining and tracking emerging, usually infectious diseases such as AIDS.<sup>79</sup>

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is lower for disease treatments than for other problems, such as baldness or skin wrinkles. The agency is less likely to approve a drug for a nondisease condition when it is shown to have serious side effects—such as those that diet drugs produce.”; see also Richard L. Atkinson, *Proposed Standards for Judging the Success of the Treatment of Obesity*, 119 ANNALS INTERNAL MED. 677, 679 (1993); Arthur Frank, *Futility and Avoidance: Medical Professionals in the Treatment of Obesity*, 269 JAMA 2132, 2132-33 (1993) (supporting the characterization of obesity as a disease); Marlene Cimonis, *Public Is Urged to Treat Obesity as Chronic Disease*, L.A. TIMES, Dec. 6, 1994, at A14.

76. See *Hearings on S. 2800 Before the Senate Comm. on Commerce*, 73d Cong. 516 (1934) (statement of W.G. Campbell, Chief of FDA); *E.R. Squibb & Sons, Inc. v. Bowen*, 870 F.2d 678, 682-83 (D.C. Cir. 1989).

77. See, e.g., Steven L. Gortmaker et al., *Social and Economic Consequences of Overweight in Adolescence and Young Adulthood*, 329 NEW ENG. J. MED. 1008, 1008 (1993) (noting the “[n]umerous health risks” now associated with obesity); F. Xavier Pi-Sunyer, *Medical Hazards of Obesity*, 119 ANNALS INTERNAL MED. 655, 655-58 (1993). “Obese” means more than 20% over a person's ideal body weight. See THE MERCK MANUAL OF DIAGNOSIS AND THERAPY 981 (Robert Berkow et al. eds., 16th ed. 1992) (conceding that this threshold is arbitrary). Another standard calculates a person's body-mass index (BMI). See June Stevens et al., *The Effect of Age on the Association Between Body-Mass Index and Mortality*, 338 NEW ENG. J. MED. 1, 2 (1998); David F. Williamson, *Descriptive Epidemiology of Body Weight and Weight Change in U.S. Adults*, 119 ANNALS INTERNAL MED. 646, 646 (1993); Jane E. Brody, *New Guide Puts Most Americans on the Fat Side*, N.Y. TIMES, June 9, 1998, at F7.

78. See, e.g., Jerome P. Kassirer & Marcia Angell, Editorial, *Losing Weight—An Ill-Fated New Year's Resolution*, 338 NEW ENG. J. MED. 52, 53 (1998) (criticizing efforts to label obesity as a disease).

79. See ELIZABETH W. ETHERIDGE, SENTINEL FOR HEALTH: A HISTORY OF THE CENTERS FOR DISEASE CONTROL 341-43 (1992) (describing the CDC's success in tracking mysterious disease outbreaks such as Legionnaires' disease, toxic shock syndrome, and AIDS); see also CDC, *Summary of Notifiable Diseases, United States, 1996*, 45 MORBIDITY & MORTALITY WKLY. REP. No. 53, Oct. 31, 1997, at 1. As the agency explained, however, its case definitions “establish uniform criteria for disease reporting and should not be used as the sole criteria for establishing clinical diagnoses . . . or providing standards for reimbursement.” CDC, *Case Definitions for Infectious Conditions Under Public Health Surveillance*, 46 MORBIDITY & MORTALITY WKLY. REP. No. RR-10 (May 2, 1997), at 3. The World Health Organization's ICD also was designed for this more limited purpose. See 2 WORLD HEALTH ORGANIZATION, INTERNATIONAL CLASSIFICATION OF DISEASES AND RELATED HEALTH PROBLEMS 2 (10th rev. ed. 1993).

In concert with the FDA, the CDC's assessment of side effects has helped turn up previously undescribed or poorly understood diseases associated with widely used products.<sup>80</sup> Finally, the National Institutes of Health (NIH) fund basic research proposals depending in part on the class of diseases targeted by the grant application.<sup>81</sup> By sponsoring, conducting, and reviewing biomedical research, these three bureaucracies directly influence, and in turn are influenced by, new developments in nosology.

### C. Tort Plaintiffs

In tort litigation, plaintiffs must prove that some act or omission by the defendant caused a compensable injury. Disputes about medical testimony typically involve causation questions, where no one doubts that the plaintiff has some "injury," but its association with the defendant's allegedly tortious conduct remains obscure. Questions about causation have become particularly difficult for courts to resolve in cases where the plaintiff contracts a long latency disease such as cancer,<sup>82</sup> and the United States Supreme Court has instructed trial judges to engage in more careful scrutiny of expert scientific evidence

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80. See 53 Fed. Reg. 21,633, 21,637 (1988) (codified at 21 C.F.R. § 201.314(h) (1998)) (requiring a warning of the association between Reye syndrome and aspirin use in children); 47 Fed. Reg. 26,982, 26,989-90 (1982) (codified at 21 C.F.R. § 801.430 (1998)) (requiring a warning of the association between toxic shock syndrome (TSS) and tampons). For a more detailed discussion of these two cases, see Lars Noah, *The Imperative to Warn: Disentangling the "Right to Know" from the "Need to Know" About Consumer Product Hazards*, 11 YALE J. ON REG. 293, 323-24 & n.133 (1994).

81. See EDWARD H. AHRENS, JR., *THE CRISIS IN CLINICAL RESEARCH: OVERCOMING INSTITUTIONAL OBSTACLES* 65-105 (1992) (describing the NIH's disease-oriented structure and process of awarding extramural research grants); INSTITUTE OF MEDICINE, *FUNDING HEALTH SCIENCES RESEARCH* 37 (1990) (noting that Congress "added numerous categorical institutes to NIH [since World War II], reflecting efforts of special interest groups to target research on specific organ groups and illnesses"). This happens because federal legislators may earmark appropriations for particular diseases, as happened with the "war on cancer" initiated in the early 1970s. See VICTORIA A. HARDEN, *INVENTING THE NIH: FEDERAL BIOMEDICAL RESEARCH POLICY, 1887-1937*, at 186 (1986); see also Robert Pear, *Health Agency Urged to Review Spending*, N.Y. TIMES, July 9, 1998, at A24 (describing a report issued by the Institute of Medicine recommending that NIH "should more systematically consider data on the prevalence, death rates and costs of different diseases in setting its research agenda and priorities," in part to combat the perception that patient advocacy groups unduly influence the process).

82. See Troyen A. Brennan, *Causal Chains and Statistical Links: The Role of Scientific Uncertainty in Hazardous-Substance Litigation*, 73 CORNELL L. REV. 469, 501-22 (1988); Heidi Li Feldman, *Science and Uncertainty in Mass Exposure Litigation*, 74 TEX. L. REV. 1, 31-33 (1995); Joseph Sanders, *From Science to Evidence: The Testimony on Causation in the Bendectin Cases*, 46 STAN. L. REV. 1, 12-17 (1993); see also JANE STAPLETON, *DISEASE AND THE COMPENSATION DEBATE* 3 (1986) (arguing that the tort system, designed to compensate accident victims for traumatic injuries, is ill-suited to deal with claims involving diseases).

in such situations.<sup>83</sup>

Disputes about medical causation typically pose scientific (usually epidemiological) questions subject to these strictures,<sup>84</sup> but courts tend to review diagnostic (clinical) judgments about the nature of particular patients' injuries under more forgiving standards. As one federal court recently explained:

Because the objectives, functions, subject matter and methodology of hard science vary significantly from those of the discipline of clinical medicine, as distinguished from research or laboratory medicine, the hard science techniques or methods that became the "Daubert factors" generally are not appropriate for assessing the evidentiary reliability of a proffer of expert clinical medical testimony.<sup>85</sup>

The judgments of treating physicians are given particular deference even though they may have little expertise on scientific questions of general causation.<sup>86</sup> In effect, courts allow them to testify about ultimate issues such as the nature of the plaintiff's damages.<sup>87</sup>

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83. See *General Elec. Co. v. Joiner*, 118 S. Ct. 512, 519 (1997); *Daubert v. Merrell Dow Pharms., Inc.*, 509 U.S. 579, 583-94 (1993); see also KENNETH R. FOSTER & PETER W. HUBER, *JUDGING SCIENCE: SCIENTIFIC KNOWLEDGE AND THE FEDERAL COURTS* (1997); Symposium, *Scientific Evidence After the Death of Frye: Daubert and Its Implications for Toxic Torts, Pharmaceutical, and Products Liability Cases*, 15 CARDOZO L. REV. 1745 (1994); Judith A. Hasko, Note, *Daubert v. Merrell Dow Pharmaceuticals, Inc.: Flexible Judicial Screening of Scientific Expert Evidence Under Federal Rule of Evidence 702*, 1995 WIS. L. REV. 479, 495-505.

84. See Jean Macchiaroli Eggen, *Toxic Torts, Causation, and Scientific Evidence After Daubert*, 55 U. PITT. L. REV. 889, 895-903 (1994); Joseph Sanders, *Scientific Validity, Admissibility, and Mass Torts After Daubert*, 78 MINN. L. REV. 1387, 1406-17 (1994).

85. *Moore v. Ashland Chem., Inc.*, 1997 U.S. App. LEXIS 33501, at \*23 (5th Cir. 1997), *vacated*, 151 F.3d 269, 275 n.6 (5th Cir. 1998) (en banc) (rejecting any such distinction); see also *id.* at \*22-28, 73-80; *id.* at \*104-09 (Davis, J., dissenting) (distinguishing between the testimony of physicians concerning (1) diagnostic judgments and (2) medical causation, which is subject to *Daubert*); David L. Faigman et al., *Check Your Crystal Ball at the Courthouse Door, Please: Exploring the Past, Understanding the Present, and Worrying About the Future of Scientific Evidence*, 15 CARDOZO L. REV. 1799, 1832 (1994) (arguing that courts inappropriately may fail to apply *Daubert* to "clinical judgments"); cf. *Kumho Tire v. Carmichael*, 119 S.Ct. 1167, 1174-79 (1999) (holding *Daubert* applicable to expert testimony from an engineer that was based on his experience and observation rather than scientific research). In medical malpractice cases, of course, physicians may testify as experts on questions about the standard of care and breach. See Karyn K. Ablin, Note, *Res Ipsa Loquitur and Expert Opinion Evidence in Medical Malpractice Cases: Strange Bedfellows*, 82 VA. L. REV. 325, 337 (1996).

86. See *Ferebee v. Chevron Chem. Co.*, 552 F. Supp. 1293, 1300 (D.D.C. 1982) (crediting the testimony of the plaintiff's "treating physicians, a qualification shared by none of the defendant's experts"), *aff'd*, 736 F.2d 1529 (D.C. Cir. 1984); *Iorio v. Grossie*, 663 So. 2d 366, 368-69 (La. Ct. App. 1995).

87. See FED. R. EVID. 704(a) ("[T]estimony in the form of an opinion or inference otherwise admissible is not objectionable because it embraces an ultimate issue to be decided by the trier of fact."); *Williams v. Wal-Mart Stores, Inc.*, 922 F.2d 1357, 1361 (8th

Even in uncomplicated tort cases, of course, treating physicians must testify about the nature and extent of a patient's injury.<sup>88</sup> (Similarly, on the assumption of the special trustworthiness of information communicated in this context, the hearsay rule includes an exception covering statements by patients "made for purposes of medical diagnosis or treatment and describing medical history, or past or present symptoms, pain, or sensations, or the inception or general character of the cause or external source thereof insofar as reasonably pertinent to diagnosis or treatment."<sup>89</sup>) The point at which an illness becomes medically diagnosable may also help define when the statute of limitations will start running on long-latency disease claims.<sup>90</sup> In some cases, however, it may be unclear whether the plaintiff has any injury whatsoever, collapsing the causation inquiry into questions about the appropriate definition of the asserted injury.

For instance, definitions of occupational diseases may explicitly incorporate the agent suspected of causing serious respiratory symptoms, such as silicosis, byssinosis, black lung disease, and asbestosis.<sup>91</sup>

Cir. 1990); Kathy Jo Cook, *An Opinion: Federal Judges Misconstrue Rule 704. (Or Is That an Impermissible "Legal" Conclusion?)*, 43 CLEV. ST. L. REV. 45 (1995).

88. See Samuel R. Gross, *Expert Evidence*, 1991 WIS. L. REV. 1113, 1119; Jeff L. Lewin, *The Genesis and Evolution of Legal Uncertainty About "Reasonable Medical Certainty"*, 57 MD. L. REV. 380, 382-83 (1998) ("Physicians provide essential opinion testimony on the issues of causation and damages in virtually all civil actions for wrongful death or personal injury [as well as in workers' compensation cases] . . . In all such proceedings, the outcome may hinge on the willingness of a physician to express an opinion with 'reasonable medical certainty.'" (footnotes omitted)); *DePass v. United States*, 721 F.2d 203, 209 (7th Cir. 1983) (Posner, J., dissenting) ("[A] tort plaintiff's burden of proving the extent of his injury is not a heavy one. Doubts are resolved against the tortfeasor.").

89. FED. R. EVID. 803(4); see also *Galindo v. United States*, 630 A.2d 202, 210 (D.C. 1993); L. Timothy Perrin, *Expert Witnesses Under Rules 703 and 803(4) of the Federal Rules of Evidence: Separating the Wheat from the Chaff*, 72 IND. L.J. 939, 947, 996-97 (1997) (criticizing this exception for covering statements made in the course of seeking a professional medical diagnosis for purposes other than treatment). See generally ELLIOTT B. OPPENHEIM, *THE MEDICAL RECORD AS EVIDENCE* (1998).

90. See, e.g., *Benne v. International Bus. Mach. Corp.*, 87 F.3d 419, 427-28 (10th Cir. 1996); *Neubauer v. Owens-Corning Fiberglas Corp.*, 686 F.2d 570, 573-77 (7th Cir. 1982); *In re FELA Asbestos Cases*, 646 F. Supp. 610, 613 (W.D. Va. 1985); *In re New York County DES Litig.*, 678 N.E.2d 474, 478 (N.Y. 1997); see also *Marinari v. Asbestos Corp.*, 612 A.2d 1021, 1022 (Pa. Super. Ct. 1992) ("Plaintiff's discovery of a nonmalignant, asbestos related lung pathology, whether or not accompanied by clinical symptoms of impaired pulmonary function, does not trigger the statute of limitations with respect to an action for a later, separately diagnosed, disease of lung cancer."); Michael D. Green, *The Paradox of Statutes of Limitations in Toxic Substances Litigation*, 76 CAL. L. REV. 965, 973-76 (1988).

91. See Gerald Markowitz & David Rosner, *The Illusion of Medical Certainty: Silicosis and the Politics of Industrial Disability, 1930-1960*, in *FRAMING DISEASE: STUDIES IN CULTURAL HISTORY*, *supra* note 33, at 185, 202; see also Frank Davidoff, Editorial, *New Disease, Old Story*, 129 ANNALS INTERNAL MED. 327 (1998) (discussing the publication of, and controversy surrounding, a new study describing "flock worker's lung" in the nylon manufacturing industry). In applying the Black Lung Benefits Act, courts have recognized a

Asymptomatic plaintiffs may try to recast their enhanced future risk of injury as a presently diagnosed syndrome, whether physical or mental,<sup>92</sup> much like the patient suffering from "breast-ovarian carcinoma syndrome" who eventually succeeded in obtaining reimbursement from her health insurer for prophylactic surgery.<sup>93</sup> In some of these cases, the availability of compensation turns on whether the plaintiff can demonstrate some type of subcellular damage.<sup>94</sup>

A number of tort plaintiffs have alleged suffering from multiple chemical sensitivity syndrome (MCS).<sup>95</sup> According to the "clinical

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distinction between the medical and legal definitions of the disease pneumoconiosis. *See, e.g., Richardson v. Director, OWCP*, 94 F.3d 164, 166 n.2 (4th Cir. 1996); *Nance v. Benefits Review Bd.*, 861 F.2d 68, 71 (4th Cir. 1988).

92. *See* David Carl Minneman, Annotation, *Future Disease or Condition, or Anxiety Relating Thereto, As Element of Recovery*, 50 A.L.R.4th 13, 49 (1986) ("[I]t may be possible to recover substantial damages by stressing the objective symptoms of an injured person's present condition rather than attempting to prove damages for a future disease or condition."); *see also* *Metro-North Commuter R.R. Co. v. Buckley*, 521 U.S. 424, 428-38 (1997) (retaining physical-impact rule for emotional distress claims in FELA actions, and denying recovery to railroad worker exposed to asbestos but not yet suffering any illness); *Potter v. Firestone Tire & Rubber Co.*, 863 P.2d 795, 804-16 (Cal. 1993) (allowing fear of cancer claim if toxic exposure will more likely than not lead to cancer); *Eagle-Picher Indus., Inc. v. Cox*, 481 So. 2d 517, 522 (Fla. Dist. Ct. App. 1985) (rejecting enhanced future risk claim where plaintiff suffered from asbestosis, noting that "asbestosis and cancer are distinct and separate diseases"); *Mauro v. Raymark Indus., Inc.*, 561 A.2d 257, 264-67 (N.J. 1989) (holding that enhanced future risk claims are only available if the development of cancer is a reasonable medical probability); *Simmons v. Pacor, Inc.*, 674 A.2d 232, 237-39 (Pa. 1996) (concluding that "asymptomatic pleural thickening is not a compensable injury which gives rise to a cause of action" and also cannot support an emotional distress claim for fear of developing cancer); Bill Charles Wells, *The Grin Without the Cat: Claims for Damages from Toxic Exposure Without Present Injury*, 18 WM. & MARY J. ENVTL. L. 285, 319-29 (1994); Glen Donath, Comment, *Curing Cancerphobia Phobia: Reasonableness Redefined*, 62 U. CHI. L. REV. 1113, 1116 (1995) (distinguishing between enhanced future risk claims and emotional distress claims, which are a present injury based on a reaction to that future risk); Note, *Latent Harms and Risk-Based Damages*, 111 HARV. L. REV. 1505, 1506 (1998) ("[A]dvances in the understanding of disease have led to the recognition of 'latent harms'—harms that may not develop into symptomatic disease for significant periods of time.").

93. *See supra* notes 57-59 and accompanying text.

94. *See* *Brafford v. Susquehanna Corp.*, 586 F. Supp. 14, 17-18 (D. Colo. 1984) (requiring only proof of damage to "cellular and subcellular structures" from radiation exposure); *cf. Anderson v. W.R. Grace & Co.*, 628 F. Supp. 1219, 1227-32 (D. Mass. 1986) (allowing emotional distress but not enhanced future risk claim based on subcellular harm and immune system impairment). *But cf. Schweitzer v. Consolidated Rail Corp.*, 758 F.2d 936, 942 (3d Cir. 1985) (rejecting enhanced future risk claim where plaintiff only had "sub-clinical injury" from asbestos exposure).

95. *See* Jack W. Synder et al., *Injury and Causation on Trial: The Phenomenon of "Multiple Chemical Sensitivities,"* 2 WIDENER L. SYMP. J. 97, 102 (1997) ("[T]he phenomenon of MCS does not represent a diagnosis, disease, or illness as defined by orthodox medical practitioners. Importantly, the proposed definitions of MCS do not require the specificity of complaints necessary to qualify MCS as an objectively verifiable medical

ecologists" who popularized this diagnosis, MCS patients have become so sensitized to chemicals from prior low-level environmental exposures that they develop a variety of vague symptoms upon any subsequent exposure.<sup>96</sup> Although several researchers defend MCS as a valid diagnostic entity,<sup>97</sup> the mainstream biomedical research community remains skeptical that this condition represents any sort of genuine *physical* illness.<sup>98</sup> So far, courts have rejected testimony diagnosing plaintiffs with multiple chemical sensitivity.<sup>99</sup> As one court noted, there is "considerable doubt in the scientific medical community regarding the legitimacy of MCS as a valid nosologic/diagnostic entity."<sup>100</sup> If courts began to accept MCS diagnoses from clinical ecologists, defendants would have no genuine opportunity to dispute

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syndrome." (footnote omitted)).

96. See Wendi J. Berkowitz, *Multiple Chemical Sensibility in the Courtroom: Is There Life After Daubert?*, 63 DEF. COUNS. J. 483, 487-89 (1996) (describing the "hodgepodge of symptoms that clinical ecologists believe may characterize MCS. Almost every abnormal body function, ache or pain appears in the literature as a possible symptom," adding that clinical ecologists have conceded that they do not know the etiology of MCS but "are satisfied with attributing causation to almost everything in the environment"); Steven H. Winterbauer, *Multiple Chemical Sensitivity and the ADA: Taking a Clear Picture of a Blurry Object*, 23 EMPLOYEE RELS. L.J. 69, 75 (1997) ("[Critics] view MCS as a diagnosis of default, a catch-all label that is overused when the attending medical professional is incapable of readily fitting the claimed symptoms within the definition of other established diagnoses.").

97. See, e.g., NATIONAL RESEARCH COUNCIL, *MULTIPLE CHEMICAL SENSITIVITIES: ADDENDUM TO BIOLOGIC MARKERS IN IMMUNOTOXICOLOGY* (1992); Alvin C. Bronstein, *Multiple Chemical Sensitivities—New Paradigm Needed*, 33 J. TOXICOLOGY 93 (1995); Mark R. Cullen, *The Worker with Multiple Chemical Sensitivities: An Overview*, 2 STATE OF THE ART REVIEWS: OCCUPATIONAL MED. 655 (1987); Ann L. Davidoff & Linda Fogarty, *Psychogenic Origins of Multiple Chemical Sensitivities Syndrome: A Critical Review of the Research Literature*, 49 ARCHIVES ENVTL. HEALTH 316 (1994); Claudia S. Miller, *Chemical Sensitivity: History and Phenomenology*, 10 TOXICOLOGY & INDUS. HEALTH 253 (1994); Patricia J. Sparks et al., *Multiple Chemical Sensitivity Syndrome: A Clinical Perspective*, 36 J. OCCUPATIONAL MED. 718 (1994) (summarizing the debate).

98. See, e.g., American College of Physicians, *Clinical Ecology*, 111 ANNALS INTERNAL MED. 168 (1989); AMA Council on Scientific Affairs, *Clinical Ecology*, 268 JAMA 3465, 3467 (1992) (concluding that "multiple chemical sensitivity should not be considered a recognized clinical syndrome"); Thomas L. Kurt, *Multiple Chemical Sensitivities—A Syndrome of Pseudotoxicity Manifest as Exposure Perceived Symptoms*, 33 J. TOXICOLOGY 101 (1995); Abba I. Terr, Editorial, *Multiple Chemical Sensitivities*, 119 ANNALS INTERNAL MED. 163 (1993).

99. See, e.g., *Bradley v. Brown*, 42 F.3d 434, 438-39 (7th Cir. 1994); *Summers v. Missouri Pac. R.R. Sys.*, 897 F. Supp. 533, 535-40 (E.D. Okla. 1995); *Carlin v. RFE Indus., Inc.*, 1995 U.S. Dist. LEXIS 19035, at \*16-20 (N.D.N.Y. Nov. 27, 1995); *Graham v. Canadian Nat'l Ry. Co.*, 749 F. Supp. 1300, 1310-11 (D. Vt. 1990); see also *Sterling v. Velsicol Chem. Corp.*, 855 F.2d 1188, 1208 (6th Cir. 1988) ("The leading professional societies in the specialty of allergy and immunology . . . have rejected clinical ecology as an unproven methodology lacking any scientific base in either fact or theory.").

100. *Cavallo v. Star Enter.*, 892 F. Supp. 756, 768 (E.D. Va. 1995) (quoting expert witness's report).

that their alleged negligence actually caused the plaintiff's present condition because an assumption of low-level, cumulative exposure to some chemical is built into the diagnosis itself.

Plaintiffs also may rely on a diagnosis of "atypical" forms of a disease when the available evidence of causation undermines assertions that the defendant caused their particular injury. For instance, in response to recent epidemiological studies finding no statistically significant association between silicone-gel breast implants and previously described autoimmune diseases such as lupus,<sup>101</sup> some plaintiffs' attorneys and treating physicians retreated from the claim that their clients had one of the traditional connective-tissue diseases and instead asserted that they suffered from some atypical form of these diseases.<sup>102</sup> Thus, rather than directly confront the defendant's causation evidence, plaintiffs have dodged that evidence through the simple expedient of effectively having their alleged injuries rediagnosed. So far, courts have rebuffed such efforts.<sup>103</sup>

Psychiatric diagnoses have become increasingly important in civil

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101. See Sherine E. Gabriel et al., *Risk of Connective-Tissue Diseases and Other Disorders After Breast Implantation*, 330 NEW ENG. J. MED. 1697, 1699-700 (1994); Jorge Sánchez-Guerrero et al., *Silicone Breast Implants and the Risk of Connective-Tissue Diseases and Symptoms*, 332 NEW ENG. J. MED. 1666, 1668-70 (1995); see also Gina Kolata, *In Implant Case, Science and Law Have Different Agendas*, N.Y. TIMES, July 11, 1998, at A1 (summarizing the mounting evidence against any link to disease and the tactic by plaintiffs' lawyers of recasting their clients' conditions as "atypical").

102. See, e.g., MARCIA ANGELL, *SCIENCE ON TRIAL: THE CLASH OF MEDICAL EVIDENCE AND THE LAW IN THE BREAST IMPLANT CASE* 97-108, 199 (1996) ("Doctors who make their living diagnosing implant-related diseases and the lawyers who pay them have every reason to postulate increasingly obscure syndromes, as the well-defined ones come under scientific scrutiny."); see also ARONOWITZ, *supra* note 32, at 49 ("[T]he very naming and rationalization of these advances as immunologic when the underlying pathophysiological etiology in most of these disorders—including ulcerative colitis—is still poorly understood suggests that larger social factors may be at work . . . [W]e may have substituted one large and malleable concept for another, autoimmunity for psychosomatics, to explain the etiology of still poorly understood chronic illnesses."); cf. COLBY & SPAR, *supra* note 21, at 15 (criticizing *DSM-III*'s inclusion of "atypical" subcategories as nothing more than a device to "reduc[e] the number of persons whose disorder cannot be classified"); *id.* at 30 ("Under the 'atypical' subcategory of most of the major diagnoses, you could place any person with any complaint that happens to contain emotional terms."); GLENN, *supra* note 4, at 12 ("If the problem persists, perhaps a diagnosis may be made of 'subacute' this or that, . . . or that the patient suffers from 'diverticulosis' (a wastebasket diagnosis in this case), or perhaps from a psychosomatic disorder, such as 'irritable bowel syndrome.'").

103. See *Kelley v. American Heyer-Schulte Corp.*, 957 F. Supp. 873, 877-80 & n.6 (W.D. Tex. 1997); *Hall v. Baxter Healthcare Corp.*, 947 F. Supp. 1387, 1402 (D. Or. 1996); see also John Schwartz, *Scientists Find Little That Links Breast Implants and Disease*, WASH. POST, Dec. 2, 1998, at A8 (describing report issued by a court-appointed panel of experts). But see *Vassallo v. Baxter Healthcare Corp.*, 696 N.E.2d 909, 915-18 (Mass. 1998) (rejecting objections to the admission of such testimony).

litigation as courts liberalize the rules for pain and suffering damages and claims for the negligent infliction of emotional distress.<sup>104</sup> For instance, several courts have allowed tort plaintiffs to recover damages based on a diagnosis of post-traumatic stress disorder (PTSD).<sup>105</sup> The American Psychiatric Association first officially recognized this condition in 1980,<sup>106</sup> and it has gradually refined the definition.<sup>107</sup> To the extent that judges traditionally restricted emotional distress claims lacking any physical trigger or manifestation out of a suspicion that such injuries were too easily feigned, psychiatric testimony that the plaintiff suffers from a diagnosable mental illness may provide some reassurance of legitimacy. Nonetheless, some critics argue that a diagnosis of PTSD inappropriately certifies the genuineness of emotional distress complaints asserted by tort plaintiffs.<sup>108</sup> It may be,

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104. See, e.g., *Bass v. Nooney Co.*, 646 S.W.2d 765, 772-73 (Mo. 1983) (requiring that emotional distress or mental injury be diagnosable and medically significant); *Johnson v. Ruark Obstetrics & Gynecology Assocs.*, 395 S.E.2d 85, 97 (N.C. 1990) (requiring "severe mental distress" constituted by "any emotional or mental disorder, such as, for example, neurosis, psychosis, chronic depression, phobia, or any other type of severe and disabling emotional or mental condition which may be generally recognized and diagnosed by professionals"); cf. *Chizmar v. Mackie*, 896 P.2d 196, 205 (Alaska 1995) ("While some jurisdictions have required claims of emotional distress to be 'medically diagnosable or objectifiable,' we do not believe that such a limitation is necessary or desirable." (footnote omitted)); Julie A. Davies, *Direct Actions for Emotional Harm: Is Compromise Possible?*, 67 WASH. L. REV. 1, 25 (1992) ("Numerous commentators and courts have observed that developments in science enable experts to adequately distinguish between trivial and non-trivial emotional distress without reliance on physical consequences of harm."). It seems unrealistic to think that jurisdictions demanding a diagnosis of a mental disorder will screen out exaggerated claims of mental distress.

105. See, e.g., *Gough v. Natural Gas Pipeline Co. of Am.*, 996 F.2d 763, 767 (5th Cir. 1993); *Nichols v. Busse*, 503 N.W.2d 173, 180 (Neb. 1993); *Berthelot v. Aetna Cas. & Sur. Co.*, 623 So. 2d 14, 22 (La. Ct. App. 1993); *Giamanco v. Epe, Inc.*, 619 So. 2d 842, 845-46 (La. Ct. App. 1993); *Sullivan v. Boston Gas Co.*, 605 N.E.2d 805, 811 (Mass. 1993); see also ROBERT I. SIMON, *POSTTRAUMATIC STRESS DISORDER IN LITIGATION: GUIDELINES FOR FORENSIC ASSESSMENT* 31 (1995) ("Because PTSD is incident specific, it has been a favorite diagnosis in litigation because it creates a presumption of causation. When other psychiatric disorders are diagnosed, legal causation may be much more difficult to prove.").

106. See AMERICAN PSYCHIATRIC ASS'N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* 236 (3d ed. 1980) [hereinafter *DSM-III*]; Wilbur J. Scott, *PTSD in DSM-III: A Case in the Politics of Diagnosis and Disease*, 37 SOC. PROBS. 294 (1990); Lawrence Raiman, *Problems of Diagnosis and Legal Causation in Courtroom Use of Post-Traumatic Stress Disorder*, 1 BEHAV. SCI. & L. 115, 119-20 (1983).

107. See Richard L. Newman & Rachel Yehuda, *PTSD in Civil Litigation: Recent Scientific and Legal Developments*, 37 JURIMETRICS J. 257, 262-65 (1997) (summarizing the recognition and gradual evolution in the definition of PTSD, as well as recent research suggesting that a diagnosis can be premised on measurable biochemical changes in a patient); John P. Wilson, *The Historical Evolution of PTSD Diagnostic Criteria: From Freud to DSM-IV*, 7 J. TRAUMA STRESS 681 (1994).

108. See, e.g., James T. Brown, *Compensation Neurosis Rides Again: A Practitioner's*

however, that courts have accepted general evidence concerning PTSD as a nosological entity to support a doctrinal expansion of emotional distress claims, recognizing that stressful events can cause serious psychological injuries even without physical manifestations, in which case the accuracy of individual diagnoses arguably becomes less important.

#### D. Criminal Defendants

Psychiatric evidence has become a fairly common feature in criminal litigation.<sup>109</sup> In addition, civil commitment proceedings depend on such information, though the Supreme Court recently explained that "we have traditionally left to legislators the task of defining terms of a medical nature that have legal significance."<sup>110</sup> As one commentator previously had noted, "the legal system should not be required to excuse or to commit a person just because mental health professionals have labeled him 'sick.' An illness for mental

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*Guide to Defending PTSD Claims*, 63 DEF. COUNS. J. 467 (1996); Karl Kirkland, *Post-Traumatic Stress Disorder vs. Pseudo Post-Traumatic Stress Disorder: A Critical Distinction for Attorneys*, 56 ALA. LAW. 90, 91-93 (1995); L.A. Neal, *The Pitfalls of Making a Categorical Diagnosis of Post Traumatic Stress Disorder in Personal Injury Litigation*, 34 MED. SCI. & L. 117 (1994); see also John A. Fairbank et al., *Psychometric Detection of Fabricated Symptoms of Posttraumatic Stress Disorder*, 142 AM. J. PSYCHIATRY 501, 501 (1985) ("Since [PTSD] is a disorder for which veterans can seek compensation and treatment from the Veterans Administration, objective means of discriminating those veterans who legitimately display its symptoms from those who intentionally simulate the symptoms are needed."); Stephen T. Perconte & Anthony J. Goreczny, *Failure to Detect Fabricated Posttraumatic Stress Disorder with the Use of the MMPI in a Clinical Population*, 147 AM. J. PSYCHIATRY 1057, 1060 (1990) ("It may be that the most effective tools for detecting fabricated symptoms of PTSD are those which verify and quantify combat exposure, such as discharge papers, combat histories, and military records."). When civilians sue, of course, no such means of checking the veracity of a PTSD diagnosis would exist.

109. See Richard J. Bonnie & Christopher Slobogin, *The Role of Mental Health Professionals in the Criminal Process: The Case for Informed Speculation*, 66 VA. L. REV. 427, 466-67 (1980) ("Because the [criminal] law . . . endorses a 'medical model' of abnormal psychological functioning, courts have generally considered the presence of a diagnosable mental illness to be a matter of some evidentiary importance."). Wholly apart from the defendant's possible use of psychiatric evidence, the testimony of medical examiners about the cause of victims' injuries or death may play a significant role in the success of criminal prosecutions. See, e.g., Mark Hansen, *Why Are Iowa's Babies Dying?*, A.B.A. J., Aug. 1998, at 74 (describing recent controversy surrounding the use of "shaken baby syndrome" diagnoses in prosecuting cases involving infant deaths).

110. *Kansas v. Hendricks*, 521 U.S. 346, 359 (1997) ("As a consequence, the States have, over the years, developed numerous specialized terms to define mental health concepts. Often, those definitions do not fit precisely with the definitions employed by the medical community."); see also Steven I. Friedland, *On Treatment, Punishment, and the Civil Commitment of Sex Offenders*, 70 U. COLO. L. REV. 73, 134-47 (1999); Gerard, *supra* note 20, at 391 ("[M]any people in the legal system have fallen into the trap of assuming that any condition that mental health professionals label as an illness must be accepted as an illness for purposes of the mental health legal system.").

health purposes need not be an illness for legal purposes."<sup>111</sup> Nonetheless, if behavior does not qualify as a mental illness in the first place, it will never count as a disease for legal purposes.<sup>112</sup>

Even more so than other types of diseases, psychiatric conditions have prompted significant controversy among medical professionals.<sup>113</sup> In an attempt to promote some consistency in the field, the American Psychiatric Association (APA) has published and periodically revised its *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.<sup>114</sup> Its latest edition, *DSM-IV*, appeared in 1994, and it now lists hundreds of psychiatric ailments.<sup>115</sup> Diagnoses based on criteria in the *DSMs* have become a central feature of litigation involving disputes about mental illness.<sup>116</sup>

Many of the new psychiatric syndromes, such as battered woman and rape trauma, represent variants of PTSD.<sup>117</sup> Other examples in-

111. Gerard, *supra* note 20, at 393.

112. *See id.* at 396 ("[E]very condition accepted as a mental illness by the legal system must be classified as an illness by mental health professionals.").

113. *See supra* note 20 and accompanying text.

114. For a description of the evolution of the *DSMs*, see STUART A. KIRK & HERB KUTCHINS, *THE SELLING OF DSM: THE RHETORIC OF SCIENCE IN PSYCHIATRY* 27-28, 77-119, 139-40, 199-218 (1992) (detailing the drafting of *DSM-III*, including the decision to drop homosexuality as a mental disorder, and the preparation of *DSM-IV*).

115. *See* AMERICAN PSYCHIATRIC ASS'N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* (4th ed. 1994) [hereinafter *DSM-IV*]; *see also* HERB KUTCHINS & STUART A. KIRK, *MAKING US CRAZY—DSM: THE PSYCHIATRIC BIBLE AND THE CREATION OF MENTAL DISORDERS* x (1997) (calling *DSM-IV* "the repository of a strange mix of social values, political compromise, scientific evidence, and material for insurance claim forms").

116. *See, e.g.,* State v. Alberico, 861 P.2d 192, 208 (N.M. 1993) (accepting PTSD testimony on the strength of its inclusion in the *DSM*); Daniel W. Schuman, *The Diagnostic and Statistical Manual of Mental Disorders in the Courts*, 17 BULL. AM. ACAD. PSYCHIATRY & L. 25, 27 (1989) (describing the extensive forensic use of the *DSM*); *see also* Gerard, *supra* note 20, at 413 ("The legal system cannot, independently of medicine, establish criteria for the reliable diagnoses of any illness, mental or otherwise. . . . But the legal system certainly can adopt the medical criteria for reliable diagnoses, and can insist that they be adhered to in the legal processes."); Sabra McDonald Owens, Note, *Diagnostic Evidence Admissibility and the Multiple Personality Disorder Defense*, 1 J. HEALTH CARE L. & POL'Y 236 (1998).

117. *See* State v. Janes, 850 P.2d 495, 502 (Wash. 1993) (describing battered woman syndrome and battered child syndrome as "abuse-induced PTSD"); David McCord, *Syndromes, Profiles and Other Mental Exotica: A New Approach to the Admissibility of Non-traditional Psychological Evidence in Criminal Cases*, 66 OR. L. REV. 19, 39 n.64 (1987) (noting that PTSD "has been the most fertile new diagnostic category in DSM III for proponents of nontraditional psychological evidence"); *see also* Karla Fischer, Note, *Defining the Boundaries of Admissible Expert Psychological Testimony on Rape Trauma Syndrome*, 1989 U. ILL. L. REV. 691, 703-31; cf. Mary Ann Dutton, *Understanding Women's Responses to Domestic Violence: A Redefinition of Battered Woman Syndrome*, 21 HOFSTRA L. REV. 1191, 1198-201 (1993) (disagreeing with the overreliance on PTSD to explain BWS); Toni M. Massaro, *Experts, Psychology, Credibility, and Rape: The Rape Trauma*

clude the child sexual abuse syndromes,<sup>118</sup> postpartum psychosis,<sup>119</sup> urban survival syndrome,<sup>120</sup> and Vietnam veteran syndrome.<sup>121</sup> Although typically introduced by defendants, syndrome evidence also may be used to rehabilitate testimony from the victim of the crime, helping prosecutors secure a conviction. As with evidence of PTSD used to support emotional distress claims in tort litigation, to the extent that courts have admitted testimony about some of these syndromes,<sup>122</sup> they may have done so as part of a doctrinal development. For instance, a diagnosis of battered woman syndrome (BWS) does

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*Syndrome Issue and Its Implications for Expert Psychological Testimony*, 69 MINN. L. REV. 395, 464 (1985) (questioning the analogy).

118. See Lisa R. Askowitz & Michael H. Graham, *The Reliability of Expert Psychological Testimony in Child Sexual Abuse Prosecutions*, 15 CARDOZO L. REV. 2027 (1994); Thomas D. Lyon & Jonathan J. Koehler, *The Relevance Ratio: Evaluating the Probative Value of Expert Testimony in Child Sexual Abuse Cases*, 82 CORNELL L. REV. 43 (1996).

119. See Jennifer L. Grossman, Note, *Postpartum Psychosis—A Defense to Criminal Responsibility or Just Another Gimmick?*, 67 U. DET. L. REV. 311, 336-37, 344 (1990) (noting the similarities between postpartum psychosis, as a defense to infanticide, and PTSD, though recognizing that the absence of the former in the DSM makes it less likely to gain judicial acceptance); see also *id.* at 337-43 (discussing the possible defensive uses of premenstrual syndrome); Beth E. Bookwalter, Note, *Throwing the Bath Water out with the Baby: Wrongful Exclusion of Expert Testimony on Neonaticide Syndrome*, 78 B.U. L. REV. 1185 (1998).

120. See Patricia J. Falk, *Novel Theories of Criminal Defense Based upon the Toxicity of the Social Environment: Urban Psychosis, Television Intoxication, and Black Rage*, 74 N.C. L. REV. 731, 738-41 (1996); cf. *Werner v. State*, 711 S.W.2d 639, 644-45 (Tex. Crim. App. 1986) (upholding the exclusion of "Holocaust syndrome" evidence).

121. See, e.g., *United States v. Crosby*, 713 F.2d 1066, 1069, 1076-77 (5th Cir. 1983); *State v. Felde*, 422 So. 2d 370, 376-78 (La. 1982); *State v. Coogan*, 453 N.W.2d 186, 190-92 (Wis. Ct. App. 1990); see also *State v. Phipps*, 883 S.W.2d 138, 141-43 (Tenn. Crim. App. 1994) (Gulf War veteran); C. Peter Erlinder, *Paying the Price for Vietnam: Post-Traumatic Stress Disorder and Criminal Behavior*, 25 B.C. L. REV. 305, 317 (1984) ("Once PTSD was recognized as a disorder that could be isolated and diagnosed by psychiatrists and psychologists, it became a legitimate issue to be raised in legal proceedings."); Michael J. Davidson, Note, *Post-Traumatic Stress Disorder: A Controversial Defense for Veterans of a Controversial War*, 29 WM. & MARY L. REV. 415, 422 (1988) ("Although PTSD has received a mixed reception in the legal community, it has achieved some success as a legal defense [for Vietnam veterans]." (footnotes omitted)).

122. See Shirley A. Dobbin et al., *A Case Law Analysis of Battered Woman Syndrome and Rape Trauma Syndrome Evidence After Daubert*, 82 JUDICATURE (forthcoming 1999) (concluding that psychiatric diagnoses are regarded as expert knowledge rather than scientific evidence subject to *Daubert*); Andrew E. Taslitz, *Myself Alone: Individualizing Justice Through Psychological Character Evidence*, 52 MD. L. REV. 1, 76-81 (1993) (explaining that clinical judgment is as much an art as science); Krista L. Duncan, Note, "Lies, Damned Lies, and Statistics"? *Psychological Syndrome Evidence in the Courtroom After Daubert*, 71 IND. L.J. 753 (1996). For the most part, however, judges and jurors have rejected testimony supporting novel psychological defenses. See Peter Arenella, *Demystifying the Abuse Excuse: Is There One?*, 19 HARV. J.L. & PUB. POL'Y 703 (1996); Richard J. Bonnie, *Excusing and Punishing in Criminal Adjudication: A Reality Check*, 5 CORNELL J.L. & PUB. POL'Y 1 (1995).

not satisfy traditional requirements for the assertion of a self-defense defense, but courts and legislatures seem to have used general evidence about BWS to justify an expansion of the self-defense doctrine in this limited context.<sup>123</sup>

Whatever its guise, the use of such syndrome evidence has attracted significant criticism.<sup>124</sup> This Article, however, centers less on the more typical inquiry about whether and how courts should accommodate this sort of information, than on attempting to understand why mental health professionals have developed these syndrome labels. In short, have the needs of litigants rather than clinicians fueled a nosological expansion in psychiatry, so that BWS and related disorders emerged at least in part to serve forensic rather than therapeutic ends? To some extent, this seems to have happened.<sup>125</sup> A fuller discussion of this development and its consequences is reserved for Part III.

### E. Disability Rights Litigation

Along with administrative agencies and courts, legislatures have expressed a distinct preference for basing eligibility for certain statutory benefits on presumably objective diagnostic judgments made by

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123. See Robert P. Mosteller, *Syndromes and Politics in Criminal Trials and Evidence Law*, 46 DUKE L.J. 461, 485-91 (1996); Christopher Slobogin, *Psychological Evidence in Criminal Trials: To Junk or Not To Junk?*, 40 WM. & MARY L. REV. 1 (1998); David L. Faigman & Amy J. Wright, *The Battered Woman Syndrome in the Age of Science*, 39 ARIZ. L. REV. 67, 79-91 (1997); Martha R. Mahoney, *Legal Images of Battered Women: Redefining the Issue of Separation*, 90 MICH. L. REV. 1, 84-91 (1991).

124. See, e.g., ALAN M. DERSHOWITZ, *THE ABUSE EXCUSE: AND OTHER COP-OUTS, SOB STORIES, AND EVASIONS OF RESPONSIBILITY* (1994); MARGARET A. HAGEN, *WHORES OF THE COURT: THE FRAUD OF PSYCHIATRIC TESTIMONY AND THE RAPE OF AMERICAN JUSTICE* 100-33 (1997); see also Victoria Nourse, *The New Normativity: The Abuse Excuse and the Resurgence of Judgment in the Criminal Law*, 50 STAN. L. REV. 1435 (1998) (reviewing JAMES Q. WILSON, *MORAL JUDGMENT: DOES THE ABUSE EXCUSE THREATEN OUR LEGAL SYSTEM?* (1997)).

125. See Mosteller, *supra* note 123, at 469-84, 507-08 (arguing that most psychological syndromes, including child sexual abuse accommodation syndrome (CSAAS) and BWS, lack diagnostic utility and therefore should serve only a limited forensic purpose); John E.B. Myers, *Expert Testimony Describing Psychological Syndromes*, 24 PAC. L.J. 1449, 1455-59 (1993) (calling these "nondiagnostic syndromes"); James T. Richardson et al., *The Problems of Applying Daubert to Psychological Syndrome Evidence*, 79 JUDICATURE 10, 13 & n.25 (1995) (noting that CSAAS does not serve any psychiatric purpose as a diagnostic tool); see also Donald Bross, *Medical Diagnosis as a Gateway to the Child Welfare System: A Legal Review for Physicians, Lawyers, and Social Workers*, 65 DENV. U. L. REV. 213, 249 (1988) ("[M]edical diagnoses provide important data to the child welfare system [concerning possible instances of abuse], and physicians and social workers must consider all of the ways in which medical issues are related to documenting or rejecting a need for intervention."); cf. Susan Stefan, *The Protection Racket: Rape Trauma Syndrome, Psychiatric Labeling, and Law*, 88 NW. U. L. REV. 1271, 1286-311 (1994) (criticizing the efforts to diagnose and treat rape trauma syndrome).

medical professionals. This section and the next ask whether federal statutes have encouraged a proliferation of vague diagnoses of learning disorders and other types of disabilities that might require accommodations by employers and educational institutions or might provide access to public disability insurance. These sections will suggest that such programs ask medical professionals to certify the legitimacy of asserted disabilities—in effect, dispensing diagnoses that may serve no particular therapeutic purpose.

In enacting the Americans with Disabilities Act (ADA),<sup>126</sup> Congress sought to bar discrimination against disabled individuals, in part by requiring the provision of reasonable accommodations in employment, public transportation, and places of public accommodation.<sup>127</sup> Under this statute, disability means “a physical or mental impairment that substantially limits one or more major life activities.”<sup>128</sup> Notwithstanding the Act’s apparently broad definition, a number of courts have construed its coverage quite narrowly.<sup>129</sup>

Although courts generally have accepted any kind of condition as constituting a physical impairment,<sup>130</sup> proof of such a medical im-

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126. Pub. L. No. 101-336, 104 Stat. 327 (1990) (codified at 42 U.S.C. §§ 12101-12213 (1994)).

127. See 42 U.S.C. §§ 12112(a) & (b)(5), 12182(a) & (b)(2)(A)(ii) (1994); see also Bonnie P. Tucker, *The Americans with Disabilities Act of 1990: An Overview*, 22 N.M. L. REV. 13 (1992). Previously, Congress had required that federal agencies and federally-funded programs not discriminate against “handicapped” persons. See Rehabilitation Act of 1973, Pub. L. No. 93-112, § 504, 87 Stat. 355, 394 (codified as amended at 29 U.S.C. § 794 (1994)). See generally LAURA F. ROTHSTEIN, *DISABILITIES AND THE LAW* (2d ed. 1997).

128. 42 U.S.C. § 12102(2) (1994) (adding that the term includes persons having “a record of such an impairment” or “being regarded as having such an impairment”); see also 29 U.S.C. § 706(8)(B) (1994) (same definition used in the Rehabilitation Act); 42 U.S.C. § 3602(h) (1994) (same definition for “handicap” in the Fair Housing Act); Symposium, *Defining the Parameters of Coverage Under the Americans with Disabilities Act: Who Is “An Individual with a Disability”?*, 42 VILL. L. REV. 327 (1997); James M. Zappa, Note, *The Americans with Disabilities Act of 1990: Improving Judicial Determinations of Whether an Individual Is “Substantially Limited,”* 75 MINN. L. REV. 1303 (1991) (identifying ambiguities in the definition).

129. See, e.g., *Thompson v. Holy Family Hosp.*, 121 F.3d 537, 539-41 (9th Cir. 1997); *Foreman v. Babcock & Wilcox Co.*, 117 F.3d 800, 805-06 (5th Cir. 1997); *McKay v. Toyota Motor Mfg., U.S.A., Inc.*, 110 F.3d 369, 372-74 (6th Cir. 1997); *Soileau v. Guilford of Maine, Inc.*, 105 F.3d 12, 15 (1st Cir. 1997); *Williams v. Channel Master Satellite Sys., Inc.*, 101 F.3d 346, 349 (4th Cir. 1996); *Gordon v. E.L. Hamm & Assocs.*, 100 F.3d 907, 911-12 (11th Cir. 1996); see also Wendy Wilkinson, *Judicially Crafted Barriers to Bringing Suit Under the Americans with Disabilities Act*, 38 S. TEX. L. REV. 907, 908-09 (1997) (criticizing this trend).

130. See, e.g., *Bragdon v. Abbott*, 118 S. Ct. 2196, 2204 (1998) (“H.I.V. infection must be regarded as a physiological disorder with a constant and detrimental effect on the infected person’s hemic and lymphatic systems from the moment of infection.”); *Whillock v. Delta Airlines, Inc.*, 926 F. Supp. 1555, 1562-66 (N.D. Ga. 1995) (holding that the plaintiff’s claim of disability based on a diagnosis of MCS, though dubious, created a jury ques-

pairment satisfies only the first part of the statute's functional definition of disability. As the Equal Employment Opportunity Commission (EEOC) explained, "[t]he determination of whether an individual has a disability is not necessarily based on the name or diagnosis of the impairment the person has, but rather on the effect of that impairment on the life of the individual."<sup>131</sup> Thus, courts have held that obesity does not amount to a qualifying disability.<sup>132</sup> As Judge Richard Posner wrote in a recent opinion rejecting the claim of an employee with hypercholesterolemia, the ADA "is not a general protection of medically afflicted persons."<sup>133</sup> Under the Act, an impairment

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tion, but that her request to work at home was unreasonable and established that she was not an otherwise qualified individual), *aff'd mem.*, 86 F.3d 1171 (11th Cir. 1996); Steven S. Locke, *The Incredible Shrinking Protected Class: Redefining the Scope of Disability Under the Americans with Disabilities Act*, 68 U. COLO. L. REV. 107, 110 (1997) (noting that "[t]he term has been construed liberally so that if a person has any kind of physical condition, courts generally assume that it constitutes a physical impairment"); William J. McDevitt, *Defining the Term "Disability" Under the Americans with Disabilities Act*, 10 ST. THOMAS L. REV. 281, 285-88 (1998); *cf.* Maulding v. Sullivan, 961 F.2d 694, 698 (8th Cir. 1992) (rejecting a disability discrimination claim under the Rehabilitation Act because plaintiff had failed to establish that she suffered from chemical sensitivity or respiratory problems that would be aggravated by her assigned job duties). *But see* Runnebaum v. NationsBank, 123 F.3d 156, 167-70 (4th Cir. 1997) (en banc) (holding that asymptomatic HIV is not an impairment).

131. 29 C.F.R. § 1630.2(j) app. (1998). The EEOC rules provide that impairments may include:

Any physiological disorder, or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genito-urinary, hemic and lymphatic, skin, and endocrine; or . . . [a]ny mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

*Id.* § 1630.2(h); *see also* H.R. REP. NO. 101-485(II), at 51 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 333 (providing the same illustrations); 28 C.F.R. § 35.104 (1998) (definition of "disability" in the DOJ's implementing regulations); Todd Lebowitz, Note, *Evaluating Purely Reproductive Disorders Under the Americans with Disabilities Act*, 96 MICH. L. REV. 724 (1997) (arguing that infertility is an "impairment" but does not rise to the status of a covered disability). Congress avoided adopting an exhaustive list of qualifying disabilities, however, in part because it recognized the need for flexibility in the definition to allow future coverage of disorders that have yet to be identified. *See* H.R. REP. NO. 101-485(III), at 27 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, 450.

132. *See, e.g.*, *Smaw v. Commonwealth of Virginia Dep't of State Police*, 862 F. Supp. 1469, 1475 (E.D. Va. 1994) ("The case law and the regulations both point unrelentingly to the conclusion that a claim based on obesity is not likely to succeed under the ADA."); *Cassista v. Community Foods, Inc.*, 856 P.2d 1143, 1154 (Cal. 1993) (rejecting employment discrimination claim where worker could not establish that her obesity was the result of a disorder); *see also* *Jane Byeff Korn, Fat*, 77 B.U. L. REV. 25 (1997) (arguing that the ADA should protect obese individuals).

133. *Christian v. St. Anthony Med. Ctr., Inc.*, 117 F.3d 1051, 1053 (7th Cir. 1997) ("If the employer discriminates against [employees] on account of their being (or being be-

must substantially limit a major life activity.

Although the ADA covers both physical and mental impairments, disability claims based on mental illnesses present special difficulties.<sup>134</sup> Courts have recognized a number of mental disorders as potentially covered by the ADA or Rehabilitation Act,<sup>135</sup> but they have rejected several others.<sup>136</sup> For example, the status of alcoholism has generated particular controversy in the past,<sup>137</sup> posing difficult questions about how best to categorize and respond to other common

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lied by him to be) ill, even permanently ill, but not disabled, there is no violation.”).

134. See, e.g., Laura F. Rothstein, *The Employer's Duty to Accommodate Performance and Conduct Deficiencies of Individuals with Mental Impairments Under Disability Discrimination Laws*, 47 SYRACUSE L. REV. 931 (1997); John D. Thompson, *Psychiatric Disorders, Workplace Violence and the Americans with Disabilities Act*, 19 HAMLINE L. REV. 25, 35-44 (1995); see also OFFICE OF TECHNOLOGY ASSESSMENT, U.S. CONGRESS, *PSYCHIATRIC DISABILITIES, EMPLOYMENT, AND THE AMERICANS WITH DISABILITIES ACT* (1994); *MENTAL DISORDER, WORK DISABILITY, AND THE LAW* (Richard J. Bonnie & John Monahan eds., 1997).

135. One commentator recently offered the following interesting catalog:

[C]ourts have found panic disorder, nervous conditions, depressive illness, anxiety disorder, apraxia, emotional conditions, personality disorders, post traumatic stress disorder, mental illness, paranoia and paranoid schizophrenia, anxiety neurosis, kleptomania, compulsive gambling, manic depression or bipolar disorder, extreme stress reaction, claustrophobia, dythmia and agoraphobia, and phobic reaction to carbon monoxide, to be covered, although in many of these cases the individual was found not to be otherwise qualified or could not be reasonably accommodated.

Rothstein, *supra* note 134, at 963-65 (footnotes omitted); see also Thompson, *supra* note 134, at 37 (“Depression, schizophrenia, post-traumatic stress disorder, compulsive gambling, borderline personality organization with obsessive compulsive features, bipolar disorder, explosive personality disorder and anxiety disorder are some of the diagnoses that have qualified as ‘mental handicaps.’” (footnotes omitted)).

136. See Rothstein, *supra* note 134, at 962-63 (“Courts have found that conditions such as fear of heights, paranoid schizophrenia controlled with medication, stress management requiring medication, bipolar modal disorder, sexual behavior disorders, post traumatic stress disorder, having a violent temper, depression, and various [other] mental health problems were *not* covered disabilities.” (footnotes omitted)); *id.* at 965 (adding that “[p]ersonality traits, such as impatience, having a short temper, rudeness, arrogance or being difficult to get along with are not impairments under the ADA”); Thompson, *supra* note 134, at 40-43 (same). Indeed, these statutes now specifically exempt from coverage the following “conditions”: homosexuality, bisexuality, transvestitism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, other sexual behavior disorders, compulsive gambling, kleptomania, pyromania, and psychoactive substance use disorders resulting from current illegal use of drugs. See 29 U.S.C. § 706(8)(E)-(F) (1994); 42 U.S.C. § 12211 (1994).

137. See *Traynor v. Turnage*, 485 U.S. 535, 550-52 (1988) (upholding VA decision to consider alcoholism “willful misconduct” which would not toll the deadline for applying for veterans’ benefits); Wendy K. Voss, Note, *Employing the Alcoholic Under the Americans with Disabilities Act of 1990*, 33 WM. & MARY L. REV. 895 (1992); see also HERBERT FINGARETTE, *HEAVY DRINKING: THE MYTH OF ALCOHOLISM AS A DISEASE* (1988); GEORGE VAILLANT, *THE NATURAL HISTORY OF ALCOHOLISM REVISITED* (1995).

addictive behaviors.

Even relatively uncontroversial mental disorders may present problems in the ADA context. Unlike many physical limitations, employees may not discover that they suffer from a mental illness until after being discharged for displaying some sort of aberrant behavior.<sup>138</sup> Even for previously diagnosed mental impairments, employees may steadfastly deny that they suffer from the illness or else hesitate to inform their employers.<sup>139</sup>

Accommodations for learning disabilities in educational settings present similar difficulties. In 1990, in tandem with the ADA, Congress updated existing federal laws in this area by revising the Individuals with Disabilities Education Act (IDEA).<sup>140</sup> That statute applies to children with "specific learning disabilities . . . who by reason thereof, need special education and related services."<sup>141</sup> It mandates that states provide such students with a free and appropriate public education in the least restrictive environment possible.<sup>142</sup>

The Department of Education estimates that more than five percent of all children enrolled in school suffer from specific learning disabilities.<sup>143</sup> Students identifying themselves with learning disabilities and requesting accommodations under the ADA also are be-

138. See, e.g., *Mears v. Gulfstream Aerospace Corp.*, 905 F. Supp. 1075, 1078 (S.D. Ga. 1995) (agoraphobia), *aff'd*, 87 F.3d 1331 (11th Cir. 1996); *Stola v. Joint Indus. Bd.*, 889 F. Supp. 133, 134-36 (S.D.N.Y. 1995) (anxiety disorder).

139. See Rothstein, *supra* note 134, at 948-50.

140. Pub. L. No. 101-476, 104 Stat. 1103 (1990) (codified as amended at 20 U.S.C. §§ 1400-1485 (1994)). See generally Daniel H. Melvin II, Comment, *The Desegregation of Children with Disabilities*, 44 DEPAUL L. REV. 599 (1995).

141. 20 U.S.C.A. § 1401(a)(1)(A) (West Supp. 1998). The statute defines learning disabled children as

those children who have a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which disorder may manifest itself in imperfect ability to listen, think, speak, read, write, spell, or do mathematical calculations. Such disorders include such conditions as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. Such term does not include children who have learning problems which are primarily the result of visual, hearing, or motor disabilities, of mental retardation, of emotional disturbance, or of environmental, cultural, or economic disadvantage.

*Id.* § 1401(a)(15); see also 34 C.F.R. § 300.541 (1998) (elaborating on this definition).

142. See 20 U.S.C.A. § 1412(a); *Cedar Rapids Community Sch. Dist. v. Garret F.*, 119 S. Ct. 992, 997-99 (1999) (construing the reach of this requirement quite broadly).

143. See U.S. DEP'T OF EDUCATION, OFFICE OF SPECIAL EDUCATION PROGRAMS, IMPLEMENTATION OF THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT: 16TH ANNUAL REPORT TO CONGRESS 7 (1994) (noting that "students with specific learning disabilities now account for . . . 5.2 percent of all students age 6 through 17 enrolled in school"); see also Cynthia Crossen, *Colleges Court Students with Learning Disabilities*, WALL ST. J., May 27, 1998, at B1 ("The number of children in the U.S. diagnosed with learning disabilities stands at an estimated two million . . .").

coming much more common in higher education.<sup>144</sup> Even more so than mental illnesses, learning disabilities have proven quite difficult to define and identify in particular individuals.<sup>145</sup> Documentation of a student's asserted learning disability generally "must come from an individual qualified to diagnose a learning disability, such as a learning disability specialist, educational psychologist or clinical psychologist."<sup>146</sup> Some have criticized the development of a cottage industry of medical or educational professionals available to certify that a student suffers from a learning disability as well as the growing tendency to define new types of such disabilities.<sup>147</sup>

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144. See Bonnie Poitras Tucker, *Application of the Americans with Disabilities Act (ADA) and Section 504 to Colleges and Universities: An Overview and Discussion of Special Issues Relating to Students*, 23 J.C. & U.L. 1, 21 (1996); see also Susan Johanne Adams, *Because They're Otherwise Qualified: Accommodating Learning Disabled Law Student Writers*, 46 J. LEGAL EDUC. 189, 197 (1996) ("According to the Law School Admission Council, between 1990 and 1993 there was a 100 percent increase in requests for accommodations on the LSAT because of learning disabilities."); Tamar Lewin, *Court Supports Aid to Disabled for Bar Exams*, N.Y. TIMES, Sept. 16, 1998, at A1.

145. See, e.g., Wynne v. Tufts Univ. Sch. of Med., 976 F.2d 791, 792 (1st Cir. 1992) (noting that the student had not been conclusively identified as having a specific learning disability). See generally JEAN KNOX, *LEARNING DISABILITIES* (1989) (identifying numerous characteristics of learning disabilities and wide ranges in their severity). In some cases, courts have found that students had failed to prove that they suffered from a learning disability. See, e.g., Price v. National Bd. of Med. Examiners, 966 F. Supp. 419, 423-24 (S.D. W. Va. 1997); Argen v. New York State Bd. of Law Examiners, 860 F. Supp. 84, 88-91 (W.D.N.Y. 1994); Pazer v. New York State Bd. of Law Examiners, 849 F. Supp. 284, 287 (S.D.N.Y. 1994).

146. Tucker, *supra* note 144, at 14 n.56; see also Guckenberger v. Boston Univ., 974 F. Supp. 106, 135-40 (D. Mass. 1997) (invalidating stringent documentation requirements that mandated retesting every three years and diagnosis by a professional with a doctoral-level degree). The *DSM-IV* provides the following guidance:

Learning Disorders are diagnosed when the individual's achievement on individually administered, standardized tests in reading, mathematics, or written expression is substantially below that expected for age, schooling, and level of intelligence. . . . Substantially below is usually defined as a discrepancy of more than 2 standard deviations between achievement and IQ.

*DSM-IV*, *supra* note 115, at 46; see also John L. Doris, *Defining Learning Disabilities: A History of the Search for Consensus*, in BETTER UNDERSTANDING LEARNING DISABILITIES 97, 107-12 (G. Reid Lyon et al. eds., 1993); M. Kay Runyan & Joseph F. Smith, Jr., *Identifying and Accommodating Learning Disabled Law School Students*, 41 J. LEGAL EDUC. 317, 317-24 (1991). For example, "dysgraphia" is a condition characterized by an inability to produce thoughts on paper in a readable form, and "dyscalculia" refers to difficulty with math. See *id.* at 341-42.

147. See, e.g., MARK KELMAN & GILLIAN LESTER, *JUMPING THE QUEUE: AN INQUIRY INTO THE LEGAL TREATMENT OF STUDENTS WITH LEARNING DISABILITIES* 29-33, 100 (1997); WALTER OLSON, *THE EXCUSE FACTORY: HOW EMPLOYMENT LAW IS PARALYZING THE AMERICAN WORKPLACE 202-06* (1997); LOUISE SPEAR-SWERLING & ROBERT J. STERNBERG, *OFF TRACK: WHEN POOR READERS BECOME "LEARNING DISABLED"* 36-38, 316-22 (1996); Robert J. Sternberg, *Extra Credit for Doing Poorly*, N.Y. TIMES, Aug. 25, 1997, at A23 ("[W]e have no way of knowing how many children

Attention deficit disorder (ADD) has attracted particular notice in recent years. ADD, sometimes also referred to as attention deficit hyperactivity disorder (ADHD), has become a common diagnosis for what in the past would have been characterized as behavioral or socialization problems.<sup>148</sup> Generally identified in disruptive elementary school students, and frequently treated with the psychoactive drug methylphenidate hydrochloride (Ritalin<sup>®</sup>),<sup>149</sup> ADD has been implicated in all manner of educational difficulties. Some have even suggested that, left untreated, ADD may last into adulthood and lead to problems in the workplace,<sup>150</sup> reckless driving, and higher divorce

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who have received such a diagnosis really have learning disabilities.”); Jon Westling, *One University Defeats Disability Extremists*, WALL ST. J., Sept. 3, 1997, at A21 (arguing that some “learning-disabled students are victims of overblown and unscientific claims by some learning disability advocates”). *But see* Note, *Toward Reasonable Equality: Accommodating Learning Disabilities Under the Americans with Disabilities Act*, 111 HARV. L. REV. 1560, 1573-74 (1998) (“Although many experts in the field recognize the problematic nature of the LD category—a broadly heterogeneous classification with disputed etiology—most appear to believe that LDs, as distinguished from low general intelligence or socio-cultural disadvantage, exist.”).

148. *See* Victor W. Henderson, *Stimulant Drug Treatment of the Attention Deficit Disorder*, 65 S. CAL. L. REV. 397, 401-04 (1991) (canvassing the debate over the diagnostic criteria for ADD); *see also* Guckenberger, 974 F. Supp. at 139-40 (rejecting challenge to stringent documentation rules for ADD); DSM-IV, *supra* note 115, at 83-85 (basing the diagnosis of ADD on the sustained presence of six out of nine vague behaviors, including “easily distracted” or “forgetful,” which “are not better accounted for by another mental disorder”).

149. *See* Larry S. Goldman et al., *Diagnosis and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents*, 279 JAMA 1100, 1100 (1998) (“Although some children are being diagnosed as having ADHD with insufficient evaluation and in some cases stimulant medication is prescribed when treatment alternatives exist, there is little evidence of widespread overdiagnosis or misdiagnosis of ADHD or of widespread overprescription of methylphenidate by physicians.”); Henderson, *supra* note 148, at 405-09 (summarizing controversies over the use of stimulants to treat ADD); *Attention Disorder in Children Still Eludes Treatment Method*, N.Y. TIMES, Nov. 19, 1998, at A24; *see also* RICHARD DEGRANDPRE, RITALIN NATION (1999); PETER SCHRAG & DIANE DIVOKY, THE MYTH OF THE HYPERACTIVE CHILD 57 (1975) (“In many respects, the cure preceded the ailment . . . CIBA-Geigy promoted Ritalin—its league-leading drug for hyperactive children—for use with children who exhibited ‘functional behavior problems,’ a category so vague that no child need be excluded.”); *id.* at xiv (objecting to the “growing scientific and corporate establishment conducting research in the proliferating ‘syndromes’ and ‘diseases’ of nonconformity”).

150. *See* David J. Morrow, *Attention Disorder Is Found in Growing Number of Adults*, N.Y. TIMES, Sept. 2, 1997, at A1 (reporting “estimate[s] that 6 million to 9.5 million American adults have the disorder, making it as common as severe clinical depression or drug abuse,” and describing some of the problems that they face in occupational settings). “But some skeptics say that A.D.D.’s prevalence has been overstated, and among these are some who question the existence of the disorder.” *Id.*; *see also* John Lang, *Fraud or Fact? Diagnosis for Attention Deficit Disorders Mushrooms, but There Are Skeptics*, KNOXVILLE NEWS-SENTINEL, June 23, 1997, at B1.

rates.<sup>151</sup> ADD's opposite, which might be called "attention surplus," may itself qualify as a mental illness.<sup>152</sup>

Finally, under the Family and Medical Leave Act of 1993,<sup>153</sup> most employers must allow their workers to take unpaid leaves of absence if they, or a close relative, suffer from a "serious health condition."<sup>154</sup> Employers may demand that any employees who request such a leave first provide an appropriate certification from their physician.<sup>155</sup> Employers may contest such a certification only if they arrange and pay for a second opinion of the employee's or family member's condition.<sup>156</sup> In the event that the first and second opinions conflict, the employer may then arrange and pay for a third and dispositive opinion from a physician concerning the seriousness of the employee's or close relative's claimed health condition.<sup>157</sup> Thus, to an even greater extent than the ADA and IDEA, diagnostic judgments by medical professionals provide the essential ticket for admission into the pro-

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151. See Wendy Swallow Williams, *Attention Deficit Disorder: Malady Thought to Affect Only Children May Actually Last a Lifetime*, PITT. POST-GAZETTE, Oct. 28, 1997, at E1.

152. Intensely focused and hard-working individuals may "suffer" from obsessive-compulsive personality disorder. See DSM-IV, *supra* note 115, at 669, 671 (analogizing this disorder to the "type A" personality popularized as a risk factor for heart disease by cardiologists); cf. WALTER O. WEYRAUCH, *THE PERSONALITY OF LAWYERS* 264-67 (1964) (suggesting that lawyers share many characteristics with compulsive neurotics). Please pass the Prozac!

153. Pub. L. No. 103-3, 107 Stat. 6 (codified as amended at 29 U.S.C. §§ 2601-2654 (1994)). See generally Jane Rigler, *Analysis and Understanding of the Family and Medical Leave Act of 1993*, 45 CASE W. RES. L. REV. 457 (1995); Nancy R. Daspit, Comment, *The Family and Medical Leave Act of 1993: A Great Idea but a "Rube Goldberg" Solution?*, 43 EMORY L.J. 1351 (1994).

154. See 29 U.S.C. § 2612(a)(1)(C) & (D) (1994). "The term 'serious health condition' means an illness, injury, impairment, or physical or mental condition that involves—(A) inpatient care in a hospital, hospice, or residential medical care facility; or (B) continuing treatment by a health care provider." *Id.* § 2611(11); see also *Bauer v. Varsity Dayton-Walther Corp.*, 118 F.3d 1109, 1110-12 (6th Cir. 1997) (holding that an employee who suffered from intermittent episodes of hematochezia (rectal bleeding) did not have a "serious medical condition" entitling him to an unpaid leave); *Vasconcellos v. Cybex Int'l, Inc.*, 962 F. Supp. 701, 705-06 (D. Md. 1997) (holding that severe nervous disorder could qualify as a "serious medical condition" under the Act); *Hodgens v. General Dynamics Corp.*, 963 F. Supp. 102, 105-06 (D.R.I. 1997) (holding that hypertension and arrhythmia did not qualify).

155. See 29 U.S.C. § 2613(a) & (b); *Oswalt v. Sara Lee Corp.*, 889 F. Supp. 253, 259 (N.D. Miss. 1995) (holding that an employee who suffered food poisoning was not entitled to the Act's protections in part because he did not provide the necessary certification), *aff'd*, 74 F.3d 91 (5th Cir. 1996) (per curiam). This section calls for certification by a "health care provider," which the statute elsewhere defines as a licensed doctor of medicine or osteopathy or "any other person determined by the Secretary [of Labor] to be capable of providing health care services." 29 U.S.C. § 2611(6).

156. See 29 U.S.C. § 2613(c).

157. See *id.* § 2613(d).

tections of this particular statutory scheme.

## F. Disability Insurance Programs

Federal disability insurance programs also require medical judgments about impairments. Under Social Security Disability Insurance, which covers disabled workers who have paid payroll taxes,<sup>158</sup> and Supplemental Security Income, which provides benefits to the disabled poor,<sup>159</sup> the definition of disability requires claimants to demonstrate an "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment."<sup>160</sup> Commentators have recognized that physicians play a critical gatekeeping role in providing access to assistance under these two programs: "[O]ur society has largely obfuscated the difficult choices raised by these issues by delegating the assessment of the functional impact of medical conditions to the medical profession. This delegation reflects an assumption that such inquiries are subject to scientific resolution and do not call for political choices."<sup>161</sup> Indeed, the drafters of the legislation consciously represented disability determinations as based on objective medical facts rather than controversial social judgments regarding which individuals to excuse from an obligation to work.<sup>162</sup>

The Social Security Administration (SSA) has tried to implement

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158. See Social Security Amendments of 1956, Pub. L. No. 84-880, § 103(a), 70 Stat. 807, 815 (codified as amended at 42 U.S.C. §§ 423-425 (1994)).

159. See Social Security Amendments of 1972, Pub. L. No. 92-603, § 301, 86 Stat. 1329, 1465 (codified as amended at 42 U.S.C. §§ 1381-1383d (1994)).

160. 42 U.S.C. § 423(d)(1)(A) (1994); see also *id.* § 423(d)(3) (adding that the impairment must result from "abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques"); Lance Liebman, *The Definition of Disability in Social Security and Supplemental Security Income: Drawing the Bounds of Social Welfare Estates*, 89 HARV. L. REV. 833, 842 (1976) ("The medical disability requirement means that workers are not insured against unemployment caused by declines in capacity or willingness to work that cannot be given a medical explanation.").

161. Matthew Diller, *Entitlement and Exclusion: The Role of Disability in the Social Welfare System*, 44 UCLA L. REV. 361, 387 (1996) (footnote omitted); see also GLENN, *supra* note 4, at 58-59 ("[S]ocial bureaucracies like Disability and Medicaid, will be set into motion by a few diagnostic words from the doctor."); *id.* at 148 ("In today's society, physicians have become an ultimate authority on people's capacity to work. They are the legitimizers, the arbitrators of disability . . .").

162. See DEBORAH A. STONE, *THE DISABLED STATE* 68-89 (1984) (elaborating on the legislature's effort to adopt a strict medical definition of disability notwithstanding physicians' protestations of unavoidable subjectivity); Wilkinson, *supra* note 129, at 913-14 & n.25 (suggesting that the federal disability support programs emerged during the "medical" model of disability policy, noting that eligibility determinations focus "on clinical diagnosis of the impairment with no regard to environmental factors"). Newer legislation, such as the ADA, represents a shift to a "civil rights" model. See *id.* at 915.

this medical approach to identifying disabled persons.<sup>163</sup> Even so, the threshold diagnostic judgments about impairments have proven to be quite imprecise,<sup>164</sup> and the SSA has struggled with the question of how much weight to give the opinions of a claimant's own physician as opposed to those designated by the Agency.<sup>165</sup> Most contested claims for Social Security disability benefits involve chronic pain,<sup>166</sup> a notoriously difficult complaint for physicians to verify.<sup>167</sup>

Chronic fatigue syndrome (CFS) has become a popular diagnosis for disability claimants in the last several years.<sup>168</sup> This condition, sometimes called chronic fatigue immune dysfunction syndrome (or associated with Epstein-Barr virus) in an effort to reinforce the claim that it has an organic source,<sup>169</sup> is associated with a combination of generalized and subjective symptoms of unknown cause such as ex-

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163. See, e.g., 20 C.F.R. pt. 404(p), app. 1, § 3.00(A) (1998) ("Respiratory impairments usually can be evaluated under these listings on the basis of a complete medical history, physical examination, a chest x-ray or other appropriate imaging techniques, and spirometric pulmonary function tests.").

164. See GLENN, *supra* note 4, at 153 ("If diagnostic certainty could be obtained, the appeal to physicians for data in eligibility or disability determinations might have a sounder basis. But since many diagnostic impressions are hypothesis at best, the prestige of the physician's statement conceals the fact that it is mainly opinion."); STONE, *supra* note 162, at 129 ("[T]he diagnostic decisions on which judgments of impairment rest are themselves subject to an enormous degree of uncertainty.").

165. See 56 Fed. Reg. 36,932, 36,950-53, 36,960-62 (1991) (codified at 20 C.F.R. § 404.1527 (1998)); see also *Bean v. Chater*, 77 F.3d 1210, 1214 (10th Cir. 1995); *Tussey v. Island Creek Coal Co.*, 982 F.2d 1036, 1042 (6th Cir. 1993); *Ghant v. Bowen*, 930 F.2d 633, 639 (8th Cir. 1991); James A. Maccaro, *The Treating Physician Rule and the Adjudication of Claims for Social Security Disability Benefits*, N.Y. ST. B.J., Nov. 1992, at 28, 29 (explaining that testimony from a claimant's treating physician is usually given significant weight). In administering the Black Lung Benefits program, the Department of Labor has proposed formally giving the medical opinion of the coal miner's treating physician controlling weight. See Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as Amended, 62 Fed. Reg. 3338, 3375 (1997) (to be codified at 20 C.F.R. § 718.104(d)) (proposed Jan. 22, 1997).

166. See Aimée E. Bierman, Note, *The Medico-Legal Enigma of Fibromyalgia: Social Security Disability Determinations and Subjective Complaints of Pain*, 44 WAYNE L. REV. 259, 273 (1998); Spencer Rich, *Seeking to End Disability Fraud, Government Lays Hands on Pain: Experts Seek Ways to Measure True Extent of Impairment*, WASH. POST, Feb. 3, 1986, at A13.

167. See KLEINMAN, *supra* note 5, at 56-59; Erin Margaret Masson, Note, *Social Security Administration Nonacquiescence on the Standard for Evaluating Pain*, 36 WM. & MARY L. REV. 1819, 1836-40 (1995); Elisabeth Rosenthal, *Chronic Pain Fells Many Yet Lacks Clear Cause*, N.Y. TIMES, Dec. 29, 1992, at C1. See generally EVALUATION AND TREATMENT OF CHRONIC PAIN (Gerald M. Aronoff ed., 1985); Oye Gureje et al., *Persistent Pain and Well-Being: A World Health Organization Study in Primary Care*, 280 JAMA 147 (1998).

168. See *infra* note 172; see also ARONOWITZ, *supra* note 32, at 30 ("Disability has also been a central concern in chronic fatigue syndrome.").

169. See ARONOWITZ, *supra* note 32, at 24-27.

haustion, sore throat, confusion, and depression.<sup>170</sup> Although profound skepticism prevails among medical professionals about the supposed pathophysiological as opposed to psychosomatic origin of these symptoms,<sup>171</sup> several courts have accepted physicians' diagnoses of CFS as a qualifying disability.<sup>172</sup> Thus, in all of these federal disability programs, especially Social Security insurance and to a lesser extent under the ADA, the definition and identification of disease by medical professionals directly informs judgments about a claimant's eligibility for coverage.

The proper administration of claims for benefits under state workers' compensation systems obviously depends on accurate medical assessments about occupational injuries.<sup>173</sup> In lieu of tort litigation, these programs allow workers to apply for limited monetary

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170. See Gary P. Holmes et al., *Chronic Fatigue Syndrome: A Working Case Definition*, 108 ANNALS INTERNAL MED. 387, 387-89 (1988); Letters, *Chronic Fatigue Syndrome*, 279 JAMA 431-33 (1998) (discussing diagnostic ambiguities); see also ARONOWITZ, *supra* note 32, at 31 ("Another ideological objection to the legitimacy of these diseases is the concern that their diagnoses are controlled more by the patient than the physician. The patient-centered CDC criteria for chronic fatigue syndrome, for example, are perceived as permitting the patient, rather than the doctor, to define the disease."); Rumi K. Price et al., *Estimating the Prevalence of Chronic Fatigue Syndrome and Associated Symptoms in the Community*, 107 PUB. HEALTH REP. 514, 521 (1992) ("An increasing number of patients with these symptoms, prompted by media information about CFS, may be seeking evaluation for CFS, even though definitive cases of CFS [as defined by CDC's restrictive criteria] represent only a fraction of these patients.").

171. See ARONOWITZ, *supra* note 32, at 168 (The controversy "over our present-day chronic fatigue syndrome is suffused with the perception that there is a large market of would-be patients searching for legitimizing diagnoses."); *id.* at 174 ("Diseases—such as chronic fatigue syndrome—whose mechanisms are obscure, whose specificity is questionable, and whose definition and meaning are transparently influenced by social factors have had their legitimacy questioned."); Gael MacLean & Simon Wessely, *Professional and Popular Views of Chronic Fatigue Syndrome*, 308 BRIT. MED. J. 776, 776 (1994) ("Most research papers did not favour organic causes."); see also John Joyce et al., *Reviewing the Reviews: The Example of Chronic Fatigue Syndrome*, 280 JAMA 264 (1998) (describing weaknesses in the quality of scientific articles on chronic fatigue syndrome).

172. See, e.g., Mitchell v. Eastman Kodak Co., 113 F.3d 433, 440-43 (3d Cir. 1997); Rose v. Shalala, 34 F.3d 13, 16-19 (1st Cir. 1994); Sisco v. HHS, 10 F.3d 739, 744-45 (10th Cir. 1993); Irwin v. Shalala, 840 F. Supp. 751, 761 (D. Or. 1993); see also Sarchet v. Chater, 78 F.3d 305, 306-08 (7th Cir. 1996) (fibromyalgia). In contrast, courts generally have upheld denials of benefits to persons complaining of multiple chemical sensitivity syndrome. See, e.g., Greenspan v. Shalala, 38 F.3d 232, 237-39 (5th Cir. 1994); Brown v. Shalala, 15 F.3d 97, 99-100 (8th Cir. 1994); cf. Donato v. Metropolitan Life Ins. Co., 19 F.3d 375, 380 (7th Cir. 1994) (rejecting a challenge to a private insurer's denial of benefits); Kouril v. Bowen, 912 F.2d 971, 976 (8th Cir. 1990) (finding possible SSA disability).

173. See generally 7 ARTHUR LARSON & LEX K. LARSON, LARSON'S WORKERS' COMPENSATION LAW §§ 79.50-79.54 (rev. ed. 1998). "The increasing tendency, then, to accept awards unsupported by medical testimony should not be allowed to obscure the basic necessity of establishing medical causation by expert testimony in all but the simple and routine cases . . ." *Id.* § 79.54(i), at 15-426.214.

awards under a schedule of benefits for different types of job-related harms. Although causation questions will arise and require medical testimony, workers' compensation boards and reviewing courts do not invariably require expert testimony on questions concerning the extent of an employee's disability.<sup>174</sup> When the claims involve acute occupational injuries, this system poses relatively few complexities, though physicians may be asked to quantify the degree of permanent impairment associated with such injuries.<sup>175</sup>

Increasingly, however, workers' compensation claims involve soft tissue injuries, long latency diseases, or mental illnesses allegedly triggered by employment.<sup>176</sup> Among physical injuries, cumulative trauma disorders such as carpal tunnel syndrome have become quite prevalent in recent years.<sup>177</sup> Among occupational diseases, workers' com-

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174. See, e.g., *Valente v. Bourne Mills*, 75 A.2d 191, 194 (R.I. 1950) (refusing to "turn a compensation case into a clinic where doctors seek to determine the 'diagnosis' of a patient's ailment and the 'pathological nature' of that condition according to the more exacting norms of medical science"); *LARSON & LARSON*, *supra* note 173, § 79.53, at 15-426.167 (explaining that "disability is not a purely medical question"). For an argument that an overemphasis on the medical model leads to undercompensation in this and other compensation systems, see Ellen Smith Pryor, *Compensation and a Consequential Model of Loss*, 64 TUL. L. REV. 783, 790, 793-94 (1990).

175. See STEVEN BABITSKY & JAMES J. MANGRAVITI, JR., UNDERSTANDING THE AMA GUIDES IN WORKERS' COMPENSATION (2d ed. 1997); see also Ellen Smith Pryor, *Flawed Promises: A Critical Evaluation of the American Medical Association's Guides to the Evaluation of Permanent Impairment*, 103 HARV. L. REV. 964, 966-69, 973-75 (1990) (book review) (criticizing the suggestion that impairments can be measured in an entirely objective, medical way). Courts have upheld decisions to exclude testimony concerning the extent of an impairment or causation offered by persons other than physicians. See, e.g., *Weis v. Division of Workers' Comp.*, 755 P.2d 1385, 1386-87 (Mont. 1988) (rejecting chiropractor's challenge to a rule requiring that licensed physicians testify as to physical impairment); *Brannan v. Department of Labor & Indus.*, 700 P.2d 1139, 1141-43 (Wash. 1985) (same); see also *Erving v. Tri-Con Indus.*, 314 N.W.2d 253, 254-56 (Neb. 1982) (holding that the agency could ignore psychiatric testimony that the claimant's impairment represented a "conversion reaction"); *In re Newcomb*, 690 A.2d 562, 564-65 (N.H. 1997) (upholding the board's decision to reject testimony by claimant's physician finding "reflex sympathetic dystrophy" where other medical evidence indicated an absence of objective symptomology); *Latraille v. North Dakota Workers Comp. Bureau*, 481 N.W.2d 446, 449-50 (N.D. 1992) (finding the testimony of two rheumatologists more credible than that of a chiropractor consulted long after the injury).

176. See, e.g., ORIN KRAMER & RICHARD BRIFFAULT, WORKERS COMPENSATION: STRENGTHENING THE SOCIAL COMPACT 18-23 (1991) (describing the expansion of the definition of compensable injuries, from traumatic accidents and soft tissue injuries to occupational diseases and mental stress).

177. See, e.g., H. Douglas Jones & Cathy Jackson, *Cumulative Trauma Disorders: A Repetitive Strain on the Workers' Compensation System*, 20 N. KY. L. REV. 765, 768-80 (1993); Denis Paul Juge et al., *Cumulative Trauma Disorders—"The Disease of the 90's": An Interdisciplinary Analysis*, 55 LA. L. REV. 895, 912 (1995) ("There is considerable controversy in the medical community regarding the validity of making a causal connection between the activities at work and the diseases associated with CTDs. There is also con-

pensation claims involving multiple chemical sensitivity syndrome have proven to be among the most controversial.<sup>178</sup> As one court wrote in the course of affirming an award of benefits based on MCS, “[i]t is of no great moment that the condition from which a claimant suffers cannot be precisely diagnosed and named by the medical experts.”<sup>179</sup> Finally, of the mental illness claims,<sup>180</sup> post-traumatic stress

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cern among physicians that psychological factors may be involved in the growing number of patients reporting symptoms of CTDs.”); Oliver Pancheri, *Is There Light at the End of the Carpal Tunnel? Compensation for Workers with Cumulative Trauma Disorders Under Theories of Accident and Occupational Disease*, 35 IDAHO L. REV. 377 (1999). Workers’ compensation boards and reviewing courts generally have approved benefits for repetitive motion injuries when supported by an appropriate medical diagnosis. See, e.g., *Lockey v. Massey Pulpwood, Inc.*, 812 S.W.2d 700, 704 (Ark. Ct. App. 1991); *Condon v. Boeing Co.*, 903 P.2d 775, 780-81 (Kan. Ct. App. 1995). By comparison, products liability claims brought against the equipment manufacturers have fared poorly. See Saul Hansell, *U.S. Jury Rejects Keyboard Injury Claims*, N.Y. TIMES, June 17, 1998, at D2.

178. See Kelly Corbett, Comment, *Multiple Chemical Sensitivity Syndrome: Occupational Disease or Work-Related Accident?*, 24 B.C. ENVTL. AFF. L. REV. 395 (1997); see also Synder et al., *supra* note 95, at 104 (arguing that “numerous psychosocial factors may influence the self-reporting of symptoms by patients labeled as MCS,” including “a workers’ compensation system that favors claimants, [and] the availability of physicians who readily provide explanatory physiologic theories in the absence of supporting evidence”); *supra* notes 95-100 and accompanying text (discussing MCS in the context of tort litigation). Most courts have affirmed denials of workers’ compensation claims based on MCS. See, e.g., *Weekley v. Industrial Comm’n*, 615 N.E.2d 59, 62-63 (Ill. App. Ct. 1993); *Ruether v. State*, 455 N.W.2d 475, 477-78 (Minn. 1990); *Halseth v. North Dakota Workers Comp. Bureau*, 514 N.W.2d 371, 373-74 (N.D. 1994); *Conrad v. Mt. Carmel Sch.*, 539 N.W.2d 713, 718-19 (Wis. Ct. App. 1995); see also *La-Z-Boy Chair Co. v. Reed*, 778 F. Supp. 954, 955 (E.D. Tenn. 1990) (rejecting testimony offered by a clinical ecologist), *aff’d mem.*, 936 F.2d 573 (6th Cir. 1991).

179. *Armstrong v. City of Wichita*, 907 P.2d 923, 928 (Kan. Ct. App. 1995) (“We do not believe that the legislature intended to deny compensation to a worker who is disabled by a condition which baffles medical experts and which resists their efforts to give it a specific name or diagnosis.”); see also *id.* (analogizing to AIDS and CFS); *Sheridan v. Catering Management, Inc.*, 558 N.W.2d 319, 328 (Neb. Ct. App. 1997) (concluding that “a claimant is not required to prove that a diagnosis is universally recognized by and agreed upon in the medical community”). A few courts have held in favor of MCS claimants. See *Marlowe v. Dogs Only Grooming*, 589 So. 2d 990, 992-93 (Fla. Dist. Ct. App. 1991); *In re Kehoe*, 648 A.2d 472, 474 (N.H. 1994); *Saif Corp. v. Scott*, 824 P.2d 1188, 1190 (Or. Ct. App. 1992); *Gray v. Workmen’s Comp. Appeal Bd.*, 657 A.2d 77, 82-83 (Pa. Commw. Ct. 1995).

180. See 3 LARSON & LARSON, *supra* note 173, §§ 41-42; *id.* § 42.22(a), at 7-858 (“There is almost no limit to the variety of disabling ‘psychic’ conditions that have already been recognized as legitimately compensable—conditions which not many years ago would have received little understanding or recognition on the part of courts.”); Thomas S. Cook, *Workers’ Compensation and Stress Claims: Remedial Intent and Restrictive Application*, 62 NOTRE DAME L. REV. 879, 895-912 (1987); Lawrence Joseph, *The Causation Issue in Workers’ Compensation Mental Disability Cases: An Analysis, Solutions, and a Perspective*, 36 VAND. L. REV. 263 (1983). For examples of recent mental illness workers’ compensation claims, many but not all of which were rejected on the facts by reviewing courts, see *South Miss. Elec. Power Ass’n v. Graham*, 587 So. 2d 291, 295 (Miss. 1991) (fear of heights); *Osborne v. Oklahoma City Police Dep’t*, 882 P.2d 75, 76-78 (Okla. 1994) (panic

disorder has become a common employee complaint, and, even though these cases generally do not involve firefighters and police officers, most reviewing courts have accepted it as compensable.<sup>181</sup> Diagnostic judgments have become more critical as the system has moved from severed limbs to immune responses of uncertain origin or mental stress disorders.<sup>182</sup> They also have become more pliable and potentially subject to fraud.<sup>183</sup>

### III. Consequences for the Health Care System

If diseases are created rather than discovered, as the social constructivists argue,<sup>184</sup> what forces influence that process? Much of the pressure is internal to the patient and the medical profession,<sup>185</sup> but

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attack disorder with agoraphobia); *Metropolitan Edison Co. v. Workmen's Comp.* Appeal Bd., 718 A.2d 759, 764 (Pa. 1998) (shift work maladaptation syndrome); see also Donald M. Zupanec, Annotation, *Mental Disorders as Compensable Under Workmen's Compensation Acts*, 97 A.L.R.3d 161 (1980 & Supp. 1998).

181. See, e.g., *Southwire Co. v. George*, 470 S.E.2d 865, 865-67 (Ga. 1996); *Wood v. Laidlaw Transit, Inc.*, 565 N.E.2d 1255, 1256-58 (N.Y. 1990); *Banks v. LTV Steel Co.*, 654 N.E.2d 439, 442-43 (Ohio Ct. App. 1995); *Daniel Constr. Co. v. Tolley*, 480 S.E.2d 145, 148 (Va. Ct. App. 1997). But see *In re Sutton*, 684 A.2d 1346, 1347-48 (N.H. 1996) (benefits inappropriate). See generally Richard S. Schottenfeld & Mark R. Cullen, *Recognition of Occupation-Induced Posttraumatic Stress Disorders*, 28 J. OCCUPATIONAL MED. 365 (1986); *supra* notes 105-108 and accompanying text (discussing PTSD in the context of tort litigation).

182. See 7 LARSON & LARSON, *supra* note 173, § 79.51(d), at 15-426.131 ("The advent of a large volume and variety of occupational—and particularly respiratory—diseases whose etiology ranges from the imperfectly-understood to the downright mysterious has begun to precipitate questions on the extent to which awards can be based on incomplete medical evidence as to the nature and causation of the disease."); Joan Hansen, Note, *Scientific Decisionmaking in Workers' Compensation: A Long Overdue Reform*, 59 S. CAL. L. REV. 911, 923 (1986) ("Occupational diseases are fraught with the potential for diagnostic error.").

183. See Gary T. Schwartz, *Waste, Fraud and Abuse in Workers' Compensation: The Recent California Experience*, 52 MD. L. REV. 983, 989-92 (1993) (describing one undercover journalist's experience of being "referred to seven different doctors, each of whom conducted a medical-legal examination (so-called because it is a diagnostic examination intended to produce medical information that is relevant to legal issues)," which "provide[d] apparent documentation for what in truth [was] a bogus claim").

184. See *supra* note 33 and accompanying text; see also Faith T. Fitzgerald, *The Tyranny of Health*, 331 NEW ENG. J. MED. 196, 197-98 (1994) (describing the tendency to medicalize social problems); Gina Maranto, *On the Fringes of the Bell Curve, The Evolving Quest for Normality*, N.Y. TIMES, May 26, 1998, at F7 (describing a recent conference sponsored by Cornell University's Department of Science and Technology Studies "discussing the diverse ways in which science and medicine, along with legal systems and states, shape society's notions of who and what people are, who is sick and who is well").

185. See MICHAEL BALINT, *THE DOCTOR, HIS PATIENT AND THE ILLNESS* 22-25, 107, 217 (1964) (describing the process of negotiating over a diagnosis); ELIOT FREIDSON, *PROFESSION OF MEDICINE: A STUDY OF THE SOCIOLOGY OF APPLIED MEDICINE* 244-301 (1970) (describing the professional and lay constructions of illness); see also ANDREW

some of it comes from outside, including from the legal profession. Just as social forces have shaped medical practice, legal institutions influence both nosology and diagnosis. Law and medicine are not autonomous domains, fully insulated from one another in spite of numerous points of intersection concerning the definition and identification of disease. Instead, at these junctures, law and medicine are mutually constitutive or perhaps co-dependent.

Legal institutions have, of course, altered medical practice quite directly, most notably through malpractice decisions.<sup>186</sup> At the federal level, however, Congress generally has disclaimed any intent to interfere with the practice of medicine. For instance, the very first section of the Medicare statute provides that “[n]othing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided.”<sup>187</sup> This Article has described one very important aspect of medical practice, diagnosis, that legal institutions have influenced indirectly and unintentionally, though pervasively. In a sense, regulators and courts function as something of a feedback mechanism for the medical profession as it defines and identifies diseases.

The recent emergence of novel diseases, such as multiple chemical sensitivity and chronic fatigue syndrome, may reflect a confluence

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ABBOTT, *THE SYSTEM OF PROFESSIONS: AN ESSAY ON THE DIVISION OF EXPERT LABOR* 40-44 (1988) (describing the role of diagnosis as a task found in many different professions); PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 20 (1982) (“As the various certifying and gatekeeping functions of doctors have grown, so has the dependence of people seeking benefits that require certification.”); Joseph Margolis, *The Concept of Disease*, 1 J. MED. & PHIL. 238, 238 (1976) (noting that “medicine and the law are the two principal professional disciplines of advanced societies systematically concerned with rendering judgments that are at once informed by selected norms of human functioning and characterizable as findings of fact”).

186. See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 781-88 (D.C. Cir. 1972) (defining the duty to secure informed consent with a patient-based standard); *Korman v. Mallin*, 858 P.2d 1145, 1149 (Alaska 1993) (same); *Hall v. Hilbun*, 466 So. 2d 856, 868-73 (Miss. 1985) (replacing the locality rule with a national standard of care for medical malpractice actions); *Sheeley v. Memorial Hosp.*, 710 A.2d 161, 166-67 (R.I. 1998) (same); *Helling v. Carey*, 519 P.2d 981, 982-83 (Wash. 1974) (holding ophthalmologists liable for malpractice notwithstanding adherence to the then-prevailing professional standard of care for glaucoma testing). Some effects are less direct. For instance, growing malpractice litigation has encouraged physicians to practice “defensive medicine” designed to protect them from liability rather than promote patient welfare. See E. Haavi Morreim, *Redefining Quality By Reassigning Responsibility*, 20 AM. J.L. & MED. 79, 90-91 (1994); W. John Thomas, *The Medical Malpractice “Crisis”: A Critical Examination of a Public Debate*, 65 TEMP. L. REV. 459, 498-503 (1992).

187. 42 U.S.C. § 1395 (1994); see also 21 U.S.C. § 396 (Supp. III 1997) (medical device regulation); 37 Fed. Reg. 16,503, 16,504 (1972) (“[I]t is clear that Congress did not intend the [FDA] to regulate or interfere with the practice of medicine . . .”).

of two factors. First, patients with previously undiagnosed complaints obviously may become frustrated and demand some medical—but preferably not a psychiatric—label for their symptoms.<sup>188</sup> They may do so for entirely personal reasons, but many patients also understand the potential legal utility of a medical diagnosis, which is only partially counterbalanced by concerns about their future insurability and even social stigma. Second, some researchers and practitioners have been willing to respond to such opportunities by defining and identifying new syndromes in these patients.<sup>189</sup> As Dr. Aronowitz has written, there is a “widespread belief that those who are stressed and mentally ill are an immense market for somatic diagnoses, making the diagnosis of these syndromes vulnerable to abuse.”<sup>190</sup> Researchers

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188. See, e.g., ARONOWITZ, *supra* note 32, at 73 (“A market for somatic labels exists in the large pool of ‘stressed-out’ or somaticizing patients who seek to disguise an emotional complaint or to ‘upgrade’ their diagnosis from a nebulous one to a legitimate disease.”); *id.* at 185. Aronowitz continues:

In receiving the [CFS] diagnosis, patients might find it easier to explain their suffering to friends and family, take some relief in the generally benign prognosis, feel satisfied that their problems are not all in their heads, make sense of the confusing medical literature and try some interventions, and join a chronic fatigue support group.

*Id.* at 185; see also *id.* at 75 (noting that “Lyme disease is socially perceived to be a fashionable diagnosis”); TOOMBS, *supra* note 8, at 45 (arguing that “a scientific diagnosis validates the patient’s experience and the lack of such a diagnosis suggests such experience is not to be taken seriously as a medical problem”); Ronald E. Gots, *Medical Hypothesis and Medical Practice: Autointoxication and Multiple Chemical Sensitivities*, 18 REG. TOXICOLOGY & PHARMACOLOGY 2 (1993) (“In every era people have suffered varieties of symptoms not readily explained by ‘known’ diseases of the day. To provide explanations and treatment approaches, individuals with symptom complexes were frequently provided a unifying disease label. . . . [But] newly named fad disorders have not survived long term.”).

189. See ARONOWITZ, *supra* note 32, at 182 (“Clinicians may be excited about the possibility of diagnosing a new disease or helping to prevent disease.”); *id.* at 73 (“These doctors explicitly link their view of Lyme disease as a serious threat to a call for funding research, suggesting at least one possible motivation for their position.”); GLENN, *supra* note 4, at 69 (“The physician is always willing, it seems, to extend the definition of illness and come up with a diagnosis for almost any problem.”).

190. ARONOWITZ, *supra* note 32, at 31-32.

The appearance of chronic fatigue syndrome . . . had everything to do with the confluence of interests of investigators, clinicians, and laypersons. Investigators were excited about the possibility of a new clinical syndrome caused by a well-known virus; clinicians had a new name and framework for the ever-present chronically fatigued patient; and patients were accorded the legitimacy attributed to a new viral syndrome and—associated with it—the hope for rational treatment.

*Id.* at 179-80; see also *id.* at 36 (“The conception of chronic fatigue as a disease also placed limits on doctors’ paternalistic judgments about the role of psychological factors in causing symptoms.”); *id.* at 104 (“[T]here has been a ‘life-cycle’ to the history of these diagnoses—initial medical interest and promotion, followed by a rapid increase in the number of patients who get the diagnosis, and finally stigmatization and decline in usage.”); Sparks et

may try to capitalize on what they hope will prove to be a major biomedical breakthrough, and some clinicians may become opportunistic popularizers of novel diseases.

To the extent that legal and related external pressures influence the labeling of diseases and their diagnosis in particular patients, is there anything troublesome about that? Do these external constraints corrupt an essentially scientific, taxonomic process? Should medical professionals be forced to undertake a patient advocacy role that competes and may even conflict with their more traditional role of treating ill patients? The phrase *primum non nocere* expressed one of the central maxims of the Hippocratic tradition—above all, physicians should do no harm in dealing with their patients.<sup>191</sup> If the medical community defines or identifies diseases for reasons other than their use in helping to select a course of treatment, however, diagnostic judgments may run afoul of this bioethical principle of nonmaleficence. Indeed, there may be significant costs to patients, the medical profession, and society. The first section addresses these questions with respect to nosology, the generic process of defining conditions as diseases; the second section does so with respect to diagnosis, the identification of these previously defined diseases in particular patients.

#### A. Nosology for Fun and Profit

As suggested in Part II, defining a condition as a disease may help secure insurance coverage for treatments, improve the odds that the FDA will approve new therapeutic products for marketing, allow tort plaintiffs to side-step tricky causation questions, assist criminal defendants in avoiding conviction, and expand eligibility for disability programs and workers' compensation benefits. For instance, pharmaceutical companies seeking FDA approval of new drugs (or hoping to guarantee the availability of insurance reimbursement for prescriptions) care whether the scientific community categorizes hypertension, obesity, or premenstrual syndrome as diseases.<sup>192</sup> Lawyers who represent parties in the ongoing breast implant litigation have an obvious stake in the direction of research on connective-tissue disorders.

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al., *supra* note 97, at 718 ("In the vacuum created by the paucity of scientific medical data, MCS is rapidly becoming a politically defined illness.").

191. See ROBERT M. VEATCH, A THEORY OF MEDICAL ETHICS 22, 159-61 (1981); see also Ben A. Rich, *Postmodern Medicine: Deconstructing the Hippocratic Oath*, 65 U. COLO. L. REV. 77 (1993).

192. See Johannes & Stecklow, *supra* note 75, at B8 (noting that the American Obesity Association is largely supported by pharmaceutical companies rather than membership dues); Joe Sharkey, *It's a Mad, Mad, Mad, Mad World*, N.Y. TIMES, Sept. 28, 1997, at D1 (describing efforts to have PMS included in the DSM and one drug company's sponsorship of supporting research).

Also, as noted in connection with the discussion of both tort and criminal litigation, nosological innovations may help promote and perhaps also disguise significant doctrinal modifications.

Patient and social advocacy groups sometimes influence nosology. Traditionally, at a time when disability programs reflected a medical or rehabilitative rather than a civil rights model, condition-specific associations formed to promote clinical research into their members' particular disease.<sup>193</sup> More recently, most notably in the case of AIDS, patients have formed advocacy groups to lobby legislators and regulators to support research and accelerate the availability of potential treatments.<sup>194</sup> But some experts warn that such "lobbying could undermine scientific objectivity in decisions such as which diseases are researched and how much funding those projects receive."<sup>195</sup> In some situations, as in the case of chronic fatigue syndrome, patient support groups have formed primarily to demand that medical professionals and the public take their ailments seriously.<sup>196</sup>

The selection of diagnostic criteria also may have important legal consequences. For instance, the CDC's surveillance activities draw the attention of patient advocacy groups because of the inevitable use

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193. See, e.g., JOSEPH P. SHAPIRO, *NO PITY: PEOPLE WITH DISABILITIES FORGING A NEW CIVIL RIGHTS MOVEMENT 20-22* (1993) (discussing the activities of the Muscular Dystrophy Association). Indeed, some commentators have suggested that the identification of learning disabilities was driven in large measure by an organized effort by parents' groups seeking special education services for their children without the associated stigma of having them labeled as mentally retarded. See JAMES G. CARRIER, *LEARNING DISABILITY: SOCIAL CLASS AND THE CONSTRUCTION OF INEQUALITY IN AMERICAN EDUCATION 93-104* (1986). A number of these organizations also make appeals directly to the public in order to raise funds, for instance through public service announcements, telethons, and even television dramas. See Andrea Petersen, *Episodic Illnesses: How Rare Ailments Get on Prime Time*, WALL ST. J., Apr. 14, 1998, at A1 ("[H]ealth foundations and patient-advocacy groups wooing Hollywood television writers and producers . . . often use emotional appeals and personal connections in hopes of landing a 'product placement' for their illness in prime time.").

194. See William B. Rubenstein, *Law and Empowerment: The Idea of Order in the Time of AIDS*, 98 YALE L.J. 975, 990-94 (1989) (book review); Lois K. Perrin, Note, *The Catch-22 for Persons with AIDS: To Have or Not to Have Easy Access to Experimental Therapies and Early Approval for New Drugs*, 69 S. CAL. L. REV. 105, 121-27 (1995); Malcolm Gladwell, *Beyond HIV: The Legacies of Health Activism*, WASH. POST, Oct. 15, 1992, at A29 (noting that a decade of AIDS activism "has had a profound impact on U.S. regulation, law and society far beyond the immediate world of those infected with HIV"); Jane Gross, *Turning Disease into Political Cause: First AIDS, and Now Breast Cancer*, N.Y. TIMES, Jan. 7, 1991, at A12.

195. Natalie Hopkinson, *NIH Needs More Input from Public, Panel Report Says*, WALL ST. J., July 9, 1998, at B7 (summarizing remarks by Dr. Leon E. Rosenberg, a professor at Princeton University who had chaired an Institute of Medicine committee charged with reviewing NIH activities, concerning the success of AIDS and breast cancer patient advocacy groups in lobbying Congress for additional funding of research into those diseases).

196. See ARONOWITZ, *supra* note 32, at 28, 33-34.

of these diagnostic criteria for other purposes: "Although the CDC's various case definitions were developed primarily for surveillance activities, these definitions have become the diagnostic standard used by other federal, state, and local agencies to determine eligibility for entitlements and benefits."<sup>197</sup> In addition to the availability of disability benefits, CDC definitions may affect reimbursement to health care providers, FDA review of therapeutic agents, and federal funding of biomedical research.<sup>198</sup> Over time, clinical researchers may narrow the definition of novel diseases, potentially leading to conflicts between patient advocacy groups and clinicians—patients may feel "disfranchised" if their illness falls outside of increasingly refined diagnostic criteria.<sup>199</sup>

The debate about the existence of "Gulf War syndrome" provides a recent illustration of an advocacy group aggressively lobbying for the formal recognition of a new ailment.<sup>200</sup> Gulf War syndrome (GWS) has aspects of both MCS (premised on possible exposure to biological agents and other toxins during combat) and post-traumatic stress disorder. PTSD itself emerged as a diagnosis for Vietnam veterans suffering from psychiatric problems that had been identified in previous generations of soldiers as shell shock or combat fatigue. Recognition of GWS would entitle many veterans of the Persian Gulf War to medical and disability benefits.<sup>201</sup> To date, however, biomed-

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197. Carol Levine & Gary L. Stein, *What's in a Name? The Policy Implications of the CDC Definition of AIDS*, 19 L. MED. & HEALTH CARE 278, 282 (1991) (adding that "[t]his has had a significant impact, both positive and negative").

198. See *id.* at 278 ("distinguish[ing] the primary purpose of the CDC's surveillance definition from the ancillary uses that it triggers in entitlements and benefits, funding formulas, clinical research, medical care, and calculations of the costs of health care and social services"); *id.* at 282-87 (elaborating on some of these ancillary uses in the context of the CDC's proposed modification of its case definition for AIDS). For a discussion of subsequent proposed modifications in and applications of the CDC's definition of AIDS, see 58 Fed. Reg. 36,008, 36,009-10 (1993); 57 Fed. Reg. 35,832 (1992).

199. See ARONOWITZ, *supra* note 32, at 180 (discussing the evolution of understanding about Lyme disease, and arguing against excessive scientific reductionism for excluding idiosyncratic disease conditions).

200. See Walter Goodman, *On Gulf Veterans, Head vs. the Heart*, N.Y. TIMES, Jan. 20, 1998, at E10 (describing the conflict between scientific organizations and those supporting the claims of veterans groups); Philip J. Hilts, *Gulf War Syndrome: Is It a Real Disease?*, N.Y. TIMES, Nov. 23, 1993, at C1; Gina Kolata, *Stress Study May Hold Clue to Gulf War Illness, Scientists Say*, N.Y. TIMES, May 28, 1998, at A25; see also Kevin J. Dalton, Comment, *Gulf War Syndrome: Will the Injuries of Veterans and Their Families Be Redressed?*, 25 U. BALT. L. REV. 179, 182-98 (1996); Claire Alida Milner, Comment, *Gulf War Guinea Pigs: Is Informed Consent Optional During War?*, 13 J. CONTEMP. HEALTH L. & POL'Y 199, 205-06 (1996).

201. See 38 U.S.C. §§ 1101-1163 (1994). Congress amended the statute to authorize disability payments under certain circumstances to Persian Gulf veterans "suffering from a chronic disability resulting from an undiagnosed illness." Veterans' Benefits Improvements Act of 1994, Pub. L. No. 103-446, § 106, 108 Stat. 4645, 4650 (codified at 38 U.S.C.

cal researchers have failed to find much scientific support for these nosological claims.<sup>202</sup>

Both the AMA and the APA have published important diagnostic guides, in some cases consciously geared toward forensic or reimbursement uses. These professional societies engage in more than a taxonomic endeavor when they compile and promote these manuals. As the significance of their diagnostic manuals grows, groups with a stake in the outcome attempt to exert some influence, and the drafting process inevitably becomes more politicized and less driven by scientific expertise.<sup>203</sup>

Although the APA explicitly cautioned that *DSM-IV* was intended primarily for therapeutic rather than forensic or reimbursement purposes,<sup>204</sup> that caveat has a decidedly hollow ring to it.<sup>205</sup> Recognition in the *DSM* has become essential for securing health insurance coverage, so much so that patient groups and pharmaceutical companies may lobby the APA to include new disorders.<sup>206</sup> Para-

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§ 1117 (1994)).

202. See Keiji Fukuda et al., *Chronic Multisymptom Illness Affecting Air Force Veterans of the Gulf War*, 280 JAMA 981 (1998); Bill McAllister, *Panel's Report Challenges Gulf War Syndrome Theory*, WASH. POST, Sept. 1, 1998, at A8.

203. Cf. *Allied Tube & Conduit Corp. v. Indian Head, Inc.*, 486 U.S. 492, 500-02 (1988) (reviewing antitrust claim against a company that had attempted to manipulate the process of revising the National Electrical Code); Jonathan R. Macey, *The Transformation of the American Law Institute*, 61 GEO. WASH. L. REV. 1212, 1225-32 (1993) (describing the growing politicization of the process of drafting the *Restatements of the Law*); Alan Schwartz & Robert E. Scott, *The Political Economy of Private Legislatures*, 143 U. PA. L. REV. 595, 650-51 (1995) (explaining that interest group competition rather than expertise dominates private law-making bodies).

204. See *DSM-IV*, *supra* note 115, at xxiii (“[T]he clinical diagnosis of a DSM-IV mental disorder is not sufficient to establish the existence for legal purposes of a ‘mental disorder,’ ‘mental disability,’ ‘mental disease,’ or ‘mental defect.’”); *id.* at xxvii (“The clinical and scientific considerations involved in categorization of these conditions as mental disorders may not be wholly relevant to legal judgments . . .”).

205. See KIRK & KUTCHINS, *supra* note 114, at 118 (“Of course, the architects of the manual could not help but know that these were the concerns that were of great importance to most of its users.”); *id.* at 214 (“[N]one of the revisions has been stimulated by clinical practitioners demanding a new classification system. Since DSM is ostensibly a clinical tool, outsiders may find this lack of clinician demand a curious fact.”); *id.* at 106-07 (noting that a couple of proposed mental disorders were deleted for fear that they might provide an inappropriate psychiatric defense in criminal trials); Robert D. Miller, *History of Psychiatric Diagnosis: A Guidebook for Nonclinicians*, COLO. LAW., Jan. 1994, at 39, 41 (“The legal profession became involved in determining the legal effects, and sometimes even the meaning, of certain diagnoses. The American Psychiatric Association responded to these attempts to define psychiatric diagnoses for legal purposes by changing the criteria for some of its diagnoses.” (footnotes omitted)); see also Thomas E. Schacht, *DSM-III and the Politics of Truth*, 40 AM. PSYCHOL. 513, 520 (1985) (“DSM-III is both a tool for the production of scientific knowledge and an instrument of rhetoric, social organization, and power distribution.”).

206. See Sharkey, *supra* note 192, at D1 (describing efforts to add road rage and pre-

doxically, the *DSM's* diagnostic criteria for mental disorders may end up serving primarily non-therapeutic purposes, whether tied to reimbursement, forensic testimony, or basic research. As a commentator noted in discussing the development of *DSM-III*, "[o]ne could not help but be skeptical of a system in which illnesses are created or eliminated substantially as a result of lobbying by special interest groups."<sup>207</sup> Other scholars have described legal influences on scientific endeavors, particularly with regard to technological innovation,<sup>208</sup> but it is hard to imagine any comparable taxonomic process influenced to this extent by non-scientific pressures external to the discipline.<sup>209</sup>

Some commentators have applauded the tendency of litigation to promote scientific research on important subjects,<sup>210</sup> but, if definitions

menstrual syndrome to the next edition of the *DSM*); see also Daniel Goleman, *Who's Mentally Ill?*, *PSYCHOL. TODAY*, Jan. 1978, at 34 ("If the diagnosis isn't in the manual, the insurance company is unlikely to pay for treatment."). Thus, some have called the *DSMs* "a gold mine for the profession." COLBY & SPAR, *supra* note 21, at 214; see also *id.* at 17 (calling *DSM-III* "a politically motivated compromise between differing interpretations of the data, outright dogma, and propaganda"). My personal favorite is "Caffeine Intoxication" disorder. See *DSM-IV*, *supra* note 115, at 213.

207. Gerard, *supra* note 20, at 389 (adding, however, that legal institutions remain free to ignore the *DSM*); see also John E. Helzer et al., *Posttraumatic Stress Disorder in the General Population*, 317 *NEW ENG. J. MED.* 1630, 1630 (1987) ("[PTSD] was included as a compromise after veterans' groups and mental health personnel engaged in caring for Vietnam veterans spearheaded a drive for the recognition of a 'post-Vietnam syndrome.'").

208. See STEVEN GOLDBERG, *CULTURE CLASH: LAW AND SCIENCE IN AMERICA* 178-80, 183 (1994) ("Law does not threaten science through the legal control of basic research; it threatens science through the adoption of legal norms by basic researchers."); SHEILA JASANOFF, *SCIENCE AT THE BAR: LAW, SCIENCE, AND TECHNOLOGY IN AMERICA* 208-09, 213-14 (1995); Harold P. Green, *The Law-Science Interface in Public Policy Decision-making*, 51 *OHIO ST. L.J.* 375, 384 (1990) ("[I]t is primarily the law that creates the societal environment in which scientific activity takes place.").

209. In the former Soviet Union, the Communist Party pressured agronomists to repudiate scientific understandings about genetics in favor of environmental explanations for plant variation that better conformed to Marxist ideology. See Bert Black et al., *Science and the Law in the Wake of Daubert: A New Search for Scientific Knowledge*, 72 *TEX. L. REV.* 715, 769-71 (1994) (discussing the rise of Lysenko under Stalin and the disastrous impact of their denunciation of plant genetics on Soviet agriculture). The Soviet Union also utilized psychiatric diagnoses and institutionalization to deal with political dissidents. See Merskey, *supra* note 7, at 221; see also MARK G. FIELD, *DOCTOR AND PATIENT IN SOVIET RUSSIA* 166-67 (1957) (describing government restrictions on the number of illness certifications that physicians could provide in response to growing worker absenteeism).

210. See Rebecca S. Dresser et al., *Breast Implants Revisited: Beyond Science on Trial*, 1997 *WIS. L. REV.* 705, 772 ("While litigation is not a good way to produce good science, scientific studies are sometimes conducted, as in the DNA cases, in response to litigation, and the breast implant controversy appears to be no exception." (footnotes omitted)); Rochelle Cooper Dreyfuss, *Galileo's Tribute: Using Medical Evidence in Court*, 95 *MICH.*

of disease serve primarily forensic rather than therapeutic purposes, the odds of objective and rigorous scientific testing may decrease.<sup>211</sup> Instead, legal institutions may embrace and unwittingly promote unorthodox medicine.<sup>212</sup> Also, to the extent that legal institutions contribute to rapid nosological revisions, they may harm both the scientific enterprise and patient care. If nosologies become moving targets, biomedical researchers cannot adequately investigate their clinical utility before revised definitions render their work moot.<sup>213</sup> Revisions also increase the risk of diagnostic errors as clinicians cannot keep up with changes in nomenclature, which in turn complicates communication among colleagues about their patients.<sup>214</sup> None of

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L. REV. 2055, 2067 (1997) (book review); David L. Faigman, *The Evidentiary Status of Social Science Under Daubert: Is It "Scientific," "Technical," or "Other" Knowledge?*, 1 PSYCHOL., PUB. POL'Y & L. 960, 974 (1995) (arguing that more stringent rules of admissibility for psychological testimony would encourage better research in this field).

211. Cf. Philip E. Enterline, Commentary, *Toxic Torts: Are They Poisoning the Scientific Literature?*, 30 AM. J. INDUS. MED. 121, 122 (1996) (noting that, in epidemiological studies sponsored by litigants, "the results are not usually made public unless they are favorable to the sponsor," and that "[t]his is unhealthy for the scientific literature"); Lars Noah, *Sanctifying Scientific Peer Review: Publication as a Proxy for Regulatory Decision-making*, 59 U. PITT. L. REV. 677, 705-09 (1998) (identifying several potential sources of bias in biomedical publications). See generally Symposium, *Biomedical Peer Review*, 280 JAMA 213 (1998).

212. Cf. ANGELL, *supra* note 102, at 185-91 (arguing that public responses to health scares such as silicone-gel breast implants, including the responses mediated by legal institutions, promote a growing anti-science movement and renewed interest in unorthodox therapies); ELAINE SHOWALTER, *HYSTORIES: HYSTERICAL EPIDEMICS AND MODERN CULTURE* 206 (1997) (describing the media's role in promoting novel diseases such as CFS and GWS, and concluding that "the hysterical epidemics of the 1990s have already gone on too long, and they continue to do damage: in distracting us from the real problems and crises of modern society, in undermining a respect for evidence and truth, and in helping support an atmosphere of conspiracy and suspicion"). For descriptions of the recent upsurge of interest in alternative medicine, see David M. Eisenberg et al., *Trends in Alternative Medicine Use in the United States, 1990-1997*, 280 JAMA 1569 (1998); Eliot Marshall, *The Politics of Alternative Medicine*, 265 SCIENCE 2000 (1994); Denise Grady, *Journal Casts a Cold Eye on Alternative Medicine*, N.Y. TIMES, Dec. 30, 1997, at F6; see also MICHAEL H. COHEN, *COMPLEMENTARY AND ALTERNATIVE MEDICINE: LEGAL BOUNDARIES AND REGULATORY PERSPECTIVES* 118-19 (1998) ("The legal view of disease . . . must embrace a broader understanding of healing than is reflected in biomedical orthodoxy.").

213. See Mark Zimmerman, *Why Are We Rushing to Publish DSM-IV?*, 45 ARCHIVES GEN. PSYCHIATRY 1135, 1136-38 (1988) (arguing that the recent rapidity of changes in the DSM impeded scientific research into diagnostic criteria for psychiatric disorders and also meant that revisions would not be able to take into account any new information because they invariably outpaced the research).

214. See Irwin N. Perr, *Medical and Legal Problems in Psychiatric Coding Under the DSM and ICD Systems*, 141 AM. J. PSYCHIATRY 418, 418-19 (1984); see also Maranto, *supra* note 184, at F7 ("[P]eople become less able to name and deal with their problems. Meaning is lost as phrases like 'feeling blue,' give way to psychological jargon. As more people seek professional help, the ranks of psychotherapists grow, and so the technical terminology proliferates.").

this is meant to discount scientific and other non-legal motivations for pursuing basic disease research, but one should not dismiss the peculiar incentives created or mediated by different legal institutions and their possible adverse consequences for biomedical work.

### B. Diagnostic Dishonesty

Even with uncontroversial diseases, legal institutions may distort the diagnosis of individual patients. For instance, it appears that health care providers, in response to payment restrictions by public and also private insurers, may misrepresent their diagnostic judgments to ensure coverage for their patients. And, to the extent that courts admit expert medical testimony concerning novel injury claims such as multiple chemical sensitivity, chronic fatigue syndrome, or atypical autoimmune diseases, such labels do not appear to help physicians when they are treating these patients. Is there anything wrong with such behavior? Is it ethical, does such complicity carry with it any demoralization costs for medical professionals, and do "fudged" diagnoses pose any potential hazards for the subsequent treatment of patients?

To help answer such questions, one could craft a simple hierarchy of possible motivations for providing a diagnosis. As emphasized from the outset, therapeutic justifications traditionally rank as the primary, if not exclusive, rationale for identifying diseases in patients. Diagnosis is only a means to the end of selecting the most appropriate course of treatment. Second, diagnoses may be generated as a means to the end of ensuring payment for the most appropriate course of treatment, which one might call "economic advocacy" in pursuit of patient therapy. Third, medical professionals may dispense diagnoses at the request of their patients to assist in securing benefits of various types from legal institutions, which one might characterize as "forensic advocacy" in pursuit of the patient's overall welfare (more broadly conceived than therapy). Finally, medical professionals may record diagnoses for their own personal gain, in effect to defraud insurers or to protect themselves from malpractice or disciplinary actions in the event of serious treatment errors. This Article largely disregards the last motivation, focusing instead on economic and forensic advocacy, where legal institutions exert their influence, and asking to what extent these conflict with the therapeutic rationale for diagnosing patients.

Some commentators have criticized overly rigid disease classification systems such as the *ICD* for encouraging physicians to render more specific diagnoses of patients than are warranted by the data.<sup>215</sup>

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215. See ALVAN R. FEINSTEIN, *CLINICAL JUDGMENT* 96 (1967); see also GLENN, *supra*

Such concerns are compounded when reimbursement turns on diagnostic labels. As insurance coverage becomes linked more directly to patient diagnoses, incentives may develop to gear diagnoses in order to maximize reimbursement,<sup>216</sup> a phenomenon some have labeled "DRG creep."<sup>217</sup> Similarly, to the extent that public and private insurers attempt to control charges by physicians, some doctors have responded by "upcoding" procedures to ensure reimbursement.<sup>218</sup> Indeed, in one survey, a majority of physicians found nothing unethical about misstating, for insurance purposes, the reasons for ordering a diagnostic test.<sup>219</sup> At some level, this behavior is less an overt at-

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note 4, at xviii, 89, 107 ("[W]hat is communicated is just an abbreviation of the whole, written for the insurance company's benefit or to 'give a handle on the illness' to someone who has asked for it."); Allan S. Brett, *New Guidelines for Coding Physicians' Services—A Step Backward*, 339 NEW ENG. J. MED. 1705, 1707 (1998) ("Coding guidelines influence the substance of the clinical encounter, because they implicitly specify the elements of a medical encounter that are valued by those who compensate physicians for their work.").

216. See David M. Frankford, *The Medicare DRGs: Efficiency and Organizational Rationality*, 10 YALE J. ON REG. 273, 322 (1993) ("There is no dispute that hospitals have expended considerable effort to upcode their discharges into higher paying DRGs."); *id.* at 329 ("Everyone in the hospital cheerfully can agree to game the coding system so as to increase the hospital's reimbursement."); Frankford, *supra* note 48, at 648-55 (elaborating on the prevalence of DRG "upcoding" by hospitals); Mary R. Kohler, Note, *When the Whole Exceeds the Sum of Its Parts: Why Existing Utilization Management Practices Don't Measure Up*, 53 U. PITT. L. REV. 1061, 1081 n.107 (1992) ("Physicians have even managed to turn a profit on Medicare's PPS. By learning which ICD-9-CM codes trigger classification into a higher reimbursement DRG, physicians and hospitals have learned how to make Medicare work to their advantage.").

217. Donald W. Simborg, *DRG Creep: A New Hospital-Acquired Disease*, 304 NEW ENG. J. MED. 1602, 1604 (1981) ("Continuing physician 'education' could certainly be implicated. There are legitimate medical vagaries and uncertainties in many diagnostic situations. . . . Minor diagnostic nuances and slight imprecisions of wording have little practical clinical importance, yet under DRG reimbursement they would have major financial consequences."); see also Lisa I. Iezzoni & Mark A. Moskowitz, *Clinical Overlap Among Medical Diagnosis-Related Groups*, 255 JAMA 927, 927-28 (1986) (suggesting that many patients could fit into a number of DRGs, in which case the most remunerative one will be chosen); Mark Notman et al., *Social Policy and Professional Self-Interest: Physician Responses to DRGs*, 25 SOC. SCI. & MED. 1259, 1266 (1987) ("[Physicians] have found ways of getting around system constraints to continue to give their patients the medical care they feel is appropriate and to help the hospital maximize reimbursement.").

218. See COLBY & SPAR, *supra* note 21, at 17 ("You will fill out forms in order to get paid by third-party carriers. For remuneration, you will, in part, make-believe just like all of us [psychiatrists] do."); *id.* at 30 ("[D]iagnosis is a silly game that all doctors, not just psychiatrists, play with insurance companies."); GLENN, *supra* note 4, at 70 ("[P]hysicians cannot be reimbursed for their work unless it is characterized as treatment of an illness."); *id.* at 159 (noting that physicians "must often use some other diagnosis in order to be reimbursed by most 'third-party' payers," and adding that this "is time-consuming, aggravating, and feels inherently dishonest"); Rhonda L. Rundle, *Medical Rip-Off: How Doctors Boost Bills by Misrepresenting the Work They Do*, WALL ST. J., Dec. 6, 1989, at A1.

219. See Dennis H. Novack et al., *Physicians' Attitudes Toward Using Deception to Resolve Difficult Ethical Problems*, 261 JAMA 2980, 2984 (1989) ("Most of our respondents

tempt to deceive than it is a medical fiction,<sup>220</sup> a transparent effort to inject some flexibility into an otherwise unduly rigid system for classifying illnesses experienced by patients.

Mental health professionals also engage in deliberate misdiagnosis, though the issues become somewhat more complicated in this context. Because psychiatric disorders carry a stigma, and review of insurance claim forms may breach client confidences, clinicians sometimes intentionally underdiagnose their patients.<sup>221</sup> This tendency does not, however, necessarily counterbalance the corresponding incentives to overdiagnose in order to secure third-party reimbursement.<sup>222</sup> Because of the difficulty in ensuring coverage for mental illnesses, coupled with the non-specificity of diagnostic categories,<sup>223</sup> mental health professionals understandably may rationalize upcoding even more readily than physicians.<sup>224</sup> Indeed, as suggested earlier, di-

were willing to misrepresent a screening test as a diagnostic test to ensure payment. This raises the possibility that offering 'creative diagnoses' to third-party payers may be a widespread practice.").

220. Cf. LON L. FULLER, *LEGAL FICTIONS* 6 (1967) (explaining that "a fiction is distinguished from a lie by the fact that it is not intended to deceive").

221. See Steven S. Sharfstein et al., *Accuracy of Diagnostic Information Submitted to an Insurance Company*, 137 AM. J. PSYCHIATRY 70, 72 (1980); see also Bruce G. Link et al., *The Effectiveness of Stigma Coping Orientations: Can Negative Consequences of Mental Illness Labeling Be Avoided?*, 32 J. HEALTH & SOC. BEHAV. 302, 315-16 (1991) (discussing the stigma associated with a diagnosis of mental illness).

222. See KIRK & KUTCHINS, *supra* note 114, at 241 ("The sensitivity of clinicians to the potential negative effects of psychiatric labeling, which may encourage the practice of underdiagnosis, does not completely counteract the financial pressure to overdiagnose."); *id.* at 244 ("[B]ecause of the structure of third-party reimbursement for certain psychiatric diagnoses, the clinical ambiguities involved present mental health organizations with irresistible opportunities to gain fiscal resources by merely labeling and mislabeling clinical conditions."); Stuart A. Kirk & Herb Kutchins, *Deliberate Misdiagnosis in Mental Health Practice*, 62 SOC. SERV. REV. 225, 229-32 (1988) (discussing a survey finding that both under- and overdiagnosing were prevalent).

223. See KIRK & KUTCHINS, *supra* note 114, at 240 ("In mental health practice, diagnostic latitude is particularly great . . . [and] deliberate misdiagnoses are hard to detect. Furthermore, when the nature of the disorder is itself ambiguous, controversial, unverifiable, and subject to extraclinical influences, intentional falsification may merge with unconscious distortion."); *id.* at 235 ("[I]t could be argued that despite a deceptive official diagnosis, the treatment used was based on the 'real,' if unofficial, diagnosis. . . . However, many third-party payers insist that treatment conform to the diagnosis."); *id.* at 239 ("Because there is no professional consensus about the appropriate treatment for specific disorders, the importance of misdiagnosis is often discounted.").

224. See *id.* at 239.

One explanation for the apparent indifference to deliberate misdiagnosis is that both under- and overdiagnosing are justified as either harmless or in the client's best interest; the client is helped to avoid a stigmatizing label or to obtain needed services. The DSM-III code may be viewed by clinicians as a fiscal formality unrelated to treatment, a white lie for a good purpose.

*Id.*

agnoses of mental disorders may represent nothing more than post hoc rationalizations for therapeutic interventions that happened to prove effective.<sup>225</sup>

Even when done for a seemingly good cause, such prevarication may erode public trust in the medical profession.<sup>226</sup> In her classic book on lying, Sissela Bok warned that "the entire institution of medicine is threatened by practices lacking in candor, however harmless the results may appear in some individual cases."<sup>227</sup> Diagnostic dishonesty may backfire in a number of ways. Occasional fudging to circumvent restrictive coverage rules may unwittingly perpetuate reimbursement policies that physicians should assail more directly.<sup>228</sup> If gaming becomes sufficiently widespread, payers may

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225. See *id.* at 235 ("There are also circumstances in mental health organizations where the treatment determines the diagnosis; the diagnosis is made only after a particular treatment has been found to be effective. If the patient got better with lithium, the diagnosis should be bipolar affective disorder."); see also *supra* notes 22-23 and accompanying text.

226. See Novack et al., *supra* note 219, at 2985 ("The physicians' overriding concern with patient welfare, consistent with the Hippocratic tradition, gives less consideration to questions about the potential harm to others of deceiving. . . . What harm may ensue if the policy of deceiving in certain circumstances becomes more general, and how will that affect public trust in the profession?"); E. Haavi Morreim, *Gaming the System: Dodging the Rules, Ruling the Dodgers*, 151 ARCHIVES INTERNAL MED. 443, 445 (1991) ("Where there is good reason to suspect that the payer is 'gaming the patient,' the physician may be sorely tempted to dodge its rules. . . . [This, however,] carries formidable moral and medical hazards. It can violate principles of nonmaleficence, veracity and justice."); cf. Carol M. Rose, *Trust in the Mirror of Betrayal*, 75 B.U. L. REV. 531 (1995) (discussing the importance of trust in other contexts); Christopher Slobogin, *Testilying: Police Perjury and What to Do About It*, 67 U. COLO. L. REV. 1037, 1041-48 (1996) (discussing the negative effects of lying by law enforcement officials in preparing reports and testifying at suppression hearings); Christopher Slobogin, *Deceit, Pretext, and Trickery: Investigative Lies by the Police*, 76 OR. L. REV. 775, 797-800 (1997) (same). For a discussion of the nature and negative consequences of gaming in administrative law, see Lars Noah, *Sham Petitioning as a Threat to the Integrity of the Regulatory Process*, 74 N.C. L. REV. 1 (1995).

227. SISSELA BOK, LYING: MORAL CHOICE IN PUBLIC AND PRIVATE LIFE 68 (1978); see also *id.* at 233 ("[Patient] fear is further nourished by the loss of trust in health professionals. In part, the loss of trust results from the abuses which have been exposed. . . ."). She focused on two primary types of deception in the medical context. First, Bok criticized the widespread use of placebos in treating patient complaints. See *id.* at 63 ("Even apart from financial and emotional costs and the squandering of resources, the practice of giving placebos is wasteful of a very precious good: the trust on which so much in the medical relationship depends."); *id.* at 67 ("In view of all these ways in which placebo usage can spread, it is not enough to look at each incident of manipulation in isolation, no matter how benevolent it may be."). Second, she questioned failures to disclose candidly the severity of illness to dying patients. See *id.* at 222 ("Lying to patients has, therefore, seemed an especially excusable act. Some would argue that doctors, and *only* doctors, should be granted the right to manipulate the truth. . . .").

228. See Morreim, *supra* note 226, at 445 ("Where physicians routinely game their way around an undesirable resource rule instead of openly challenging it, they may help to perpetuate unwise policies."); *id.* ("Where [government insurance] policies are unwise or

clamp down and further erode physician autonomy.<sup>229</sup> In either case, patient welfare ultimately could suffer. In addition, widespread misdiagnosis may undermine public health surveillance and intervention efforts, providing policymakers with inaccurate data on the prevalence and severity of particular diseases in the population.<sup>230</sup>

Finally, upcoding may directly compromise the treatment of patients. "[I]f a physician exaggerates the seriousness of a patient's condition to utilization review officers on the telephone, he or she may have to write those exaggerations in the chart, thus jeopardizing the patient's future care."<sup>231</sup> In one particularly striking case, a physician had upcoded the diagnostic rationale for ordering a CT scan for purposes of filing a Medicare claim form.<sup>232</sup> Rather than justify the procedure as an effort to rule out the possibility of brain cancer, which Medicare apparently would not have reimbursed, the neurologist "diagnosed" the patient as having a brain tumor. The patient inadvertently received a copy of the completed insurance form and

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inadequate they should be corrected not by a gaming that undermines both the social decision and the democratic process by which it was made but, rather, through public discussion.").

229. See *id.* ("[N]o resource system can long survive widespread abuse and dishonesty, nor can physicians expect to retain either their professional integrity or, equally important, their clinical autonomy, if they treat with duplicity those who own the medical and monetary resources essential to their patients' care."). Physicians who fudge diagnoses may also lose credibility with jurors in medical malpractice cases. See *id.*

230. See KIRK & KUTCHINS, *supra* note 114, at 242 ("Policy and program development in mental health frequently rely on reported rates of treated disorder. Are depression, alcoholism, and schizophrenia becoming more or less prevalent? Uncharted and unrecognized distortion of diagnostic practices could lead to invalid conclusions and misguided intervention efforts."); *id.* ("Deliberate misdiagnosis to avoid stigma or to obtain reimbursement for treatment for individual clients cannot be justified ethically or legally, but such practices, in the aggregate, present even greater problems for mental health planners."); see also Lawrence K. Altman, *Diagnoses and the Autopsies Are Found to Differ Greatly*, N.Y. TIMES, Oct. 14, 1998, at A16 (noting that, because "[a]utopsies help monitor public health by identifying new diseases and changes in ones long recognized," concerns have arisen about declining autopsy rates); Lawrence K. Altman, *Getting It Right on the Facts of Death*, N.Y. TIMES, Dec. 22, 1998, at F7 (reporting that "death certificate information is often flawed, and that misinformation can affect policy," adding that "even hospital billing practices[] can influence what is listed as a cause of death," leading to "comments in medical journals that some certificates 'are pure fabrication'").

231. Morreim, *supra* note 226, at 445 ("Similarly, a psychiatrist who identifies a patient's illness according to the most serious, best-reimbursed diagnosis . . . may needlessly stigmatize the patient elsewhere in life."); see also KIRK & KUTCHINS, *supra* note 114, at 233 ("A deliberately false diagnosis, whatever the merits of the motivation behind it, officially labels a client as suffering from a mental disorder that he or she in fact does not have."); *id.* at 239 ("To the extent that there are negative effects of psychiatric labeling, overdiagnosis may unnecessarily harm the client."); WILLIAM O. ROBERTSON, *MEDICAL MALPRACTICE: A PREVENTIVE APPROACH* 19-21 (1985) (noting that problems in written communication can precipitate treatment errors).

232. See *Stafford v. Neurological Med., Inc.*, 811 F.2d 470, 471-72 (8th Cir. 1987).

soon thereafter committed suicide. Her husband then sued the neurologist and his employer for negligence, and the jury returned a verdict in favor of the plaintiff. Although the trial judge granted the defendants' post-trial motion for a judgment notwithstanding the verdict on the ground that no reasonable jury could find that the neurologist's act had caused his patient's suicide, the appellate court reversed and remanded the case for entry of the judgment in the plaintiff's favor.<sup>233</sup>

The medical profession may need to address diagnostic dishonesty through revisions in ethical codes for practitioners. Historically, codes were notable for the absence of any guidance on the importance of veracity in dealing with patients and third parties.<sup>234</sup> The AMA's *Principles of Medical Ethics* now provide that "[a] physician shall deal honestly with patients and colleagues, and strive to expose those physicians . . . who engage in fraud or deception."<sup>235</sup> External checks exist in some contexts, such as prohibitions on fraud in the Medicare program or on perjury in judicial and administrative proceedings, but diagnostic upcoding in these settings does not necessarily transgress rules against outright fabrication,<sup>236</sup> and physicians may too readily agree to help their patients when asked to provide a diagnosis that attests to the genuineness of a patient's illness for some collateral purpose. Some professional associations have responded by providing ethical guidance limiting the appropriate scope of forensic testimony.<sup>237</sup>

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233. See *id.* at 473-75.

234. See BOK, *supra* note 227, at xvi ("Honesty from health professionals matters more to patients than almost everything else that they experience when ill. Yet the requirement to be honest with patients has been left out altogether from medical oaths and codes of ethics, and is often ignored, if not actually disparaged, in the teaching of medicine."); *id.* at 223 ("[Veracity] is absent from virtually all oaths, codes, and prayers. The Hippocratic Oath makes no mention of truthfulness to patients about their condition, prognosis, or treatment.").

235. AMA COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS xiv (1998). However, the accompanying annotations suggest that this principle is directed primarily at other types of problems. See *id.* at xx-xxiii.

236. See 42 U.S.C. § 1320a-7a(a)(1)(A) (1994); see also *United States v. Larm*, 824 F.2d 780, 782-83 (9th Cir. 1987) (upholding Medicaid fraud conviction of allergist for upcoding treatments); JOSEPH A. SNOE, AMERICAN HEALTH CARE DELIVERY SYSTEMS 641, 646-47 (1998) (explaining that DRG upcoding may violate prohibitions against Medicare fraud); cf. *United States v. Krizek*, 859 F. Supp. 5, 8-12 (D.D.C. 1994) (finding that a psychiatrist had violated the False Claims Act for overbilling but not for allegedly upcoding treatments); Jerry L. Mashaw & Theodore R. Marmor, *Conceptualizing, Estimating, and Reforming Fraud, Waste, and Abuse in Healthcare Spending*, 11 YALE J. ON REG. 455, 487 (1994) (noting that most upcoding involves close judgment calls rather than clear fraud, and doubting that it represents a significant problem).

237. See AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW, ETHICAL

As mentioned previously, medical professionals have become important gatekeepers in disability benefit programs.<sup>238</sup> Indeed, according to Michel Foucault, this became true in France two centuries ago: "In addition to [the doctor's] role as a technician of medicine, he would play an economic role in the distribution of help, and a moral, quasi-judicial role in its attribution."<sup>239</sup> As one court explained more recently:

Today, the patient commonly, and necessarily, enlists the aid of his or her physician in preparing claims forms for health and disability benefits. Such forms ordinarily require information possessed solely by the treating physician as well as the physician's signature attesting to the bona fides of that medical information.<sup>240</sup>

Obligations to assist patients seeking to secure payment do not, however, contemplate that physicians assume a broader advocacy role for their patients.<sup>241</sup> Their professional relationship is primarily a thera-

GUIDELINES FOR THE PRACTICE OF FORENSIC PSYCHIATRY (1991); American Psychol. Ass'n, *Ethical Principles of Psychologists and Code of Conduct*, 47 AM. PSYCHOLOGIST 1597, 1610 § 7.04(b) (1992) (calling on psychologists to acknowledge the limits of their forensic assessments); see also MELTON ET AL., *supra* note 18, at 17 (arguing that, even if courts allow or urge mental health professionals to testify about ultimate issues or legal conclusions, psychiatrists and others should not exceed the scope of their expertise).

238. See *supra* note 161 and accompanying text; see also Timothy S. Carey & Nortin M. Hadler, *The Role of the Primary Physician in Disability Determination for Social Security Insurance and Workers' Compensation*, 104 ANNALS INTERNAL MED. 706 (1986); Pryor, *supra* note 174, at 813 ("[P]hysicians make hundreds of thousands of 'disability determinations' each year for purposes of eligibility to benefits of some type.").

239. FOUCAULT, *supra* note 28, at 42; see also *id.* at 41 ("[T]he doctor began to play a decisive role in the organization of assistance. . . . [I]t was the doctor who discovered where it was needed and judged the nature and degree of the assistance to be given.").

240. *Chew v. Meyer*, 527 A.2d 828, 832 (Md. Ct. Spec. App. 1987); see also *The Inter-professional Code 1987*, 65 DENV. U. L. REV. 267, 271 (1988) ("[T]he primary duty of a physician is to treat a patient's illness or injuries. However, an additional responsibility of a treating physician is to provide necessary medical information and opinions by virtue of his or her acceptance of that patient for treatment . . . if such information will aid the judicial process.").

241. See AMA PRINCIPLES OF MEDICAL ETHICS § 9.07 (1997) ("If a patient who has a legal claim requests a physician's assistance, the physician should furnish medical evidence. . . . The medical witness must not become an advocate or a partisan in the legal proceeding."); see also *Wilson v. Blue Cross*, 271 Cal. Rptr. 876, 883-84 (Ct. App. 1990) (noting that a physician might be held jointly liable for the consequences of the denial of insurance coverage); *Murphy v. Godwin*, 303 A.2d 668, 673 (Del. Super. Ct. 1973) ("[T]he question of a doctor's legal duty toward his patients with respect to completing insurance forms is apparently novel. The existence of such a duty may be found, however, by reference to established tort theory and recognized incidents of the doctor-patient relationship."); GLENN, *supra* note 4, at 149 ("[T]hey can be trusted to tell the truth to the courts, not to give welfare certificates out indiscriminately, and to weed out moral slouchers from the ranks of the truly sick. However, the recent view of physicians (especially the family physician) as the patient's advocate appears to challenge this."); William M. Sage, *Physicians as Advocates*, 35 HOUS. L. REV. 1529 (1999) (criticizing the shift to a patient advocacy role).

peutic one.

In addition, in both civil and criminal litigation, medical professionals frequently testify about the condition of one of the parties. To the extent that treating physicians are willing to certify that their patient suffers from some novel disease,<sup>242</sup> they have been criticized for complicity with the lawyers pressing these claims for recovery or diminished capacity.<sup>243</sup> If these complaints have merit, legal institutions must design mechanisms to prevent such misconduct.<sup>244</sup> This Article, however, inquires whether the medical profession needs to concern itself with the extent to which legal institutions have influenced the diagnostic enterprise.

Delinkage offers one solution. Rather than cloak legal decisions about eligibility with seemingly objective and authoritative clinical judgments, courts and agencies could reduce their reliance on medical diagnoses. The ADA does this to some extent by making the requirement for a physical or mental impairment quite loose and only a threshold step leading to more difficult non-medical inquiries, in contrast to the Family and Medical Leave Act's or the SSA's much greater dependence on purely medical determinations of disability. In addition, managed care reimbursement methods that pay providers a flat amount per year to care for each enrolled member (capitation) may help reduce incentives for upcoding.<sup>245</sup>

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242. See ANGELL, *supra* note 102, at 131 ("The common contention that breast implants cause diseases that cannot be objectively described is a theory that cannot be tested. Doctors who believe in it simply assert that such diseases exist and that they know them when they see them."); EDWARD SHORTER, FROM PARALYSIS TO FATIGUE: A HISTORY OF PSYCHOSOMATIC ILLNESS IN THE MODERN ERA 317 (1992) (noting that "[t]he chronic fatigue subculture brims with folklore about choosing physicians thought to be sympathetic").

243. See ANGELL, *supra* note 102, at 147-52, 207 ("The lawyers could not exploit the breast implant controversy without the help of doctors who collect fees for making what are often dubious diagnoses. . . . [T]he medical profession as a whole bears some responsibility for the fact that a small group of doctors is able to get away with such blatantly unethical behavior."); Robert L. Brent, *The Irresponsible Expert Witness: A Failure of Bio-medical Graduate Education and Professional Accountability*, 70 PEDIATRICS 754, 755-56 (1982); Gina Kolata & Barry Meier, *Implant Lawsuits Create a Medical Rush to Cash In*, N.Y. TIMES, Sept. 18, 1995, at A1.

244. See Gerard, *supra* note 20, at 413 ("If the legal system fails to establish standards to control the degree of reliability a diagnosis must have to make it admissible as evidence, experts can put any diagnostic label they wish upon any individual they choose."); see also Steven I. Friedland, *Law, Science and Malingering*, 30 ARIZ. ST. L.J. 337 (1998).

245. See George J. Annas, *When Should Preventive Treatment Be Paid for by Health Insurance?*, 331 NEW ENG. J. MED. 1027, 1029 (1994) (noting that the shift to capitation may "slow the proliferation of new 'diseases'"); see also Frances H. Miller, *Foreword: The Promise and Problems of Capitation*, 22 AM. J.L. & MED. 167 (1996); Barbara A. Noah, *The Managed Care Dilemma: Can Theories of Tort Liability Adapt to the Realities of Cost Containment?*, 48 MERCER L. REV. 1219, 1225-27 (1997). Upcoding might still occur to circumvent restrictive utilization rules such as limitations on referrals to specialists.

Courts might do well to show less deference to the expert testimony of a party's treating physician or clinical psychiatrist, in favor of evidence from epidemiologists and forensic psychiatrists whose testimony can satisfy more stringent admissibility criteria. For instance, in a tort suit involving an emotional distress claim, it makes more sense for courts to credit general evidence about the prevalence of PTSD among civilians exposed to industrial accidents than to rely on the essentially untestable diagnosis of PTSD by the plaintiff's treating physician. Such "social framework" evidence would not eliminate the need to demonstrate that the plaintiff manifests behaviors and other signs of this disorder, but a treating physician or mental health professional would not be essential for even this limited purpose if other experts had described the characteristics to the jury.

Indeed, one could avoid using diagnostic labels altogether, allowing clinicians to testify only about facts elicited during the evaluative interview such as statements by the patient, observed behaviors, and the results of laboratory tests. The drawing of any inferences from this raw data would remain within the province of the factfinder asked to decide whether those signs had some legal relevance. Clinicians could not testify about ultimate issues or even convey their conclusory diagnostic labels which might unduly influence the decisionmaker.<sup>246</sup> Such delinkage would encourage more careful role differentiation by medical professionals. Because the forensic experts have no therapeutic relationship with the plaintiff and would not purport to diagnose conclusively his or her alleged disorder, there is less of a risk that the forensic assessment will negatively affect subsequent clinical treatment.

Legal institutions could get along without resort to medical diagnosis, though agencies and courts surely would resist losing this ready proxy or short-cut for making difficult decisions. In whatever form, delinkage may help reduce existing incentives to gear diagnoses toward non-therapeutic ends. Such reforms would free medical professionals to focus on their primary role as care-givers to patients suffering from some illness.<sup>247</sup> As an added benefit, the quality of legal decisionmaking may improve in these contexts.<sup>248</sup>

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246. See Morse, *supra* note 20, at 625; cf. MELTON ET AL., *supra* note 18, at 17-20 (arguing that mental health professionals should only be barred from testifying about ultimate issues and legal conclusions about which they lack expertise).

247. See LEE COLEMAN, *THE REIGN OF ERROR: PSYCHIATRY, AUTHORITY, AND LAW* 242-45 (1984).

248. See *id.* at 242 ("If this divorce were accomplished, the criminal justice system would do a better job of law enforcement, the courts would do a better job of deciding civil and criminal questions, and psychiatry would finally be free to offer honest and voluntary services to those who want help."); Bonnie & Slobogin, *supra* note 109, at 457 ("Many clinicians have no business in the courtroom. Their training in clinical methods of

Diagnostic labels have significant consequences for patients. As Dr. Aronowitz wrote: "Modern classificatory practices . . . run the risk of constructing diseases that may have little or no clinical significance yet carry costs to individuals and society, such as iatrogenic harm, worry, stigma, and abuse of the sick role."<sup>249</sup> To the extent that some of the novel illnesses have a psychogenic origin, diagnostic labels actually may be counterproductive in caring for these patients.<sup>250</sup> Although the suggestion of a physiological cause may help legitimize their undoubted illness, persons suffering from depression will not improve if they receive a CFS diagnosis from a sympathetic physician along with a prescription for vitamin supplements.<sup>251</sup> Assigning such

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inquiry and treatment encourages them to err in the direction of diagnosing illness, invites many of them to speculate wildly about unconscious determinants of behavior, and frequently discourages systematic theoretical inquiry."); *see also* JASANOFF, *supra* note 208, at 123-26 (noting objections to the "treating physician syndrome" in tort litigation).

249. ARONOWITZ, *supra* note 32, at 107 ("This is no mere semantic exercise . . ."); *see also id.* at 246 n.20 ("Diagnosing disease is an act with consequences, not merely a cognitive exercise that matches the particular patient to specific disease criteria.").

When I make a diagnosis of hypertension, my patient's life might change in any number of ways: . . . by becoming fearful of developing a heart attack or stroke, by quitting a high-pressured job and looking for a less pressured one out of concern about the effect of stress on heart disease, or by taking medications that lead to impotence, cough, or bad dreams. None of these effects directly result from pathophysiological derangements associated with high blood pressure itself; rather, they are effects of behaviors and attitudes triggered by the act of diagnosis.

*Id.*; *see also id.* at 37 ("In an era in which the financial burden of health care coupled with a perception of declining or static health gains is generally recognized as the major problem facing modern medicine, more attention might be paid to the costs and health effects of the creation of new diseases . . .").

250. *See id.* at 19 ("Almost every branch of medicine makes use of such 'functional' diagnoses. . . . Often both physician and patient are left with the uneasy feeling that organic disease has been missed or that important but difficult to manage psychosocial issues have been sidestepped."); GLENN, *supra* note 4, at 69 ("[T]he patient's distress soon becomes transformed into a 'disease,' thus blurring the real meaning of his or her experience."); Kirkland, *supra* note 108, at 92 (warning that a PTSD-based claim "can develop into a situation that creates an actual disservice to the patient from a therapeutic point of view in that acceptance of an inaccurate etiology of the problem is fostered"); Synder et al., *supra* note 95, at 110 ("Reinforcement of illness behavior by unjustifiably giving a patient a diagnosis of a disease . . . that is clinically unsubstantiated or invalid may actually perpetuate illness, prolong disability, and delay effective therapy."); Rosenthal, *supra* note 167, at C1 ("Neurologists say that they are being called upon to resolve a barrage of legal disputes [involving chronic pain] but that litigation frequently clouds diagnosis and interferes with medical care.").

251. *See* Simon Wessely, *Old Wine in New Bottles: Neurasthenia and "ME,"* 20 PSYCHOL. MED. 35, 50 (1990) ("Patients may be denied the most appropriate treatment available, and may instead receive 'new' diagnoses which are later found to be spurious . . . . Such uncritical diagnoses may reinforce maladaptive behaviour, and may create more severe and persistent morbidity than the initial illness . . . ."); *see also* BOK, *supra* note 227, at 63 ("[T]he resort to placebos may actually prevent the treatment of an under-

vague syndrome labels may “contribut[e] to dysfunctional illness behavior patterns that increase disability and medical dependency, waste resources, and add to iatrogenic illness.”<sup>252</sup> The disdain for psychological explanations of illness, suggesting that such a diagnosis makes the patient’s complaint less genuine, arises from numerous sources.<sup>253</sup> To some extent, legal institutions contribute to this preference for physiological explanations of disease, and some in the medical profession have satisfied these demands even where such diagnoses do not serve—or, worse yet, disserve—therapeutic purposes.

### Conclusion

What does it mean to be ill? It depends in part on whom you ask. Physicians, historians, philosophers, and sociologists have struggled to answer this important question. It also depends on why you want to know. The traditional response would emphasize therapeutic purposes, in which case the medical model of disease made perfect sense. If, however, non-therapeutic motives underlie the question, then the range of possible answers might proliferate and depart substantially from the medical model. Legal institutions, by looking to medical professionals for answers to non-therapeutic questions about disease, have failed to appreciate these distinctions.

Why should we care that legal institutions misunderstand the answers that they receive to their non-therapeutic questions about the meaning of disease? At one level, it may distort decisions having important personal, financial, and societal consequences, and legal decisionmakers may wish to reorient their understandings of illness for that reason alone. At another level, which this Article has emphasized, the misunderstanding and distortion may rebound in various

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lying, undiagnosed problem.”).

252. Timothy E. Quill et al., *The Medicalization of Normal Variants: The Case of Mitral Valve Prolapse*, 3 J. GEN. INTERNAL MED. 267, 275 (1988). “Using diseases such as normal-variant [mitral valve prolapse] to explain complex human experience is an unscientific, inhumane oversimplification, . . . and contributes to the somatization and medicalization of the patient.” *Id.* at 273; see also Donald W. Black, *Environmental Illness and Misdiagnosis—A Growing Problem*, 18 REG. TOXICOLOGY & PHARMACOLOGY 23, 29-30 (1993) (objecting to the diagnosis of MCS on similar grounds); Ronald E. Gots, *Multiple Chemical Sensitivities—Public Policy*, 33 CLINICAL TOXICOLOGY 111, 113 (1995) (“[T]he diagnosis of MCS has the paradoxical effect, not of helping the victim, but of condemning him or her to a course of misguided treatment destined to enhance disability.”).

253. See KLEINMAN, *supra* note 5, at 59 (noting “the unwillingness of many [chronic] pain patients to accept psychosocial explanations that appear to deny that their pain is founded in a ‘real’ bodily experience deserving of somatic remedies and a legitimate medical sick role”); SHORTER, *supra* note 242, at 317 (“The rejection of psychiatric diagnoses by chronic fatigue patients is much more violent than are the normal reactions of medical patients to psychiatric consultation, and is itself a characteristic of the illness. Anything smacking of psychiatry or psychology is completely taboo.”).

ways that influence the behavior of medical professionals. In this respect, legal institutions do more than make a mistake in relying on diagnostic judgments for their own non-therapeutic purposes; by becoming dependent on these medical judgments, they also distort nosology and diagnosis in ways that may threaten clinical research and patient care.

Various legal institutions play an important role in the diagnostic enterprise, though these institutions are not the only, or even the most important, factor in defining and identifying illness. Their influence is, however, largely ignored. Nor do courts and agencies seem to understand their potentially significant effects on the definition and identification of disease, even if they sense that nosology and diagnosis may lack the degree of objectivity and trustworthiness typically ascribed to these scientific and clinical judgments. It bears repeating, however, that one should not idealize the diagnostic process or exaggerate the influence of legal institutions. If the social constructivists are correct, even total delinkage by courts and agencies would not make nosology and diagnosis approach the therapeutic ideal of the traditional medical model of disease, which has never existed in any event.

Beyond hoping to promote heightened awareness, this Article has proposed some tentative responses to the ways in which legal institutions influence medical diagnosis. Courts and agencies can try to delink themselves from an overreliance on the gatekeeping role traditionally placed on treating physicians, and the medical profession should insist on a clearer demarcation between diagnostic judgments for therapeutic purposes and forensic diagnoses. Organized medicine should not unnecessarily multiply nosologies in response to reimbursement pressures or perceived forensic opportunities, and physicians should not feel pressured into becoming zealous advocates for their patients outside of the therapeutic relationship. Otherwise, health care professionals risk losing sight of the primary purpose for making a diagnosis, namely, caring for a patient with an illness.

