

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF IOWA
CENTRAL DIVISION

RICHARD B. DAVIES,

Plaintiff,

vs.

MICHAEL J. ASTRUE,
Commissioner of Social Security,

Defendant.

No. 4:07-cv-0209-JAJ

ORDER

This matter comes before the court pursuant to briefs on the merits of this application for disability insurance benefits. The court finds that the decision of the Social Security Administration is supported by substantial evidence. This case is dismissed.

I. PROCEDURAL BACKGROUND

Plaintiff Richard B. Davies (hereinafter “Davies”) filed an application for Disability Insurance Benefits on June 28, 2002, alleging an inability to work from August 21, 2002. The Social Security Administration (“SSA”) denied Davies’s application initially and again upon reconsideration. Administrative Law Judge (“ALJ”) Peter Belli held a hearing on Davies’s claim on May 18, 2004. Judge Belli found that a psychological evaluation was necessary and continued the hearing in order for Davies to be evaluated. A second hearing was held on November 18, 2004, before ALJ Richard Mueller. The ALJ denied Davies’s appeal on March 9, 2005. The SSA Appeals Council denied Davies’s request for review on March 15, 2007. Davies filed this action for judicial review on May 14, 2007. (dkt. no. 1).

II. FACTUAL BACKGROUND

Davies was forty-three at the time of his alleged disability onset date. He was forty-six years old at the time of his first hearing and forty-seven at the time of his second hearing. Davies attended high school through tenth grade and later earned his GED. He

attended two years of college. His vocationally relevant work experience includes work as a mental retardation aide, handyman, window assembler, battery line inspector, illustrator, and soldier.

A. Relevant Medical History

Davies alleges disability due to depression, anxiety and coronary artery disease. Most of Davies's cardiac history is not summarized below as the present issues involve the ALJ's assessment and Davies's psychological issues.

On August 16, 2001, Davies presented to Montgomery County Memorial Hospital with chest pains and shortness of breath, which occurred while mowing the lawn. He was admitted to the hospital and on August 23, 2001, he had a four-vessel coronary artery bypass graft. Davies was treated by Dr. Brian Couse, M.D., who put him on several medications for his heart-related conditions: Prilosec, Lipitor, and Atenolol.

At a check-up on August 29, 2001, Davies reported that he was having difficulty sleeping and was experiencing "night terror dreams." (Tr. 164). Dr. Couse wrote that Davies was "quite fatigued and looks exhausted." (Tr. 164). He prescribed Paxil and Ativan for his anxiety.

On September 6, 2001, Dr. Couse saw Davies after an episode in which he became dizzy and felt like "things were spinning." (Tr. 161). Dr. Couse wrote that the incident sounded like a panic attack. Dr. Couse's impression was that Davies had anxiety with panic disorder and re-prescribed Ativan. At Davies's next appointment on September 28, 2001, Dr. Couse wrote that Davies's "anxiety is minimal. He just uses the Ativan for sleep as needed." (Tr. 159). On November 5, 2001, Dr. Couse wrote that Davies continued to have nightmares and flashbacks to his service in the Korean War. Dr. Couse recommended that he see a psychologist about this. At a follow-up on January 18, 2002, Dr. Couse did not note any anxiety-related problems. Dr. Couse said that he had been "doing . . . more with his hobbies." (Tr. 153).

At his next visit on April 18, 2002, Davies's anxiety problems had worsened. Dr. Couse wrote, "Anxiety problems have been so bad it has been affecting his concentration. Had to quit his job at Nichener Production because of it." (Tr. 148). Dr. Couse diagnosed panic disorder. He increased Davies's anxiety medication, Celexa, and recommended a follow-up in two weeks.

On April 23, 2002, Davies saw psychiatrist Dr. Subhash C. Bhatia at the Veterans Administration hospital ("VA") for treatment of depression and panic attacks. Dr. Bhatia's impression of Davies was that he was cooperative but "anxious and ill at ease." (Tr. 315). His mood was "dysphoric and anxious." (Tr. 315). Dr. Bhatia diagnosed posttraumatic stress disorder, adjustment disorder with depression/anxiety, but no major depressive disorder or anxiety disorder. He assigned a GAF of 55. Dr. Bhatia increased his Celexa for depression/anxiety, prescribed trazodone for his sleep problems, and recommended that he go to the PTSD clinic at the VA.

On the same day, VA physician Dr. Scott F. Menolascino, M.D., evaluated Davies for the purpose of VA benefits and services. Davies reiterated the same complaints to Dr. Menolascino – nightmares of his time in Korea, difficulty sleeping, decreased energy, difficulty with concentration and focus, depression and "episodes of anxiety where he begins sweating and becomes lightheaded and nervous." (Tr. 312-13). He also related difficulties in large groups, where he "feels that spaces are closing in on him." (Tr. 313). Davies also relayed anger management problems. Dr. Menolascino wrote that he suffered from "anxiety, probable secondary to posttraumatic stress disorder, adjustment disorder, possibly generalized anxiety," depression and anger management problems. (Tr. 313).

On May 8, 2002, he had a psychological consultation with psychologist Constance Logan. He complained to Logan of similar problems: anxiety, depression, nightmares, and problems interacting socially.

He cannot stand to be in a room full of people, or to be far away from a door. . . . He related that he can be irritable and perfectionistic, especially demanding that all of his personal items be kept exactly as if they would be subject to inspection at any time. He does not consider himself short-tempered, but he realizes that others do. His girlfriend and her children feel he blows up too easily. The veteran has also had panic attacks, both while sleeping and while awake. These have been related to traumatic nightmares.

(Tr. 311).

Logan administered a series of psychological assessment tests. On the Los Angeles Symptom Checklist, Davies gave responses similar to Vietnam veterans who were diagnosed with PTSD. On two of the tests, the Traumatic Symptom Inventory and Personality Assessment Inventory (“PAI”), Logan found that Davies likely exaggerated his symptoms. Logan wrote, “The veteran’s responses to the PAI also showed a possible tendency to present a more negative impression of his situation than might actually be the case. Therefore, his profile must be interpreted with caution.” (Tr. 311).

Logan assessed Davies in the following way:

The most marked elevations suggest a high degree of depression and anxiety, leading to confusion, agitation, and difficulty managing on a daily basis. This level of helplessness and low self-esteem can present a risk of self-harm. Preoccupation with sources of his anxiety (both small setbacks and larger traumas) probably make him over-reactive to stressors. It is likely that he is impaired in memory or concentration because of his distress. . . . His responses also suggest social isolation and alienation. Instead of close relationships, he remains isolated and preoccupied with his own physical and mental function, keeping himself to a high standard of behavior that is unlikely to be shared by others. It is likely that he is seen by others as liable to rapid changes in mood, particularly getting angry easily. Alcohol use may further the swings in mood or the tendency towards

aggressive. . . . [T]he veteran did express a realization that he has problems and wants help in solving them.

(Tr. 311).

Logan wrote that Davies's "life-threatening encounter with heart disease" "exacerbated his anxiety and his post-traumatic stress disorder symptoms." (Tr. 312). Logan wrote that he may have "a great deal of trouble finding employment because of his depression and anxiety, on top of his heart condition." (Tr. 312). Logan determined that Davies suffered from chronic posttraumatic stress disorder, "which is presently having an acute episode." (Tr. 312). She recommended that he be evaluated for substance abuse issues and once those issues are dealt with, group coping skills therapy to deal with his PTSD.

On June 18, 2002, Davies saw substance abuse therapist Susan O'Brien at the VA regarding his alcohol issues. Davies reported that in the previous two to three months, he had been drinking six to eight beers per day. Davies identified that he had been "drinking a little too much." (Tr. 300). She wrote that the longest period of abstention from alcohol was two weeks in the last six months. He had been drinking despite being on medication, which contradicts the effects of the medication. Davies started drinking at around twelve years of age and has a history of alcohol abuse in his family. O'Brien determined that Davies met the criteria for alcoholism and recommended treatment, suggesting a two-week inpatient treatment, followed by up to a year of outpatient treatment. Davies was very resistant as it would interfere with finding employment. Davies said he was not an alcoholic and blamed it on his anxiety and depression; if he could receive treatment for those disorders, it would take care of the alcoholism. O'Brien explained that in order to receive treatment in the PTSD unit, he would first have to get treatment for his alcoholism. He said he wanted to try to quit drinking on his own before he entered a substance treatment program.

O'Brien followed up with telephone calls in the following days, again encouraging substance abuse treatment. Logan and O'Brien set up a plan for his alcoholism and possible PTSD, in which Logan would meet with him monthly for four months to monitor his progress. She did not enroll him in "PCT"¹ because of his "reluctance to commit to substance-treatment and his sobriety is potentially unstable." (Tr. 299). She said she would assess a depression and anxiety diagnosis "once substances clear." (Tr. 299).

On June 25, 2002, Davies saw Dr. Couse after passing out a couple of times in the preceding week. Dr. Couse speculated that the episodes might be anxiety-related. Dr. Couse could see no pattern in his passing out: "There is no rhyme or reason to when he has had the episodes. One was while he was outside in the hot weather mowing the lawn. Others have been inside." (Tr. 146).

On July 2, 2002, Davies had another appointment with Logan. He appeared late to the appointment because he had overslept due to nightmares. Logan said there "were no signs of severe mental illness noted." (Tr. 299). Davies assertively and forcefully stated that he was not an alcoholic. He said that he had a panic attack and passed out after speaking with O'Brien on the telephone. Logan again determined that Davies had alcohol dependence and diagnosed him with "panic." (Tr. 299). She wrote that she would assess PTSD once he stopped drinking. Logan recommended a follow-up appointment in three weeks. Davies did not show up or cancel his appointment on July 23, 2002.

Davies visited Dr. Couse on August 28, 2002, for the purpose of a disability evaluation. (Tr. 331-32; 335-38). Dr. Couse assessed Davies as suffering from coronary artery disease, depression, panic attack, posttraumatic stress disorder, and short-term memory loss. Dr. Couse wrote that the paramount problems were those related to anxiety "which have been difficult to control despite medication therapy." (Tr. 332). Dr. Couse also wrote that Davies had to leave his job at Nichener Productions because of his memory

¹ O'Brien does not identify what "PCT" stands for.

problems and inability to perform the tasks of the job appropriately. Davies had been working in snow removal but had to quit that job because of his sensitivity to cold.

Dr. Couse also assessed his physical restrictions, most of which stem from his heart condition. (Tr. 337-38). He had no major restrictions in range of motion, grip strength, or muscle strength.

Dr. Couse concluded, "I believe that Richard could do jobs where he is seated in a cool environment, however, he would have a lot of difficulty doing a lot of exertional activity, especially when he is in an uncontrolled climate." (Tr. 332).

Logan spoke with Davies over the phone on October 2, 2002. He reported that he had stopped taking his antidepressants and Logan encouraged him to re-start them. Davies said he quit drinking. He was still very angry with Logan and her staff for diagnosing him with alcoholism and encouraging substance abuse treatment.

On October 18, 2002, Davies had an appointment with Logan. She wrote that Davies had been having a lot of problems getting along with his family, largely due to his desire to maintain a harsh, army-like household. Davies said that he sometimes got very "worked up" about the messiness around him and got headaches. He stated that sometimes he got so worked up that he faints. Regarding his alcohol issues, Davies reported that he had quit drinking beer and only occasionally drank wine with dinner.

Logan wrote that Davies "showed no signs of psychosis or severe mental illness. He did become very worked up and described anxiety, although it looked like anger to this clinician: loud voice, vehement speech, red face, gestures that emphasized what he was saying." (Tr. 324). She recommended individual treatment for his anxiety, interpersonal problems, substance abuse, and "conflict over having been harangued by overly-harsh father into a state of perfectionism." (Tr. 325).

On March 30, 2003, Logan evaluated Davies for PTSD and concluded he was "subthreshold for PTSD." He was referred to the VA for treatment of his other

conditions.

On April 1, 2003, Davies was seen at the VA's primary care clinic by Dr. Michael Polansky. He was experiencing increased anger and anxiety problems and was interested in restarting psychiatry treatment. Davies was no longer drinking any alcohol. Dr. Polansky diagnosed coronary artery disease, hypertension, and panic disorder. Dr. Polansky ordered a mental health consultation.

On May 28, 2003, Davies did not show up for his scheduled mental health consultation at the VA.

On September 8, 2003, Davies presented to the VA's primary care clinic for a routine visit and was treated by Physician's Assistant Christy Shearer. He primarily complained of anxiety and depression. He complained of anxiety attacks two to three times per week in which he experiences "dizziness, hyperventilation and passes out." (Tr. 434). He had stopped using Celexa because he said it was not working. He continued to use Trazadone as needed when he had nightmares and trouble sleeping. He said that he enjoys doing artwork. Shearer referred Davies to the Mental Health Clinic. "He has had appointments in the past that he missed and I did reinforce that the patient needs to keep this appointment in order to improve his current mental state." (Tr. 435). Several tests were administered the same day. The alcohol screening was negative. He had a positive screening for PTSD and depression.

Davies saw Dr. Polansky on October 7, 2003, for a routine check-up. He wrote that Davies had not shown up for a scheduled mental health consultation.

On December 15, 2003, Davies was seen by psychiatrist Dr. Thomas Svolos at the VA's Mental Health Clinic upon Dr. Polansky's referral. Dr. Svolos found that Davies appeared "anxious and somewhat depressed, but more anxious than anything else. Thoughts were organized." (Tr. 398). He diagnosed panic disorder with agoraphobia, generalized anxiety disorder, possible organic cognitive disorder, possible mild PTSD, and

a possible mood disorder. He assigned a GAF of 60. He prescribed Remeron and recommended psychotherapy.

Davies saw Dr. Svolos for a follow-up on January 20, 2004. Dr. Svolos switched Davies from Remeron to Zoloft because Remeron was “extremely sedating.” (Tr. 417). Dr. Svolos concluded that Davies had “[u]nchanged panic disorder, and some mood symptoms as well.” (Tr. 417).

Davies saw Dr. Polansky on February 3, 2004, for a routine visit. He was depressed and complained of lethargy and disinterest in activities. Dr. Polansky “[e]mphasized to patient that he needs to increase his activity levels as in walking, exercise and/or perhaps volunteer work, something to get him out of the house and get him motivated, and also improve his condition.” (Tr. 414).

On July 21 and 23, 2004, Dr. Russell Moulton performed a psychological evaluation of Davies, per the request of ALJ Belli following Davies’s first SSA hearing. In a seven-page report, Dr. Moulton described his impressions of Davies and the methods and results of several assessment tests.

Dr. Moulton wrote that his mood “seemed depressed and affect flat. He was sad and was misty-eyed at times.” (Tr. 453). He also noted that his attention and concentration seemed to be “somewhat impaired.” (Tr. 453). Dr. Moulton wrote that his memory “seemed adequate for recent and remote events.” (Tr. 453).

Upon administering the Weschler Adult Intelligence Scale-Third Edition test, Dr. Moulton wrote the results were “indicative of borderline intellectual functioning.” (Tr. 453). Davies had knowledge of current and past events. His thoughts were coherent and organized. He was paranoid and distrusted his friends.

Regarding the panic attacks, Dr. Moulton wrote,

He talked about the panic attacks and indicated he passes out three or four times per week. According to Richard, he particularly gets panicked when he feels like he can’t control

the situation, such as in the grocery store or while driving. He said he avoids stores 'like the plague' and doesn't like crowds or using money.

(Tr. 454).

Dr. Moulton also identified Davies as possibly having obsessive-compulsive disorder due to how orderly he wants everything to be.

Dr. Moulton administered two psychological tests. The first, the Beck Depression Inventory, was used to gauge Davies's level of depression. He scored in the "middle of the severe range of the scale." (Tr. 454). The second test, the MMPI-2, rendered invalid results because his answers "were seen to contain an unusually large number of extreme items in the deviant direction, with the probability of an indiscriminate and exaggerated response pattern." (Tr. 456). Dr. Moulton noted, "The invalid results could come from many sources, including conscious distortion or faking, confused and disoriented states due to acute psychological disturbance, or confusion about using the answer sheet, which it is felt can be ruled out." (Tr. 456). Despite the numerous reasons for an invalid result, Dr. Moulton indicated that he thought Davies exaggerated his responses. He also stated, "[I]t needs to be mentioned that the results of the MMPI-2, indicating an exaggerated response, could also bring into question some of his statements regarding symptoms in other areas." (Tr. 457).

Overall, Dr. Moulton found "some fairly major mental distress regarding his overall physical functioning after the heart attack and it would seem that would be a normal human reaction." (Tr. 457).

Dr. Moulton diagnosed (1) Mood Disorder due to Heart Condition, with depressive features (DSM-IV 293.83); (2) Anxiety Disorder Not Otherwise Specified (DSM-IV 300.00); (3) Post-Traumatic Stress Disorder (Rule Out) (DSM-IV 309.81); (4) Obsessive Compulsive traits; (5) a heart condition; and (6) "problems with primary support group; health problems in family; problems related to social environment, isolation, limited social

support; Occupational problems, unemployment.” (Tr. 458). Dr. Moulton assigned a GAF of 51.

In regards to residual functional capacity and ability to interact in the workplace, Dr. Moulton wrote:

[I]t appears as if he would have the ability to understand instructions, but possibly could have some problems with carrying them out due to concentration difficulties. His pace would most likely be less than that of a typical employee. If he is experiencing anxiety, pace would probably be lessened even more. Although judgment seems fairly good in most areas, any kind of change in the work environment would probably need to be explained to Richard in advance of that change, so he was aware of the new expectations. From his input, he seems to be fairly hyper-vigilant of his environment and somewhat distrustful of others, which could impact interactions with others to a degree, but he would most likely have an adequate ability to interact with people in an appropriate manner.

(Tr. 457).

On August 9, 2004, Dr. Moulton also completed a checklist-style form provided by the SSA. In it, he indicated that Davies would only have “slight” problems with memory, concentration, and ability to carry out instructions. He would have moderate restrictions in carrying out detailed instructions. Dr. Moulton indicated that Davies would also have moderate restrictions in his interactions with co-workers, supervisors, and the public. He would have moderate difficulties “respond[ing] to work pressures in a usual work setting” and in “repond[ing] appropriately to changes in a routine work setting.” (Tr. 461).

B. Plaintiff’s Subjective Complaints

On June 24, 2002, Davies completed a Disability Report Adult form. He wrote that since his bypass surgery, he “experience[s] panic attacks, dizzy spells, [and has] a

decrease in stamina.” (Tr. 80). He indicated that these symptoms first began to bother him on August 10, 2001, and he became unable to work on April 12, 2002. He wrote that he needed help carrying out his job duties, including needing help to “lift, turn and care” for his clients. He stopped working because his “[c]ondition was causing me to make mistakes while at work – med errors, documentation, etc.” (Tr. 80). He “bec[a]me very dizzy at times – hard to perform duties.” (Tr. 80).

Davies completed a “Chest Pain Questionnaire,” in which he stated that he has trouble handling stress. He stated:

I get real upset and have anxiety or panic attacks. I don't have the strength or drive anymore to push myself. I get dizzy and short of breath a lot. I forget simple things. I can't stay on task with project[s], and the heat just takes away all my strength. I can't sleep and have a lot of nightmares. I'm very tired all the time. I just don't have the drive I used to. And I worry a lot about my finances. I used to be a very resourceful business and working person. Now I do good just to . . . help around the house. And get thru the day. Or just to have a good day. Or get a good night's sleep.

(Tr. 107).

Davies submitted a Daily Activities Questionnaire on August 6, 2002. He wrote that he has a lot of difficulty sleeping. “I have nightmares, cannot sleep all thru the night.” (Tr. 108). He wrote that he does not have the stamina he used to. He sometimes does the grocery shopping but has problems standing for long periods of time and gets dizzy and light-headed. He also has “panic attacks while in situations I don't feel comfortable with.” (Tr. 110).

In terms of interests and hobbies, he wrote that he does crafts and art. He watches a lot of television, but forgets a lot. He wrote that he helps take care of his dog.

He visits friends and relatives “a little, not a lot.” (Tr. 111). He has difficulty going out in public because he “get[s] upset and tense around people, which causes my

panic attacks.” (Tr. 111). He does not participate in group activities such as church or sports. He indicated that it bothers him a lot when people point out his mistakes.

He wrote that he has a lot of trouble concentrating and remembering. “When I was working I forgot daily task[s] that I used to be very good at.” (Tr. 112). He reads newspapers and magazines but has trouble remembering what he reads. At times, he forgets to take his medications.

Changes bother him – “[they] cause[] me to get upset, and brings on my panic attacks.” (Tr. 112). He has trouble completing tasks and chores. “Cannot remember or stay focused.” (Tr. 112). His girlfriend manages the money. “I just can’t do simple task[s] like I could befor[e]. I get to[o] stressed.” (Tr. 112).

C. Third-Party Statements

On July 31, 2002, Davies’s girlfriend, Wendy Griger, submitted a third-party report. She indicated that Davies regularly bathes, dresses, shaves, and maintains his hair. Griger wrote that Davies’s sleeping habits had changed. He “has nightmares from time to time” and his “sleep definitely has been disrupted.” (Tr. 101). He “has trouble falling asleep” and “awakens frequently.” (Tr. 101).

In terms of household chores, Davies regularly takes out the trash, washes the car, and mows the lawn. However, he has trouble completing chores because he “does not have the stamina he had before his surgery.” (Tr. 102). He “tires easily, at times experiences chest pain or becomes light headed during or after chores.” (Tr. 104). He cannot tolerate the heat as he used to.

Griger wrote that Davies does drive but often needs help finding his way around unfamiliar areas. He also needs reminders “from time to time” to take his medications.

In terms of his interests, Davies “[w]orks on crafts, usually 2-3 times [per] week.” (Tr. 103). He also “[e]njoys spending time with his dog.” (Tr. 103). She wrote that he likes to watch sci-fi television programs and will sometimes rent movies. However, he

will often forget the movie they watched. He also reads magazines but has difficulty remembering the content.

Regarding his social functioning, Griger wrote that he rarely sees relatives. He visits with friends about once per week. He sometimes goes out in public but “[w]orries about crowds, or becoming dizzy, having panic attacks.” (Tr. 103). She also wrote that he does not have much patience, he is “quicker to snap.” (Tr. 103). He does not participate in family gatherings, sports, church, clubs or other social activities and rarely gets involved socially. He does not respond well to criticism. He “[w]orries more now what others think of him – feels inadequate.” (Tr. 103).

Griger indicated that he has “a lot” of problems concentrating and remembering. (Tr. 104). He becomes frustrated with change and, at times, will have panic attacks. Under stress, Griger wrote that Davies is “[q]uick to snap” and becomes angry and lashes out. He will experience shortness of breath and chest pain in such situations.

Davies sometimes has trouble completing a task or chore and often has trouble following directions. Griger gave the example of when she thrice instructed Davies to put extra postage on a letter but he mailed the letter without the extra postage. She wrote that he is unable to handle the finances and bills because he gets too frustrated.

Griger wrote that Davies is “[u]nable to do things as before – he’ll become angry or depressed.” (Tr. 104). He has “low stamina, requires help with simple tasks – unable to lift, etc. . . . At times, has ‘passed out,’ experiences panic attacks.” (Tr. 104). She wrote that he also takes more naps now and “never took naps before.” (Tr. 104).

D. Residual Functional Capacity

On September 26, 2002, Dr. Dee Wright, Ph.D., completed a Psychiatric Review Technique Form (“PRTF”), which was reviewed by Dr. David G. Beeman, Ph.D. Dr. Wright concluded that Davies had a 12.06 anxiety-related disorder. Dr. Wright found that Davies had mild restrictions in his daily activities, moderate difficulties with social

functioning, moderate difficulties maintaining concentration, persistence or pace, and no episodes of decompensation. There was no evidence of a “C” criteria. In affirming Dr. Wright’s PRTF, Dr. Beeman wrote, “It is further noted that the subsequent record indicates that as the claimant reduced his substance intake it was determined that PTSD symptoms are subthreshold.” (Tr. 270).

Dr. Wright also completed a Residual Functional Capacity report on September 26, 2002. She indicated that Davies’s memory and understanding were not significantly limited, nor was he significantly limited in most categories of sustained concentration and persistence. Dr. Wright found that Davies was moderately limited in his ability to: (1) carry out detailed instructions; (2) maintain attention and concentration for extended periods; (3) work in coordination with or proximity to others without being distracted by them; (4) complete a normal workday and workweek without interruptions from psychologically based symptoms; and (5) perform at a consistent pace without an unreasonable number and length of rest periods. Dr. Wright found few restrictions with social interactions, except that he would be moderately limited in his ability to get along with coworkers or peers without distracting them or exhibiting behavioral extremes. He would also have moderate difficulty in responding appropriately to changes in the work setting.

In her narrative statements, Dr. Wright wrote,

[T]he preponderance of the evidence in the file would currently support moderate restrictions of function cognitively in this claimant’s case. He has been exhibiting variable sustained attention and concentration when he is stressed. During these times, the claimant would have difficulty performing any complex cognitive activity that would require prolonged attention to minute details in rapid shifts and alternating attention. Despite these restrictions, the claimant is currently able to sustain sufficient concentration and attention to perform non-complex, repetitive, and routine cognitive activity when it

is in his interest to do so. By history, the claimant has exhibited some difficulties interacting with others when unduly stressed. At the present time, his condition appears to be stable when he can sustain short-lived, superficial interactions with others in appropriate ways when it is necessary to do so.

(Tr. 333-34). Dr. Wright did not find that Davies had any severe limitations in his daily living functions. She wrote that he does have a medically determinable impairment, adjustment disorder with depression/anxiety. She diagnosed Davies with alcohol dependence. She wrote that a PTSD assessment was still pending.

On October 23, 2002, Dr. H. Richard Hornberger completed another Residual Functional Capacity Assessment which was reviewed and accepted by Dr. Gary J. Cromer, M.D. He found that Davies could occasionally lift fifty pounds, frequently lift twenty-five pounds, stand and/or walk about six hours in an eight-hour day, sit for a total of six hours in an eight-hour day, push and/or pull an unlimited amount. Dr. Hornberger found no postural, manipulative, communicative or visual limitations.

On May 10, 2004, Dr. Thomas Svolos completed a Mental Residual Functional Capacity assessment. In a checklist questionnaire, Dr. Svolos wrote that Davies had marked limitations in (1) his ability to deal with work stress; (2) his ability to complete a work week without interruptions due to psychologically based symptoms, (3) his ability to interact appropriately with the general public; and (4) maintaining concentration, persistence, or pace resulting in failure to complete tasks in a timely manner. Davies would be moderately limited in his ability to “perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances.” (Tr. 444). Davies would also be moderately limited in his ability to get along with co-workers or peers without distracting them or exhibiting behavioral extremes. Davies would not be significantly limited in his ability to accept instructions and respond appropriately to criticism from supervisors or co-workers. He also indicated that marginal adjustments in

mental demands or environment, would cause decompensation.

In a checklist form about his symptoms, Dr. Svolos indicated that he had symptoms of “generalized persistent anxiety accompanied by . . . motor tension . . . autonomic hyperactivity . . . apprehensive expectation.” (Tr. 446). He also indicated that Davies had a “persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity, or situation.” (Tr. 446). He also checked “[r]ecurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week.” (Tr. 446).

E. Hearing Testimony

ALJ Peter Belli held Davies’s hearing on May 18, 2004. At the time of the hearing, Davies was forty-six years old. He was represented by a non-attorney representative, Robert Johnson. Johnson asked the court to amend the onset date from August 21, 2001 to April 12, 2002.

Davies completed tenth grade, received his GED, and attended some college through the military. He was on active duty in the military for fifteen years and in the National Guard for two years.

Davies said he suffered from several medical problems, including panic attacks, high blood pressure, cholesterol, heart disease and short-term memory loss. He had quadruple bypass surgery in August of 2001. Due to a lack of evidence in the record, the ALJ ordered that he get a psychological evaluation with a full battery of tests. ALJ Belli recessed the hearing so that Davies could get the evaluation.

A second hearing was held in front of ALJ Richard Mueller on November 18, 2004. Davies was again represented by Robert Johnson. Vocational Expert (“VE”) George Myers testified.

Davies first testified about his employment history. He most recently worked at Nichener Productions, an agency that provides services to mentally handicapped individuals. Davies was a residential counselor at the facility. He worked overnight shifts, ensuring the residents' safety during the night. In the mornings, he dressed, fed and gave them medications. He said that on two occasions, he made mistakes with clients' medications. Davies quit the job after the company told him that they intended to terminate him.

Before his job at Nichener Productions, Davies worked at a window factory, assembling windows on an assembly line. He said the job involved a lot of lifting, anywhere between 5 and 100 pounds.

Prior to his job at the window factory, he worked at the Eveready Battery Plant on the battery recovery line. It involved "constantly standing on an assembly line, assembling batteries and putting batteries, Eveready Batteries together." (Tr. 489). The batteries, in their case, weighed between 40 and 75 pounds.

Davies also previously worked as an illustrator. He received two years of commercial training in illustrations while working in the military. He described it as an "office job," where he primarily sat all day without much exertional work.

Davies was in the military from 1978 to 1993, followed by two or three years in the National Guard. He holds eight military specialties and his highest rank was staff sergeant. He left the army to take care of his son who had multiple heart problems and his wife who had a stroke that left her paralyzed on the left side.

Davies then described the event that triggered his alleged disability onset. On August 22, 2001, he had a four-way open-heart bypass surgery. After the surgery, he was ordered to adopt a healthier diet and to limit how much he lifts. He testified that, at the time of the hearing, he could comfortably lift 35 to 40 pounds. His heart condition also caused him to tire more easily. He said he does not think that he would be comfortable

standing for more than a hour-and-a-half at a time. He estimated that in an eight-hour day, he could only be on his feet for a total of three to four hours.

He also described a mental change after his surgery. “Before I was a very strong person.” (Tr. 492). He described being raised in a military household and the mind-set it instilled.

[T]he word can’t was not in my vocabulary. And now, I, I’m, I’m a bowl of jelly. . . . I can’t concentrate and I, I feel like I want to cry all the time. . . . I have panic attacks and crowds scare me. . . . I’m scared to even go to the grocery store some of the time.

(Tr. 492-93).

Davies testified that he was receiving treatment in the post traumatic stress syndrome program at the VA every other week. He is treated by Dr. Svolos. He said that he sometimes misses appointments. “[T]here’s some days I just – I can’t even make it out of the house to, to get there.” He estimates that he has missed one or two out of five appointments.

Davies started having nightmares after the operation. He said that at first, he thought the nightmares were due to the strong medication he was on. “I los[t] a lot of sleep because I’m scared to go to sleep. Most of my nightmares are from, from the service. . . . [A] normal person has civilian dreams. I, I’m always in, in – still in the service.” (Tr. 494). In April 2002, he said he quit his job at Nichener Productions because of the anxiety.

Davies takes medications to deal with his anxiety and depression. He has been on Zoloft, Paxil, and Celexa. He had various side effects with each medication. He said he takes about seven pills per day. In addition to the depression/anxiety medication, he takes medication for his heart, cholesterol, blood pressure, and esophageal problems. Davies said the medications “cause a lot of drowsiness and I’m just tired all the time.” (Tr. 499).

He said that the drowsiness affects his ability to remember things. He said that he is “constantly sleepy all the time. But when I try to sleep, the nightmares comes. So it’s a constant battle.” (Tr. 499). The Paxil and Celexa also cause sexual side-effects.

He said his sleep is interrupted and not constant. “I might stay asleep for about an hour and then have a nightmare and wake up. And I’m up for two or three hours. And then I might get sleepy and go back to sleep again. And sleep for 45 minutes. Have a nightmare and be back up for another hour or two.” (Tr. 500).

Davies said he also experiences panic attacks. He described the attacks: “It’s, it’s like you get short of breath, and then it – then you get – start getting lightheaded. And I get real shaky. And, and then things start getting dizzy. And if I don’t catch it, if I don’t see it coming, a lot of times I’ll pass out. I’ll just fall completely out.” (Tr. 500). He said he has panic attacks when “the kids mess up the house, or if somebody upsets me.” (Tr. 501). He said it happens more in public and is the worst when he gets mad. He described a “good week” as having two bad panic attacks and five or six short ones, whereas a bad week will be three or four bad panic attacks. “[U]sually with those, I end up passing out on the floor and falling on something, or breaking something, or injuring myself” (Tr. 502).

He also suffered from depression. “I know I’m a constant mess . . . I used to be so much in control.” (Tr. 502). He described immense difficulties with motivation and a lack of concentration.

The VE then testified. He first classified his past work. The ALJ posed a hypothetical. He asked the VE to assume Davies’s education and work background and then to add on a limitation of light work. The VE testified that he could be an illustrator as well as an assembler, but would be unable to work as a retardation aide, handyman or soldier.

The ALJ then asked,

Assume that he is physically limited to the performance of light work but that he's [also] limited to simple routine tasks. And little contact with others at the work site. And no public contact. Would there be jobs with those limitations for which he would be occupationally suited?

(Tr. 510). The VE responded that he could do unskilled, assembly-type work. There would be 57,000 of those jobs in the state of Iowa and 490,000 jobs in the national economy.

The ALJ next asked,

[A]ssume that I would find that his ability to deal with work stress would be markedly limited. That his ability to complete a normal work day [is] markedly – would be markedly limited. And that his ability to perform activities within a schedule, maintain regular attendance, . . . become punctual, and that his ability to get along with peers was moderately limited. Would there be any jobs existing in the national economy for which he would be suited?

(Tr. 511). The VE responded that there would not be jobs with those limitations.

The ALJ then asked the VE to assume that Davies's complaints were supported by the medical evidence, "particularly relative to concentration, panic, attacks." (Tr. 512). He asked if those conditions did exist, whether there would be any jobs in the national economy that Davies could do. The VE testified that there would not be any jobs Davies could do with those limitations.

III. CONCLUSIONS OF LAW

A. Scope of Review

In order for the court to affirm the ALJ's findings of fact, those findings must be supported by substantial evidence appearing in the record as a whole. See Baker v. Barnhart, 457 F.3d 882, 892 (8th Cir. 2006). "Substantial evidence is less than a

preponderance, but is enough that a reasonable mind would find it adequate to support the Commissioner's conclusion.” McKinney v. Apfel, 228 F.3d 860, 863 (8th Cir. 2000). The court must take into account evidence that fairly detracts from the ALJ’s findings, as well as evidence that supports it. Id. (citing Craig v. Apfel, 212 F.3d 433, 436 (8th Cir. 2000)). The court must consider the weight of the evidence appearing in the record and apply a balancing test to contradictory evidence. Gunnels v. Bowen, 867 F.2d 1121, 1124 (8th Cir. 1989); Gavin v. Heckler, 811 F.2d 1195, 1199 (8th Cir. 1987).

B. ALJ’s Disability Determination

Determining whether a claimant is disabled involves a five-step evaluation. See 20 C.F.R. § 404.1520(a)–(f); Bowen v. Yuckert, 482 U.S. 137, 140 (1987).

The five steps are:

- (1) If the claimant is engaged in substantial gainful activity, disability benefits are denied.
- (2) If the claimant is not engaged in substantial gainful activity, her medical condition is evaluated to determine whether her impairment, or combination of impairments, is medically severe. If the impairment is not severe, benefits are denied.
- (3) If the impairment is severe, it is compared with the listed impairments the Secretary acknowledges as precluding substantial gainful activity. If the impairment is equivalent to one of the listed impairments, the claimant is disabled.
- (4) If there is no conclusive determination of severe impairment, then the Secretary determines whether the claimant is prevented from performing the work she performed in the past. If the claimant is able to perform her previous work, she is not disabled.
- (5) If the claimant cannot do her previous work, the Secretary must determine whether she is able to

perform other work in the national economy given her age, education, and work experience.

Trenary v. Bowen, 898 F.2d 1361, 1364 n.3 (8th Cir. 1990) (citing Yuckert, 482 U.S. at 140–42); 20 C.F.R. § 404.1520(a)–(f).

“To establish a disability claim, the claimant bears the initial burden of proof to show that he is unable to perform his past relevant work.” Frankl v. Shalala, 47 F.3d 935, 937 (8th Cir. 1995) (citing Reed v. Sullivan, 988 F.2d 812, 815 (8th Cir. 1993)). If the claimant meets this burden, the burden of proof then shifts to the Commissioner to demonstrate that the claimant retains the physical residual functional capacity (RFC) to perform a significant number of other jobs in the national economy that are consistent with the claimant’s impairments and vocational factors such as age, education and work experience. Id.

At the first step, the ALJ found that Davies had not engaged in substantial gainful activity since his alleged onset date. At the second step, the ALJ determined that Davies had two severe impairments, being anxiety/depression and coronary artery disease. At the third step, the ALJ determined that Davies’s impairments did not meet or equal one of the listed impairments. At the fourth step, the ALJ determined that Davies could perform light, exertional, unskilled work “with pushing, pulling, lifting, and/or carrying up to 20 pounds occasionally and up to 10 pounds frequently; sitting, standing, and/or walking about six hours each during an eight-hour workday based on his heart condition.” The ALJ also limited Davies to simple, routine tasks that involved little contact with co-workers and no contact with the public. Based on these limitations, he found that Davies could not perform any of his past work. The ALJ found, however, that there were other jobs in the national economy that he could perform. He could be an assembly worker, a production inspector, or a packaging/machine operator. Having found jobs in the national economy that Davies could perform, the ALJ concluded that he was not disabled.

C. Weight of the Medical Evidence

Davies argues that the ALJ improperly weighed the medical evidence. He argues that the ALJ disregarded the treating physicians' opinions while giving undue weight to non-treating doctors. Further, Davies argues that the ALJ drew his own medical conclusions when he determined that Davies does not suffer panic attacks. The Commissioner counters that the ALJ gave clear reasons for the weight he assigned each doctor's opinion and those reasons were consistent with the Social Security regulations.

Whether the ALJ gives great or small weight to the opinions of treating physicians, the ALJ must give good reasons for giving the opinions that weight. See Holmstrom v. Massanari, 270 F.3d 715, 720 (8th Cir. 2001); 20 C.F.R. § 404.1527(d)(2). The Eighth Circuit of Appeals has stated,

A treating physician's opinion should not ordinarily be disregarded and is entitled to substantial weight. A treating physician's opinion regarding an applicant's impairment will be granted controlling weight, provided the opinion is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the record.

Singh v. Apfel, 222 F.3d 448, 452 (8th Cir. 2000) (citation omitted).

"The ALJ may discount or disregard [a treating] opinion if other medical assessments are supported by superior medical evidence, or if the treating physician has offered inconsistent opinions." Hogan v. Apfel, 239 F.3d 958, 961 (8th Cir. 2001). Moreover, a treating physician's opinion does not deserve controlling weight when it is nothing more than a conclusory statement. Piepgras v. Chater, 76 F.3d 223, 236 (8th Cir. 1996); see also Thomas v. Sullivan, 928 F.2d 255, 259 (8th Cir. 1991) (holding that the weight given a treating physician's opinion is limited if the opinion consists only of conclusory statements).

In weighing opinions of non-treating medical sources, the ALJ should consider the following factors: (1) the examining relationship; (2) the treating relationship; (3) supportability; (4) consistency; (5) specialization; and (6) “any factors you or others bring to our attention, or of which we are aware, which tend to support or contradict the opinion.” 20 C.F.R. 404.1527(d) (2007); see also Wagner v. Astrue, 499 F.3d 842, 848 (8th Cir. 2007) (discussing how to weigh physician and psychiatrist opinions).

First, Davies argues that the ALJ erred when he found that Dr. Wright’s assessment the “most credible.” (Tr. 31). Dr. Wright is a non-treating agency physician. While the court recognizes that treating physician opinions should be given great weight, the ALJ gave good reasons for favoring Dr. Wright’s opinion over Davies’s treating physicians, specifically, Dr. Couse, Dr. Svolos, and Dr. Moulton.

The ALJ did not find Dr. Couse’s August 28, 2002, evaluation of Davies “entirely credible” for several reasons. First, he found the sole purpose of the August 28 appointment was to receive an evaluation for his disability case. The ALJ noted that Davies complained of back and neck pain, but there was no medical evidence to support those complaints. The ALJ also found that Dr. Couse overly relied on the “claimant’s reported impairments and limitations in making his opinion.” (Tr. 30). Last, the ALJ gave “minimal weight to the claimant’s effort during this examination. He appears to have been exaggerating his limitations.” (Tr. 30). The court also notes that the ALJ was not discrediting all of Dr. Couse’s opinions and treatment notes, only the assessment conducted on August 28, 2002, for the purpose of disability.

Davies next complains that, while the ALJ gave Dr. Moulton’s first opinion “great weight,” he gave “no weight” to his second opinion. The ALJ gave clear reasons why he did not credit Dr. Moulton’s second opinion. The ALJ stated,

[Dr. Moulton’s second opinion is] not supported by the medical evidence and is not reflective of the claimant’s overall

condition since April 2002. Further, it is a simple yes/no form submitted by the claimant's counsel and is not supported by Dr. Moulton's own assessment made several months before. It appears to be merely a guess on Dr. Moulton's part. The doctor opined that he was not the best medical profession[al] to make this assessment. The undersigned agrees. Therefore, the undersigned does not find Dr. Moulton's opinion in exhibit 18F credible.

(Tr. 32-33). If a physician's opinion is inconsistent with other medical evidence, it is entitled to less weight. Flynn v. Astrue, 513 F.3d 788, 792 (8th Cir. 2008). Here, Dr. Moulton's opinion is not only inconsistent with other medical evidence in the record, but Dr. Moulton's findings are inconsistent with his own previous opinion. See Anderson v. Barnhart, 344 F.3d 809, 813 (8th Cir. 2003) (discrediting an opinion because internally inconsistent). The court also notes that Dr. Moulton, himself, thought he was not the best person to give an opinion about Davies's limitation.

Next, Davies contests the weight given to Dr. Svolos's opinion. Of Dr. Svolos's opinion, the ALJ wrote,

The undersigned gives Dr. Svolos' assessment little weight for several reasons. (Ex. 16F). First, Dr. Svolos saw the claimant two times (December 2003 and January 2004) before making this assessment. The undersigned finds that he is an examining physician, as the claimant did not have an ongoing treatment relationship with him. (20 CFR 404.1502 and 416.902). Second, in the initial consultation on December 2003, Dr. Svolos made tentative diagnoses such as generalized anxiety disorder, possible organic cognitive disorder, possible mild PTSD and possible mood disorder indicating Dr. Svolos was not sure what was the claimant's diagnoses. Third, Dr. Svolos relied solely on the claimant's self-reports and did not check additional medical records. The claimant reported panic attacks every couple of days and agoraphobia that kept him from many personal interactions. Yet, the medical evidence does not show that he has ever had a panic attack in all the

examination[s] he has had with numerous doctors and medical personal [sic] since April 2002. Additionally, Dr. Svolos' own observations were that the claimant was 'initially somewhat guarded,' but the claimant was cooperative, his thoughts were organized, and he was alert and oriented. While Dr. Svolos noted that the claimant appeared anxious, he did not observe any panic attacks, blackouts, or tremors as the claimant reported he experienced. The claimant's panic attacks seem to be non-existent in the treatment reports.

(Tr. 31). The weight the ALJ gave Svolos's opinion was appropriate and followed the factors discussed in the SSA regulations. He considered the frequency of treatment, the examining relationship, and whether Dr. Svolos's opinion was supported by the medical record. See 20 C.F.R. § 404.1527(d)(1)-(3). The court finds no error or lack of evidence for the reasons the ALJ gave Dr. Svolos's opinion little weight.

Davies also contends that Dr. Svolos was a "treating physician" and not an "examining physician" as the ALJ indicated. The regulations define a treating source:

Treating source means your own physician, psychologist, or other acceptable medical source who provides you, or has provided you, with medical treatment or evaluation and who has, or has had, an *ongoing treatment relationship* with you. . . . [A]n ongoing treatment relationship [is] when the medical evidence establishes that you see, or have seen, the source with a frequency consistent with accepted medical practice for the type of treatment and/or evaluation required for your medical condition(s).

20 C.F.R. § 416.902 (emphasis added). Regarding treatment of Davies's conditions – anxiety and depression – he has failed to present evidence to show that only two treatment sessions is the accepted medical practice for treatment of anxiety and depression. Nor is there evidence in the record that Dr. Svolos treated Davies on more than two occasions. For these reasons, the court refuses to disturb the ALJ's conclusion that Dr. Svolos's was an "examining physician" rather than a "treating physician."

Last, Davies argues that the ALJ drew his own medical conclusion about whether Davies suffers panic attacks. The court disagrees. Instead of drawing his own conclusions, he relies on the opinion of Dr. Wright, whose opinion he found “most credible.” (Tr. 31). “Dr. Wright indicated that there was no treatment record supporting the claimant’s assertions that when he becomes socially upset, it triggers a panic attack. The undersigned notes that this has been true throughout the medical record.” (Tr. 31). The court finds that substantial evidence supports this conclusion.

D. Credibility

Davies next argues that the ALJ’s credibility finding is inconsistent, confusing, and unsupported by substantial evidence. Devoting several paragraphs to the issue of credibility, the ALJ made the following findings relating to credibility:

- (1) Davies’s “encounters with doctors appear to be linked primarily to his quest to obtain benefits (either from the Veteran’s Administration or the Social Security Administration), rather than [to] obtain medical treatment”;
- (2) Davies has “refused mental health treatment such as counseling and has not been compl[ia]nt with his treating physicians’ treatment plans and prescribed medication.”
- (3) “He has never been objectively tested for cognitive problems that might support his claim of memory problems.”
- (4) Davies has been able to maintain activities of daily living, including a “long-term relationship with his girlfriend, shop[ping], tak[ing] care of his personal needs, and clean[ing] his house”;
- (5) Davies’s panic attacks had not been witnessed by others nor had he “presented to an emergency room with panic attacks”; and
- (6) He has “refused alcohol treatment even though it was strongly suggested by his treating sources that he needed [it].”

(Tr. 33).

When evaluating the credibility of a claimant’s subjective complaints, the ALJ may not disregard them “solely because the objective medical evidence does not fully support

them.” Polaski v. Heckler, 739 F.2d 1320, 1322 (8th Cir. 1984). “The [ALJ] is not free to accept or reject the claimant's subjective complaints solely on the basis of personal observations. Subjective complaints may be discounted if there are inconsistencies in the evidence as a whole.” Id. In evaluating a claimant’s subjective impairment, the following factors are considered: (1) the applicant’s daily activities; (2) the duration, frequency and intensity of pain; (3) precipitating and aggravating factors; (4) dosage, effectiveness and side effects of medication; and (5) functional restrictions. Id. at 1321-22. Where an ALJ seriously considers but for good reasons explicitly discredits a plaintiff’s subjective complaints, the court will not disturb the ALJ’s credibility determination. Johnson v. Apfel, 240 F.3d 1145, 1147 (8th Cir. 2001). “The credibility of a claimant’s subjective testimony is primarily for the ALJ to decide, not the courts.” Pearsall v. Massanari, 274 F.3d 1211, 1218 (8th Cir. 2001).

Here, the court will not disturb the ALJ’s credibility finding. There is substantial evidence in the record to support the ALJ’s findings regarding credibility and the factors he considered are consistent with SSA regulations. The record demonstrates at least three instances where Davies did not show up for appointments. He also resisted alcohol treatment and started and stopped his medications. See Guilliams v. Barnhart, 393 F.3d 798, 802 (8th Cir. 2005) (“A failure to follow a recommended course of treatment also weighs against a claimant’s credibility.”). There is also evidence in the record to support the ALJ’s finding that he was still able to engage in activities of daily living. In Davies’s live-in girlfriend’s statement, she indicated that he does chores around their home, including taking out the trash, washing the car, and mowing the lawn, albeit with more difficulty than before his surgery in August 2001. She also indicated, as did Davies in his Daily Activities Report, that Davies still engages in hobbies of creating arts and crafts. See Wagner v. Astrue, 499 F.3d 842, 851 (8th Cir. 2007) (an ALJ should give consideration to daily activities when evaluating credibility). Last, while the medical

evidence demonstrates that Davies has issues relating to anxiety and depression, there is little objective evidence aside from Davies's own complaints to support a claim that he suffers from panic attacks. The court finds that the ALJ properly considered the Polaski factors and his credibility finding was supported by substantial evidence.

E. Residual Functional Capacity

Davies argues that the ALJ's residual functional capacity assessment was not supported by substantial evidence. Specifically, Davies contends that the RFC does not reflect his problems with panic attacks, difficulty sustaining a competitive pace, and the side-effects of his medications.

The residual functional capacity is "the most you can still do despite your limitations." 20 C.F.R. § 404.1545 (quoting 20 CFR 2). Determining a claimant's residual functional capacity is a medical question. Lauer v. Apfel, 245 F.3d 700 (8th Cir. 2001); Singh v. Apfel, 222 F.3d 448, 451 (8th Cir. 2000). "The Commissioner must determine a claimant's RFC based on all of the relevant evidence, including the medical records, observations of treating physicians and others, and an individual's own description of [his] limitations." McKinney v. Apfel, 228 F.3d 860, 863 (8th Cir. 2000); 20 CFR § 404.1545 ("We will assess your residual functional capacity based on all the relevant evidence in your case record."). However, the record "must include some medical evidence that supports the ALJ's residual functional capacity finding." Dykes v. Apfel, 223 F.3d 865, 867 (8th Cir. 2000) (citing Anderson v. Shalala, 51 F.3d 777, 779 (8th Cir. 1995)); see also Lauer, 245 F.3d at 704 (noting that while the ALJ was not "limited to considering medical evidence," the ALJ was "required to consider at least some supporting evidence from a professional"). "The opinions of doctors who have not examined the claimant ordinarily do not constitute substantial evidence on the record as a whole." Nevland v. Apfel, 204 F.3d 853, 858 (8th Cir. 2000).

The ALJ made the following finding RFC finding:

Based on the evidence in its entirety, the undersigned finds that the claimant has the residual functional capacity to perform light exertional work-related activities with pushing, pulling, lifting, and/or carrying up to 20 pounds occasionally and up to 10 pounds frequently; sitting, standing, and/or walking about six hours each during an eight-hour workday based on his heart condition. He is able to perform unskilled work with simple routine tasks, little contact with others at the worksite, and no public contact based on his mental impairments.

(Tr. 34).

Davies's first complaint is that the RFC does not reflect his panic attacks. As discussed above in Part II.D, the ALJ appropriately found that his complaints of panic attacks are not credible. The RFC need not include limitations that the ALJ did not find credible. See Tindell v. Barnhart, 444 F.3d 1002, 1007 (8th Cir. 2006) (including only "Tindell's credible limitations in his RFC assessment"). However, the court notes that the RFC includes a social limitation – Davies should have "little contact" with co-workers and no contact with the public. According to Davies's own testimony, his panic symptoms are brought on when is around other people, especially large crowds. While the ALJ found his attestations of panic attacks incredible, he nevertheless limited contact with co-workers and public so as to not exacerbate his alleged panic symptoms.

Next, he argues that the RFC does not reflect his potential level of absenteeism. In support of this argument, he points to two medical sources, Drs. Moulton and Svolos, who have opined that Davies is neither able to complete a normal workday nor week. In a checklist questionnaire, Dr. Svolos checked the line next to "markedly limited" in response to the question about whether Davies would be able to complete a normal workday and workweek "without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods." (Tr. 443). Dr. Moulton opined that he would work at a slower pace. He

checked the line next to the question whether Davies would “occasionally work[] at a pace slower than an average unimpaired worker (up to 1/3 of the day).” As discussed in Part II.C, the ALJ appropriately gave little weight to both opinions. Dr. Moulton’s evaluation was inconsistent with his previous, more thorough evaluation. He also considered the fact that Dr. Moulton himself acknowledged that he was “not the best medical profession[al] to make this assessment.” (Tr. 33). As for Dr. Svolos, he gave his opinion little weight because at the time of his report, Dr. Svolos had only treated Davies twice and his conclusions were inconsistent with other medical evidence in the record. For the reasons stated above, the court will not disturb the ALJ’s RFC finding on the issue of absenteeism and pace.

Davies also argues that the RFC does not reflect the limitations associated with the side-effects from his medications. Reviewing his treatment record, the court finds that the only ongoing, major side-effect reflected in the medical record is a sexual side-effect. However, Davies contends that the RFC should have reflected a side-effect of drowsiness. While Davies frequently complained of tiredness, only one treatment note linked it to his medication. During an appointment with Dr. Svolos on January 20, 2004, Davies complained that the Remeron was “extremely sedating.” (Tr. 417). Accordingly, Dr. Svolos switched his medication from Remeron to Zoloft to address the sedation side-effect. There are no treatment notes following the medication change to discuss whether the new medication reduced the drowsiness. In sum, there was one treatment note discussing tiredness as a side-effect, which his doctor tried to address by adjusting his medication. Davies now claims that it was error to not include this limitation in his RFC. One treatment note is insufficient to reverse the ALJ’s RFC finding.

F. Hypothetical

Davies’s last argument is based on his previous arguments. He argues that the hypothetical presented to the VE failed to account for the side-effects of Davies’s

medication, his slow pace, and his panic attacks. The VE's testimony, therefore, is not based on substantial evidence.

For the reasons discussed in the preceding sections, this argument also fails. A hypothetical need not include impairments that the ALJ found were not credible. See Guilliams v. Barnhart, 393 F.3d 798, 804 (8th Cir. 2005) ("Discredited complaints of pain, however, are properly excluded from a hypothetical question so long as the ALJ had reason to discredit them."); Haynes v. Shalala, 26 F.3d 812, 815 (8th Cir. 1994) ("A hypothetical question need only include those impairments that the ALJ accepts as true.")

Upon the foregoing,

IT IS ORDERED that the decision of the Commissioner of Social Security is hereby affirmed. This matter is dismissed. The Clerk of Court shall enter judgment accordingly.

DATED this 23rd day of September, 2008.



JOHN A. JARVEY
UNITED STATES DISTRICT JUDGE
SOUTHERN DISTRICT OF IOWA