

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

CONSTANCE S. DEDERICH,

Plaintiff,

v.

LARRY G. MASSANARI¹, Acting Commissioner
of Social Security,

Defendant.

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3-00-CV-90234,

ORDER

Plaintiff, Constance S. Dederich, filed a Complaint in this Court on December 19, 2000, seeking review of the Commissioner's decision to deny her claim for Social Security benefits under Title II and Title XVI of the Social Security Act, 42 U.S.C. §§ 401 *et seq.* and 1381 *et seq.* This Court may review a final decision by the Commissioner. 42 U.S.C. § 405(g). For the reasons set out herein, the decision of the Commissioner is affirmed.

BACKGROUND

Plaintiff filed applications for Social Security Disability Benefits on November 2, 1998, claiming to be disabled since February 11, 1994. Tr. at 91-93 & 239-42. After the applications were denied, initially and on reconsideration, Plaintiff requested a hearing before an Administrative Law Judge. A hearing was held before Administrative Law Judge J. Michael

¹Larry G. Massanari became the Acting Commissioner of Social Security on March 29, 2001. Pursuant to Rule 25(d)(1) of the Federal Rules of Civil Procedure [Rule 43(c)(2) of the Federal Rules of Appellate Procedure], Larry G. Massanari should be substituted, therefore, for Commissioner Kenneth S. Apfel, or for Acting Commissioner William A. Halter as the defendant in this suit. No further action need be taken to continue this suit by reason of the last sentence of section 205(g) of the Social Security Act, 42 U.S.C. § 405(g).

Johnson (ALJ) on March 1, 2000. Tr. at 41-72. The ALJ issued a Notice Of Decision – Unfavorable on April 26, 2000. Tr. at 10-30. After the decision was affirmed by the Appeals Council on October 21, 2000, (Tr. at 5-7), Plaintiff filed a Complaint in this Court on December 19, 2000.

MEDICAL RECORDS BEFORE THE ALJ

In July of 1998, while in Florida, Plaintiff fell while she was walking in a parking lot. When she saw Adriana Gioia, M.D. on July 10, 1998, Plaintiff complained of pain in her left hand, right shoulder and right knee. Plaintiff was noted to be a poor historian. It was also noted that because of Prednisone, which Plaintiff was taking for asthma, she had a high tolerance for pain. Plaintiff's past medical history included Asthma, anxiety, and status post duodenal ulcers. Tr. at 177. After a physical examination (Tr. 177-78), Dr. Gioia's assessment was: Right knee effusion, abrasion, and contusion; right arm pain; and, left hand contusion and pain. No fracture of the humerus. Plaintiff was given a padded thumb spike and advised to wear a sling. She was also given a prescription for Flexeril and one for Vicodin which Plaintiff said she would not need. Tr. at 178. Plaintiff saw Dr. Gioia again on July 13, 1998, at which time she was still complaining of pain in her left hand and wrist. Dr. Gioia wrote that it was difficult to tell if Plaintiff's pain was due to radiculopathy from her neck. X-ray reports were all negative except for an old fracture or small ossicle distal ulnar styloid, and there was evidence of disk degeneration at C5-6 and spondylosis at C5-6. Degenerative disk narrowing was also seen at C3-4. Dr. Gioia's assessment was left wrist musculoskeletal sprain, contusion left wrist and cervical musculoskeletal pain with radiating symptoms.

Plaintiff underwent an evaluation at Quad City Neurosurgical Associates on August 12,

1998. Tr. at 1182-85. Plaintiff had been referred to Dr. Piper for the evaluation by Dr. Crowley. Plaintiff complained of pain in her left upper anterior arm and pain in her left thumb into her wrist area. Plaintiff said that she awakens at night with numbness in the left hand, but that she did not experience that during the day. Asthma was listed as an active medical problem for which she was taking Prednisone, Proventil inhaler, Singulair, Azmacort, Valium, and Serevent inhaler. It was noted that Plaintiff smoked 10 cigarettes per day and had done so for the previous eight years. Tr. at 185. After Dr. Piper's neurological examination (Tr. at 183), the doctor recommended an MRI scan and an EMG, however Plaintiff was "not really enthusiastic about being aggressive at this point in time and requested to be sent to the Pain Clinic for acupuncture." Tr. at 184.

Plaintiff was seen for an examination by Thomas J. Hughes, M.D., at the request of Disability Determination Services, on January 8, 1999. Tr. at 186-90. Plaintiff told the doctor that she was applying for disability benefits because of her uncontrolled asthma and because of herniated disc problems in her neck. "The patient wishes to speak in terms of her diagnoses and the specifics of her diagnoses rather than her specific symptoms or specific physical limitations," wrote Dr. Hughes. Plaintiff told the doctor that her asthma is brought on by many different odors and by being around people especially if people have been around cats. Plaintiff said that she is not able to walk more than a block, and that she can climb a flight of stairs, albeit slowly. Plaintiff said that her chronic neck pain causes her to have trouble falling asleep and that she awakens frequently to reposition herself. Tr. at 186. Plaintiff reported numbness and tingling in her left hand but could not specify which, if any fingers. Dr. Hughes wrote:

The patient's past medical history reveals that she has never undergone any surgical procedures. She has been hospitalized on one

occasion at Samaritan Hospital in Clinton for an eight day period in 1988 with asthma. She apparently has also been found to have pernicious anemia for which she takes monthly B-12 shots. I was not able to elicit any other specific past medical history or chronic illnesses that have any specific relevance to her current condition.

Tr. at 187. After a physical examination (Tr. at 188-190), Dr. Hughes opined that Plaintiff would be limited to lifting and carrying “lighter levels in terms of both weight and frequency.” He said that Plaintiff “seems capable of standing, moving about, walking, and sitting during the course of an eight-hour work day.” The doctor found no impairment in terms of manual dexterity, vision, hearing, or speech. “She would certainly be a poor candidate for work with exposure to dust, fumes, extremes of temperatures, and other associated hazards.” Tr. at 190.

Plaintiff was seen at the DeWitt Community Hospital on March 22, 1999, for a gallbladder ultrasound because of right upper quadrant pain. The study demonstrated no evidence of cholelithiasis or other abnormality. The diagnosis was minimal uncomplicated gastroesophageal reflux. It was also the doctor’s impression that nonunited fractures of the right and left 11th ribs should be ruled out to determine if that was the source of Plaintiff’s symptoms. Tr. at 201.

In an office note dated January 27, 1999, Diane M. Crowley, M.D., wrote that Plaintiff had fallen on January 19, 1999 outside of her mother’s house, falling face first, mainly on her stomach. Thereafter, Plaintiff complained of rib pain and right knee pain. Dr. Crowley diagnosed bruised ribs. Tr. at 207. On a prescription form on which Plaintiff's name appears and which appears to be dated December 14, 1998, the words "Cannot lift over 10#" appear. Tr. at 210. At the hearing, the ALJ indicated that he was of the opinion that the note was written by Dr. Crowley. Tr. at 52. The remainder of Dr. Crowley's office notes are treatment records of follow

up visits for bronchitis or asthma.

Plaintiff saw Thomas L. Millard, Ph.D. on April 17, 1999, at the request of Disability Determination Services. Tr. at 216-19. After an interview which did not include any formal testing, Dr. Millard opined that Plaintiff appeared to be of average intelligence. The doctor concluded his report:

Connie denied any significant problems with memory, and she appeared to be able to remember and understand instructions, procedures and locations. She also seemed to have adequate ability to carry out instructions. However, during the course of the conversation she appeared to have difficulty directly answering questions and seemed to have difficulty maintaining attention and concentration. It is also questionable that given her reported physical difficulties that she could maintain an appropriate pace during work activities. Moreover, given that she has some difficulty in staying on topic, there is a question of her ability to interact appropriately with supervisors and coworkers on an ongoing basis. She gave no reason to question her use of good judgement or ability to respond appropriately to changes in the workplace. However, Connie exhibits symptoms of an affective disorder including non appetite, difficulty sleeping, low self-esteem, feelings of guilt and difficulties with concentration.

The psychologist's diagnostic impression, on Axis I, was a mood disorder and an anxiety disorder, both due to general medical conditions, namely asthma and chronic pain. Tr. at 218. On Axis V, the doctor estimated the Global Assessment of Functioning (GAF) to be 50. Tr. at 219.

MEDICAL RECORDS SUBMITTED TO THE APPEALS COUNCIL

Plaintiff was treated at the Nevada Occupational Health Clinic in Sparks, Nevada in 1995. The physical therapy initial evaluation dated February 27, 1995, states that Plaintiff was injured on February 11, 1994, when she was involved in a motor vehicle accident in which she was rear ended while she was looking to the left. An MRI showed moderate central disc

protrusion at the C5-6 level. Tr. at 255. The physical therapist's assessment was C5-6 HNP with discogenic neck pain. The treatment plan was for Plaintiff to be seen three times a week for two or three weeks during which she would be instructed in stretching and other exercises. Tr. at 256. On April 13, 1995, Plaintiff underwent an EMG evaluation by Robert G. Berry, Jr., M.D. because she was having continuing problems with left arm and shoulder pain. The study was "mildly abnormal." Tr. at 338. The doctor concluded his report by stating that Plaintiff was on a home exercise program and that other types of treatment, including surgery or medication, were not indicated. Finally, the doctor wrote: "The electrodiagnostic evaluation does seem to indicate a mild and chronic radiculopathy in the right upper extremity but there are no acute denervation changes seen which is reassuring." Tr. at 339.

ADMINISTRATIVE HEARING

At the administrative hearing, Plaintiff testified that she had gained 70 pounds in the previous 12 years, and 50 pounds since 1997. She attributed the weight gain to the medication Prednisone. Tr. at 46. Plaintiff explained that at the last place she tried to work she was not able to tolerate the perfume or hair spray worn by the people with whom she worked. She also testified that if someone had been around a cat, the odor causes an asthma attack. Tr. at 49. Plaintiff said that she had been limited to lifting 10 pounds since her automobile accident in 1994. Tr. at 50. Plaintiff said that she found it difficult to maintain attention and concentration. Tr. at 51. Plaintiff said that because of the pain in her neck and left shoulder, she is unable to stand more than 20 minutes. Tr. at 55. Plaintiff said that she takes Tylenol-3 (Tr. at 56) and Flexeril for pain, and she uses a TENS unit quite frequently. Tr. at 57. Plaintiff said that she tries to go to bed at 8:00 p.m. and is up every two hours thereafter. Plaintiff said that, depending

on her pain, she lays down between 2 and 4 times per day for about a half hour. Tr. at 58. When asked about mental health care, Plaintiff said that she had been seeing a counselor for about a month. Tr. at 59. She said that a psychiatrist had prescribed Paxil, but that she had not been able to afford to buy it. Tr. at 60.

After Plaintiff testified, the ALJ called Carma Mitchell to testify as a vocational expert. Tr. at 63. After asking some questions regarding Plaintiff's past work, the vocational expert testified that Plaintiff's past relevant work was limited to two jobs – administrative assistant and secretarial work. Tr. at 67 and 173.

The ALJ asked the vocational expert to consider an individual with back difficulties including findings of degenerative disc disease, a history asthma, and "psychiatric difficulties variously identified and diagnosed." As a result of these impairments, the ALJ asked the vocational expert to consider that the individual would be able to lift a maximum of 20 pounds, and occasionally be able to lift 10 pounds. The ALJ said that there should be no more than an occasional requirement to stoop, kneel, crawl or climb. There should be no requirement for exposure to extremes of heat, humidity, cold, dust, fumes, or smoke beyond that which would be found in a commercial office. Finally, that there should be no requirement for fast paced work. Tr. at 68. In response, the vocational expert testified that such an individual would be able to do both of Plaintiff's past relevant jobs. When the hypothetical was modified to limit the individual to lifting a maximum of 10 pounds, and that the work would be sedentary in nature in that standing and walking would not be required more than two hours per day, the vocational expert testified that the past relevant work would only be able to be performed as done in the national economy, not the way Plaintiff did it. As a third hypothetical, the ALJ told the vocational expert

to assume that the individual would need to sit and stand at will, and that up to one third of the time the individual would only be able to work at a slow pace. Tr. at 69. In response, the vocational expert testified that no work would be possible under such limitations because of the need to sit and stand at will. Tr. at 70. The vocational expert also testified that an individual who is unable to tolerate being around perfume, hair spray or dyes found in clothing, would not be able to work. Tr. at 71.

ALJ'S DECISION

In his decision, the ALJ, following the familiar five step sequential evaluation, found that although Plaintiff has severe impairments of degenerative disc disease and spondylosis, neither of which meet or equal a listed impairment, that she is able to return to her past relevant work. The ALJ, therefore, stopped the sequential evaluation at the fourth step and held that Plaintiff is neither disabled nor entitled to the benefits for which she had applied. In making the fourth step finding, that ALJ found that Plaintiff's residual functional capacity is consistent with his first hypothetical question. Tr. at 26-27.

DISCUSSION

The scope of this Court's review is whether the decision of the Secretary in denying disability benefits is supported by substantial evidence on the record as a whole. 42 U.S.C. § 405(g). *See Lorenzen v. Chater*, 71 F.3d 316, 318 (8th Cir. 1995). Substantial evidence is less than a preponderance, but enough so that a reasonable mind might accept it as adequate to support the conclusion. *Pickney v. Chater*, 96 F.3d 294, 296 (8th Cir. 1996). We must consider both evidence that supports the Secretary's decision and that which detracts from it, but the denial of benefits shall not be overturned merely because substantial evidence exists in the record to support a contrary decision. *Johnson v. Chater*, 87 F.3d 1015, 1017 (8th Cir. 1996)(citations omitted). When evaluating contradictory evidence, if two inconsistent positions are possible and one represents the Secretary's findings, this Court must affirm. *Orrick v. Sullivan*, 966

F.2d 368, 371 (8th Cir. 1992)(citation omitted).

Fenton v. Apfel, 149 F.3d 907, 910-11 (8th Cir. 1998).

In short, a reviewing court should neither consider a claim de novo, nor abdicate its function to carefully analyze the entire record. *Wilcutts v. Apfel*, 143 F.3d 1134, 136-37 (8th Cir. 1998) citing *Brinker v. Weinberger*, 522 F.2d 13, 16 (8th Cir. 1975).

In her brief, Plaintiff first argues that the ALJ erred by failing to credit her testimony due to her good work history. While Plaintiff is correct that a work history may entitle a claimant to substantial credibility (*See Nunn v. Heckler*, 732 F.2d 645, 648 (8th Cir. 1984)), a work history is not the only factor to be considered when evaluating credibility. *Polaski v. Heckler*, 739 F.2d 1320, 1322 (8th Cir. 1984).

Among the other factors to be considered, the *Polaski* Court wrote that subjective complaints may be discounted if there are inconsistencies in the evidence as a whole. *Id.* In the case sub judice, Plaintiff's complaints of disabling pain are totally at odds with the opinion of the treating and examining physicians. When Plaintiff had the car accident in 1994, she was treated with physical therapy for "two or three weeks" at which time she was instructed in stretching and other exercises. No surgery was recommended. At the conclusion of the therapy sessions, Plaintiff saw a doctor because she was still having pain. An electrodiagnostic study showed a chronic but mild radiculopathy with no evidence of denervation which the doctor said was reassuring. No restrictions were imposed. The only restriction imposed by Plaintiff's treating physician, Dr. Crowley, was "cannot lift over 10#" which was written on a piece of prescription note paper. In the opinion of the Court, the fact that the ALJ accepted this note as being signed by the doctor indicates that the ALJ was giving Plaintiff the benefit of every doubt.

Furthermore, as the Court stated in *Piepgas v. Chater*, 76 F.3d 233, 236 (8th Cir. 1996): "A treating physician's opinion deserves no greater respect than any other physician's opinion when the treating physician's opinion consists of nothing more than vague, conclusory statements." Even when the ALJ's hypothetical question was modified to limit lifting to 10 pounds, the vocational expert testified that Plaintiff's past work could be done as normally done in the national economy. *See also Melton v. Apfel*, 181 F.3d 939, 941 (8th Cir. 1999)(testimony undermined by lack of consistent treatment and by lack of significant restrictions placed on activity by doctors.); *Johnson v. Chater*, 87 F.3d 1015, 1017-18 (8th Cir. 1996)("The strongest support in the record for the ALJ's finding that Johnson is not disabled is the lack of reliable medical opinions to support Johnson's allegations of a totally disabling condition.").

After his physical examination, Dr. Hughes opined that Plaintiff was capable of light work. The fact that Dr. Hughes referred to lifting, carrying, standing, walking and sitting at a light exertional level indicates that the ALJ's finding that Plaintiff is able to lift 20 pounds occasionally and 10 pounds frequently is supported by substantial medical evidence. Although the doctors mentioned that Plaintiff was being treated with medication for asthma, there is no medical opinion to corroborate Plaintiff's testimony regarding the severity of that condition.

While no one doubts that Plaintiff experiences pain and difficulty breathing, there is no substantial evidence to support a finding that these conditions are severe enough to prevent Plaintiff from performing her past relevant work. *See e.g. Hutton v. Apfel*, 175 F.3d 651, 654 (8th Cir. 1999), *quoting Spradling v. Chater*, 126 F.3d 1072, 1074 (8th Cir. 1997) and *Woolf v. Shalala*, 3 F.3d 1210, 1213 (8th Cir. 1993). The Court finds no error with the ALJ's credibility finding.

Next, Plaintiff argues that Dr. Millard's Axis V diagnoses of a GAF of 50, entitles her to a finding of disability. In support of that argument, Plaintiff cites this Court's opinion in *Brown v. Apfel*, 990 F.Supp. 714 (S.D. Iowa 1998). Reliance on *Brown*, however, is misplaced. In the case at bar, the only evidence of a mental impairment was Dr. Millard's examination which included no formal testing. In *Brown*, the evidence was clear that Plaintiff was unable to do her past relevant work. In *Brown*, after the administration of several testing procedures including mental status examinations and an MMPI, psychiatrists and psychologists opined that Plaintiff was severely limited. The psychiatrist who opined regarding Brown's GAF, stated that the best rating during the current year was 50, and that at the time of his opinion Plaintiff was rated at somewhere between 30 and 40. Psychologists at DDS had opined that Brown was severely limited in several significant domains on the residual functional capacity forms that they had completed as part of the review of her case.

In the case at bar, on the other hand, Dr. Millard was the only doctor who opined that Plaintiff was in any way limited by a mental impairment. Although Plaintiff testified that she had begun counseling, no records were submitted to verify that assertion. While Dr. Millard's report is some evidence which detracts from the ALJ's decision, it is not enough to say that the decision is not supported by substantial evidence on the record as a whole. As stated above, if inconsistent positions are possible and one represents the Secretary's findings, this Court must affirm.

Plaintiff argues that the ALJ erred in failing to submit further questions to Dr. Millard. In support of that argument, Plaintiff cites *Matthew v. Chater*, Civil No. 4-95-cv-80864 (S.D. Iowa 1996). In that case, the ALJ credited part of a medical report while rejecting other parts

without explaining his reasons. The Court held that questions should have been submitted to clarify the seemingly contradictory parts of the report. In the case at bar, in the opinion of the Court, the ALJ gave Dr. Millard's report the weight to which it was entitled and further development was not mandated. The Court would note that although Plaintiff had been represented by her counsel since March 26, 1999 (Tr. at 89), no request was made for clarification of Dr. Millard's report, nor did Plaintiff request the ALJ to supplement the record in any way.

Finally, Plaintiff argues that because the vocational expert testified in response to the ALJ's third hypothetical, that Plaintiff was not able to work, substantial evidence supports a reversal with an award of benefits. As is common in the records of many Social Security Disability cases, the ALJ asked several hypothetical questions which encompassed various views of the evidence. When he made his decision, the ALJ made a specific finding regarding Plaintiff's residual functional capacity. The hypothetical upon which the ALJ relied encompassed the impairments and limitations which he found to be credible. *Roe v. Chater*, 92 F.3d 672, 675 (8th Cir. 1996)(the ALJ's hypothetical question needs to include only those impairments that the ALJ finds are substantially supported by the record as a whole). The fact, therefore, that the vocational expert, in response to a more restrictive hypothetical, testified that an individual under those restrictions would not be able to work, does not detract from the ALJ's decision.

CONCLUSION AND DECISION

The Commissioner's decision is supported by substantial evidence on the record as a whole and not affected by errors of law which require reversal. *See Bradley v. Bowen*, 660

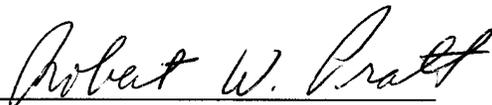
F.Supp. 276, 278 (W.D. Arkansas 1987). The Court has considered the evidence which detracts from the Commissioner's decision as well as evidence which supports it.

In the opinion of the Court, it is only arguably possible to draw inconsistent conclusions from the evidence in this record. In the opinion of the Court, however, Plaintiff did not meet her burden of proving that she is unable to do her past relevant work. The Commissioner's decision, therefore, is affirmed.

Plaintiff's Motion to reverse is denied. The case is hereby dismissed.

IT IS SO ORDERED.

Dated this ___21st___ day of June, 2001.



ROBERT W. PRATT
U.S. DISTRICT JUDGE