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

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CLERK U.S. DISTRICT COURT
SOUTHERN DISTRICT OF IA

NANCY SCHNEIDER,	*	
	*	3-00-CV-90082
Plaintiff,	*	
	*	
v.	*	
	*	
KENNETH S. APFEL, Commissioner of Social Security,	*	
	*	ORDER
Defendant.	*	
	*	

Plaintiff, Nancy Schneider, filed a Complaint in this Court on May 31, 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 reversed.

BACKGROUND

Plaintiff filed an application for Social Security Disability Benefits on February 14, 1995, claiming to be disabled since August 14, 1994. Tr. at 163-66. The application for Supplemental Security Income benefits was protectively filed November 3, 1994. Tr. at 167-71. Plaintiff did not earn an insured status for purposes of Title II benefits until October 1, 1994. For that reason, the ALJ explained, that portion of Plaintiff's claim between August 14, 1994 through October 1, 1994 was denied on the basis of a lack of insured status. After the applications were denied initially and upon reconsideration, Plaintiff requested a hearing before an Administrative Law

13

Judge. A hearing was held before Administrative Law Judge Cheryl M. Rini (ALJ) on January 8, 1997. Tr. at 51-116. After additional evidence was obtained and added to the record, a supplemental hearing was convened on May 5, 1997. Tr. at 117-162. The ALJ issued a Notice of Decision – Unfavorable on March 18, 1998. Tr. at 22-42. The ALJ's Decision was affirmed by the Appeals Council of the Social Security Administration on May 3, 2000. A Complaint was filed in this Court on May 31, 2000.

In her decision, following the familiar five step sequential evaluation, the ALJ found that Plaintiff had not engaged in substantial gainful activity after her alleged onset of disability. At the second step, the ALJ found that Plaintiff's severe impairments were fibromyalgia and irritable airways disease. At the third step, the ALJ found that Plaintiff's impairments do not meet or equal a listed impairment. At the fourth step, the ALJ found that Plaintiff retains the ability to do her past work as a telephone solicitor and market researcher. In making this finding, the ALJ wrote that Plaintiff's severe impairments "have imposed the following limitations upon her ability to perform basic work-related functions: frequent lifting/carrying of objects weighing 10 pounds; more than occasional lifting/carrying of objects weighing 10 pounds; frequent reaching, balancing, bending, stooping, climbing, kneeling, and/or squatting; moderate exposure to fumes, odors, gases, or dust; and/or exposure to extremes of cold, heat, or humidity." Tr. at 36. The ALJ found that Plaintiff was not disabled or entitled to the benefits for which she had applied. Tr. at 37.

The medical reports that are a part of the record of this case have been reviewed in detail by this court. A summary of those reports is contained in the appendix attached to this decision. At the administrative hearing, after Plaintiff had testified, the ALJ asked the vocational expert a

series of hypothetical questions each one of which was more restrictive than the previous one. The first question assumed that Plaintiff would be able to lift and carry 20 pounds occasionally, ten pounds frequently, stand or walk and sit for six hours of a work day with normal breaks, i.e. every two hours. The first hypothetical also assumed an unlimited ability to push and pull and that all postural maneuvers could be accomplished occasionally with no manipulative, visual, or communicative limitations. The ALJ also told the vocational expert to assume that the hypothetical person would need to avoid even moderate exposure to fumes, odors, dusts, and gases. Tr. at 153-54. In response, the vocational expert testified that Plaintiff would be able to do her past work as a phone solicitor, customer service clerk, demonstrator, bar waitress and market research analyst. Next the ALJ told the vocational expert to assume the limitations of the first hypothetical but add "no prolonged repetitive motions with the right wrist." Tr. at 154. In response, the vocational expert said that Plaintiff would be able to do the work of a telephone solicitor and of a customer service clerk as well as the market research position. The job of bar waitress would be eliminated. Tr. at 154-55. For a third hypothetical, the ALJ asked the vocational expert to consider the limitations of the second question but to reduce the lift and carry to ten pounds occasionally and small objects frequently. The vocational expert said that customer service clerk would be eliminated but phone solicitor and market research analyst would remain. When asked if there would be work other than Plaintiff's past relevant work, the vocational expert pointed to cashier work. Tr. at 156. Next, the ALJ asked the vocational expert to assume that Plaintiff could carry ten pounds "in a non-continuous manner" and but would have to carry a quart of milk with both hands. Under this hypothetical, Plaintiff would be able to walk or stand for 20 to 25 minutes at a time and sit for 15 to 20 minutes. Tr. at 157. The vocational expert said Plaintiff

could do her past work as a phone solicitor. Finally the ALJ asked:

> All right then, hypothetical number five. If I assume all that the claimant testified to is credible, including what I gave you in number four, but including the difficulty she has with pushing and pulling in every postural maneuver, the difficulty with occasional, I guess it is, vision problems, the restriction on cold environments, on fumes, odors, dusts and gases, which includes paints and cleaners, and her frequent headaches which affect her concentration as, as well as her fatigue, but not having named all of what she testified to, but just asking you to assume that everything she testified to I find credible. Can you identify any jobs that this individual could do.

Tr. at 158-59. The vocational expert testified that no work would be possible. By way of explanation, the vocational expert said:

> A combination of all of those things, but specifically the, fatigue, sometimes getting nauseous, the headaches causing mood swings and some paranoid panic attacks, the headaches putting her down for periods of time. She said having the frequency of one to three times a week occurring at a seven to nine pain scale, dizziness, all of those things in combination. Her vision being affected by the headaches. She described floaters in her vision.

Tr. at 159.

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 the opinion of the Court the ALJ's finding at the second step of the sequential evaluation, because it is incomplete, is not supported by substantial evidence on the record as a whole. The medical evidence in this record clearly establishes that Plaintiff suffers from the following severe impairments: Chemical sensitivity; Raynaud's disease; depression and anxiety; post traumatic stress syndrom; histrionic personality disorder; panic attacks and psychosomatic symptoms; an injury to the right wrist diagnosed as mild first dorsal compartment tenosynovitis right wrist, i.e. DeQuervain's, mild right carpal tunnel syndrome, mild trapeziometacarpal instability; fibromylagia; and, a learning disorder in the area of math. All of these impairments are well established in the medical records and all of them impose more than a minimal limitation on Plaintiff's ability to function. *See Gasaway v. Apfel,* 187 F.3d 840, 844 (8th Cir. 1999) (a severe impairment is one that significantly limits a claimant's ability to do basic work activities.) *Citing* 20 C.F.R. § 404.1520(c); 42 U.S.C. § 423(d)(1)(A), § 423(d)(2)(A), § 423(d)(2)-(B), and 20 C.F.R. § 404.1521(a). Some of Plaintiff's impairments are more severe than others, but all contribute to Plaintiff's disability. Furthermore, the impairments cannot be seen as isolated but must be considered in their totality. In *Davis v. Califano*, 605 F.2d 1067, 1073 (8th Cir. 1979), the Court wrote: "A claimant's illnesses must be considered in combination and must not be fragmentized in evaluating their effects. ... The fact that each illness standing alone

may not be disabling is not conclusive on the question of whether the individual is disabled." *Quoting Dressel v. Califano*, 558 F.2d 504, 508 (8th Cir. 1977).

In order to find that Plaintiff is able to do her past relevant work, it was necessary that the ALJ find that Plaintiff is able to do sedentary work in which she could tolerate a moderate amount of exposure to environmental irritants. In the opinion of the Court, however, the substantial evidence in this record supports the opposite conclusion. This is not a case of evaluating contradictory evidence and finding that two inconsistent positions are possible. In this case, when viewed in its totality, the record supports only one conclusion, namely that Plaintiff is unable to work.

It is well established in the medical record that Plaintiff suffers from debilitating symptoms when ever she is exposed to chemicals fumes of any kind whether it be noxious insecticides or common cleaning solutions. These symptoms include chest congestion, cough, shortness of breath, puffiness of the eyes and face, some vomiting and diarrhea. These symptoms became so severe that Plaintiff was missing one to two days of work per week. As late as March, 1995, Dr. Wilkens, whose speciality is internal medicine (Tr. at 385), wrote that Plaintiff was disabled whenever she is exposed to chemicals. Although Dr. Keller wrote that Plaintiff could be cured of her allergic response to chemicals in six to eight months, he saw her only once, which makes his opinion less than substantial evidence upon which to base a denial of benefits. In addition, Dr. Keller is a family practice physician while Dr. Wilkens' speciality is internal medicine. Furthermore, Plaintiff had already suffered from these symptoms for several years, in spite of seeking treatment from numerous physicians beginning, at least, in August of 1990. Finally, Plaintiff lost her job at Communication Data Services due to her inability to tolerate the

work environment, and that company paid Plaintiff severance pay in lieu of claims for other types of benefits or damages. Tr. at 428-34.

At the hearing, all of the ALJ's hypotheticals contained the proviso that Plaintiff must "avoid *even moderate* exposure to fumes, odors, dusts, and gases." Emphasis added. It appears, however, that until the final hypothetical, that the vocational expert focused on the exertional elements of the questions. When the vocational expert considered the effect of Plaintiff's inability to tolerate fumes, odors, dusts and gases, it was the testimony that no work, neither Plaintiff's past work nor any other work, would be possible. It is well settled law that an ALJ has a duty to fully and fairly develop the record even when a claimant is represented by counsel. *Nevland v. Apfel*, 204 F.3d 853, 857 (8th Cir. 2000) *citing Warner v. Heckler*, 722 F.2d 428, 431 (8th Cir. 1983). In the opinion of the Court, the ALJ failed in this duty by neglecting to focus the attention of the vocational expert on this crucial element of her hypothetical. Although the ALJ found that Plaintiff is able to tolerate moderate exposure to fumes, odors, gases and dust, the extensive medical record discussed in the Appendix detracts from that finding and supports the hypothetical that was put to the vocational expert.

In *Kouril v. Bowen*, 912 F.2d 971, 977 (8th Cir. 1990), the Court held that a remand was necessary after the Court held that the finding that Kouril, who suffered from chronic allergies, was unable to do past relevant work because the Commissioner had not been afforded the opportunity to meet his burden at step five of the sequential evaluation. In the case at bar, we have vocational expert testimony regarding the effects of Plaintiff's intolerance of fumes etc. Furthermore, this impairment, while debilitating by itself, is not the only impairment suffered by Plaintiff which interferes with her ability to work.

Plaintiff injured her right wrist on February 29, 1993, for which she received treatment from a hand specialist (Tr. at 387), Delwin E. Quenzer, M.D. Although Dr. Quenzer's final diagnoses all included the word "mild," he said that Plaintiff "should be permanently restricted from keyboard work." The fact that this impairment may not be disabling in and of itself does not mean that it does not impose limits or restrictions on Plaintiff's ability to work. *Baker v. Apfel*, 159 F.3d 1140, 1145 (8th Cir. 1998) ("However, the fact that the claimant's pain is not so severe as to be disabling does not necessarily mean that it places no limits or restriction on his ability to work.").

The Court does not agree with the ALJ that Plaintiff, in spite of the fibromyalgia, is able perform the exertional demands of sedentary work. Dr. Radia, the Rheumatologist who diagnosed the condition, said that Plaintiff would only be able to sit for two hours of a work day and that she could only stand and/or walk for two hours of a work day, would sometimes need to lie down during a work shift and would need to be absent more than three times a month because of the impairment. This is not compatible with sedentary work in the competitive job market. *See* 20 C.F.R. 404.1567 (a).

Perhaps the most serious of Plaintiff's severe impairments are post traumatic stress disorder and the histrionic personality disorder. Plaintiff's therapist wrote that because of these impairments that Plaintiff was unable to work and that it was debatable whether she would ever progress to the point where she can work. In *Rhines v. Harris*, 634 F.2d 1076, 1079 (8th Cir. 1980), the Court, quoting *Thomas v. Celebreeze*, 331 F.2d 541, 546 (4th Cir. 1965) wrote: "Employers are concerned with substantial capacity, psychological stability, and steady attendance ... It is unrealistic to think that they would hire anyone with the impairments of this claimant."

Hopefully, with time and appropriate medical and psychological therapy Plaintiff's mental and physical health status will improve. In the meantime, the Court agrees with Plaintiff's therapist who wrote that Plaintiff should apply for SSI benefits "so that she can have some time to heal emotionally and physically." *See Rohan v. Chater*, 98 F.3d 966, 970 (7th Cir. 1996) (mental health professionals are the experts on mental illness rather than lawyers or judges).

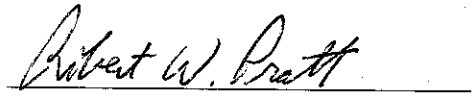
CONCLUSION AND DECISION

The Court holds that Commissioner's decision is not supported by substantial evidence on the record as a whole. The Court finds that the evidence in this record is transparently one sided against the Commissioner's decision. *See Bradley v. Bowen*, 660 F.Supp. 276, 279 (W.D. Arkansas 1987). The medical and vocational evidence establish that Plaintiff does not have the residual functional capacity to work either at her past relevant work, or any other work in the national economy. A remand to take additional evidence would only delay the receipt of benefits to which Plaintiff is clearly entitled. Therefore, reversal with an award of benefits is the appropriate remedy. *Parsons v. Heckler,* 739 F.2d 1334, 1341 (8th Cir. 1984).

Defendant's motion to affirm the Commissioner is denied. **This cause is remanded to the Commissioner for computation and payment of benefits.** The judgment to be entered will trigger the running of the time in which to file an application for attorney's fees under 28 U.S.C. § 2412 (d)(1)(B) (Equal Access to Justice Act). *See Shalala v. Schaefer*, 509 U.S. 292 (1993) and LR 54.2(b).

IT IS SO ORDERED.

Dated this 16th day of February, 2001.



ROBERT W. PRATT
U.S. DISTRICT JUDGE

Appendix
MEDICAL RECORDS
BROADLAWNS MEDICAL CENTER

A treatment note dated August 1, 1990, states that Plaintiff was complaining of hoarseness for two days. Plaintiff some time in the recent past she had been exposed to fog spraying for mosquitoes while at a lake. Plaintiff also reported that the previous autumn she had been told that she had a thickness of her vocal cords Tr. at 314. On August 9, 1990, Plaintiff was still complaining hoarseness, along with mild chest discomfort coughing, dizziness and nausea. The doctor noted that Plaintiff was a smoker and advised her to quit smoking and she was given a prescription for medication. Tr. at 313. When she was seen on September 4, 1990, Plaintiff said that she had discontinued the medication when it caused bruising on her arms and legs. She also reported a personality change after taking the medication. Tr. at 312.

On September 6, 1990, Plaintiff underwent a microsuspension direct laryngoscopy with biopsy to remove the nodulus on her vocal cords. Tr. at 311.

On October 23, 1990, Plaintiff saw a doctor for a nutritional problem and because of bruising on her face, arms and legs without apparent cause. Plaintiff reported that she was eating at least twice each day. Tr. at 305. When she was seen in December, 1990, it was noted that Plaintiff has a metal intolerance and that although Plaintiff reported that she had a rash on her neck, she said that she had not been wearing jewelry. Tr. at 304. On January 31, 1991, Plaintiff stated that her hoarseness comes and goes. Plaintiff asked for a test for lupus. Tr. at 302. When Plaintiff was seen on March 18, 1991, she reported doing fairly well. She was working at the Des Moines Register. The doctor's diagnoses were Hypoglycemia and irritable bowel syndrome. Tr. at 301. On March 18, 1991, a registered dietitian wrote a plan to help

Plaintiff control her hypoglycemia. Plaintiff told the dietitian that she "drinks moderately (1-2 pitchers of beer – 2-3 [times a] week). Plaintiff also reported experiencing black-outs while drinking. The dietitian told Plaintiff that she was drinking too much and recommended further guidance for a "possible drinking problem." Tr. at 307.

Plaintiff was seen by the crisis team on May 14, 1991. Plaintiff had tears streaking down her eyes and cheeks. She said that she had lost her job "because I did some irresponsible behav-ior." Plaintiff said that she was having problems with her "man friend", that she was not eating properly, was on the verge of being evicted, not sleeping well, and having "a big financial crisis." Plaintiff agreed to begin seeing a therapist on an outpatient basis. Tr. at 300. On May 31, 1991, Plaintiff saw Bruce Barker, M.S. for an outpatient intake interview. Tr. at 297-99. Mr. Barker wrote:

> Family of Origin: When pt was seven years old her parents were divorced and she lived with her mother at that time. Father, Joseph, died when he was 54 years old in '70 of blood clot in his lung. He was a cook and is described as an average man. She saw him for a little while as a child and then was cut off completely from him until she was 15 years old when she did go to live with him. She reports that on an everyday level their relationship was pretty good, although he had "molesting tendencies." Pt had to fight to keep their relationship appropriate. Pt's mother is Stella, 63, and runs an office for her son. She is described as a typical mother and a hard worker. She "sparkles." She has always been there for pt. They talk occasionally but they do not see each other often. She does feel close to her mother. Pt has two brothers living. Rick is 43 and Kurt is 41. She also had one brother, Danny, who was killed at age 21. She reports that her mother boarded all the children out until the court later separated them. She was the only one that went to live with her father. She rarely sees her two brothers. They lost much of their closeness. They all check in occasionally and she describes their relationship as "loosely tight knit." Pt reports she was sexually abused by her father from the time she was five and she is not sure how long that lasted. She was also sexually abused by a babysitter

> from age 7-10. She was raped by her uncle at age 12. She was also raped by some school boys at 14. She feels she was emotionally abused by father and was physically abused by court appointed foster parents two times. She was also beaten as a baby by a sitter.

Tr. at 297-98. Plaintiff said that her medical problems began at age seven when she had problems with her breathing. Plaintiff developed food allergies from age five through twelve had rheumatic fever at age twelve. Plaintiff had a partial hysterectomy in 1970 and, the same year, was hospitalized for three months for blood clots. The hysterectomy was completed in 1980. From 1980 to 1984 Plaintiff underwent five surgeries to remove cysts and tumors. In 1990, Plaintiff had the surgery on her larynx, and at the time of the interview was suffering from aching joints and "loose feeling in her toes." Plaintiff said she was diagnosed with Raynaud's in 1985. Plaintiff described herself as an alcoholic but said that she had not had anything to drink for two months. She admitted to smoking marijuana to help with joint pain and to relax. She also said that she smoked one and a half packs of cigarettes per day until the previous week. Tr. at 298. Mr. Barker's therapeutic assessment was that Plaintiff was showing signs of depression and anxiety. He referred Plaintiff to a psychiatrist to clarify the diagnosis and to review the treatment plan. Plaintiff was also assigned to Anna Parks to begin individual therapy. Tr. at 299.

Plaintiff saw physician's assistant Barb Clemens on June 21, 1991. Plaintiff was still concerned about having Lupus and was upset with "Dr. Bradford" because he did not order the tests that she had requested. Plaintiff said that she "gets a rash across her face, and her joints, fingers, hands and bones ache all the time." Ms. Clemens wrote that she had ordered several lab tests all of which came back normal. Plaintiff was working part time at the Des Moines

Register, but was having a hard time punching keys because of the pain in her hands and wrists. Ms. Clemens ordered some additional lab tests and referred Plaintiff to a pain clinic and a Rheuma-tology clinic. Tr. at 294.

Plaintiff saw Timothy Olson, M.D. on July 3, 1991, for a psychiatric evaluation. Tr. at 292-93. Plaintiff told Dr. Olson that she believed she may have lupus even though this had not been confirmed by any physician. Depressive symptoms included crying spells, insomnia, poor appetite, poor concentration, memory problems, anxiety and social withdrawal. Plaintiff had been unable to tolerate an anti-depressant medication that had recently been prescribed for her, although she was willing to try something else. Tr. at 292. After his mental status examination, Dr. Olson diagnosed major depression and histrionic personality disorder, as well as alcohol dependence in remission and cannabis dependence. Dr. Olson prescribed Prozac. Tr. at 293. On July 11, 1991, Plaintiff told Ms. Clemens that she had not been able to tolerate the Prozac which Dr. Olson had prescribed. Tr. at 291.

On July 11, 1991, in addition to seeing Ms. Clemens, Plaintiff saw Anna Parks, A.C.S.W. for her first individual therapy session. Plaintiff related much of the same history regarding sex-ual abuse to Ms. Parks as she did to Mr. Barker. Ms. Parks was of the opinion that Plaintiff suf-fers from post traumatic stress disorder in addition to dysthymia. Ms. Parks wrote:

> Nancy is preoccupied with her body, somatic complaints, and whether or not she is going to survive. She knows she can't work full time because she is weak, tired, and overwhelmed with what appears to be post-traumatic symptoms. She has little knowledge or insight about these symptoms and is not able to recognize any of the triggers. She has not read much about sexual abuse and thinks that she "has it under control." However, she has joint swelling and her immune

> system appears to be quite low over this past year in that she has had bruising and many upper respiratory infections, sores in her mouth, and is tired all the time. She is becoming more reclusive as her fear mounts. She states that she has not applied for SSI and was encouraged to do so today, so that she can have some time to heal emotionally and physically. She worked in a gift shop for four hours a day but found that exhaustive and had to sleep around the clock in order to maintain this schedule, finally quitting. ... She wonders if there is something in herself that "brings out the worst in other people." She is the "typical victim" and may indeed perpetuate her own victimization in various ways. However, she is unaware of how she does this and this may take some time in order for her to turn it around.

Tr. at 289-90. On July 17, 1991, Ms. Parks wrote that Plaintiff was having panic attacks, and that Plaintiff has "many physical symptoms that are psychosomatic." Tr. at 288. Plaintiff saw Ms. Parks on August 20 and August 27, 1991. Tr. at 286-87. On August 27, Plaintiff reported that she had a boy friend who was very interested in helping her back to health through exercise and healthy eating. However, "he also has admitted to her that he is sexually addicted. When he was a child, he apparently was molested by an uncle and has not had serious therapy around this issue. He did then offend his sister and 3 brothers." Tr. at 286. On September 4, 1991, Plaintiff was seen in the medical clinic complaining of a rash on her face and body. Her extremities itch-ed. The doctor opined that the rash was possibly a reaction to Naproxin and advised Plaintiff to discontinue the medication. Tr. at 285. On September 10, 1991, Plaintiff told Ms. Clemens that the rash was resolving since she had discontinued the medication as she had been instructed. Tr. at 284. On September 11, 1994, Plaintiff described two incidents which sounded to Ms. Parks like panic attacks. Plaintiff said that "she shakes from the inside out." Tr. at 283. Plaintiff also saw Dr. Olson on September 11, 1994. Plaintiff told the doctor that she had become disenchant-ed with her boyfriend because he had "recently tried to set her

up with up with a transient. He has also tried to interest her in being menagea trois sexual escapades. She recently learned that he had sex with a prostitute." Dr. Olson's diagnoses were Major depression, recurrent; Alcohol dependence, in remission; Cannabis dependence; Histrionic personality disorder. Tr. at 282.

When Plaintiff saw Ms. Parks on October 8, 1991, Ms. Parks wrote: "She has a great sense of responsibility for what has happened to her [i.e. childhood sexual abuse] and there were times in the foster home when she was accused of having 'bedroom eyes'... Her mother also saw her as competitive and accused her of competing with herself for the favors of one of her mother's boyfriends or husbands." Tr. at 280.

Plaintiff was seen in the Rheumatology clinic on October 16, 1991. Much of the hand written report is very difficult to read but the following can be safely gleaned from the report. Plaintiff was described as a 41 year old thin white female in no acute distress. Examination of Plaintiff's head, eyes, ears, nose and throat was within normal limits. Her heart had a regular rate and rhythm with no mummer. The lungs were clear to auscultation. There was good range of motion in all joints, but Plaintiff's hands and feet were purple with cold. Plaintiff had no symp-toms of sclurodurma and no joint effusion. There were no tender points consistent with fibro-mylagia. The doctor's diagnosis was non-specific musculoskeletal tenderness, Raynauds phen-omenon without symptoms of connective tissue disease. The doctor advised watching for symp-toms of connective tissue disease. Tr. at 279.

On October 22, 1991, Plaintiff reported to Ms. Parks that someone had given her name as a witness to a murder. The information that was given to the police was false, and she was re-lieved when the murder suspect was taken to jail. Tr. at 278. On November 20, 1991,

Plaintiff became upset with Dr. Olson when he refused to do more to help her with the Department of Hu-man Services. The doctor told her that he wanted her to do more things for herself. Plaintiff left the interview prematurely, apparently angry. Tr. at 277. Plaintiff also saw Ms. Parks on Novem-ber 20. Plaintiff had been to Las Vegas to visit with her mother. "She stated that her mother is still 'paranoid' and accused her of sleeping with her husband on the last visit. Nancy states that this never took place and that her husband is sexually addicted and has had a number of affairs and this is why her mother is 'paranoid.'" Ms. Parks wrote that the post traumatic stress disorder was aggravated by the visit and that Plaintiff cried through the entire interview. Tr. at 276.

Plaintiff was seen at Broadlawns Medical Center on December 2, 1991 after she had been assaulted. Plaintiff had been held in a choke hold, and hit in the back. She was complaining of aching in the right side of the neck. She was able to walk without difficulty. The doctor's diag-nosis was acute cervical thoracolumbar myofascial strain. Tr. at 274.

On December 4, 1991, Plaintiff told Dr. Olson that she would rather see a different psychiatrist and he told her that he did not object to her request. Plaintiff told Dr. Olson that her attacker had been arrested. Tr. at 273.

Plaintiff saw Ms. Parks on December 6, 1991, she was feeling very sore and had blood in her urine from the rapes she had endured the previous Monday. Plaintiff was pleased that she had reported the incident and was pleased with the efforts of the police to apprehend her attacker. Tr. at 271. When Plaintiff was seen in the primary care clinic on December 16, 1991, it was re-ported that she had not been drinking for the previous ten months and that she was feeling much better. Plaintiff said that her attacker was still in jail and that the trial was

pending. The note states that Plaintiff was pleased with her visit to the Rheumatology clinic, and that the sessions with Ms. Parks were helpful. Tr. at 272. On January 3, 1992, Plaintiff told Ms. Parks that she found out that her attacker had been released from jail. Tr. at 269. On January 17, 1992, Plain-tiff had been told by the County Attorney's office, where she went to get a restraining order against the rapist, that the attacker had not been stalking her personally, but was "a random stalk-er." Plaintiff had been doing volunteer labor with a veterinarian was this was helping to raise her self-esteem. Tr. at 268.

Plaintiff saw psychiatrist Kirpal Singh, M.D. on January 20, 1992, for a medication check. Tr. at 267. On February 5, 1992, Ms. Parks wrote that because of post traumatic stress symptoms, Plaintiff is unable to hold a job, and that it was debatable whether she would progress to the point where she can work. Tr. at 266. When Plaintiff was seen by Ms. Parks on March 13, 1992, she had tripped on a rug and dislocated a shoulder[1]. Plaintiff and Ms Parks spent time talk-ing about Plaintiff's relationship with her own daughter. Tr. at 265.

On April 10, 1992, Plaintiff talked to Ms. Parks about her "lupus symptoms." She said that a dentist had told her that two sores in her mouth were like lupus sores. Although Plaintiff was still suffering from depression, her crying spells, poor appetite and poor sleep had improved with the medication. Tr. at 261.

Dr. Singh wrote a psychiatric evaluation on April 20, 1992. Tr. at 259-60. Much of the history taken by Dr. Singh has been recited above. Plaintiff said that she was going through the

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1. On the evening of March 4, 1992, Plaintiff was seen at the emergency room of Iowa Methodist Medical Center after she tripped and fell on a carpet and fell injuring her right shoulder. The diagnosis was right shoulder strain. Tr. at 250.

trial of the man who raped her earlier. The fact that she was now known to him was upsetting to her. Tr. at 259. On mental status examination, Plaintiff "appeared very tearful, perplexed, agitated but not suicidal, homicidal or psychotic." The doctor wrote that Plaintiff's life "seems to be full of incredible stressful experiences including many episodes of traumatic sexual experiences and drug abuse." Although Plaintiff's memory and concentration were fair, the doctor said her insight and judgment were rather questionable. Dr. Singh's medical diagnosis included renal dis-ease in addition to chronic arthritis and hypoglycemia by history. His psychiatric diagnosis was: Major Depression, recurrent; post traumatic stress disorder; alcohol dependence, partial remis-sion; cannabis dependence, in remission; and, on Axis II, histrionic personality disorder. Dr. Singh recommended that Plaintiff continue her medication although at an increased dosage, and that she continue to see Ms. Parks on a regular basis to improve her coping skills. Tr. at 260.

On May 11, 1992, Ms Parks noted that Plaintiff was working part time "as a telephone person" and that she had gone through vocational rehabilitation but that Plaintiff's physical ailments had interfered greatly in the evaluation process. Ms. Parks opined that the antidepressant medication was quite helpful to Plaintiff. Tr. at 258. Plaintiff was seen by Ms Parks on May 22, 1992, at which time she said that the inflammation of her joints was "a bit better" and that she was exercising "in a mild form." Tr. at 257.

On June 5, 1992, Plaintiff was seen for a vision test at Broadlawns because she had failed the eye test when she went for a drivers licence. Plaintiff was tested for new glasses. Tr. at 256.

The final medical record from Broadlawns is a report of a physical examination by Ms.

Clemens on July 1, 1992, at which time Plaintiff did not express any complaints or concerns. The diagnosis was Raynaud's. Tr. at 255.

DES MOINES ORTHOPAEDIC SURGEONS

Plaintiff was seen by Delwin E. Quenzer, M.D. on June 1, 1993, for an evaluation of pain in her right wrist. It was noted that Plaintiff had worked for Communication Data Services since October, 1992 and that she injured her wrist on February 29, 1993. Dr. Quenzer wrote:

> She said that she had a small stack of documents, not heavy, and reached forward with this in her right hand, using a pinching maneuver, and extended her elbow and turned her arm to pronate. She felt that a "thousand needles" attacked the palmar aspect of her wrist. She went home. She applied heat and the wrist swelled to the size of "half an egg." She has had pain over the volar radial wrist since this time. She went to the IMMC-ER where x-rays were negative.

Dr. Quinzer noted Plaintiff's history of Raynaud's disease in her hands and feet which was first diagnosed in 1965. Tr. at 318. Dr. Quinzer noted that Plaintiff had previously seen Dr. Cherny who recommended surgery to repair DeQuervain's extensor tenosynovitis of the right wrist and that he (Dr. Quinzer) was being seen for a second opinion. The doctor noted that Plaintiff was working "light duty", "working 45 minutes on her regular job and then 15 minutes of rest." On examination, each of Plaintiff's forearms, wrists, and hands had a reddish-blue coloration with mottling. There was no swelling or other deformity of the right wrist. Wrist range of motion was equal and there was full digital range of motion. The median nerve was slightly irritable at the wrist. Dr. Quenzer wrote: "She has similar findings on the left side which are less severe." Sensation was normal but Plaintiff had some pain with resisted exercises. Tr. at 319. X-rays of the right wrist were normal. Dr. Quenzer's diagnoses were: 1) Pain-dysfunction syndrome of

right forearm secondary to work-related accident; 2) Pain at base of right thumb secondary to DeQuervain's extensor tenosynovitis, flexor carpi radialis, tendonitis, and trapezia metacarpal instability; and 3) Mild right carpal tunnel syndrome despite negative EMG/NCS. The doctor did not recommend surgery but he did recommend an injection of Lidocaine to see how much re-lief Plaintiff obtained. Dr. Quenzer also noted that a splint was made for Plaintiff and that her work restrictions should be "limited use of right hand; five-pound lifting restriction; avoid repeti-tive grasping, pinching, pushing, pulling, and twisting; may need to wear splint; work at own speed; agree with 45 minutes work, 15 minutes rest routine. Physical therapy should continue as well[2]." Tr. at 317. Plaintiff saw Dr. Quenzer again on September 15, 1993. Tr. at 317-16. Plaintiff continued to have significant pain part of which was due to Raynaud's and mild right carpal tunnel syndrome. Tr. at 317. The doctor wrote: "The most striking finding on examina-tion is that she has what I believe to be rather definite instability of the trapeziometacarpal joint. I suspected this last time, but did not confirm it. I am not finding much evidence today for a De-Quervain's extensor tenosynovitis." Dr. Quenzer wrote that Plaintiff should be permanently re-stricted from keyboard work. He also wrote that if more conservative measures did not relieve Plaintiff's pain that consideration should be given to an endoscopic carpal tunnel release. Tr. at 316.

Plaintiff next saw Dr. Quenzer on February 9, 1994 for a permanent partial impairment rating. Tr. at 316-15. Plaintiff had been working but was recently off work because she had an allergic reaction to insecticide that was sprayed at her work site. Plaintiff had been doing cus-

2. Physical therapy records are in the transcript at pages 325 to 345.

tomer service work at her own speed. Although Plaintiff was having intermittent numbness, she had not been dropping things or having difficulty sleeping. Tr. at 316. After his examination, Dr. Quenzer's diagnoses were: 1) Mild first dorsal compartment tenosynovitis right wrist, i.e. DeQuervain's; 2) Mild right carpal tunnel syndrome; 3) Mild trapeziometacarpal instibility; 4) Raynaud's disease. Tr. at 315.

OTHER MEDICAL RECORDS

Plaintiff was seen by Mary A. Radia, D.O. on May 18, 1992 and again on June 12, 1992. Dr. Radia, in a report written to the Iowa Division of Vocational Rehabilitation, said that because of three negative ANA test for lupus, and a negative rheumatoid factor and normal sedimentation rates within the previous two years, along with an essentially normal physical examination, she could not make a diagnosis of lupus, arthritis, or any collagen vascular disease with the exception of Raynaud's. Rather, Dr. Radia opined that Plaintiff has fibromyalgia, a condition "associated with poor sleep and musculoskeletal aches and pains." The doctor said that if Plaintiff were go-ing to work, she would need to have a sedentary job, and, because of Raynaud's phenomenon would need to avoid cold, hot or humid condition. Dr. Radia said that there was no cure for fi-bromyalgia although the symptoms varied in intensity depending on multiple factors including weather, stress, and activity level. Tr. at 422. Dr. Radia's examination report is at 425-26 of the transcript. Plaintiff returned to Dr. Radia on April 15, 1997, for an examination to use as evi-dence in her Social Security Claim. On examination there were "multiple tender points noted over the cervical spine, shoulders, elbows, hips, knees, and ankles. Dr. Radia's impression was that Plaintiff has fibromyalgia. Tr. at 482. Dr. Radia, with the assistance of a nurse practitioner, completed a Fibromyalgia Residual Functional

Questionnaire for submission to the ALJ. Tr. at 483-87. On this form, Dr. Radia stated that if Plaintiff were going to work, she would be able to sit less than two hours and to stand/walk less than two hours. Dr. Radia opined that Plaintiff's functional limitation would vary between 40 to 75% depending on her varying symptoms. Tr. at 485. Plaintiff would need a job that allowed for shifting positions from sitting to standing and she would sometimes need to lie down at unpredictable intervals during a work shift. Dr. Radia said that Plaintiff would not be able to tolerate prolonged sitting and would only occasionally be able to lift "less than 10 lbs." Tr. at 286. Dr. Radia said that more than three times a month, Plaintiff would need to be absent from work because of her impairment and/or treatment. When asked if there were any other limitations that would affect Plaintiff's ability to work, the doctor wrote: "chemical sensitivity, depression, PTS syndrome." Dr. Radia said that Plaintiff has head-aches, sleep deprivation, morning stiffness, weakness, fatigue, dizziness, speech difficulties, memory impairment, motor coordination problems, nausea, sensitivity to cold, heat, light, and humidity, panic attacks, buckling ankles, buckling knees, leg cramps, confusional states, numb-ness and tingling, problems climbing stairs, anxiety, lack of endurance, and mood swings. Tr. at 487.

In a letter dated February 1, 1994, Rick Wilkens, M.D. wrote to Barb Beerglund, R.N. at Communications Data Services that Plaintiff had been seen on December 17, 1993, complaining of having chest congestion and shortness of breath, as well as diarrhea after being in her work area which had recently been sprayed with insecticide. Dr. Wilkens said that Des Moines Pest Control had confirmed for him that a chemical that causes symptoms similar to those reported by Plaintiff had been use in the building. Tr. at 374.

On April 20, 1994, James A. Wille, M.D., of Allergy/Asthma Associates in Des Moines,

Iowa, wrote a report to Rick Wilkens, M.D. Tr. at 320-23. Dr. Wille wrote that he saw Plaintiff because of chest and nasal symptoms thought to be secondary to pesticide exposure at work Plaintiff reported that the previous November, while at work, she had been exposed to pesticide and developed a cough, shortness of breath, puffiness of the eyes and face, some vomiting and diarrhea, and sinus congestion. Plaintiff said that she was better at home and worse while at work. Plaintiff was off work from February 1 through March 15, and seemed to do better. Tr. at 320. Dr. Wille was not able to identify any particular triggers, but he noted that other people at Plaintiff's work site had been bothered by the pesticide exposure, and he admitted that he had little knowledge in that area. Tr. at 321.

According to a nurse's note, dated September 6, 1994, on a treatment record of Michael J. Makowsky, M.D., of Iowa Methodist Medical Center, Occupational Medicine, on August 14, 1994[3], while at work, one of Plaintiff's fellow employees was cleaning using Windex. Plaintiff became short of breath, developed a tightness in her chest and developed sinus congestion. According to Dr. Makowsky, Plaintiff had been told by a doctor in Iowa City that she has multiple allergies, including solvents and insecticides as well as other environmental agents. Tr. at 348.

Plaintiff was seen at the Occupational Medicine Clinic at the University of Iowa Hospitals and Clinics on May 4, 1994. Tr. at 351-59. In a report addressed to Dr. Wilkens, David A. Schwartz, M.D. wrote:

> In October 1992, she began working as a scan operator but transferred to her current job as a magazine fulfillment 800 operator after a wrist injury in October, 1993. She works at a computer with a headset but

3. Plaintiff's alleged onset of disability date is August 14, 1994. Tr. at 163. As the ALJ pointed out, however, Plaintiff was not insured to receive Title II benefits until October 1, 1994. Tr. at 56. Plaintiff did not file an application for Title XVI benefits until November 28, 1994. Tr. at 56 and 167.

> has no contact with chemicals in her routine job. Following the Thanksgiving holiday in 1993, she was at work when she saw a person spraying in a hallway. Apparently the building was near the 1993 flood zone but was not contaminated however a problem with gnats and roaches developed. Within the next week, the patient began to experience symptoms beginning with sinus drainage, but progressed to chest congestion with episodes of coughing to the extent of resulting in vomiting. According to the company supervisors, no spraying occurred until late December 1993. Over the next couple of months, her symptoms persisted. They would begin after she was a work approximately 3 hours and worsen until she left the environment. By an hour following work, her symptoms were largely resolved. She was first seen by her internist on December 17. ... Her symptoms became so severe that she began missing 1-2 days of work per week because of the severe coughing episodes. She was referred to an allergist and had negative allergy testing and PFTs ... She reports being off work from February 1 to March 14 during which she remained symptom-free. In addition to the respiratory symptoms, she reports episodes of rash involving her back and hands which were exposed to surfaces. She described the rash as "itchy red blisters". This resolved with a topical cortisone ointment. During March and April, the patient was off work with her back pain due to pinched nerve during coughing[4]. She has returned to work and continues to have symptoms but reports they are diminishing. Industrial hygiene monitoring in February by Chart Services which included air samples of work site revealed no pyrethrins type pesticides.

Tr. at 351-52. Dr. Schwartz' impression was that Plaintiff had potentially been exposed to pesticide with chronic sinus drainage and cough. Tr. at 352. Plaintiff told Dr. Schwartz that she had been exposed to pesticides on other occasions with detrimental results. In 1986 she was at a camp ground that was sprayed for mosquitoes and other insects. Even though she was in a car, she became nauseous, dizzy and suffered from respiratory symptoms which lasted approximately 1 ½ weeks. On another occasion, in the winter of 1988-89, people living in the

4. See Tr. at 378 which are physical therapy records from Mercy Hospital Medical Center in Des Moines, Iowa, which indicate that Plaintiff was seen on February 24, 1994 because of "a severe coughing spell which eventually created low back pain."

same apartment complex used a "bug bomb" to control insects after which she had numerous medical complaints. Sometime between 1988 and 1991, Plaintiff went to a store that had been sprayed an hour previ-ous. Upon entering the store, Plaintiff became congested and started suffering from acute respir-atory symptoms. Tr. at 358. Dr. Schwartz wrote:

> The chronology of Ms. Schneider's symptoms follows a pattern, in that they do not develop until the evening hours (6 - 7 p.m.) of her work shift, when the employee count drops to approximately 20 workers, and continues until approximately one hour following Ms. Schneider's departure from the CDS environment. A logical assumption would be that there is some possible indoor contaminant introduced at that time of the evening, or that it takes the patient approximately 3-4 hours to become symptomatic, and that the ventilation supply (possible reduction during after-office hours, when few employees remain) may in some way be a factor.

Dr. Schwartz reported that on July 14, Plaintiff had called him and said that CDS had moved her to an office area with greater ventilation which seemed to have resolved her symptoms. Plaintiff was not using any medication and the company had agreed to notify her when spraying activities were going to occur. Tr. at 359.

On November 1, 1994, Dr. Wilkens wrote to Communications Data Services that Plaintiff was disabled when ever she is exposed to chemicals which cause her symptoms. Tr. at 375.

On November 7, 1994, Dr. Schwartz wrote to Dr. Wilkens that Plaintiff had stopped working on August 14, after which her symptoms had diminished although they still occur in public areas. On physical examination, Plaintiff was in no acute distress, her nose and throat were clear and normal, and her chest was clear to auscultation and percussion. Dr. Schwartz wrote: "The etiology of her symptoms is not at all clear. There is no objective data supporting

the presence of these symptoms or the diagnosis related to these symptoms." Tr. at 350.

On March 15, 1995, Rick L. Wilkens, M.D. wrote to Disability Determination Services that when Plaintiff is exposed to chemicals such as insecticides and cleaning sprays, she develops dyspnea, cough, nasal congestion, nausea and headache. Tr. at 371. On an insurance form dated March 8, 1995, Dr. Wilkens said that Plaintiff's symptoms, in addition to those listed in the letter of March 15, include diarrhea, chest congestion, and vomiting. Tr. at 372.

Plaintiff was seen at the emergency room of Iowa Lutheran Hospital on April 2, 1995, at 3:42 a.m., after she fell while getting out of bed. The diagnoses was a sprain of the left shoulder and Plaintiff was given a sling and a prescription of Darvocet. Tr. at 360.

Plaintiff was seen for a disability examination by David P. Harrison, D.O. on May 25, 1995. Tr. at 365-66. Plaintiff told Dr. Harrison that her primary disability was the symptoms she experiences when exposed to pesticides, carpet cleaning solutions and other chemicals. Plaintiff told the doctor that she can walk several miles without difficulty, can climb stairs, stand, sit and bend without problems. She said that she can lift 25 pounds, but that she cannot type well be-cause of her history of carpal tunnel and tendinitis symptoms. Plaintiff said that house cleaning products, perfumes, paints, carpet cleaners, nail polish remover, bug sprays, etc., all affect her breathing. For that reason, when ever she leaves her home, her stay is limited by exposure to those types of things. Plaintiff told the doctor that she no longer drank alcohol or used drugs. And that alcohol caused her joints to ache. Tr. at 365. Plaintiff told Dr. Harrison that she still received psychiatric counseling for stress and depression. After his examination, Dr. Harrison diagnosed, in addition to an upper respiratory infection and tobacco use, "Possible chemical in-duced irritation to her upper airway mucous membranes." Tr. at 366.

David M. Keller, M.D. wrote a report for Disability Determine Services on December 14, 1995. Dr. Keller wrote that whenever Plaintiff is exposed to any chemical, either a cleaning agent or some kind of solvent, she initially gets a headache with a lot of sinus congestion and rhinorrhea and both maxillary sinuses get full and she has pain in that area. After Plaintiff has tearing she develops a severe cough with a lot of phlegm and dyspnea that will last 24 hours. Tr. at 382. Sometimes, wrote Dr. Keller, the coughing gets so bad that Plaintiff has to vomit. Traf-fic fumes cause the same problems. After a physical examination, Dr. Keller wrote:

> Regarding her lungs, she certainly appears to have very significant allergic response to chemicals. It would seem that this could be a limiting factor for her although there should be ample ways of treating that with moderate and easily used agents. I am thinking it would take six to eight months to affect a change in her symptoms with therapy. Any kind of work exposed to chemicals does sound rather significantly serious for her.

Tr. at 384.

On November 4, 1996, Jocelyn Tan-Shalaby, M.D. responded to a request from Plaintiff's attorney to clarify Plaintiff's history of fibromyalgia and irritable bowel syndrome. The doctor explained that she was originally of the opinion that Plaintiff was not taking medication because she was not symptomatic. In reality, however, Plaintiff was not taking medications because she was not able to tolerate them. "She probably has multiple allergies to these medications as well as environmental allergens. Because of this, she has found it almost impossible to gain stable employment. I would assume that this condition is a chronic one unless she seeks special treatment by an allergist." Dr. Tan-Shalaby concluded that the "special treatment" would entail numerous followup visits as well as being expensive. Tr. at 394.

On May 12, 1997, Scott Allen, B.S. and John E. Lindsey, M.S. LMHP, reported that

Plaintiff had been seen for mental health care at Greater Omaha Community Action, Inc. Plain-tiff went to the clinic reporting long term depression. It was noted that Plaintiff's experience of "a series of dehumanizing life events" including physical and sexual abuse, had weakened her ability to cope with stressors. Tr. at 488.

Plaintiff was seen at the Iowa Department of Vocational Rehabilitation. Tr. at 242-49. Although it is difficult to read all of the dates because they are written in the margins and did not photo copy well, it appears that Plaintiff had contact with the agency between November 21, 1991 when she was seen for a psychological evaluation by Eva. Christiansen, Ph.D. (Tr. at 247-48), and sometime in 1994 when her case was closed because Plaintiff had found employment at Communication Data Services (Tr. at 243). Plaintiff was referred to Dr. Christiansen to assess her intellectual functioning and to assess the possibility of a learning disability. On the Wechsler Adult Intelligence Scale - Revised, Plaintiff scored a verbal IQ of 92, a performance IQ of 106, and a full scale IQ of 97. Tr. at 247. After the administration of the Woodcock-Johnson-Revised, Dr. Christiansen observed that Plaintiff's basic math skills fall in the learning disability category. Tr. at 249.