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

	*
ELAINE M. OSWALD,	*
	* 3-01-CV-90004
Plaintiff,	*
	*
v.	*
	*
LARRY G. MASSANARI ¹ , Acting Commissioner	er *
_	*
•	* ORDER
Defendant.	*
	*
v. LARRY G. MASSANARI¹, Acting Commissioner of Social Security,	* * * * * * * * * * ORDER *

Plaintiff, Elaine M. Oswald, filed a Complaint in this Court on January 10, 2001, 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 applications for Social Security Disability Benefits on November 7, 1997, claiming to be disabled since July 28, 1997. Tr. at 112-14 & 434-36. 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 Andrew T. Palestini (ALJ) on

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).

February 15, 2000. Tr. at 54-88. The hearing was reconvened on August 2, 2000, for the purpose of taking testimony from a medical advisor and from a vocational expert. Tr. at 439-77. 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 EVIDENCE

Plaintiff was a patient at the Henry County Health Center in Mt. Pleasant, Iowa from July 28, to August 2, 1997. On July 28, while sitting, Plaintiff experienced pain on the right side of her abdomen. Plaintiff underwent a laparoscopic appendectomy and excision of a left ovarian cyst. Thereafter, Plaintiff was referred to the University of Iowa Hospitals and Clinics because it was felt that she may have had sepsis intra-abdominally and also because of asthma and wheezing. Tr. at 191. Plaintiff arrived at the University on August 2, at which time she underwent exploration and secondary closure of wound dehiscence. Plaintiff was discharged on August 11, 1997. Tr. at 216. The condition on discharge was described as "stable," and Plaintiff was advised to do no heavy lifting for the next six weeks. Tr. at 217. Plaintiff was seen at the University on August 21, 1997 for a follow up examination at which time sutures were removed. Tr. at 218.

On October 7, 1997, Plaintiff was seen by Thomas E. Layman, M.D. at Eastern Iowa Heart Clinic. Plaintiff complained of shortness of breath with activity such as walking across a room or turning over in bed. Plaintiff admitted to smoking a pack of cigarettes daily. Tr. at 221. Dr. Layman started Plaintiff on Lanoxin and Theodur, and "urgently asked her to discontinue her cigarettes smoking." Tr. at 222. An echo-cardiogram on October 14, 1997, "showed a rather

plump somewhat soft nodularities on the mitral valve." Plaintiff was again urged to quit smoking. Tr. at 219. Plaintiff underwent a treadmill test on November 13, 1997. The test was stopped after seven minutes because of fatigue and dyspnea. An electrocardiogram was normal with no evidence of ischemia. Tr. at 220.

Plaintiff's primary care physician is Annette Yvonne Hill, D.O., whose treatment notes are found at pages 223-243 of the record. On August 20, 1997, Plaintiff presented with vague complaints of not feeling well and lack of energy. Tr. at 237. Plaintiff saw Dr. Hill on August 27, 1997 complaining of some lung congestion. Tr. at 236. On September 10, 1997, Plaintiff complained of wheezing and difficulty breathing as well as excessive abdominal gasses and bloating. Tr. at 234. A nebulizer unit was prescribed on September 11, 1997. Tr. at 233. On September 12, 1997, Dr. Hill diagnosed mild congestive heart failure, and prescribed medication for the treatment thereof. Tr. at 232. When seen on September 18, 1997, Plaintiff reported improvement in her coughing, shortness of breath and inability to sleep lying down. Her weight had dropped from 213 to 208. Dr. Hill's diagnosis on this occasion was congestive heart failure resolved. Dr. Hill also noted that Plaintiff "would like to see a different psychiatrist." A referral, therefore, was made to a Dr. Jarvis, and Plaintiff was instructed to discontinue treatment with Dr. Fleming. Tr. at 231. Plaintiff returned to Dr. Hill on September 23, 1997, complaining of shortness of breath, cough, and an inability to lie down at night to sleep. Once again, Dr. Hill diagnosed congestive heart failure and renewed Plaintiff's prescriptions. Tr. at 230. On September 26, 1997, Plaintiff reported that she was feeling better and Dr. Hill opined that the congestive heart failure was resolved. Tr. at 229. On October 23, 1997, Plaintiff complained of abdominal pain which Dr. Hill attributed to adhesions. Tr. at 224. On November 26, 1997

Plaintiff complained of shortness of breath, dyspnea on exertion, and pitting edema in her legs.

Dr. Hill referred Plaintiff to Dr. Layman. Tr. at 223.

Plaintiff saw Dr. Layman on December 2, 1997. It was the doctor's impression that Plaintiff was not suffering from congestive heart failure, but rather that the primary problems were pulmonary. Dr. Layman, therefore, asked Plaintiff to see Thomas Gross, M.D. at a pulmonary clinic in Fairfield, Iowa. Tr. at 256. Plaintiff saw Dr. Gross of the Division of Pulmonary Diseases at the University of Iowa on December 5, 1997. After a review of Plaintiff's history and pulmonary function studies that were completed that day, as well as his own examination, Dr. Gross wrote:

Impression/Recommendations: Exertional dyspnea in an obese young woman - the etiology of her complaints is unclear to me at present. I do not believe her present symptoms suggest active bronchospasm and I question her history of asthma in the past. She has no evidence for desaturation with exercise to the point of limiting dyspnea. She has no obvious evidence for pulmonary hypertension on a recent echocardiogram although this was not specifically performed to evaluate this. Her left ventricular function did appear normal. Her V/Q scan does not suggest pulmonary emboli and, in fact, does not even suggest primary pulmonary hypertension, although it can be normal early in the phase of the disease. I believe the most efficient approach here might be to try and ascertain the cause of her exercise limitation through a formal cardiopulmonary exercise test. Then, once an organ system can be identified which is limiting her, further tests can be honed towards that diagnosis. I asked that she discontinue the Theo-Dur and Lanoxin and I question the need for Accupril given her normal left ventricular function unless this is used for hypertension. I also doubt whether she needs her Azmacort and I asked that she discontinue this, using only prn Albuterol. She will return next week for her cardiopulmonary exercise test. If she develops significant upper airway wheezing, we will also consider fiberoptic laryngoscopy as she could potentially be suffering from vocal cord dyskinesia (functional laryngeal dyskinesia). I also took the liberty of sending thyroid function studies today in the off chance she has occult hypothyroidism. Screening chemistries and CBC's recently through your office were normal.

Tr. at 262-63.

A CT scan of Plaintiff's abdomen taken on February 2, 1998, showed fatty infiltration of the liver with borderline hepatomegaly. Tr. at 244. On April 14, 1998, Plaintiff underwent bilateral coronary arteriogram, left ventriculogram, right and left heart catheterization. The final diagnoses were: 1) Normal left ventriculogram with 72% ejection fraction and no mitral regurgitation; 2) Normal coronary arteries with right coronary artery dominant; 3) Moderate pulmonary hypertension with pulmonary systolic pressure of 64 mm Hg; and, 4) Elevated pulmonary artery capillary wedge pressure of 28 mm Hg. Tr. at 269.

On May 1, 1998, Plaintiff was seen at the University of Iowa by Rudolph P. Galask, M.D. for evaluation of recurrent ovarian cysts. Plaintiff complained of recurrent abdominal pain with referred low back pain. The doctor opined that Plaintiff "most likely has irritable bowel." It was the doctor's impression that Plaintiff has functional bowel disease and he prescribed Metamucil. Tr. at 271.

Plaintiff was hospitalized at the Henry County Health Center May 19 - 23, 1998 for treatment of Cellulitis on her abdomen. Tr. at 273-81.

In an undated report, Dr. Layman wrote an assessment of work related capacities. The doctor wrote:

Lifting and Carrying: Ms. Oswald may lift up to 15 pounds and carry every 15 minutes.

Standing, Walking & Sitting: No limitations.

Stooping, Climbing, Kneeling, Crawling: Ms. Oswald may not do any stooping, climbing, kneeling or crawling.

Handling, Seeing, Hearing, Speaking, Traveling: Unlimited Dust, Fumes, Temperature, Etc: Ms. Oswald must have a clean environment without dust, hazards and fumes. The temperature should be between 60 and 80 degrees.

Tr. at 282.

Plaintiff was hospitalized at the University of Iowa for two days between July 13 and 15, 1998 for gastritis, iron deficiency anemia, and non-alcoholic steatohepatitis. Among other things, Plaintiff complained of pain in the upper right and left quadrants of her abdomen.

Plaintiff was described as an obese, white female lying comfortably in bed, in no acute distress.

Tr. at 295. On discharge, Plaintiff was stable and essentially without complaints. Tr. at 296.

Plaintiff was seen August 17, 1998, by D. Michael Shasby, M.D., at the University of Iowa's Pulmonary Outreach Consultation Clinic. Dr. Shasby wrote that Plaintiff's respiratory function had significantly deteriorated over the previous three to four weeks. The doctor wrote: "Her past history of respiratory disease was relevant in that she says she was born with a collapsed lung and had multiple episodes of what was called pneumonia as a child (perhaps as many as 30). She also had polio at age one." Tr. at 307. On physical examination, it was noted that Plaintiff had "audible wheezes from across the room." In the same paragraph, however, the doctor wrote: "On auscultation she had normal breath sounds. There were no wheezes other than a faint, persistent wheeze on expiration which was really localized over the upper airway and voice box." Dr. Shasby opined that Plaintiff has severe diastolic pulmonary hypertension which required a significant amount of diuresis. Tr. at 308.

Plaintiff was hospitalized at the University of Iowa September 4 to 10, 1998 for revision of her ventral scar. By September 9, 1998, Plaintiff's wound had significantly improved, she was tolerating a regular diet, and she was discharged with a restriction of five pound lifting for six weeks. Tr. at 314. Plaintiff was seen for a followup visit on September 15, 1998. Because Plaintiff complained of pain, she was given a prescription for a 15 day course of Morphine IR.

Tr. at 322.

On December 8, 1998, J. Scott Ferguson, M.D. completed a residual functional capacity check list which was submitted to Disability Determination Services by Plaintiff's counsel. Dr. Ferguson opined that Plaintiff was limited to lifting 5 pounds. When asked for how long Plaintiff is able to stand and walk, the doctor responded 10 minutes without interruption, and a total of two hours in an eight hour day. The doctor stated that Plaintiff can sit without limitation and would not need to lie down during a workday. The doctor said that Plaintiff should never climb, but that she can frequently reach overhead and that she can occasionally balance, stoop, crouch, kneel, and crawl. Likewise, the doctor indicated that Plaintiff can reach, handle, feel, see, hear, and speak. Plaintiff can occasionally push/pull as well as bend forward. The doctor said that temperature and dust can exacerbate Plaintiff's asthma. Tr. at 326. When asked if there were other factors which affected Plaintiff's ability to work, the doctor stated that when Plaintiff is talking, she must stop frequently to catch her breath. Finally, Dr. Ferguson said that Plaintiff is unable to work. Tr. at 327.

When Plaintiff saw Dr. Hill on December 8, 1998, depression was listed among the diagnoses (Tr. at 328) and the doctor prescribed Paxil. Tr. at 329. In a letter dated December 31, 1998, Dr. Hill wrote that Plaintiff had been disabled through 1998 due to surgeries and hospitalizations, and that she would "most likely be disabled in the year 1999." Tr. at 354. Dr. Hill completed a residual functional capacity form (Tr. at 357-60 & 371) dated December 31, 1998, on which she opined, among other things, that Plaintiff is able to lift a maximum of 10 pounds and frequently lift 5 pounds. Tr. at 357. The doctor opined that Plaintiff is able to stand 30 minutes without interruption for a total of two hours in a work day. Tr. at 358. The doctor

concluded the form by opining that Plaintiff is unable to work. Tr. at 371.

Plaintiff was seen at the University of Iowa's Pulmonary Outreach Consultation Clinic on February 9, 1999. Plaintiff reported that Dr. Layman's treatment had markedly improved her shortness of breath, and that she was able to continue with her activities of daily living and was sleeping well. One week prior to the visit, however, she awoke from sleeping in a chair and was unable to move or talk for approximately four hours. At the time of the examination, she was completely better. It was noted that Plaintiff would see a neurologist later in the month. After a physical examination, the doctor opined that Plaintiff has a respiratory disorder although the doctor believed that the primary cause of her shortness of breath was congestive heart failure. Tr. at 361. The second page of the report is missing from the record. On February 19, 1999, Plaintiff saw R. Tyson Garrett, M.D. for a neurological examination. Tr. at 378-80. After his examination, Dr. Garrett opined that Plaintiff had experienced a hypertensive TIA. There was no residuals on the day of the examination and the neurological exam was negative. Tr. at 379. Dr. Garrett ordered a CT scan to rule out a tumor. The scan was negative. Tr. at 380.

On February 14, 1999, Plaintiff went to the emergency room of the Henry County Health Center complaining of chest pain. The doctor's impression was bronchitis and possible asthma exacerbation. Tr. at 362. Plaintiff's heart demonstrated regular rate and rhythm with no murmurs. An EKG showed sinus tachycardia, nonspecific T-wave abnormalities but no other ischemic changes. Tr. at 364. Plaintiff was treated with injections and an albuterol nebulizer after which there was "dramatic improvement of symptoms." Tr. at 365.

Plaintiff was hospitalized at the University of Iowa from May 4 to May 12, 1999 with Diastolic dysfunction, mitral valve regurgitation, pulmonary hypertension, asthma, elevated liver

function tests, and migraine headache. Tr. at 381. Plaintiff's symptoms of asthma improved quickly with treatment. Heart catheterization revealed reveled pulmonary hypertension. Plaintiff was discharged in good condition with an agreement to stop smoking. Tr. at 383.

On June 11, 1999, Plaintiff saw Dr. Ferguson for a follow-up of diastolic dysfunction, mitral valve regurgitation and chronic bronchitis. Tr. at 424 & 401. Since the discharge from the hospital, Plaintiff had been doing relatively well. Noncompliance with the low salt diet had resulted in a return of lower extremity edema for which Plaintiff doubled the dose of Lasix. Plaintiff complained of occasional chest pain and dyspnea after walking several blocks on a level surface. She also complained of orthopnea. Tr. at 424. After the physical examination, Dr. Ferguson noted that Plaintiff's blood pressure medication was "remarkably effective in reducing her wheezing syndrome. Tr. at 401.

Plaintiff was hospitalized at the University of Iowa from January 24, to February 3, 2000, for hepatitis of unclear etiology, choledochal lithiasis status post endoscopic retrograde cholangiopancreatography (ERCP), and abnormal liver function tests. At the time of this hospitalization, Plaintiff was incarcerated at the Iowa Women's Correctional Institute (Department of Corrections medical records are at pages 402-423 of the administrative record). An ultrasound showed hepatomegaly and a liver biopsy showed nonspecific inflammation with mild fatty change, mild fibrosis and portal inflammation suspicious for adverse drug reaction. The ERCP resulted in the extraction of a small stone. On discharge, the etiology of Plaintiff's hepatitis was unclear. Tr. at 426.

ADMINISTRATIVE HEARING

On February 15, 2000, Plaintiff appeared, via the ICN from the prison, at an

administrative hearing. Plaintiff testified that she had been incarcerated for forgery since July 11, 1999, and that in June of 1996 she had been sentenced to 30 days in jail for driving under the influence. Tr. at 57-58. Plaintiff testified that she stopped working in the spring of 1997 because she was unable to breathe in the factory. Tr. at 59.

Plaintiff testified that she had worked in the prison, first for four or five hours, and then, because of her condition, her hours were reduced to one hour, and finally, after the last hospitalization, she had been prohibited from working at all. Tr. at 64. Plaintiff said that she was restricted to lifting no more than five pounds, and that she did not attend classes in the prison because she is unable to sit long enough to attend. Tr. at 65. Plaintiff said that because the prison does not provide her with a low salt diet, fluid builds up and causes her legs and ankles to swell. Tr. at 66.

Plaintiff said that one of her medications, Xyprexa (see Tr. at 186), causes interruptions in her ability to concentrate. "Well, like I can be talking and forget what I'm saying and just forget about it for a few seconds and then sometimes who I'm talking to has to remind me of what I was talking about. Some of that could be caused from the TIAs I had last year too." She said that in April of the previous year, she had suffered a series of the "mini-strokes." Tr. at 68.

Plaintiff said that because of the congestive heart failure, she must sleep with her head propped up and her feet elevated, otherwise she is unable to breathe. Tr. at 70. She said that during the day, she has to lay down three or four times because she gets short of breath. Tr. at 71. Plaintiff said that she was not using the nebulizer at the time of the hearing. Tr. at 73.

Plaintiff testified that she had not used drugs or alcohol since October 12, 1996. Tr. at 73-74.

Referring to the residual functional capacity form filled out by Dr. Hill (Tr. at 359), Plaintiff was asked about her ability to use her hands to grasp, push/pull, and for fine manipulation. Plaintiff responded by saying that since the time of the TIAs, she has had some weakness on the left side of her body and that she is left handed. Tr. at 74. Plaintiff said that her ability to lift was limited to two or three pounds because if she lifted more she becomes exhausted. Tr. at 75.

The hearing was reconvened on August 2, 2000, at which time testimony was taken from medical advisor Paul From, M.D., and from vocational expert Barbara Laughlin. Tr. at 439-477. Plaintiff's attorney noted that Plaintiff had been released from prison and provided the ALJ with a current address and phone number for his client.

Dr. From testified that he had reviewed the medical records and had listened to a tape of Plaintiff's testimony. Tr. at 444. Dr From reviewed the diagnoses from the medical records. Tr. at 444-47. The doctor testified that he had reviewed the Commissioners regulations regarding the listings of impairments. Tr. at 447. The doctor opined that Plaintiff's condition most closely resembled that listed in § 4.02, although he was not able to testify that Plaintiff met the requirements thereof. The doctor said:

I didn't think that she met any of the regulation requirements as such, although the narrative description of 4.02 A did seem to meet that criteria. I think that this had so many complicating features over a long period of time, with different physicians, different studies, very little correlation between the physicians themselves, that it was difficult to pick it out. Listening to her description and from what I could gather from all of the findings, there did appear to be cardiopulmonary impairment here, which probably taken as a whole, is significant.

Tr. at 451. The ALJ asked Dr. From whether Plaintiff's cardiopulmonary impairment was as

severe as any listed under the listings for the cardiac system. Tr. at 451-52. The doctor responded in the affirmative and, when asked to which it would have been comparable, continued:

I think the fact that recurring congestive heart failure along with her respiratory problems, especially of an asthmatic, bronchitis or chronic obstructive pulmonary disease, would make that determination possible. I don't think it can only be an assumption that the problem here is in totality impaired, but not under any one regulation except under the description of 4.02 A. ... I'm not sure that there's any cardiac enlargement that's been document or demonstrated, but certainly there are symptoms at rest, with increasing severity. The other criteria that you listed are mostly there.

Tr. at 452. Dr. From also noted that, while there was a time when Plaintiff had a residual functional capacity which may have allowed her to do some kind of work, when she made the attempt, her condition "began to deteriorate so that further restrictions are placed against her." Tr. at 458. The doctor agreed with the ALJ that between February and the beginning of May of 1999, Plaintiff was able to be rather active, but that thereafter her symptoms progressed to the point that he physician restricted her from working. Tr. at 460. The doctor said that after May of 1999, Plaintiff's condition was more or less stable, or that it progressed downhill. Tr. at 461. Dr. From testified that the reports from Dr. Ferguson and Dr. Hill in the middle of 1999 placed significant limitations on Plaintiff and indicated "significant impairment." Tr. at 461.

ALJ'S DECISION

In his decision, the ALJ first noted that in order to prevail on her Title II claim, it was necessary for Plaintiff to prove that she was disabled on or before September 30, 1998 when she was last insured for benefits. Tr. at 25. The application for Title XVI benefits was filed November 7, 1997. Tr. at 433. Following the familiar five step sequential evaluation, the ALJ

found that Plaintiff had not worked since her alleged onset of disability date, July 28, 1997. At the second step, the ALJ found Plaintiff's severe impairments were pulmonary hypertension, obesity, history of congestive heart failure, and a history of appendectomy and ovarian cystectomy. The ALJ found that none of Plaintiff's impairments meet or equal a listed impairment. At the fourth step, the ALJ found that Plaintiff is unable to return to her past relevant work. At the fifth step, the ALJ found that Plaintiff has a residual functional capacity for a reduced range of sedentary work and that semi-skilled and unskilled jobs exist which Plaintiff can perform in her impaired condition. Tr. at 26-27. The ALJ, therefore, held that Plaintiff was not disabled nor entitled to the benefits for which she applied. Tr. at 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).

The Commissioner's regulations provide that the evaluation of a case proceeds in a five step sequential manner. 20 C.F.R. § 404.15. The sequential evaluation stops anytime a decision of disabled or not disabled is directed; otherwise it proceeds through the fifth and final step. *See Ingram v. Chater*, 107 F.3d 598, 601 (8th Cir. 1997). As in *Ingram*, there is no dispute that Plaintiff in the case at bar met her burden at the first two steps. At the third step, the ALJ found that Plaintiff did not meet her burden of proving that her impairments meet or equal a listed impairment. In the opinion of the Court, this finding is not supported by substantial evidence on the record as a whole.

To assist in making the third step finding, the ALJ called Dr. From to testify as a medical advisor. This is in conformity with the regulations. 20 C.F.R. § 404.1526(b) states: "We will also consider the medical opinion given by one or more medical or psychological consultants designated by the Commissioner in deciding medical equivalence." Dr. From did not provide testimony that Plaintiff meets the requirements of any of the listings. He did, however, establish that Plaintiff's impairments are of a severity which is equal to one which is listed. The critical portion of Dr. From's testimony on this point bears repeating:

I think the fact that recurring congestive heart failure along with her respiratory problems, especially of an asthmatic, bronchitis or chronic obstructive pulmonary disease, would make that determination possible. I don't think it can only be an assumption that the problem here is in totality impaired, but not under any one regulation except under the description of 4.02 A. ... I'm not sure that there's any cardiac enlargement that's been document or demonstrated, but certainly there are symptoms at rest, with increasing severity. The other criteria that you listed are mostly there.

Tr. at 452. Although worded somewhat awkwardly, the Court reads Dr. From's testimony to mean that while Plaintiff's recurring congestive heart failure along with the respiratory problems

do not fit into any specific listing regulation, the result is total impairment which is most closely described in listing 4.02 A.

Social Security Ruling 83-19 (SSR 83-19) establishes three ways in which medical equivalence can be established. The first circumstance is where there is a listed impairment for which one or more of the specified medical findings is missing from the evidence but for which other medical findings of equal or greater clinical significance and relating to the same impairment are present in the medical evidence. Second, where an unlisted impairment in which the set of criteria for the most closely analogous listed impairment is used for comparison with the findings of the unlisted impairment, medical equivalence can be established. The third circumstance in which equivalence can be established is where there is a combination of impairments (none of which meet or equal a listed impairment), each manifested by a set of symptoms, signs, and laboratory findings which, combined, are determined to be equivalent in medical severity to that listed set to which the combined sets can be most closely related.

In the opinion of the Court, Dr. From, the Commissioner's designated medical advisor, clearly established medical equivalence when he testified that a combination of Plaintiff's cardiac and pulmonary problems are as severe as the requirements of listing 4.02 A. In *Paris v*. *Schweiker*, 674 F.2d 707, 709-10 (8th Cir. 1982), the Court wrote:

It is difficult to treat seriously the contention that a person with the foregoing conditions is capable of any gainful activity. To support such a determination by the ALJ, the government attempts to isolate each medical condition and rely on evidence that, at any one point in time, not all of Mrs. Paris's problems were actively concurring. The diabetes is insignificant, under this reasoning, because Mrs. Paris has gone into insulin shock only once and is not presently having such reactions. Two non-examining physicians asserted that the intestinal conditions were not disabling because they have not resulted in end organ damage, malnutrition or vein obstruction. One of these doctors,

never having seen Mrs. Paris, also opined that she "retains a reasonable capacity for seeing, walking, lifting and standing." The government also emphasizes part of one of the treating physician's reports to the effect that at the time of that one report, there were no dizzy spells or skin rashes from the ileostomy bag.

This approach fails to account for the overwhelming evidence that Mrs. Paris's impairments have been chronic and recurring, becoming ever more complicated and requiring ever more restrictions with respect to her activity. Moreover, the non-examining physicians' reports can have little weight, especially when considered against the treating physician's repeated documentation and corroboration of the essential elements of Mrs. Paris's claim. *See*, *e.g.*, *Woodard v. Schweiker*, *supra*. The treating physician also deemed Mrs. Paris disabled due to the combined effects of her conditions.

The fundamental flaw with the government's approach is that it isolates each condition and weighs its effects standing alone. As this Court has stated: In evaluating whether a claimant is capable of engaging in any gainful activity it is essential that the Secretary view the individual as a whole. It is senseless to view several disabilities as isolated from one another as the medical advisers did here. Each illness standing alone, measured in the abstract, may not be disabling. But disability claimants are not to be evaluated as having several hypothetical and isolated illnesses. These claimants are real people and entitled to have their disabilities measured in terms of their total physiological well-being. *Landess v. Weinberger*, 490 F.2d 1187, 1190 (8th Cir. 1974).

Viewing Mrs. Paris's conditions as a whole, we find it impossible to reasonably conclude that she is capable of any gainful activity. This standard is the core of the medical equivalence test and we find that Mrs. Paris has met it. *See* 42 U.S.C. § 423(d)(2)(B). The case is, therefore, remanded with instructions that the Secretary be ordered to pay widow benefits to Mrs. Paris based upon her 1979 claim.

As in *Paris*, in the case at bar neither of Plaintiff's illnesses, alone, may be disabling. Plaintiff, however, suffers from both cardiac and pulmonary illnesses and, in the opinion of the Commissioner's medical advisor, as well as in the opinions of the treating physicians (Dr. Ferguson at page 327 and Dr. Hill at page 371), the result is total disability. Likewise,

Plaintiff's impairments, like those in the *Paris* case, have been chronic, recurring, and progressive. In the opinion of the Court the sequential evaluation should have been stopped at step three. For that reason, it is not necessary to proceed to a review of the fourth and fifth steps of the sequential evaluation. *Bartlett v. Heckler*, 777 F.2d 1318, 1320 n. 2 (8th Cir. 1985) (when the sequential evaluation directs a finding of disabled at the third step, the inquiry need not continue), *citing Heckler v. Campbell*, 461 U.S. 458, 460, 103 S.Ct. 1952, 76 L.Ed.2d 66 (1983). Therefore, a remand to take additional evidence would do nothing other than delay the receipt of benefits to which Plaintiff is entitled. In such a circumstance, a reversal is the appropriate remedy.

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 evidence, particularly the testimony of the medical advisor, establishes that a combination of Plaintiff's impairments is of a severity which equals a listed impairment. 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). *See also, McDannel v. Apfel*, 78 F.Supp.2d 944 (S.D. Iowa 1999) (discussing, among other things, the relationship between the EAJA and fees under 42 U.S.C. § 406 B), and LR 54.2(b).

IT IS SO ORDERED.

Dated this ____27th___ day of July, 2001.

ROBERT W. PRATT
U.S. DISTRICT JUDGE