

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

CAROL D. COCHRAN,

Plaintiff,

v.

LARRY G. MASSANARI¹, Acting Commissioner
of Social Security,

Defendant.

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3-00-CV-90210

ORDER

Plaintiff, Carol D. Cochran, filed a Complaint in this Court on November 17, 2000, seeking review of the Commissioner's decision to deny her claim for Social Security benefits under Title II of the Social Security Act, 42 U.S.C. §§ 401 *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.

Plaintiff filed her application for benefits on November 24, 1997². Tr. at 122-25.

Plaintiff alleged that she became disabled April 4, 1996. Tr. at 118. After the application was denied initially and upon reconsideration, Plaintiff requested a hearing before an Administrative

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).

² Plaintiff filed a prior application on December 2, 1996. Tr. at 118-21. The ALJ did not reopen the prior application and this Court is without jurisdiction to review that decision. *Califano v. Sanders*, 430 U.S. 99, 107-08, 97 S.Ct. 980, 985-86, 51 L.Ed2d 192 (1977).

Law Judge. A hearing was held before Administrative Law Judge Jean M. Ingrassia (ALJ) on March 17, 1999. Tr. at 54-94. The ALJ issued a Notice of Decision – Unfavorable on June 25, 1999. Tr. at 12-40. The decision was affirmed by the Appeals Council of the Social Security Administration on September 21, 2000. Tr. at 78. Plaintiff's Complaint was filed in this Court on November 17, 2000.

MEDICAL EVIDENCE
PRE-ALLEGED ONSET OF DISABILITY EVIDENCE

On February 4, 1985, Plaintiff saw neurologist E. Torage Shivapour, M.D., complaining of intermittent but frequent severe pain in the base of her skull, the back of her neck between the shoulder blades, lower back pain and at times in her lower extremities. Plaintiff also complained of intermittent headaches, emotional disorder, irritability and of being somewhat depressed. Plaintiff related a history of being involved in car accidents in September of 1982, 1977 and 1972. On all occasions, Plaintiff had head trauma, whiplash injuries and multiple bruises. The doctor noted that on November 6, 1984, he had performed EMGs and NCVs, including evaluation of the cervical paraspinal muscles and evaluation of the S1 root, and that all the results were normal. Tr. at 471. When seen again on March 5, 1985, Plaintiff reported doing somewhat better with a decrease in the severity and persistency of the pain and discomfort. Tr. at 470. Plaintiff next saw Dr. Shivapour on October 23, 1987, at which time she stated that she was having headaches and that she was under stress because of a new job as a security guard. Tr. at 469.

On the night of November 17, 1988, while working as a security guard, Plaintiff fell twisting her right ankle, knee, elbow, wrist and back. David C. Wenger-Keller, M.D. referred Plaintiff to Keith W. Riggins, M.D. for an evaluation of the injury to her right wrist which the

doctor suspected may have been a navicular fracture. Tr. at 445. Dr. Riggins saw Plaintiff on November 22, 1988. X-rays of the right wrist, knee, ankle and foot did not reveal fractures or other abnormalities. An x-ray of the lumbar spine was within normal limits with the exception of the possibility of traumatic spondylolysis at L5. Tr. at 462. On January 12, 1989, Dr. Riggins wrote that based on a bone scan which Plaintiff underwent, the spondylolysis was developmental rather than traumatic. Tr. at 459. On January 30, 1989, Dr. Riggins noted that Plaintiff had undergone magnetic resonance imaging which demonstrated posterior midline L3-4 and L4-5 disc protrusion without evidence of impingement on neural structures. EMG studies had demonstrated no evidence of radiculopathy. The doctor wrote that in spite of a failure to improve by all conservative modes of therapy, Plaintiff was not a candidate for surgical treatment. The doctor concluded that Plaintiff was unable to engage in work activities which require prolonged standing or walking, repeated forward bending or significant amounts of lifting for the foreseeable future. Tr. at 458. In a letter dated February 22, 1989, Dr. Riggins stated that Plaintiff had reported a sensation of weakness and a sense of impending collapse of the legs after walking. Examination of Plaintiff's back revealed bilateral paravertebral spasm. The doctor scheduled a repeat MRI to determine if Plaintiff was developing increased prominence of a herniated nucleus pulposus. Tr. at 456. When Plaintiff saw Dr. Riggins on March 22, 1989, she had undergone follow-up EMG and nerve conduction studies which were suggestive of underlying L4 and/or L5 radiculopathy, greater on the left than on the right. Dr. Riggins wrote that it was unlikely that Plaintiff would improve without surgical treatment. Tr. at 455.

On April 10, 1989, Plaintiff saw Jerry L. Jochims (Tr. at 4) on referral from Dr. Riggins for a 2nd opinion regarding surgery. Tr. at 447-48. On physical examination, Plaintiff

demonstrated “remarkable apprehension. She sits in a very guarded fashion, stands in a very stiffened guarded fashion, and moves about very, very stiffly.” Dr. Jochims³ wrote that his review of the x-rays, CAT scans and MRI did not show a condition which should be operated upon. Nevertheless, the doctor wrote that Plaintiff would probably want to have surgery because “she is convinced that surgery is the appropriate answer.” The doctor wrote that he was convinced that Plaintiff would not have a good post-surgical result, and that she should undergo a very intensive type of physical therapy program for exercise and endurance training. He predicted that it would take Plaintiff months to recuperate due to muscle atrophy and weakness. Tr. at 448.

Plaintiff saw Dr. Riggins on July 3, 1989 noting increasing levels of low back pain along with intermittent numbness of the toes of both feet. Examination demonstrated continued paravertebral spasm. Tr. at 454.

On December 28, 1989, Plaintiff saw W.J. Robb, M.D. Tr. at 449-52. On examination of the lumbar spine there was some mild tenderness, but the doctor did not detect any paravertebral muscle spasm. Straight leg raising was performed without pain. Tr. at 450. Dr. Robb wrote:

Review of the x-rays accompanying the patient of the lumbosacral spine included routine x-rays of the lumbosacral spine, right knee, right foot, and thoracic spine and right wrist taken on 11-18-89, and no abnormality of the bone or joint was noted. Tomograms of the lumbosacral spine on 11-29-88 did not show any significant abnormality of the bone or joint. Routine x-rays 11-27-88, oblique views, showed some slight narrowing of the L4-5 and L5-S1 disc

3. The Court assumes that Jerry L. Jochims is a physician because Plaintiff was referred to him by Dr. Riggins for a 2nd opinion regarding the advisability of surgery. No qualification for that individual, however, appear in the record.

spaces. However, there were no adjacent bone spurring or bone abnormality. The CT scan of 12-15-89 showed a slight bulge at L4-5. I felt the bulging centrally at L3-4 was minimal. The bone scan of 12-5-88 was within normal limits. The MRI of 3-1-89 shows a slight bulge at L3-4 centrally and a moderate protrusion at L4-5 centrally.

Dr. Robb stated that Plaintiff's low back was showing improvement and that improvement in her range of motion would be expected. Tr. at 451. "The extent of this (improvement), of course, will depend partly on her commitment to a fairly aggressive exercise program, including walking and possibly even swimming." Tr. at 451-52.

On June 3, 1991, Plaintiff returned to Dr. Riggins with an onset of low back pain seven to ten days previous. Plaintiff had not worked for one week. Examination of the back revealed paravertebral spasm. Otherwise, wrote the doctor, the examination was essentially unchanged. Dr. Riggins said that he had nothing to offer but restriction of activity and use of anti-inflammatory medication. Tr. at 453.

MEDICAL EVIDENCE CONTEMPORANEOUS TO THE CURRENT APPLICATION

Plaintiff was treated at Fort Madison Community Hospital March 8 to 14, 1995 after she was taken to the hospital in a comatose state after an overdose of Elavil and benzodiazepines. Tr. at 253. Plaintiff had been found on the floor by her boyfriend. Plaintiff had gone out drinking after she and her boyfriend had an argument about him leaving. Tr. at 254. Plaintiff told the doctors "that she drinks about a 6-pack every other day or so. She has a history of getting drunk but no history of blackouts, shakes or DTs. She appears to be minimizing her symptoms." Tr. at 256. Psychiatrist Prasad Mikkilineni, M.D. diagnosed, on Axis I, dysthymic disorder. Tr. at 257.

Plaintiff saw Tonita Rios, Ph.D. for a psychological evaluation, at the request of the

Social Security Administration, on December 19, 1996. Tr. at 327-30. Plaintiff was described as a forty-one year old white divorced female. Her chief complaint was: “It’s hard to work in different areas, I have three back injuries, neck surgery, lower back, fall in April I fell and injured lower, lower back.” Tr. at 327. Plaintiff reported that she had never seen a psychiatrist but that Dr. Wenger-Keller and Dr. Shivapour had prescribed Amitriptiline and “a nerve pill” but that she was no longer taking the medication because of the overdose. Tr. at 328. After a mental status examination (Tr. at 329), Dr. Rios diagnosed dysthymic disorder. Dr. Rios wrote:

In terms of a description of limitations of work related activities, this patient will be able to remember and understand simple instructions, procedures and locations. She will be able to carry out simple instructions, maintain attention, concentration and pace. She will be able to interact appropriately with supervisors, co-workers and the public. She will to use (sic) good judgment and respond appropriately to changes in the work place.

Tr. at 330.

On January 8, 1997, Plaintiff saw David C. Wenger-Keller, M.D. Plaintiff reported that she had fallen down cement steps at McDonalds on April 8, 1996 and injured her lower back which had resulted in numbness in the outer aspect of her right foot including her right little toe. Plaintiff said that she was seeing a chiropractor and had been seen by a neurologist (Dr. Shivapour). Plaintiff complained of lower back pain, tail bone pain, shoulder pain, neck pain, and headaches. Plaintiff was working as a waitress 20-30 hours per week. Tr. at 368. After a physical examination (Tr. at 369), Dr. Wenger-Keller diagnosed degenerative disc disease of the back with history of S1 radiculopathy with possible ruptured disc, degenerative disc disease of the neck, chronic pain recently made worse after a fall, chronic depression, cough that hasn’t resolved for a month and a smoker, decreased hearing in left ear for 1 year with family history

positive for hearing loss. Dr. Wenger-Keller wrote:

It is advised that she lift and carry 10 pounds frequently, carry 25 pounds occasionally, she may stand if given an opportunity to sit down. She can move about at her own pace, and she can walk as long as it doesn't need to be straight out walking, such as walking down a road, as she is able to do her job as a waitress. She may sit in an 8 hour work day, but she needs to be given an opportunity to stand up and move around whenever her back is hurting her. She may occasionally stoop, kneel and crawl. She should avoid climbing. There should be no problems with handling objects, seeing, hearing as she could carry on a normal conversation with me in the office, speaking or traveling, although she does say that her back hurts after sitting for about ½ hour. There are no particular reasons for her to avoid dust, fumes or temperature extremes. She should avoid working in high places or operating dangerous equipment.

Tr. at 370. On January 21, 1998, Dr. Wenger-Keller wrote that he had not seen Plaintiff since his examination the previous year. He repeated the lifting restrictions he had given at that time. Tr. at 367.

George Bedell, M.D. of the Pulmonary Clinic at the University of Iowa Hospitals and Clinics (University of Iowa) wrote to Dr. Wenger-Keller on January 29, 1997. Tr. at 360-61. Dr. Bedell found no evidence of pulmonary disease and advised Plaintiff to stop smoking. Tr. at 361.

On February 5, 1997, Plaintiff was seen at the University of Iowa by Ernest M. Found, Jr., M.D. on referral from Dr. Wenger-Keller for evaluation of right foot numbness and low back pain. Dr. Found noted that Plaintiff had a long history of chronic low back pain but that in April of 1996 Plaintiff fell down some steps. Plaintiff had an acute onset of low back pain but no radiculopathy. Plaintiff sought treatment by a chiropractor. About one week after the fall, Plaintiff developed numbness in the lateral aspect of her right foot. Plaintiff's past medical history included a discectomy in her cervical spine. X-rays revealed six lumbar vertebrae but no

other pathology. Dr. Found opined that Plaintiff had mechanical low back pain which was not causing a functional problem. Dr. Found opined that Plaintiff's pain would resolve gradually over time, and stated that he did not expect any permanent neurological sequelae from the condition. Tr. at 353.

Plaintiff was seen again at the University by a physical therapist on November 24, 1997. Plaintiff reported chronic low back pain and more recently neck pain as well. Plaintiff was being seen by a chiropractor. Plaintiff said that she was not doing the exercises she had been shown in February "because she works 2 jobs and feels that it is enough exercise." Tr. at 358.

Plaintiff saw Shan Bedi, M.D. for a disability physical on February 20, 1998. Tr. at 373-76. The report, without explanation, indicates that the examination was interrupted and continued on March 12, 1998, at which time Dr. Bedi wrote:

As far as this patient's physical capacity and limitations are concerned:

1. Lifting and carrying weight: The patient can carry about 15-20 pounds without much problem.
2. Standing, moving about, walking, and sitting for eight hours: If in divided times and with some limitations, the patient should be able to function in a job where she is involved with these activities.
3. Stooping, climbing, kneeling, and crawling: The patient may have a little trouble with these activities because of the pain she is experiencing in the lumbar spine.
4. Handling objects, seeing, hearing, speaking, and traveling: Can be handled without much problem.
5. Work environment, dust, fumes, temperatures, and hazards: Can be handled without much problem.

In summary, I have seen Ms. Carol Cochran before, on February 20, 1998, and looking at the reports she says she was not able to perform those activities today which she was able to do before. She says she had some herniated disk, about a few months ago she had a physical done by Social Security. In my honest opinion she has a tendency to perform some of these activities and she still carries out one job in the college.

Tr. at 374.

Plaintiff was seen at the Spine Diagnostic And Treatment Center of the University of Iowa on March 13, 1998. 377-400. At the conclusion of the evaluation, Dr. Found and Rehabilitation Director Ted Wernimont, MSW, wrote that Plaintiff, because of a recent significant flare up of pain, was limited to a one-time lift – not to be done more than four times per hour – of 5 to 10 pounds. Tr. at 377. Plaintiff was also limited to standing no longer than one-half hour and no repetitive bending, reaching and stooping. “Again, these are not permanent restrictions and we feel will improve as we proceed with a much more positive approach to rehabilitation.” It was recommended that Plaintiff enroll in a two week rehabilitation program at the University. Tr. at 378. Plaintiff saw Dr. Found on April 22, 1998. She presented with a list of 40 items that she was not able to do since February of that year. Plaintiff said that she was prevented from doing her normal daily activities because of pain. On physical examination, Plaintiff’s gait was normal and she was able to ambulate independently, and was able to heel and toe walk although both of those maneuvers produced lower left back pain. Dr. Found recommended an MRI to determine if surgery was indicated. Tr. at 410. On May 8, 1998, Plaintiff spoke with Dr. Watson and Dr. Rashid at the University. The doctors had reviewed the report of the MRI (Tr. at 409). The doctors wrote: “There was no evidence of abnormalities or disc herniations consistent with her physical exam.” Tr. at 408.

In an undated letter to Disability Determination Services, Plaintiff’s chiropractor, Timothy S. Benson, D.C., stated that when she presented to his office, Plaintiff was unable to walk without a cane and was in obvious distress. Dr. Benson stated that Plaintiff continued to have decreased lumbosacral spine range of motion despite making some progress. The doctor

wrote: “Carol cannot lift more than five to eight pounds with any frequency nor any carrying capacity. Her ability to stand is impaired with greatest weight bearing on right leg to decrease left leg pain, cannot stand more than ten minutes.” Dr. Benson also said that Plaintiff is unable to walk more than fifty yards without resting or sit more than ten minutes. Tr. at 431. Dr. Benson opined that Plaintiff’s prognosis was poor and that surgery would not help because of permanent motor and sensory nerve damage. Tr. at 432.

ADMINISTRATIVE HEARING

When Plaintiff appeared at the administrative hearing, she was 43 years old and was attending college. Tr. at 57. Plaintiff said that she gets Bs and Cs in her course work. Tr. at 83.

Plaintiff’s attorney asked her what kind of problems she was having with her back to which she responded that she is unable to do anything repeatedly. Tr. at 68. Plaintiff said that she can lift five pounds. She said that her back hurts her all the time but that some days it’s worse than others depending on the amount of movement she engages in. Tr. at 69.

Plaintiff said that she suffers from depression for which she takes medication. Tr. at 74. Plaintiff said that two or three times a month the depression causes her to stay isolated in her home for two days at a time. Tr. at 75.

Plaintiff testified that she can sit for “maybe a half hour.” Tr. at 76. Plaintiff said that she is unable say how long she is able to stand without changing positions. Tr. at 77. Plaintiff told the ALJ that the last time she had seen Dr. Wenger-Keller was two years before the hearing. Tr. at 79. Plaintiff said that she had never gone to the two week back program at the University of Iowa. Tr. at 80.

After Plaintiff and her mother had testified, the ALJ called Barbara Loughlin to testify as

a vocational expert. Tr. at 88. The ALJ asked the following hypothetical question:

Please consider a 43-year-old individual with a 12th grade education. As to her physical problems, an MRI evaluation as late as May of '98 indicated no abnormalities or disk herniations and no more surgery. There was some indication of a disk bulge at L3, 4/L4,5. She underwent an evaluation which is at Exhibit 11F [Tr. at 373-76], which was prior to the results of the MRI evaluation by Dr. Beebe (phonetic), and he estimated lifting and carrying between 15 and 20 pounds. In regard to walking, sitting and standing, he recommended dividing the time which I presume meant at least an ability to alternate between sitting and standing every couple of hours but that she should not have any problems with these activities, occasional stooping, climbing, kneeling, crawling, no restrictions as to manipulation and no restriction as to environmental factors. In terms of her mental problems, she has been diagnosed as suffering from dysthymic disorder as well as she described herself as an alcoholic with a relapse as late as last year but with good effort she has at least been able to be sober most of the time. She's not under any current treatment for any mental problems, doesn't see any counselor or psychologist on a regular basis, and appears able to understand, remember and carry out instructions, relate appropriately, she's attending school, and appears to be able to concentrate, getting B's and C's, can read the materials that she's assigned and does not appear, except for a couple of times when she's got really depressed, that this condition more than mildly interferes with her ability to mentally function. With those restrictions, would she be able to return to any of her past work activity?

Tr. at 91-92. In response, the vocational expert testified that Plaintiff would be able to return to her past jobs as an assembler of small products, exterminator, dispatcher/jail clerk, and security guard. The vocational expert said that those jobs are in the light work category. Tr. at 92. The vocational expert said that if Plaintiff were, because of depression, absent from work four to six times per month, she would not be able to work. Tr. at 93.

ALJ'S DECISION

In her decision, the ALJ, following the familiar five step sequential evaluation, found that Plaintiff had not engaged in substantial gainful activity since her alleged onset date of April 4,

1996, with the exception of July and August, 1996 and March, April, July, August, October and November of 1997 during which months Plaintiff earned over \$500.00 per month. From March 1997 through February 1998, Plaintiff performed clerical work in a work study program but the ALJ held that this was not substantial gainful activity. Tr. at 34. At the second step of the sequential evaluation, the ALJ found that Plaintiff's severe impairments are chronic lower back pain, complaints of left leg pain; and a history of substance abuse. The ALJ also found that a dysthymic disorder, while not a severe impairment for purposes of the second step, would be considered in combination with her other impairments. At the third step, the ALJ found that Plaintiff's impairments alone or in combination, do not meet or equal a listed impairment. At the Fourth step, the ALJ found that Plaintiff is able to do her past work as a small products assembler, exterminator, dispatcher, jail, security guard, clerk, and cashier. In making the fourth step finding, the ALJ found that Plaintiff has the residual functional capacity consistent with the hypothetical question read to the vocational expert at the hearing. Tr. at 35. It was the decision of the ALJ that Plaintiff is not disabled nor entitled to the benefits for which she applied. Tr. at 36.

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 give controlling weight to the opinion of the treating physician regarding Plaintiff's residual functional capacity. The Court disagrees. Plaintiff was treated by doctors at the University of Iowa who, after a functional capacity evaluation on March 30, 1998, told Plaintiff that she should limit herself to lifting five to ten pounds no more than four times an hour, and that this restriction was related to the significant flare up of pain during the previous several weeks. Plaintiff was also told to limit her standing to one half hour, and not repetitive bending, reaching or stooping. The doctors were quick to add, however, that those were not permanent restrictions but that "we feel will improve as we proceed with a much more positive approach to rehabilitation." Plaintiff was offered the opportunity for a two week rehabilitation program at the University, but for reasons not made clear in the record she did not take advantage of the offer. Dr. Wenger-Keller limited Plaintiff to lifting and carrying ten pounds frequently, and twenty five pounds occasionally. He said that Plaintiff could stand if given an opportunity to sit down, and that she can move about at her own pace, and she can walk as long as it doesn't need to be straight out walking, such as walking down a road, as she is able to do her job as a waitress. She may sit in an 8 hour work day, but she needs to be given an opportunity to stand up and move around whenever her back is

hurting her. The only doctor who put more severe restrictions on Plaintiff's ability was the chiropractor. Although a chiropractor's opinion regarding residual functional capacity should be considered (*Cronkhite v. Sullivan*, 935 F.2d 133, 134 (8th Cir. 1991)(chiropractic opinion may be used only to show how an impairment affects the claimant's ability to work)), an ALJ may reject the opinion of any medical expert if that opinion is inconsistent with the evidence as a whole. *Pierce v. Apfel*, 173 F.3d 704, 707 (8th Cir. 1999). The ALJ in the case at bar chose to rely on the statement of residual functional capacity provided by the examining doctor, Shan Bedi, M.D. While the opinion of a physician who has never examined a claimant, or who has only examined the claimant once, ordinarily does not constitute substantial evidence, *Jenkins v. Apfel*, 196 F.3d 922, 925 (8th Cir. 1999), citing *Kelly v. Callahan*, 133 F.3d 583, 589 (8th Cir. 1998)(the opinion of a consulting physician who examines a claimant once or not at all does not generally constitute substantial evidence), in this case, Dr. Bedi's opinion is consistent with the bulk of the medical evidence in the record including the opinion of Dr. Wenger-Keller and of the doctors at the University of Iowa. The ALJ, therefore, did not commit error by relying on his opinion.

Next, Plaintiff argues that the ALJ erred by discrediting her testimony. Again, the Court disagrees. In *Polaski v. Heckler*, 739 F.2d 1320, 1322, (8th Cir. 1984), the Court wrote:

The absence of an objective medical basis which supports the degree of severity of subjective complaints alleged is just one factor to be considered in evaluating the credibility of the testimony and complaints. The adjudicator must give full consideration to all of the evidence presented relating to subjective complaints, including the claimant's prior work record, and observations by third parties and treating and examining physicians relating to such matters as:

1. the claimant's daily activities;
2. the duration, frequency and intensity of the pain;
3. precipitating and aggravating factors;

4. dosage, effectiveness and side effects of medication;
5. functional restrictions.

The adjudicator is not free to accept or reject the claimant's subjective complaints solely on the basis of personal observations. Subjective complaints may be discounted if there are inconsistencies in the evidence as a whole.

In the case at bar, there is no question that Plaintiff has sustained injuries which limit her ability to work. The question, however, is how much Plaintiff is limited. *Hutton v. Apfel*, 175 F.3d 651, 654 (8th Cir. 1999)(“As is true in many disability cases, there is no doubt that the claimant is experiencing pain; the real issue is how severe that pain is.”)

Plaintiff’s daily activities of going to college undermine her claim that she is unable to work. Furthermore, Plaintiff engaged in significant periods of employment after her alleged onset of disability date. In November, 1997, Plaintiff told the physical therapist at the University of Iowa that she was working two jobs. *See Melton v. Apfel*, 181 F.3d 939, 941 (8th Cir. 1999)(credibility undermined by the fact that Plaintiff continued to work part-time after his alleged onset of disability date).

No one doubts that Plaintiff has chronic and frequent pain in her low back and other areas of her body. Nevertheless, no one, other than the chiropractor, opined that Plaintiff’s pain is so intense as to be totally incapacitating.

The Court can find no evidence of precipitating or aggravating factors discussed in the record which either adds to or detracts from Plaintiff’s credibility.

Plaintiff’s use of medication does not bolster her credibility regarding complaints of pain. At the time of the hearing, the only medication that Plaintiff was taking for pain was non-prescription ibuprofen. Tr. at 242. “The ALJ may properly consider...the type of medication prescribed in order to determine the sincerity of the claimant’s allegations of pain.” *Gray v.*

Apfel, 192 F.3d 799, 804 (8th Cir. 1999). Although Plaintiff was taking medication for depression, she testified that it had been two years since she had seen her doctor.

No functional restrictions, other than those included in the ALJ's hypothetical have been identified in the record. In the February 5, 1997 report, Dr. Found explicitly wrote that Plaintiff's mechanical low back pain was not causing a functional problem.

Likewise, Plaintiff's lack of medical care is inconsistent with a claim of total disability. *Melton v. Apfel*, 181 F.3d at 941. If Plaintiff is unable to afford private physicians, there is no evidence in this record that she is precluded from returning to the University of Iowa where she has received medical care in the past. The long periods of time between doctors visits do not add to Plaintiff's credibility regarding the severity of her pain.

There is no medical evidence to support Plaintiff's testimony that she is as depressed as she testified. Every mental health professional who saw Plaintiff diagnosed a dysthymic disorder which is a chronically depressed mood. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* at page 345. None of those same mental health professionals, however, articulated any limitations as a result of this impairment. Although Plaintiff was taking anti-depressant medication, she admitted that she had not seen the physician who prescribed it for two years to determine if the medication or dosage was still appropriate. It would be reasonable to expect that if Plaintiff were unable to function to the extent that she was able to articulated to the ALJ, that she would have told at least one of the doctors who evaluated her for mental disorders. Plaintiff's ability to work for several months after the alleged onset of disability and her ability to attend school, undermine her credibility regarding the severity of the dysthymic disorder.

The Court finds no fault with the ALJ's credibility finding.

Plaintiff's final argument is similar to her first. She argues that the ALJ's hypothetical questions in incomplete and unsupported by substantial evidence on the record as a whole. The Court disagrees. As stated above, the hypothetical reflected the impairments and limitations identified by the medical experts who have treated and examined Plaintiff. In *Roberts v. Heckler*, 783 F.2d 110, 112 (8th Cir. 1985) the Court wrote that a hypothetical is sufficient if it sets forth the impairments which are accepted as true by the ALJ. In the case at bar, the ALJ's hypothetical question captured the concrete consequences of Plaintiff's impairments and mirrored the limitations supported by the evidence in the record. *Fenton v. Apfel*, 149 F.3d 907, 912 (8th Cir. 1998) (the point of the hypothetical question is to clearly present to the VE a set of limitations that mirror those of the claimant).

It is well settled law that the burden of proof at the first four steps of the sequential evaluation belongs to the claimant. *McCoy v. Schweiker*, 683 F.2d 1138, 1146-47 (8th Cir. 1982)(en banc). In the opinion of the Court, Plaintiff failed to meet her burden of proof that she is unable to do her past relevant work. The Commissioner's final decision, therefore, is affirmed.

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); See also *Holley v. Massanari*, — F.3d — , No. 00-2357, slip op. at 4 (8th Cir. June 15, 2001)(as long as substantial evidence in the record supports the Commissioner's decision, we may not reverse it either because substantial evidence exists in

the record that would have supported a contrary outcome, or because we would have decided the case differently). 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 possible to draw only one conclusion from the evidence in this record, namely that 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 ___15th___ day of June, 2001.



ROBERT W. PRATT
U.S. DISTRICT JUDGE