

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

JACQUELINE T. GRESHAM,

Plaintiff,

vs.

MICHAEL J. ASTRUE,  
Commissioner of Social Security,

Defendant.

No. 3:06-cv-0099-JAJ

**ORDER**

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**I. PROCEDURAL BACKGROUND**

Plaintiff Jacqueline Gresham protectively filed an application for Social Security Disability Insurance on February 19, 2004, alleging an onset date of April 23, 2004 (Tr. 52, 53-55). On August 31, 2004, the Social Security Administration found Plaintiff not to be disabled (Tr. 37-39). Plaintiff timely filed for reconsideration, and was denied by the agency on April 13, 2005. On April 22, 2005, Plaintiff requested a hearing before an Administrative Law Judge (“ALJ”) (Tr. 45). On November 16, 2005, a hearing was held before ALJ George Gaffaney in Davenport, Iowa (Tr. 215-46). Plaintiff was present and represented by attorney Michael DePree. (Tr. 215). Vocational expert Jeff Johnson also testified at the hearing (Tr. 236-42). On June 14, 2006, the ALJ issued a denial of benefits to Plaintiff (Tr. 11-24). Plaintiff requested a review of the hearing decision from the Appeals Council on June 21, 2006 (Tr. 7-8). The Appeals Council denied Plaintiff’s request for review on July 28, 2006 (Tr. 4-6). Pursuant to 42 U.S.C. § 405(g), Plaintiff filed her Complaint in this action on September 20, 2006.

**II. FACTUAL BACKGROUND**

Plaintiff was 56 years-old at the time of hearing (Tr. 233). She is single and has never been married, has no children, and has lived alone in Davenport, Iowa since 2003

(Tr. 141). Prior to 2003, Plaintiff lived in Seattle, Washington for approximately 33 years (Tr. 141).

Plaintiff completed her high school education and attended community college for about two years (Tr. 141). In 1972, Plaintiff obtained employment as a general clerk at Bank of America in Seattle (Tr. 74, 222). Plaintiff worked as a general clerk with Bank of America in Seattle from her date of hire until April 23, 2003, a total of 31 years (Tr. 102). She has worked in the banking industry for a total of 36 years (Tr. 223). Her job duties as a general clerk at a bank included customer service, working with safe deposit boxes, answering phones, looking up customer information such as account numbers, and manually recording customer information (Tr. 103).

Plaintiff's alleged onset date is April 23, 2003 (Tr. 102). She alleges that she is unable to work due to depression, exhaustion, carpal tunnel syndrome in both wrists, tendinitis, and arthritic pain in hands, elbows, hips, knees, and feet (Tr. 17, 101, 220). At hearing, the ALJ determined that Plaintiff had the severe impairments of right carpal tunnel syndrome and Hepatitis B (Tr. 16). The ALJ found that Plaintiff did not have an impairment or combination of impairments that meets or medically equals a listed impairment in 20 CFR Part 404, Subpart P, Appendix 1 (20 CFR 404.1520(d), 404.1525 and 404.1526) (Tr. 17).

#### **A. Relevant Medical History**

Plaintiff had right carpal tunnel release surgery in 2001 (Tr. 209). Plaintiff testified at the hearing that despite surgery, she still experiences pain in her right hand that prevents her from completing daily activities with her right hand, such as eating with utensils (Tr. 230). Plaintiff was approved to undergo left carpal tunnel release surgery, but has not done so because she feels that the surgery did not correct the condition in her right hand (Tr. 209).

On January 28, 2003, Dr. Wallace R. Hodges, M.D., of Seattle, Washington, saw Plaintiff and listed her diagnoses as carpal tunnel syndrome and overuse syndrome, goiter, anxiety/depression/and insomnia, dyspepsia, and possible gluten sens (Tr. 133). Dr. Hodges noted that Plaintiff was taking Neurotin and Percocet for pain associated with carpal tunnel syndrome, Klonopin to aid sleep, Nexium for dyspepsia, and Paxil for depression and anxiety (Tr. 133). Dr. Hodges indicated that he prescribed Oxycotin to Plaintiff on January 8, 2003.

In 2003, Plaintiff saw Dr. Hodges two to three times per month between January and May to address pain associated with carpal tunnel syndrome and to obtain refills of prescriptions (Tr. 116-33). Dr. Hodges reported that Plaintiff was complaining of symptoms of depression or anxiety during at least four appointments (Tr. 121, 131, 132, 133). On February 13, 2003, Dr. Hodges reported that Plaintiff was still having anxiety episodes, despite taking Paxil (Tr. 131). The anxiety episodes were characterized by heart palpitations and rapid heart rate (Tr. 131). On February 25, 2003, Dr. Hodges reported that Plaintiff had received steroid injections in both hands in February to treat pain associated with carpal tunnel syndrome (Tr. 129).

On March 24, 2003, Plaintiff underwent a bilateral x-ray of her hands (Tr. 134). The x-rays were normal, showing no evidence of inflammatory or degenerative arthropathy (Tr. 134). On April 11, 2003, Dr. Peter Mohai, M.D., an apparent associate of Dr. Hodges, examined Plaintiff (Tr. 119). Dr. Mohai stated in his report, "In spite of the normal studies and normal hand x-rays, by symptoms and past examination, she would appear to have an early inflammatory arthritis" (Tr. 119). On May 19, 2003, Plaintiff reported to Dr. Hodges that she had been fired from her job at SeaFirst Bank as a result of a "personality dispute" (Tr. 116). Plaintiff indicated to Dr. Hodges that she was moving to Iowa at the end of May (Tr. 116).

Plaintiff saw Davenport physician Dr. Syed Haque, M.D., for the first time on December 1, 2003 (Tr. 198). Dr. Haque noted that Plaintiff reported a history of chronic pain in hands, arms, shoulders, and neck areas and degenerative joint disease all over her body (Tr. 198). Dr. Haque noted that Plaintiff was taking Vioxx to alleviate pain associated with degenerative joint disease (Tr. 198). Dr. Haque increased Plaintiff's prescription for Vioxx upon her request (Tr. 198). Dr. Haque also noted that Plaintiff had a prescription for Paxil, which she was not taking on the date of the appointment (Tr. 198). Dr. Haque continued to treat Plaintiff for pain and depression between December of 2003 and December of 2004 (Tr. 175-99). Plaintiff saw Dr. Haque seven times in this approximate one-year time period (Tr. 175-99).

On July 13, 2004, Dr. Christine Deignan, M.D., of the Work Fitness Center in Bettendorf, Iowa, conducted a medical evaluation of Plaintiff (Tr. 144-48). Dr. Deignan noted that Plaintiff walked into the clinic dramatically, holding her back and walking very slowly (Tr. 145). Plaintiff reported to Dr. Deignan that she was taking Tramadol, a pain medication, Paxil, and Klonopin (Tr. 145).

During Dr. Deignan's evaluation of Plaintiff's range of motion in her upper extremities, Plaintiff reportedly "whimpered with pain" (Tr. 146). While Plaintiff complained of pain and at times performed slowly throughout the testing of her upper extremities, she was able to complete or substantially perform most of the exercises (Tr. 146). Dr. Deignan found no joint deformities or effusions and no atrophy of thenar eminence nor interosseus muscles (Tr. 146). Dr. Deignan found that Plaintiff had slight swan neck deformity of the right index, middle, and ring fingers and the left index and middle fingers (Tr. 146).

During Dr. Deignan's evaluation of Plaintiff's back, Plaintiff bent forward two-degrees to demonstrate forward flexion, and then collapsed on the floor (Tr. 147). Plaintiff ended up in a squatting position sitting on the step of the exam table, leaning

sideways with her head against the exam table (Tr. 147). According to Dr. Deignan's report, Plaintiff's posture after her collapse demonstrated that Plaintiff had been overstating the amount of pain in her knees, hips, and neck (Tr. 147). As a result of Plaintiff's complaints of pain, Dr. Deignan could not complete the evaluation (Tr. 148).

Dr. Deignan noted that Plaintiff exited the clinic dramatically by walking slowly, bending forward, and holding her back (Tr. 147). Dr. Deignan noted that she observed Plaintiff throw her purse into the car with force, bend at a 90-degree angle to get into her car, and maneuver her car out of the parking lot without difficulty (Tr. 147). Dr. Deignan found that Plaintiff "feigned weakness and limitation of motion in excess during the examination" (Tr. 148).

Following her appointment with Dr. Deignan on July 13, 2004, Plaintiff saw Dr. Phillip L. Kent, Phys.D., ABMPP, of Psychology Associates, Ltd., in Davenport, Iowa (Tr. 140-43). Dr. Kent conducted a psychological evaluation of Plaintiff (Tr. 140-43). Dr. Kent found that Plaintiff has impairment in her attention and concentration (Tr. 143). Dr. Kent found that Plaintiff would have difficulty interacting appropriately with supervisors, coworkers, and the public, and would have difficulty responding to changes in the workplace that involve fast movements or require her to respond quickly to external demands (Tr. 143).

On December 30, 2004, Plaintiff was seen by Dr. Jaroslaw Pryzbyl, M.D., in the Center for Pain Medicine and Regional Anesthesia at the University of Iowa Hospitals and Clinics (Tr. 200). Dr. Pryzbyl found that Plaintiff was suffering from chronic pain syndrome and possibly fibromyalgia (Tr. 201). Dr. Pryzbyl recommended that Plaintiff continue therapy for anxiety and depression, as well as utilize imagery and relaxation techniques for pain control (Tr. 201). Plaintiff was given a prescription for Iodine twice a day and Trazedone for sleep (Tr. 201).

On January 10, 2005, Dr. Kent performed another psychological evaluation of Plaintiff at the request of the agency (Tr. 203-05). Dr. Kent found that Plaintiff appeared slightly more depressed than when he evaluated her in 2004 (Tr. 205). Dr. Kent found that Plaintiff was not impaired in her ability to remember and understand instructions, procedures, and locations, and did not have “clinical significant deficits in her attention and concentration” (Tr. 205). Dr. Kent found that Plaintiff was impaired in her ability to maintain a constant pace at work and was unable to interact appropriately with supervisors, coworkers, and the public (Tr. 205).

### **B. Plaintiff’s Subjective Complaints**

In Plaintiff’s disability forms, she states that she suffers from arthritis in her arms, hands, neck, and shoulders, tendinitis, and carpal tunnel syndrome (Tr. 68, 101). Plaintiff states that she has pain in every joint of her body (Tr. 87). Plaintiff states that her conditions make it difficult to perform simple tasks, such as writing, bathing, dressing, cooking, cleaning, and using the restroom (Tr. 30, 87). In her October 14, 2005, Disability Report, Plaintiff stated:

I am limited because I am not able to write my name or hold a pen for any length of time. I can barely write my name, or complete more than 1/4 of the way through. The pain goes throughout the entire hand. It is in every joint in my hand, down the arm to my shoulders and back and down the rest of the way to my feet.

Plaintiff reports that she is no longer able to take the pain medication Vioxx for relief because it upsets her stomach (Tr. 82, 83). Plaintiff states that she hired a person to pay bills for her because she cannot use her hands to write checks or open mail (Tr. 87).

Plaintiff also states that she suffers from anxiety and depression (Tr. 76). She testified at hearing that she takes Paxil for depression and Klonopin to control her anxiety attacks (Tr. 226). Plaintiff testified that she is unable to “emotionally deal” working as

a customer service position, specifically emphasizing that the “pressures, time constraints, and deadlines” are unmanageable for her (Tr. 228).

### **C. Competing RFCs**

On August 21, 2004, Dr. J.D. Wilson, M.D., provided a medical consult report and a Physical RFC Assessment regarding Plaintiff (Tr. 149-58). Dr. Wilson’s reports appeared to be primarily based on Dr. Deignan’s reports from her examination of Plaintiff and Plaintiff’s medical records (Tr. 149-50). Dr. Wilson stated in his report “CE was unable to determine if she had physical limitations, as she feigned weakness and LOM” (Tr. 149). The only restrictions that Dr. Wilson placed on Plaintiff’s ability to work were that she could occasionally carry twenty pounds, she could frequently carry ten pounds, and that she could stand and/or walk (with normal breaks) about six hours out of an eight hour workday (Tr. 152).

On August 25, 2004, clinical psychologist Dr. Herbert L. Notch, Ph.D., conducted a Psychiatric Review Technique and provided a Medical Consultant Review Summary regarding Plaintiff (Tr. 159-74). Dr. Notch found that Plaintiff suffered from an affective disorder and an anxiety-related disorder (Tr. 159). Dr. Notch found that Plaintiff “has no psychological impairment in her ability to remember and understand tasks and instructions, maintain concentration and attention, interact appropriately with supervisors, coworkers, and the public, use good judgment and handle changes in the workplace” (Tr. 173).

Plaintiff’s treating physician, Dr. Haque, completed the form “Medical Opinion Re: Ability to Do Work-Related Activities (Mental)” (Tr. 176-78). The form, which appeared in the record immediately before the “Physical RFC Questionnaire,” was undated and unsigned (Tr. 178). In regards to the mental abilities and aptitudes necessary to perform unskilled work, Dr. Haque reported in over half the categories that Plaintiff had poor or none of such abilities (Tr. 176). Dr. Haque attributed the low scores to Plaintiff’s diffuse pain and resultant restrictions in performing simple tasks (Tr. 176). In regards to the

abilities necessary to perform semiskilled and skilled work, Dr. Haque reported in three of four categories that Plaintiff had poor to no such abilities (Tr. 177). Dr. Haque explained his responses by noting that Plaintiff had problems with concentration and performing repetitive actions (Tr. 177). In regards to the mental abilities and aptitudes necessary to perform particular types of jobs, Dr. Haque reported twice that Plaintiff had poor to no such abilities, twice that she had fair abilities, and once that she had good abilities (Tr. 177). Dr. Haque stated that Plaintiff would miss work four or more days monthly on average due to her impairment or treatment (Tr. 177).

On December 27, 2004, Dr. Haque completed the form "Physical RFC Questionnaire" (Tr. 179-82). Dr. Haque listed Plaintiff's diagnoses as depression, anxiety, and degenerative arthritis (Tr. 179). Dr. Haque reported that Plaintiff suffered from constant and overwhelming joint pain in her neck, back, arms, shoulders, hips, knees, hands, and feet that prevents her from being able to maintain any type of employment (Tr. 179-82). Specifically, Dr. Haque found that Plaintiff needs to take a break from work every five minutes to lie down and would need to rest 30 minutes before returning to work (Tr. 181). In response to the question whether or not Plaintiff's condition would cause her to experience "good days" and bad days," Dr. Haque marked "No," explaining that Plaintiff will always feel pain and will never have a "good day" (Tr. 182).

On December 6, 2005, Dr. Stanley Rabinowitz, M.D., of Silvis, Illinois, performed a Consultative Examination of Plaintiff (Tr. 209-14). Dr. Rabinowitz found that Plaintiff had a decreased range of motion in the shoulders, elbows, and lumbar spine (Tr. 212-13). Dr. Rabinowitz found no evidence of active joint inflammation, instability, contracture, or paravertebral muscle spasm (Tr. 212). Dr. Rabinowitz noted that "The patient complained of pain which was out of proportion to the objective findings present" (Tr. 210). Dr. Rabinowitz found that Plaintiff would be able to do gross and fine motor movements with either hand" (Tr. 212). Dr. Rabinowitz noted that Plaintiff "had no difficulty getting on and off of the examining table but had mild difficulty squatting with support (Tr. 212).

Dr. Rabinowitz noted in the report that Plaintiff's cooperation during the evaluation was adequate, and that she put forth limited effort when testing grip strength and digital dexterity (Tr. 211).

#### **D. Hearing Testimony**

On November 16, 2005, Plaintiff appeared with her attorney, Michael DePree, before ALJ George Gaffaney for a hearing in Davenport, Iowa (Tr. 215). Vocational expert Jeff Johnson also appeared at the hearing (Tr. 215).

##### **1. Plaintiff's Testimony**

Plaintiff testified that she is unable to work due to depression and pain in her hand, elbow, shoulders, hips, knees, and feet (Tr. 220). With medication, Plaintiff rated her level of pain as a seven on a scale of one to ten (Tr. 227). Plaintiff testified that she stopped working in April of 2003 because she was "tired, worn out, and exhausted" and could not do her job anymore (Tr. 223). Plaintiff testified that while living in Seattle, she took the pain medications Percocet, Morphine, and Oxycotin to relieve her joint pain, but at the time of hearing was no longer taking such medications because she had been unable to see a doctor in the past year (Tr. 224). Plaintiff testified that she takes Paxil for depression, Klonopin for anxiety, Tramadol, Tylenol, and Ibuprofen for pain, and Prilosec and other over-the-counter medications to deal with stomach sensitivity (Tr. 226-27).<sup>1</sup> Plaintiff testified that due to anxiety and depression, she is unable to emotionally deal with pressures, time constraints, and deadlines associated with being employed in a customer service position (Tr. 228). Plaintiff testified that the constant pain she experiences impairs her concentration (Tr. 229).

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<sup>1</sup> Plaintiff testified that she is able to obtain refills of prescriptions without having seen a doctor in the past year because she calls the prescriptions into the clinic and the clinic has, so far, filled them for her (Tr. 232). Plaintiff testified that she sometimes waits up to a couple of weeks for the prescriptions to be filled by the clinic (Tr. 232).

Plaintiff testified that she was experiencing one of her most painful days when Dr. Deignan examined her on July 13, 2004 (Tr. 230). Plaintiff testified that Dr. Deignan forced her body into positions that caused Plaintiff pain (Tr. 229). Plaintiff testified that Dr. Deignan “got very red in the face” and stopped the examination when Plaintiff reported that she was in pain (Tr. 229). Plaintiff testified that she had “no idea what she was talking about” in regards to Dr. Deignan’s report that Plaintiff bent at a 90-degree angle and threw her purse into the car with force following Dr. Deignan’s evaluation of Plaintiff on July 13, 2004 (Tr. 229).

Plaintiff testified that she is unable to write her name, use a fork, or drink from a glass with her right hand (Tr. 230). She testified that the pain in her right hand makes it difficult for her to bathe and use the restroom (Tr. 230-31). Plaintiff testified that she had not driven her car in the past year and that she uses cabs and friends for transportation (Tr. 231, 234). She testified that even though July 13, 2004 was one of her most painful days, she drove to her appointment with Dr. Deignan because she felt she had no other choice (Tr. 235-36). She testified that the driving causes her excruciating pain and she does not do it unless it is absolutely necessary (Tr. 236).

## **2. Vocational Expert’s Testimony**

The ALJ asked the vocational expert three hypothetical questions (Tr. 238-39). First, the ALJ instructed the vocational expert to consider a hypothetical individual who is age 56 and was age 54 at alleged onset date of disability, and has the same past relevant work as Plaintiff (Tr. 238). The ALJ then asked if this hypothetical individual would be able to perform her past relevant work if she had the following restrictions: could lift no more than twenty pounds and could frequently lift ten pounds; could stand and sit for six hours each in an eight-hour work day; could occasionally climb, balance, kneel, crouch, or crawl; have no production rate pace, with production rate pace defined as strict quotas or time frames (Tr. 238). The vocational expert testified that the hypothetical individual could perform both customer service and clerical work under such restrictions (Tr. 238).

Second, the ALJ proposed to the vocational expert the same hypothetical as above, except he added a restriction of occasional interaction with the public and coworkers (Tr. 238). The ALJ asked the vocational expert if the hypothetical individual could perform any of the past relevant work under such restrictions (Tr. 238). The vocational expert testified that the hypothetical individual could perform clerical work, but could not perform customer service work due to the restriction of occasional public interaction (Tr. 238).

Third, the ALJ asked the vocational expert whether the hypothetical individual would be able to perform clerical work if she were under the following restrictions: could lift no more than ten pounds and could frequently lift five pounds; could stand for two hours and sit for six hours during an eight-hour work day; 30-minute limit on sitting, then a brief change; 30-minute limit on standing, then a brief change; could occasionally climb, balance, kneel, crouch, or crawl; have no production rate pace, with production rate pace defined as strict quotas or time frames; could have occasional interaction with public and coworkers (Tr. 239). The vocational expert testified that the hypothetical individual could not perform clerical work under such restrictions because of the limitation of lifting no more than ten pounds and lifting five pounds frequently (Tr. 239).

Plaintiff's attorney asked the vocational expert two hypothetical questions. First, Plaintiff's attorney asked the vocational expert to consider a hypothetical individual, age 56, with the sole restriction of no interaction with the public, coworkers, or supervisor (Tr. 239-41). Plaintiff's attorney asked the vocational expert if the hypothetical individual would be able to return to past relevant work, transfer skills to other work, or do unskilled work under such a restriction (Tr. 241). The vocational expert testified that the hypothetical individual would likely be precluded from securing employment under such restriction because it would be very difficult for a person to work at a job without communicating with coworkers, supervisors, or the public (Tr. 241). Second, Plaintiff's attorney asked the vocational expert whether competitive employers would tolerate an employee who was absent more than four days per month (Tr. 242). The vocational expert

testified that a competitive employer would not tolerate an employee who was absent more than four days a month (Tr. 242).

### **III. CONCLUSIONS OF LAW**

#### **A. Standard of Review**

In order for the court to affirm the ALJ's findings of fact, those findings must be supported by substantial evidence appearing in the record as a whole. See Lochner v. Sullivan, 968 F.2d 725, 727 (8th Cir. 1992); Cruse v. Bowen, 867 F.2d 1183, 1184 (8th Cir. 1989). Substantial evidence is more than a mere scintilla. It means relevant evidence a reasonable mind might accept as adequate to support a conclusion. Richardson v. Perales, 402 U.S. 389, 401 (1997); Cruse, 867 F.2d at 1184; Taylor v. Bowen, 805 F.2d 329, 331 (8th Cir. 1986). The court must take into account evidence that fairly detracts from the ALJ's findings. Cruse, 867 F.2d at 1184; Hall v. Bowen, 830 F.2d 906, 911 (8th Cir. 1987). Substantial evidence requires "something less than the weight of the evidence, and the possibility of drawing two inconsistent conclusions from the evidence does not prevent an administrative agency's findings from being supported by substantial evidence." Cruse, 867 F.2d at 1184 (quoting Consolo v. Fed. Mar. Comm'n, 383 U.S. 607, 620 (1966)). The court must consider the weight of the evidence appearing in the record and apply a balancing test to contradictory evidence. Gunnels v. Bowen, 867 F.2d 1121, 1124 (8th Cir. 1989); Gavin v. Heckler, 811 F.2d 1195, 1199 (8th Cir. 1987).

#### **B. ALJ's Disability Determination**

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

The five steps are:

- (1) If the claimant is engaged in substantial gainful activity, disability benefits are denied.
- (2) If the claimant is not engaged in substantial gainful activity, her medical condition is evaluated to determine

whether her impairment, or combination of impairments, is medically severe. If the impairment is not severe, benefits are denied.

- (3) If the impairment is severe, it is compared with the listed impairments the Secretary acknowledges as precluding substantial gainful activity. If the impairment is equivalent to one of the listed impairments, the claimant is disabled.
- (4) If there is no conclusive determination of severe impairment, then the Secretary determines whether the claimant is prevented from performing the work she performed in the past. If the claimant is able to perform her previous work, she is not disabled.
- (5) If the claimant cannot do her previous work, the Secretary must determine whether she is able to perform other work in the national economy given her age, education, and work experience.

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

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

Under the first step of the analysis, the ALJ found that Plaintiff has not engaged in substantial gainful activity at any relevant time (Tr. 16). Under the second step, the ALJ found that the Plaintiff has the severe combination of impairments of right carpal tunnel

syndrome and Hepatitis B (Tr. 16). Under the third step of the analysis, the ALJ found that the Plaintiff's impairments individually or in combination do not meet or medically equal one of the listed impairments (Tr. 17). Under the fourth step, the ALJ found that the Plaintiff was capable of performing her past relevant work as a general clerk and customer service representative (Tr. 23). Thus, the ALJ found that Plaintiff was not disabled at any time during the requested period of disability (Tr. 23-24). The ALJ found that Plaintiff had the following residual functional capacity: "lift twenty pounds occasionally and ten pounds frequently; stand and sit for six hours in an eight hour work day; occasionally climb stairs, climb ladders, balance, stoop, kneel, crouch, and crawl; no production rate pace defined as a strict quotas or time frames" (Tr. 17).

**C. ALJ's Denial of Plaintiff's Request to Subpoena Dr. Deignan for  
Cross Examination During Hearing**

The use of subpoenas in a Social Security hearing is governed by 20 C.F.R. § 404.950(d)(1)-(4).

- (1) When it is reasonably necessary for the full presentation of a case, an administrative law judge or a member of the Appeals Council may, on his or her own initiative or at the request of a party, issue subpoenas for the appearance and testimony of witnesses and for the production of books, records, correspondence, papers, or other documents that are material to an issue at the hearing.
- (2) Parties to a hearing who wish to subpoena documents or witnesses must file a written request for the issuance of a subpoena with the administrative law judge or at one of our offices at least 5 days before the hearing date. The written request must give the names of the witnesses or documents to be produced; describe the address or location of the witnesses or documents with sufficient detail to find them; state the important facts that the witness or document is expected to prove; and indicate why these facts could not be proven without issuing a subpoena.

20 C.F.R. § 404.950(d)(1) and (2).

Plaintiff argues that the ALJ violated her right to procedural due process by denying her request to subpoena Dr. Deignan, the author of a pre-hearing report, for cross examination because cross examination of Dr. Deignan was “reasonably necessary for the full presentation of a case.” 20 C.F.R. § 404.950(d)(1). Plaintiff essentially argues that a claimant has an absolute right to cross examination during a hearing under Richardson v. Perales, 402 U.S. 389, 410, (1971), Goldberg v. Kelly, 397 U.S. 254, 270 (1970), and Coffin v. Sullivan, 895 F.2d 1206 (8th Cir. 1990). Defendant argues that a claimant does not have an absolute right to cross examination of the author of a report in a hearing. Defendant argues that the decision to grant a claimant’s request to subpoena a witness is within the discretion conferred on the ALJ in 20 C.F.R. § 404.950(d)(1) and that the ALJ in this case properly exercised such discretion to fulfill his obligation to provide a “full presentation of a case.” 20 C.F.R. § 404.950(d)(1) . This Court finds that the ALJ did not violate Plaintiff’s procedural due process right by denying her request to cross examine Dr. Deignan at hearing. This Court does not purport to determine definitively if the Eighth Circuit Court of Appeals recognized in Coffin a claimant’s absolute right to cross examine an author of a report in a hearing under Perales.<sup>2</sup> However, unlike the

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<sup>2</sup>In Coffin, the Eighth Circuit Court of Appeals stated “The ALJ is required to allow the claimant to cross examine the witness, but if the claimant’s attorney fails to object to the post-hearing reports or remains silent when the opportunity to request cross-examination arises, the right to cross-examination is waived.” Coffin, 895 F.2d at 1212. There are no cases in the Eighth Circuit that interpret Coffin to confer on a claimant an absolute right to cross examination of an author of a pre-hearing report during a hearing. In Coffin, the Eighth Circuit Court of Appeals found that the ALJ did not violate a claimant’s right to due process when he failed to inform Plaintiff that he had a right to cross examination of an author of a post-hearing report. Coffin, 895 F.2d at 1212. The ALJ in Coffin informed Plaintiff about the post-hearing report, permitted Plaintiff to object to the ALJ’s written interrogatories prior to submission, permitted Plaintiff to submit own interrogatories, and presented completed report to Plaintiff with a request for Plaintiff’s comments or further evidence. Coffin, 895 F.2d at 1210-11.

vocational expert's post-hearing report in Coffin, Dr. Deignan provided a pre-hearing report regarding claimant's alleged disabilities, of which Plaintiff had notice. See Flatford v. Chater, 93 F.3d 1296, 1300 (6th Cir. 1996) citing Calvin v. Charter, 73 F.3d 87, (6th Cir. 1996) (holding that a claimant does not have an absolute right to cross examine a physician that provided a pre-hearing report). Unlike the claimant in Coffin, Plaintiff had an opportunity to rebut at hearing and did extensively rebut at hearing Dr. Deignan's allegations in the report (Tr. 229-230, 236-36). See Bush v. Apfel, 34 F.Supp.2d 1290, 1298-99 (N.D. Okla, 1999) (holding that an ALJ did not abuse discretion when he denied claimant's request to subpoena an author of a report because the claimant rebutted the allegations in the report at two subsequent hearings and claimant was permitted to submit additional medical evidence to contradict report). The ALJ also allowed Plaintiff to introduce additional medical evidence to refute Dr. Deignan's report by permitting Plaintiff to undergo a post-hearing examination with Dr. Rabinowitz in order to rebut Dr. Deignan's allegations (Tr. 244-45). Id. Thus, this Court finds that the ALJ did not violate the procedural due process rights of Plaintiff by denying her request to subpoena Dr. Deignan for cross examination.

#### **D. ALJ's Refusal to Accord Any Weight to Treating Physician's Opinion**

##### **Based on Absence of Signature**

"A treating physician's opinion should not ordinarily be disregarded and is entitled to substantial weight. A treating physician's opinion regarding an applicant's impairment will be granted controlling weight, provided the opinion is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the record." Singh v. Apfel, 222 F.3d 448, 452 (8th Cir. 2000) (citing Ghant v. Bowen, 930 F.2d 633, 639 (8th Cir. 1991)). "The ALJ may discount or disregard such an opinion if other medical assessments are supported by superior medical evidence, or if the treating physician has offered inconsistent opinions." Hogan v. Apfel, 239 F.3d 958, 961 (8th Cir. 2001). Moreover, a treating physician's

opinion does not deserve controlling weight when it is nothing more than a conclusory statement. Piepgas v. Chater, 76 F.3d 223, 236 (8th Cir. 1996). See also Thomas v. Sullivan, 928 F.2d 255, 259 (8th Cir. 1991) (holding that the weight given a treating physician's opinion is limited if the opinion consists only of conclusory statements).

Plaintiff argues that the ALJ improperly disregarded a mental assessment and a RFC questionnaire that were completed by Dr. Haque, Plaintiff's treating physician. Plaintiff argues that the ALJ's RFC formulation and hypothetical questions to the vocational expert were improper because they did not take into consideration Dr. Haque's reports, which included mental limitations for Plaintiff. Defendant argues that the ALJ properly weighted the medical evidence, and that the ALJ's RFCs were proper because they are supported by substantial evidence in the record.

In his decision, the ALJ states, "The undersigned accords no weight to the checklist from the primary care physician as the mental assessment was not signed . . ." (Tr. 23). The regulations require the ALJ to give reasons for giving weight to or rejecting the statements of a treating physician. See 20 C.F.R. § 404.1527(d)(2). Whether the ALJ gives great or small weight to the opinions of treating physicians, the ALJ must give good reasons for giving the opinions that weight. Holmstrom v. Massanari, 270 F.3d 715, 720 (8th Cir. 2001). In the record, Dr. Haque's physical RFC Questionnaire, which is signed and dated by Dr. Haque, immediately follows the mental assessment (Tr. 176-82). Dr. Haque's handwriting on the physical assessment clearly matches the handwriting found on the mental assessment. (Tr. 176-82). The ALJ's summary dismissal of the treating physician's opinion because it lacked a signature, without further inquiry or action by the ALJ, does not comply with the requirements of the regulations. See 20 C.F.R. § 404.1512(e) ("We will seek additional evidence or clarification from your medical source when . . . the report does not contain all the necessary information . . ."). This Court

finds that the ALJ erred in according no weight to the opinion of the treating physician, Dr. Haque based upon the lack of signature.

In his decision, the ALJ stated that he accorded no weight to Dr. Haque's RFC questionnaire because "the physical assessment was not supported by other evidence or third party statements" (Tr. 23). The ALJ referred to Dr. Haque's RFC questionnaire on only one other instance in his decision.<sup>3</sup> It is well-established in the case law that the report of a treating physician should be accorded some amount of weight in determining the disability of a claimant. See Singh, 222 F.3d at 452 (citing Ghant v. Bowen, 930 F.2d 633, 639 (8th Cir. 1991)); Reed v. Barnhart, 399 F3d 784, 786 (8th Cir. 1995). An ALJ can disregard reports by a treating physician "if other medical assessments are supported by superior medical evidence, or if the treating physician has offered inconsistent opinions." Hogan, 239 F.3d at 961. The ALJ summarily dismissed Dr. Haque's RFC questionnaire without providing a reason or explanation in his decision, as is required by the case law. This Court finds that remand is necessary so that the ALJ can properly assess the weight to be afforded to Dr. Haque's opinion, pursuant to the legal standards set forth above.

#### **E. ALJ's Credibility Determination**

The ALJ made the following remarks regarding Plaintiff's credibility after finding the that her statements concerning her symptoms were "not entirely credible:"

There is evidence that the claimant stopped working for reasons not related to her allegedly disabling impairments. The claimant alleged performing few, if any, household chores. Yet, she lives alone and reported obtaining assistance only with yard work in maintaining the residence. The

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<sup>3</sup> The ALJ stated, "Dr. Haque completed a checklist for the claimant's representative indicating various extreme physical restrictions. However, the severe restrictions are not supported by objective findings" (Tr. 21).

claimant indicated she could slowly prepare simple meals, clean, and do laundry. The record reveals the claimant failed to follow-up on recommendations made by physicians with respect to an endocrinologist consultation and she declined mental health services, suggesting symptoms may not have been as serious as alleged. Significant narcotic use was noted early on in the claimant's history of treatment and later notes indicated that the claimant was very vague concerning medication dosages. The claimant described extreme severity of pain including sharp, burning, aching, stabbing, shooting, and throbbing pain in all joints of her body sparing none resulting in more than one opinion indicating pain was out of proportion to the objective findings present. There is evidence that the Plaintiff was less than fully cooperative and put forth less than maximal effort during examinations. Although the undersigned finds drug addiction and alcoholism are not contributing factors not material to the determination of disability, the issue of alcohol use raises a question with respect to Plaintiff's credibility. The claimant reported drinking 15 alcoholic beverages per week to a specialist at the pain clinic; however she did not disclose the information to her primary care physician or consultative examiners. For these reasons, the undersigned finds the claimant has been less than credible regarding her allegation that she is totally disabled. (Tr. 22).

When evaluating the credibility of a claimant's subjective complaints, the ALJ may not disregard them "solely because the objective medical evidence does not fully support them." Polaski v. Heckler, 739 F.2d 1320, 1322 (8th Cir. 1984). "The [ALJ] is not free to accept or reject the claimant's subjective complaints solely on the basis of personal observations. Subjective complaints may be discounted if there are inconsistencies in the evidence as a whole." Id. In evaluating claimant's subjective impairment, the following factors are considered: (1) the applicant's daily activities; (2) the duration, frequency and intensity of pain; (3) precipitating and aggravating factors; (4) dosage, effectiveness and side effects of medication; and (5) functional restrictions. Id. at 1321-22. Subjective complaints may be discounted if inconsistencies exist in the evidence as a whole. Hinchey

v. Shalala, 29 F.3d 428, 432 (8th Cir. 1994); Woolf v. Shalala, 3 F.3d 1210, 1213 (8th Cir. 1993). Where an ALJ seriously considers but for good reasons explicitly discredits a plaintiff's subjective complaints, the court will not disturb the ALJ's credibility determination. Johnson v. Apfel, 240 F.3d 1145, 1147 (8th Cir. 2001).

This Court finds that the ALJ should have taken into consideration Plaintiff's 36-year work history in determining her credibility. "The existence of a strong and consistent work record should and must be an important factor in assessing credibility." Duncan v. Harris, 518 F.Supp. 751, 758 (E.D. Ark. 1980). "An ALJ may properly consider a claimant's work record in determining the claimant's credibility." Rhodes v. Apfel, 40 F.Supp.2d 1108, 1124 (citing Brown v. Sullivan, 958 F.2d 817, 821 (8th Cir. 1992) and Polaski, 739 F.2d at 1332. The record demonstrates that Plaintiff worked as a clerk for Bank of American for 31 years and in the banking industry for 36 years. On remand, the ALJ shall consider this factor as well and reassess Plaintiff's credibility.

Upon the foregoing,

**IT IS ORDERED** that the decision of the Commissioner of Social Security is hereby reversed and this matter is remanded for further proceedings, consistent with this opinion.

**DATED** this 28<sup>th</sup> day of September, 2007.

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