

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

DEBRA K. SEARS,
Plaintiff,

vs.

MICHAEL J. ASTRUE,
Commissioner of Social Security,
Defendant.

4:07-cv-00216-JAJ

ORDER

This matter comes before the court pursuant to briefs on the merits of plaintiff's applications for disability insurance benefits and supplemental security income benefits. The final decision of the Commissioner of Social Security is remanded to the ALJ for further proceedings, consistent with this opinion.

I. PROCEDURAL BACKGROUND

Plaintiff Debra K. Sears applied for disability benefits on January 8, 2004, alleging an inability to work since September 19, 2002 (Tr. 64-66). Sears later amended her alleged onset date to May 12, 2003 (Tr. 81). Sears application was denied initially, and on reconsideration (Tr. 40-46; 50-51). Sears requested a hearing by an Administrative Law Judge ("ALJ") (Tr. 57). A hearing before ALJ Jean M. Ingrassia was held on February 10, 2006 (Tr. 657-91). The ALJ denied Sears' appeal in a decision dated September 1, 2006 (Tr. 15-29). The Appeals Council denies Sears' request for further review on April 26, 2007 (Tr. 7-9). This action for judicial review was filed on May 17, 2007.

II. FACTUAL BACKGROUND

A. Medical History

On November 28, 2002, Sears was seen at the Grinnell Regional Hospital emergency room complaining of “episodic ‘numbness’ in her hand off and on for the last week or so.” (Tr. 381).

On December 19, 2002, Sears was seen by Dr. Edward A. Aul, M.D., of the University of Iowa Hospitals and Clinics (UIHC) Department of Neurology (Tr. 355-56). On December 20, 2002, Dr. Aul wrote a letter to Sears’ primary care physician, Dr. Dustin Arnold, M.D., wherein he diagnosed Sears with left hemispheric cerebral infarction and symptomatic left carotid artery stenosis (Tr. 355). Dr. Aul further wrote “She has had good neurologic recovery and currently has only mild impairment of fine motor skills in her right hand. She is found to have symptomatic left carotid artery stenosis, which accounts for the ischemic changes noted on neuroimaging studies. She will be referred to vascular surgical evaluation.” (Tr. 356).

On January 13, 2003, Sears underwent a left carotil endarterectomy (Tr. 230-232). On September 12, 2003, Sears underwent a left superficial parotidectomy (Tr. 254-58). On May 15, 2003, Dr. Aul wrote:

[Sears] developed a stroke circa 11/02, due to which she has residual weakness and numbness of her right arm. She has also noticed mild cognitive and language problems. She was found to have high grade blockage of the left internal carotid artery, for which she underwent surgery with success. She has been referred to occupational therapy to improve upon strength and coordination of her right arm. Neuropsychological tests will be performed to assess her language and memory. Further management will be addressed as necessary. She may continue to work, as she tolerates. Sh has not requested any particular restrictions at this time.

(Tr. 329).

Also on May 15, 2003, Dr. Aul wrote a more detailed letter to Sears' primary care physician, Dr. Arnold (Tr. 332-33). Dr. Aul's letter to Dr. Arnold, which followed Sears' May 8, 2003 follow-up appointment with Dr. Aul states, in pertinent part:

Speech was fluent. Comprehension was normal. Naming was unimpaired. Visual fields were full. Extraocular movements were intact . . . Motor strength was 5/5 in all extremities, with the exception of 4+/5 in the right hand . . . Finger tapping movements were slowed in the right hand.

(Tr. 332)

On May 13, 2003, Sears underwent a neuropsychological examination at the UIHC (Tr. 335). The results of the examination state, in relevant part:

Cognitive difficulties were not evident to the patient until she returned to work following the CVA, where mistakes were noticed by supervisors. It is notable that the patient started her current position in April, 2002, but was on medical leave for approximately 4 months for unrelated medical conditions prior to the CVA in November, 2002; she reports that she missed some important work training sessions, as a result.

Impressions: In the context of emotional distress, current neuropsychological evaluation indicated mild inefficiency on measures of executive function (e.g., speeded set shifting, complex nonverbal problem-solving), variability in auditory attention, and mildly impaired bilateral manual dexterity (right hand worse than left), thorough assessment of language word findings, visual naming, sentence repetition, auditory comprehension, writing, reading) and aspects of cognition were also preserved, including working memory, visuoconstruction, and speeded visuomotor integration. The patient endorsed symptoms consistent with a moderate level of depression and anxiety on brief self-report questionnaires. Overall, the patient's mild cognitive inefficiency is likely referable to a combination of mild frontal cortical dysfunction secondary to CVA and emotional distress. Her limited experience with her employment responsibilities coupled with anxiety related to negative attention from supervisors because

of mistakes very likely exacerbates her mild cognitive problems while in the work setting.

Recommendations: 1. Neuropsychological evaluation does not indicate a level of cognitive deficit that is expected to be disabling for this patient, from an employment perspective. She would benefit from a “job coach” who could observe her work and provide her with strategies for increasing efficiency and compensating for her areas of weakness . . . 3. The patient has a history of alcohol abuse and currently reports that she consumes 1-2 alcoholic beverages each night. In light of her mild cognitive efficiency, we recommend that she restrict her alcohol intake as much as possible.

(Tr. 335).

On July 11, 2003, Dr. Aul wrote a letter to Dr. Arnold summarizing the results of Sears’ May 13, 2003 neuropsychological examination (Tr. 334). Dr. Aul’s letter states, in pertinent part:

Neuropsychological examination (5/13/03) revealed mild inefficiency on measures of executive function, variability in auditory attention, and mildly impaired manual dexterity, right worse than left. Language and memory performances were at expected levels. Self-report questionnaires were consistent with a moderate level of depression and anxiety. It was felt that her mild cognitive deficits were not disabling from the perspective of employment. Psychiatric evaluation for management of depression and anxiety were recommended. She was also advised to restrict alcohol intact [sic] as possible.

(Tr. 334).

On November 6, 2003, Sears was seen at the Grinnell Regional Hospital emergency room for a possible stroke (Tr. 316). She was diagnosed as having a Jacksonian march seizure (Tr. 316). On November 12, 2003, Dr. Arnold wrote the following in a letter “To Whom It May Concern”:

Deb Sears has continued to follow in the Internal Medicine Clinic for cognitive deficits that involve decision making skills related to a cerebrovascular event. That has been complicated recently by a neurological event. The etiology is undetermined at this time, but may have represented possible seizure. Workup is in progress.

At this time I would like to extend her medical leave until we have a thorough workup completed for the neurological event.

(Tr. 418). Dr. Arnold had previously extended Sears' medical leave on several occasions (Tr. 422, 423, 425, 426).

On January 27, 2004, Sears was hospitalized for alcohol induced pancreatitis (Tr. 273- 301). She was advised to avoid fatty foods and alcohol (Tr. 273). Dr. Arnold's notes of his February 5, 2004 examination of Sears state: "She continues to have cognitive impairment from her cerebrovascular disease and her return to work is unlikely but she is participating with rehabilitation and will have to clinically reassess the patient as the outpatient course progresses." (Tr. 419). In his treatment notes of March 11, 2004, Dr. Aul characterized Sears' residual cognitive problems as "mild." (Tr. 462).

On April 20, 2004, Sears was evaluated for seizures by Dr. Michael J. Rosenfeld, M.D., a neurologist and movement disorder specialist (Tr. 486-91). Dr. Rosenfeld's letter to Dr. Arnold summarizing the results of the evaluation state that Sears' orientation, memory, attention/concentration, fund of knowledge, and language are intact (Tr. 488). Dr. Rosenfeld further notes that Sears' strength was 5/5 in her upper and lower extremities bilaterally (Tr. 488). Dr. Rosenfeld evaluated Sears again on November 29, 2005, wherein he noted that her attention and concentration were normal, her memory testing is mildly deficient, and she had diminished right hand dexterity and grip (Tr. 530-31).

B. Vocational Assessments

On November 24, 2004, Sears underwent a vocational assessment by Suzanne McKinley, MS, CRC of Prism Group, Inc. (Tr. 169-175) With respect to personality issues, Sears overall was rated as having many “good worker traits.” The evaluator opined that Sears “could be expected to do well once she gains appropriate employment.” (Tr. 171). Sears scored well enough on the Career Ability Placement Survey (CAPS) to “succeed in a few occupational areas.” In summary, the evaluator noted “Debra’s test scores indicate she has the talent and ability to succeed in few fields. She can no longer do her previous work. On the basis of her work life and her occupation, Debra appears to be a self-directed, self-sufficient person. Debra had considerable success working in her previous job.” (Tr. 174-75). Selective Placement services were recommended to help Sears find an appropriate employment match. (Tr. 175).

On February 8, 2006, Sears underwent a work evaluation by WESCO Industries (Tr. 185-88). Colleen Wessel, the evaluator, opined that “it would be very difficult for Mrs. Sears to function in a competitive job market.” (Tr. 188). Sears was also evaluated by Manpower (Tr. 190-99). On her Data Entry-Alphanumeric Test Sears received a “fair” rating which, according to Manpower, “indicates that the applicant is likely to be slow-paced and not very productive when entering alphanumeric or numeric information into a computer system.” (Tr. 190-91). On the “Coordinated Rapid Movement” test, Sears made a total of 66 errors out of 250 possible errors, and did not complete either part of the test (Tr. 193). The evaluator from Manpower observed that Sears had difficulty working with both hands equally well and had trouble with arm-hand steadiness (Tr. 194). The notes state “Do not place her on assignment requirement coordinated movement.” (Tr. 194).

C. Consultative Examiners

On February 27, 2004, Dr. Dee E. Wright, Ph.D. completed a Mental Residual Functional Capacity Assessment of Sears, wherein she opined that Sears would be moderately limited in her ability to maintain attention and concentration for extended periods, but otherwise not significantly limited in any areas of understanding and memory, sustained concentration and persistence, social interaction, or adaptation (Tr. 440-41). In so determining, Dr. Wright noted that May 13, 2003 neuropsychological report from the UIHC and stated that the records do not “indicate severe deterioration of function” from that assessment (Tr. 445). Dr. Wright further opined:

The evidence in file documents the fact the claimant does have some cognitive limitations of function secondary to her CVA. She does appear to have some moderate limitations of function in her ability to sustain rapid alternating attention and concentration for extended periods. Despite these limitations, the claimant currently appears capable of sustaining sufficient concentration and attention to perform non-complex, repetitive and routine cognitive activity to moderately complex cognitive activity without serious limitations of function.

(Tr. 445).

On March 12, 2004, Dr. J.D. Wilson, M.D. completed a Physical Residual Functional Capacity Assessment of Sears, wherein he opined that Sears had no exertional limitations, that Sears should never climb ladders, ropes, or scaffolds, but could occasionally climb ramps/stairs, balance, stoop, kneel, crouch, and crawl (Tr. 478-79). Dr. Wilson further opined that Sears had no manipulative limitations in terms of reaching, handling, fingering, and feeling, and no visual limitations (Tr. 480). Dr. Wilson opined that Sears had no communicative limitations and no environmental limitations except that she should not be exposed to hazards (machinery, heights, etc.) due to her seizures (Tr. 481). In support of his opinions, Dr. Wilson commented:

Credibility of the allegations is eroded by the fact that the claimant's "seizure activity" is not occurring on a frequent basis nor is it fully described as true seizure activity. There are several doctor comments that note it is unclear whether the episodes are true seizures. Also, the claimant continues alcohol usage despite being on anticonvulsant medication. Further, the treatment note dated 2/5/04 states that there are no cerebrovascular concerns or seizure activity. Overall, the claimant would be capable of activities as marked on the RFC. Her impairments have not resulted in a current reduction in her residual functional capacity as far as exertional limitations go.

(Tr. 485).

On July 20, 2004, Dr. Koons completed a Physical Residual Functional Capacity Assessment of Sears (Tr. 492-499). Dr. Koons opined that Sears had no exertional limitations, but should never climb ladders, rope, or scaffolds due to her seizures (Tr. 493, 496). Dr. Koons opined that Sears had no manipulative, visual, nor communicative limitations (Tr. 497-98).

On July 28, 2004, Dr. M. Jane Bibber, Ph.D. completed a Mental Residual Functional Capacity Assessment of Sears and a Psychiatric Review Technique (Tr. 500-518). Dr. Bibber opined that Sears was moderately limited in her ability to understand and remember detailed instructions and in her ability to carry out detailed instructions (Tr. 500). Otherwise, Dr. Bibber opined that Sears was not significantly limited in terms of her understanding, memory, and sustained concentration and persistence (Tr. 500). Dr. Bibber further opined that Sears was moderately limited in her ability to respond appropriately to changes in the work setting and in her ability to travel in unfamiliar places or use public transportation (Tr. 501). Aside from those limitations, Dr. Bibber opined that Sears was not significantly limited in terms of social interaction or adaptation (Tr. 501). Dr. Bibber opined that Sears was mildly restricted in her activities of daily living and had moderate difficulties in maintaining concentration, persistence or pace (Tr. 514). In her Mental Review Summary, Dr. Bibber concluded:

[T]he claimant is able to understand and remember simple instructions that are given some guided practice initially. In the same manner, she could respond appropriately to simple changes in the work place when given some initial guidance. The claimant will not be able to effectively perform detailed or complex tasks. The claimant is able to concentrate adequately in a moderately paced work setting. She can interact appropriately with supervisors, coworkers, and the public.

(Tr. 518).

D. Hearing Testimony

Sears testified that she suffered a stroke on November 28, 2002 and tried to return to work on January 27, 2003 (Tr. 660). Upon her return, Sears testified that she had difficulty with the keyboard on her computer, with her speed, and with transposing numbers and entering incorrect data (Tr. 661). Sears testified that, due to her seizures, she was not allowed to drive, take a bath, or climb ladders (Tr. 664). Sears testified that, since her stroke, her husband must open jars for her, that her penmanship is very poor, and she has problems alphabetizing (Tr. 666-67). Sears testified that, prior to her stroke, she was a heavy drinker and smoked two packs of cigarettes per day (Tr. 667). Since her stroke Sears smokes about one pack of cigarettes per day and drinks only on occasion (Tr. 667-68). Sears testified that she suffered her first seizure in November 2003 and that they were currently happening approximately every five to six months (Tr. 675).

III. CONCLUSIONS OF LAW

A. Scope 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 Sears had not engaged in substantial gainful activity at any time pertinent to the decision (Tr. 19). At the second step, the ALJ determined that Sears has the following severe impairments: a history of a total abdominal hysterectomy and bilateral salpingo-oophorectomy on September 19, 2002, a history of a left carotid artery endarterectomy on January 13, 2003, a history of chronic sialandentitis of left parotid gland, status post superficial parotidectomy on September 12, 2003, a history of a displaced fracture of the right proximal humerus, status post closed intramedullary rodding of the right proximal humerus fracture on January 20, 2005, a history of alcohol-induced pancreatitis, a history of partial complex seizures, gastroesophageal reflux disease, mild cognitive deficits secondary to her history of left hemispheric stroke, and alcohol abuse (Tr. 28). At the third step, the ALJ found that

Sears did not have an impairment or combination of impairments that meets or medically equals a listed impairment (Tr. 28). Proceeding to the fourth step, the ALJ determined that Sears was able to perform her past relevant work as a business services sales agent or customer complaint clerk (Tr. 29). Therefore, the ALJ found that Sears was not disabled within the meaning of the Social Security Act at any time through the date of the decision (Tr. 29).

C. Treating Physician's Opinion

Sears argues first that the ALJ erred in relying almost exclusively on the opinions of non-treating, non-examining medical consultants, i.e, Drs. Wilson, Koons and Bibber, while not specifically mentioning the weight due the opinions of her treating physicians Dr. Arnold and Dr. Aul.

The defendant argues that the ALJ properly weighed the medical opinion evidence. The defendant argues that the ALJ merely noted that no treating physician's opinion was inconsistent with the consultative physicians' opinions, and that no physician who actually examined Sears found limitations that are consistent with a finding of disability under the Social Security Act. The defendant argues that the July 28, 2005 opinion of Dr. Arnold, submitted in the first instance to the Appeals Council, is not likely to alter the ALJ's decision as it is on the letterhead of Sears' private disability insurer and appears intended to qualify Sears for disability benefits.

“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) (citation omitted). 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). “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).

In assessing the various medical opinions in the record, the ALJ stated:

The undersigned finds that Dr. Wilson’s opinion is entitled to some weight in determining the physical portion of the claimant’s residual functional capacity . . . However, in light of the claimant’s history of seizures, the undersigned concludes that the claimant should avoid even moderate exposure to hazards. In addition, the undersigned concludes that the claimant can frequently balance, stoop, kneel, crouch, crawl, or climb ramps or stairs. The evidence indicates that the claimant has a normal gait and can heel walk, toe walk, and tandem walk without difficulty. The undersigned also concludes that the claimant cannot perform tasks that require a high degree of fine motor skills due to her residual fine motor deficits.

(Tr. 22). Likewise, the ALJ stated that Dr. Koon’s opinion was entitled to “some weight.”

In assessing the opinions of the consultative mental examiners, the ALJ stated:

The undersigned finds that Dr. Wright’s opinion is entitled to some weight in determining the mental portion of the claimant’s residual functional capacity. The undersigned agrees that the claimant can perform simple to moderately complex cognitive activity without significant restrictions, especially when she already knows how to do the job.

However, the undersigned does not find any evidence to indicate that the claimant has any limitations in her ability to interact with others. Although the claimant reported having moderate symptoms of anxiety and depression during the neuropsychological evaluation, she did not follow through with the recommendation to seek psychiatric treatment for her symptoms. She did not routinely report having symptoms of depression or anxiety to her treating physicians. In addition, there is nothing in the record to indicate that the claimant has had episodes of decompensation, each of extended duration.

. . .

The undersigned finds that Dr. Bibber's opinion is entitled to some weight in determining the mental portion of the claimant's residual functional capacity. Although the undersigned agrees that the claimant does not have any significant limitations in her ability to relate properly to others, the undersigned does not agree that the claimant is limited to performing only simple, routine, repetitive work. The neuropsychological evaluation indicated that the claimant had only mild deficits in her executive functioning and mild variability in her auditory attention. Her attention and concentration, memory, intelligence, and language skills were within normal limits. In addition, the claimant experienced a 50 percent improvement in her executive functioning and auditory attention as a result of undergoing occupational therapy. Based on these considerations, the undersigned concludes that the claimant has the capacity to perform more than simple, routine cognitive activity.

(Tr. 23-24).

The ALJ further stated: "[T]he state agency medical consultants who evaluated the claimant's impairments concluded that they were not disabling. There are no treating source opinions to the contrary." (Tr. 27).

The May 21, 2003 notes of Dr. Arnold, Sears' primary care physician, state:

Due to the cognitive impairment at this time I am going to extend the patient's medical leave until June 9th and she is going to meet with vocational rehab in the interim. Her job at present consists of data processing and making decisions as far as the customer service center at Maytag and certainly she can not perform her job to her best ability at this time with the residual cognitive impairment from her cardiovascular event.

(Tr. 426).

On October 27, 2003, Dr. Arnold submitted a statement to Unum, Sears' private long-term disability carrier, wherein he stated that Sears had not been released to work in any occupation (Tr. 519). Dr. Arnold further stated that Sears cannot "engage[] in complicated skills that require cognitive function, decision making, and time processing." (Tr. 519). Dr. Arnold stated that it was "unknown" when Sears would be able to return to work (Tr. 519). Dr. Arnold submitted a supplemental statement to Unum on July 28, 2005 wherein he stated that Sears suffers from "continued cognitive impairment." (Tr. 613). Dr. Arnold still did not release Sears to work in any occupation and remarked "Pt. remains with disability due to CVA." (Tr. 613). Dr. Arnold further opined that Sears could occasionally lift one to 10 pounds, but never more than that, and that Sears could occasionally bend, kneel and climb stairs, but never crawl or reach above her shoulders (Tr. 614). Dr. Arnold opined that Sears could not use her right hand for simple grasping, fine manipulation, medium dexterity and power grip (Tr. 614).

The ALJ failed to acknowledge Dr. Arnold's 2003 records, let alone provide good reasons for apparently discounting his opinion that Sears was unable to work in any occupation as of October 2003. Likewise, the ALJ gave no reason for discounting Dr. Rosenfeld's opinion that Sears is a likely candidate for long-term disability. The ALJ did discuss the May 2003 neuropsychological examination conducted by Dr. Aul, which is implicitly credited, but again, no rationale was provided. This is not to say that such opinions are entitled to controlling weight, given the circumstances, but only that the ALJ

did not comply with 20 C.F.R. § 404.1527(d)(2), which warrants remand. On remand, the ALJ shall consider, in full compliance with the regulations, the newly submitted evidence provided by Sears to the Appeals Council, including the July 28, 2005 report of Dr. Arnold, as well as the evaluation by psychologist Bruce Dawson. Depending on the weight afforded these opinions by the ALJ, Sears' residual functional capacity should be adjusted, if necessary.

E. Credibility Determination/Daily Activities

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).

However, "a claimant need not prove that he or she is bedridden or completely helpless to be found disabled." Thomas v. Sullivan, 876 F.2d 666, 669 (8th Cir. 1989). See also Keller v. Shalala, 26 F.3d 856, 859 (8th Cir. 1994) (finding it error to discredit the claimant's subjective complaints of pain based on her daily activities which consisted of watching television, taking care of her dogs, and doing household chores, which

claimant testified she could not do when she was suffering from a disabling headache); Forehand v. Barnhart, 364 F.3d 984, 988 (8th Cir. 2004) (“We have long stated that to determine whether a claimant has the residual functional capacity necessary to be able to work we look to whether she has ‘the ability to perform the requisite physical acts day in and day out, in the sometimes competitive and stressful conditions in which real people work in the real world.’”) (citing McCoy v. Schweiker, 683 F.2d 1138, 1147 (8th Cir. 1982) (en banc)). When evaluating the credibility of a claimant’s subjective complaints, the ALJ may not disregard complaints “solely because the objective medical evidence does not fully support them.” Polaski, 739 F.2d at 1322. Furthermore, “[t]he [ALJ] is not free to accept or reject the claimant’s subjective complaints solely on the basis of personal observations.

In finding Sears’ allegation of total disability not credible, the ALJ noted:

First, the claimant’s allegation is not supported by the objective medical evidence. As noted above, the claimant has not had additional strokes, further symptomatic carotid artery stenosis, additional bouts of pancreatitis, or more recent episodes of having bright red blood in her stool. Her right proximal humerus fracture healed well, and her treating surgeon concluded that she has no permanent restrictions as a result of the fracture and surgery. The claimant has had seizures. However, there is nothing in the medical evidence to indicate that she has had seizures with such frequency as to preclude her from working. The claimant has exhibited at times some very mild neurological findings in her right upper extremity. The neuropsychological testing indicated that the claimant has mild deficits in her executive functioning, auditory attention, and bilateral manual dexterity that were not disabling. Moreover, she experienced significant improvement in these deficits as a result of undergoing occupational therapy. Second, the state agency medical consultants who evaluated the claimant’s impairments concluded that they were not disabling. There are no treating source opinions to the contrary. Third, the claimant testified that the range of motion and strength of

her right upper extremity have not fully returned since the fracture and surgery. However, on November 2, 2005 her treating surgeon noted that she had a good range of motion and normal strength in her right upper extremity. Fourth, the claimant does not have very much financial incentive to return to work as long as she is receiving long-term disability benefits from her employer. Fifth, there is nothing in the record to indicate that the claimant has attempted to return to her former job since she completed the occupational therapy that improved her cognitive deficits. Sixth, despite being on anti-seizure medications, the claimant has continued to consume alcohol on a regular basis. Finally, the neuropsychological evaluation indicated that the claimant's cognitive deficits may be caused in part by depression and anxiety. However, the claimant did not seek treatment for depression and anxiety despite being advised to do so.

(Tr. 27).

Sears argues that the ALJ's credibility assessment is unfair, inappropriate, and not supported by substantial evidence in the record as a whole. Specifically, Sears notes that no treating physician has ever suggested malingering or symptom exaggeration. Sears further points to her solid work and earnings history, as well as her continual seeking of medical treatment. Sears further argues that a 40% reduction in earnings would actually provide an incentive for her to return to work, and that there is no evidence that her continued alcohol consumption prevented her from returning to competitive employment. Likewise, Sears claims that the record contains no evidence that treatment for depression or anxiety would restore her ability to work.

The defendant counters that the ALJ's credibility determination consisted of a very specific point-by-point evaluation and was supported by substantial evidence. The defendant notes that an ALJ's credibility decision should not be disturbed, even if substantial evidence supports a different conclusion, as long as the ALJ's determination falls within the available "zone of choice." The defendant further argues that the ALJ's

mention of Sears' continued alcohol use was allowed as failure to comply with treatment recommendations is a valid factor, as is Sears' failure to seek out treatment for depression and anxiety.

The court will not disturb the ALJ's credibility determination. While there is evidence that would support a finding that Sears' is credible, the ALJ's decision is supported by substantial evidence in the record as a whole.

F. Residual Functional Capacity

Determining a claimant's residual functional capacity is a medical question. Lauer v. Apfel, 245 F.3d 700 (8th Cir. 2001); Singh v. Apfel, 222 F.3d 448, 451 (8th Cir. 2000). "The Commissioner must determine a claimant's RFC based on all of the relevant evidence, including the medical records, observations of treating physicians and others, and an individual's own description of his limitations." McGivney v. Apfel, 228 F.3d 860, 863 (8th Cir. 2000) (citing Anderson v. Shalala, 51 F.3d 777, 779 (8th Cir. 1995)). However, the record "must include some medical evidence that supports the ALJ's residual functional capacity finding." Dykes v. Apfel, 223 F.3d 865, 867 (8th Cir. 2000) (citing Anderson, 51 F.3d at 779); Later, 245 F.3d at 704 (noting that while the ALJ was not "limited to considering medical evidence," the ALJ was "required to consider at least some supporting evidence from a professional."). "The opinions of doctors who have not examined the claimant ordinarily do not constitute substantial evidence on the record as a whole." Nevland v. Apfel, 204 F.3d 853, 858 (8th Cir. 2000). Further, an ALJ "may not draw upon his own inferences from medical reports." Lund v. Weinberger, 520 F.2d 782, 785 (8th Cir. 1975). "If the ALJ did not believe, moreover, that the professional opinions available to him were sufficient to allow him to form an opinion, he should have further developed the record to determine, based on substantial evidence, the degree to which [the claimant's] mental impairments limited his ability to engage in work-related

activities.” Later, 245 F.3d at 706 (citing Nevland, 204 F.3d at 858; 20 C.F.R. § 404.1519a(b)).

With respect to Sears’ RFC, the ALJ found:

Having considered the evidence of record most carefully, the undersigned finds that the claimant retains the residual functional capacity to frequently balance, stoop, kneel, crouch, crawl, or climb ramps or stairs. She cannot climb ladders, ropes, or scaffolds. She cannot perform tasks that require a high degree of fine motor skills. She must avoid even moderate exposure to hazards such as unprotected heights or dangerous machinery. She cannot perform highly complex, technical work, but can perform at least moderately complex work. She can work at a regular pace.

(Tr. 27-28).

Sears argues that the ALJ’s failure to pose a hypothetical to the vocational expert was error, and that the RFC determined by the ALJ was inconsistent with a significant body of evidence in the record. Specifically, Sears points to the fact that Sears’ private long-term disability carrier found that she was unable to return to her previous work, and to two vocational assessments, both of which concluded that she was unable to engage in competitive employment. According to Sears, there is no evidence in the record supporting the ALJ’s conclusion that she can work at a regular pace.

The defendant contends that the ALJ properly determined Sears’ RFC based on all of the evidence in the record, including Sears’ credible limitations. The defendant argues that the ALJ fulfilled her duty to develop Sears’ work history and that the evidence supported the ALJ’s determination that Sears’ possessed the RFC to perform her previous jobs as a sales agent and customer clerk, both of which were light, sedentary, lower-level skilled, and do not require a high degree of fine motor skills.

Should the ALJ, on remand, decide that Dr. Arnold’s opinions are entitled controlling weight, then Sears’ RFC will obviously be amended accordingly. However, the court finds it was no error to discount the findings of the WESCO and Manpower

assessments, as they are medical evidence and are not consistent with the neuropsychological evaluation conducted by Sears' treating neurologist in May 2003. Moreover, the vocational assessment conducted on November 24, 2004 found that Sears would be expected to do well in an appropriate position, although she was unable to perform her previous jobs.

Upon the foregoing,

IT IS ORDERED that the decision of the ALJ is remanded for further proceedings, consistent with this opinion. The Clerk of Court shall enter judgment accordingly.

DATED this 11th day of September, 2008.



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