

UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF MISSOURI  
EASTERN DIVISION

MAGGIE HAIRSTON, )  
 )  
 Plaintiff, )  
 )  
 v. ) No. 4:01 CV 421 SNL  
 ) DDN  
 LARRY G. MASSANARI, )  
 Acting Commissioner of )  
 Social Security, )  
 )  
 Defendant. )

**REPORT AND RECOMMENDATION  
OF UNITED STATES MAGISTRATE JUDGE**

This action is before the court for judicial review of the final decision of the defendant Commissioner of Social Security terminating plaintiff's supplemental security income benefits under Title XVI of the Social Security Act (Act), as amended, 42 U.S.C. § 1381, et seq. The action was referred to the undersigned United States Magistrate Judge under 28 U.S.C. § 636(b) for a recommended disposition.

Plaintiff Maggie Hairston filed for supplemental security income benefits on June 13, 1989. She alleged that her disability began on June 13, 1989. (Tr. 125-28). An Administrative Law Judge (ALJ) awarded benefits on July 19, 1991, finding that plaintiff's somatoform disorder met the Listing of Impairments § 12.07. (Tr. 85-90).

On February 10, 1997, plaintiff was notified that her case needed review to determine if her disability continued. (Tr. 433-34). On April 15, 1997, plaintiff was informed by the Social Security Administration (SSA) that her condition had improved and she was able to do work that was simple, with low people contact. (Tr. 413-32). Plaintiff appealed the decision, but it was upheld

on reconsideration with the notation by the medical consultant that plaintiff's functional capacity required that she be restricted to minimal contact with others. (Tr. at 397-412). On July 22, 1997, plaintiff filed a request for hearing by an ALJ. (Tr. 378).

On March 25, 1998, following an evidentiary hearing, an ALJ denied plaintiff's claims finding she had medically improved, no longer met the Listing of Impairments, and retained the residual functional capacity to return to her past relevant work. (Tr. 12-24). Additional medical evidence was submitted to the Appeals Council to support plaintiff's request for review. (Tr. 699-714). On January 6, 2000, the Appeals Council denied plaintiff's request for review. (Tr. 4-5). Therefore, the decision of the ALJ became the final decision of the Commissioner that is now before this court for review.

Under the Act, benefits may be terminated, if it is determined by findings supported by substantial evidence that demonstrate a medical improvement in the individual's impairment(s) coupled with evidence that the individual can engage in substantial gainful activity. See 42 U.S.C. § 423(f)(1); 20 C.F.R. § 404.1594. The recipient of benefits "bears a continuing burden of showing, by means of 'medically acceptable clinical and laboratory diagnostic techniques,' that he has a physical or mental impairment" which prevents him from working. Mathews v. Eldridge, 424 U.S. 319, 336 (1976) (citations omitted). No inference is to be drawn from the fact that the claimant had been previously granted benefits. Nelson v. Sullivan, 946 F.2d 1314, 1315 (8th Cir. 1991).

If the Commissioner seeks to terminate disability benefits due to improvement in the claimant's medical condition, he must demonstrate that the conditions which previously rendered the claimant disabled have ameliorated and that improvement of the

physical condition is related to the recipient's ability to work. Id.; Muncy v. Apfel, 247 F.3d 728, 734 (8th Cir. 2001). Medical improvement is defined as a decrease in the medical severity of the impairments present at the time of the most recent favorable medical condition. Nelson, 946 F.2d at 1316. See also 42 U.S.C. § 423(d)(3).

The court must affirm findings of the ALJ that are supported by substantial evidence. 42 U.S.C. § 405(g). The decision of whether a claimant's condition has improved is a factual one allotted to the ALJ which must be upheld if based on substantial evidence. Nelson, 946 F.2d at 1316. Substantial evidence is evidence of sufficient quality that a reasonable person would accept as adequate to support a conclusion. Richardson v. Perales, 402 U.S. 389, 401 (1971); Singh v. Apfel, 222 F.3d 448, 451 (8th Cir. 2000). In reviewing the record, the court may not make its own findings of fact or substitute its judgment for that of the Commissioner. Locher v. Sullivan, 968 F.2d 725, 727 (8th Cir. 1992). Nevertheless, when the court reviews the record for substantial evidence, it must review the entire record and consider whatever detracts from the weight of the evidence invoked by the ALJ. Singh, 222 F.3d at 451; Piercy v. Bowen, 835 F.2d 190, 191 (8th Cir. 1987); see also Wilcutts v. Apfel, 143 F.3d 1134, 1136-37 (8th Cir. 1998).

#### The ALJ's Decision

Following the evidentiary hearing, the ALJ made the following relevant findings of fact and conclusions of law:

1. Plaintiff has not engaged in substantial gainful activity since at least 1991.
2. The medical evidence established that plaintiff has bilateral arthritis of the hands, carpal tunnel syndrome

of the right wrist, diabetes mellitus, a peptic ulcer, a hiatal hernia by history, hypertension, and an unspecified mental disorder (non-psychotic) and a personality disorder, NOS<sup>1</sup>, but that she does not have an impairment or combination of impairments listed in, or medically equal to one listed in Appendix 1, Subpart P, Regulations No. 4.

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3. Plaintiff's allegations of disabling symptoms totally precluding all substantial gainful activity are not consistent with the evidence as a whole and are not persuasive.
4. Plaintiff has experienced medical improvement related to the ability to work since she no longer meets Listing 12.07.<sup>2</sup>
5. Plaintiff has the residual functional capacity to perform work-related activities except for work involving occasionally lifting over twenty pounds and frequently lifting over ten pounds. Plaintiff can perform prolonged standing, walking, and sitting. She does not have non-exertional limitations that significantly reduce the range of light work that she can perform (20 C.F.R. § 416.945).
6. Plaintiff's past relevant work as a cashier in a retail store did not require the performance of the work-related activities precluded by the above limitations (20 C.F.R. § 416.965).
7. Plaintiff's impairments do not prevent her from performing her past relevant work.

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<sup>1</sup>Not otherwise specified. See Tr. 89 (ALJ's use of term "not otherwise specified" when referring to "NOS" in report, Tr. 361).

<sup>2</sup>Under Impairment Listing § 12.07, a person is disabled who suffers from "[p]hysical symptoms for which there are no demonstrable organic findings or known physiological mechanisms" with a prescribed level of severity. 20 C.F.R. Pt. 404, Subpt. P, App. 1, § 12.07 (1996).

8. Plaintiff was not under a disability as defined in the Social Security Act at any time through the date of the decision (20 C.F.R. § 416.920(e)).

(Tr. 23-24).

#### The Administrative Record<sup>3</sup>

A review of the Administrative Record establishes that in 1991, although the ALJ found plaintiff suffered from poorly controlled hypertension, abnormal EKG with over first-degree AV block, age indeterminate inferior infarct, hiatal hernia, and reflux esophagitis, plaintiff's main problem was her mental condition. He noted a history of psychiatric treatment in the early 1970s; a diagnosis of borderline personality in 1982; and a diagnosis of generalized anxiety disorder in 1989. (Tr. 88).

A consultative psychiatric evaluation in 1990 stated that plaintiff's prognosis was guarded in view of the nature and chronicity of her problems. Family members reported an increase in her emotional symptoms. Further, the ALJ noted that multiple diagnostic tests demonstrated dull normal intellectual functioning, undifferentiated somatoform disorder, generalized anxiety disorder, anxiety disorder not otherwise specified (phobic avoidant anxiety), dysthymic disorder secondary to the somatoform and anxiety disorders, and attention-deficit hyperactivity disorder. (Tr. 89).

A board certified psychiatrist, after reviewing all of the evidence, concluded that plaintiff had somatoform disorder as a

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<sup>3</sup>Certain evidence pertaining to the Administrative Record of the July 19, 1991, ALJ decision is missing and unavailable. Items listed as missing evidence are the transcript of the oral hearing dated April 8, 1991, an earnings record, work activity reports, vocational reports, a reconsideration disability report, a claimant's statement, reports of contact, and numerous medical records. (Tr. 96-100).

long standing illness manifested by many symptoms, including dizziness, weakness, fatigue, blackouts, and digestive problems. The ALJ, relying on the testimony of the psychiatrist, determined that as a result of the somatoform disorder, plaintiff had marked restriction in activities of daily living, marked difficulty maintaining social functioning, and repeated episodes of deterioration or decompensation in a work or work-like setting. Consequently, the ALJ concluded that plaintiff met Listing of Impairments § 12.07 and had been disabled since at least 1989.<sup>4</sup> (Tr. 88-89).

Dr. Luzviminda R. Santos, M.D., treated plaintiff from February 28, 1992, to July 18, 1994. (Tr. 630). Plaintiff was examined nine times over two years. (Tr. 632-42). She failed to keep appointments on four occasions. Id. A questionnaire was not completed by Dr. Santos in 1997 because plaintiff "was non compliant in seeing Dr. Santos." (Tr. 630). While the office notes are largely illegible, it appears that Dr. Santos prescribed Haldol, Cogentin, and Zoloft for plaintiff. (Tr. 630-42). Dr. Santos diagnosed schizoaffective disorder (DSM-4 § 295.7). (Tr. 642).

Members of the St. Louis Regional Medical Center treated plaintiff from February 1991 through March 1997. Plaintiff, again, missed many appointments, although she often appeared as a walk-in without an appointment. (Tr. 517-604, 623-29). The following examinations are relevant to this proceeding.

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<sup>4</sup>Plaintiff has applied for disability and supplemental security income benefits on numerous occasions, including in 1984, 1986, and 1989. (Tr. 101-03, 114-17, 125-28). These applications were denied; but in 1991, she was found to be disabled since at least 1989.

In February and March 1991, plaintiff was seen for complaints of right side facial pain and popping sounds in the right ear. X-rays of the jaw and audiological evaluation were negative. (Tr. 626-29).

In August 1992, she complained of numbness and weakness on the left side and anxiety. Severe hypertension and depression were assessed. Clorazepate was prescribed. (Tr. 564-68).

In December 1993, plaintiff was seen for complaints of tightness in the chest, weakness, and shortness of breath. A stress test and echocardiogram were negative. (Tr. 554-56, 603-04). These symptoms resolved, and in April 1994, she was diagnosed as suffering from high blood pressure and anxiety. (Tr. 553). This diagnosis of anxiety continued through 1994 and 1995. (Tr. 547-53).

In April, May, and July 1995, plaintiff was examined for complaints of right and left wrist pain. In May 1995, she complained of difficulty holding and picking up objects. The July 1995 examination revealed some tenderness, but the Tinel sign<sup>5</sup> and Phalen's test were negative, and plaintiff's wrists showed good strength. Ibuprofen was recommended for pain. (Tr. 548-50, 623-25).

In January and February 1996, plaintiff sought treatment for complaints of fatigue, weakness, anxiety, and nervousness. The assessment was anxiety reaction. (Tr. 544-46).

On March 25, 1996, plaintiff reported a burning pain in her left wrist and arm, coupled with a history of a puncture wound at the base of her left thumb. She also complained of back pain.

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<sup>5</sup>A sensation of tingling when percussion is made over the site of an injured nerve. Stedman's Medical Dictionary (25th ed.) at 1422.

There was no evidence of any new puncture wound. Nothing of significance was noted on examination. (Tr. 540-41).

On August 29, 1996, plaintiff received nutritional counseling for a diabetic diet. (Tr. 534).

Plaintiff continued to carry diagnoses of anxiety and depression through 1996 and 1997. (Tr. 532, 529, 523).

On March 31, 1997, pursuant to the Commissioner's continuing disability review, Joseph Shuman, M.D., conducted a consultative psychiatric examination of plaintiff at the Forest Park Medical Clinic. Plaintiff complained about the "difficult time she has being around people," forgetfulness, sudden crying spells, and "at times everything just goes blank and she does not remember anything." She reported a psychiatric hospitalization in 1968. She "woke up" in 1969 and continued with outpatient treatment. She recently changed psychiatrists because she became angry with the then current psychiatrist. She reported taking Tranxene and Zoloft. She stated that she had no friends and does not socialize very much. During the interview, plaintiff told Dr. Shuman that she always gets along with fellow workers and supervisors. She stated that she looked through the paper for jobs but has not worked in many years. She stated she would like to become an entrepreneur. Dr. Shuman noted plaintiff could understand and follow instructions and perform simple repetitive tasks. He also noted that plaintiff's ability to withstand stress and pressure was apparently variable, but on the day of the examination she was fine. He diagnosed plaintiff with chronic depression and noted a

Global Assessment of Functioning (GAF) score of 80.<sup>6</sup> Her prognosis was guarded. (Tr. 611-15).

On March 31, 1997, Elbert Cason, M.D., conducted a consultative physical examination of plaintiff at the Forest Park Medical Clinic. Plaintiff reported she suffered from diabetes, arthritis of the wrists and hands, peptic ulcer, a hiatal hernia, hypertension, and a stroke by history.<sup>7</sup> Dr. Cason noted that plaintiff's wrists and hands had full mobility and completely normal ranges of motion with normal grip strength, and she could write and button clothing. An eye examination showed corrected 20/20 vision in both eyes. Cason concluded that plaintiff had diabetes that was treated with medication, arthritis of the wrists and hands, a peptic ulcer treated by Tagamet, a hiatal hernia, hypertension with a blood pressure reading of 140/108, and a stroke in 1993 with no residual effects. (Tr. 605-10).

On April 10, 1997, David W. Bailey, Psy.D., conducted a psychiatric review of plaintiff in connection with the Commissioner's determination to cease benefits. Based upon his review of records, he noted that plaintiff had reduced residual functional capacity due to affective disorders. He diagnosed the

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<sup>6</sup>The ALJ stated, "A GAF score of 71 to 80 indicates that if symptoms are present they are transient and expectable reactions to psychosocial stressors and entail no more than a slight impairment in social, occupational, or school functioning. See, Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders 4th Edition (DSM-IV) 32 (1994)." Tr. 15. "A score of 40-49 indicates major difficulty in several areas such [as] occupational, family, and social functioning." Id. at 16 (same authority cited). "A GAF score of 51 to 60 indicates moderate difficulty in occupational functioning." Id. at 17 (same authority cited).

<sup>7</sup>Dr. Cason reported that plaintiff had a stroke in 1993 which resulted in left side weakness. Thereafter, plaintiff substantially recovered her normal strength. (Tr. 607).

affective disorder as a depressive reaction. He also noted that a "GAF of 80 seems appropriate [sic]." He noted that plaintiff may have reduced frustration tolerance levels, and while these did not meet or equal the Listing of Impairments, "lowered pace/pressure/public contact would be helpful." (Tr. 428). He determined that plaintiff was moderately limited in her ability to complete a normal workday and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number or length of rest periods. Similarly, he found plaintiff moderately limited in ability to interact appropriately with the general public, and in her ability to get along with co-workers or peers without distracting them or exhibiting behavioral extremes. (Tr. 418-32).

On April 29, 1997, Scott Jones, M.D., at Lutheran Medical Center, examined plaintiff.<sup>8</sup> Plaintiff reported difficulty dealing with stress and "stressful places with other people." She indicated that when another person "talks down to [her]" or "threatens [her]," she feels like she "could explode." She is unnerved by people or yelling. Dr. Jones diagnosed post traumatic stress disorder. He also ruled out affective disorder and anxiety disorder. He noted that plaintiff suffered extensive childhood and adult trauma, and she killed her first husband in self-defense. Dr. Jones noted a GAF score of 45/49 and did not believe plaintiff could be gainfully employed in a competitive work setting consistently over a period of time. (Tr. 514-16).

On May 21, 1997, John S. Rabun, M.D., conducted a consultative psychiatric examination of plaintiff at the West Park Medical Clinic. Dr. Rabun noted plaintiff's mood changes were consistent

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<sup>8</sup>Plaintiff subsequently described Dr. Jones as her treating physician. (Tr. 510).

with a temperamental disposition and lacked the characteristics of a bipolar illness. Dr. Rabun did not see any evidence of a psychotic disorder, endogenous major depression, abnormal psychomotor activity, or a deficit in memory. He noted plaintiff had an irritable and sarcastic demeanor and often complained of a headache and held her hand to her forehead. Dr. Rabun diagnosed an unspecified mental disorder (non-psychotic), a personality disorder (with borderline histrionic, and narcissistic features), and a GAF of 60. (Tr. 509-12).

On May 21, 1997, Eric Johnson, M.D., conducted a consultative examination of plaintiff at the West Park Medical Clinic. Plaintiff reported pain in her wrists and hip. She also reported a diabetic condition treated with oral hypoglycemics and diet, an ulcer, and a hiatal hernia that had not reoccurred since eliminating aspirin from her medication. There was limitation in the range of motion of plaintiff's wrists. There was a positive Tinel's sign on the right hand. Dr. Johnson diagnosed carpal tunnel syndrome but noted no nerve conduction studies were available to confirm this. He also diagnosed diabetes, a history of hiatal hernia and ulcers, and hypertension. X-rays taken of the claimant's right wrist were negative. (Tr. 500-08).

On June 5, 1997, Judith A. McGee, Ph.D., conducted a Mental Residual Functional Capacity Assessment and Psychiatric Review Technique on plaintiff. Dr. McGee reviewed Dr. Shuman's diagnosis of March 31, 1997, and Dr. Rabun's report of May 21, 1997, and determined plaintiff was suffering from chronic depressive reaction with a nonspecific mental disorder and a personality disorder. She found plaintiff to be moderately limited in her ability to accept instructions and respond appropriately to criticism from supervisors. She noted that plaintiff, "retains ability to

understand, remember and complete simple directions and tasks and knows appropriate social skills but may have some difficulty relating so would need minimal contact. No evidence of difficulty adapting to routine change." (Tr. 400). Dr. McGhee noted a moderate degree of limitation in maintaining social functioning. She also noted an RFC assessment was necessary due to affective disorders and personality disorders. (Tr. 398-410).

Additional medical evidence submitted to the Appeals Council shows that plaintiff returned to Lutheran Medical Center and Dr. Jones for follow-up psychiatric care on June 10, 1997, July 22, 1997, August 28, 1997, October 2, 1997, January 5, 1998, February 10, 1998, and March 31, 1998. Most of these notes are illegible. (Tr. 699-709).

A disability hearing was conducted on July 9, 1997. Plaintiff told the hearing officer that she could not handle stress or dealing with people. The presence of two or three people makes her uncomfortable. She also complained of constant hand pain limiting her ability to do such things as comb her hair or grip objects. She engaged in no social activities. The hearing officer noted that she had difficulty relating to people and exhibited a tendency toward defensiveness and mild arrogance. (Tr. 436-46).

Subsequent to the hearing, plaintiff was to obtain medical records from Dr. Santos. She reported to the SSA that she was getting "static" from Dr. Santos' secretary who was "crazy" and plaintiff stated that she was "going down to office and forcibly take records if must." (Tr. 446).

Jean Jose, Ph.D., saw plaintiff for a consultative psychological evaluation on October 7, 1997. Plaintiff reported she had anxiety attacks, was paranoid-schizophrenic and had difficulty handling crowds and noise. She stated that she did not

like being around people and so she avoided her family. She reported having no close friends, staying home most of the time, and no longer attending church because of the crowds and noise. Plaintiff reported having auditory hallucinations. She stated that she was under the care of a psychiatrist, Dr. Han, and goes to counseling every two weeks. She also complained of wrist pain and appeared to have difficulty with her hands in moving her hair and lifting her purse. Wrist pain prevented her from taking care of her personal needs.

Dr. Jose noted plaintiff did not seem to be distracted by extraneous noises or movements and that her mood was mildly depressed. Dr. Jose noted plaintiff's thought process and comprehension were adequate with average cognitive functioning. Dr. Jose found that "[h]er ability to interact socially and to adapt to her environment may be somewhat limited by her anxiety and her preference to stay home and avoid being around other people." He noted that, if plaintiff were limited regarding her ability to work, her physical limitations would be the primary deterrent. He diagnosed a personality disorder and assigned a GAF of 55. Dr. Jose further found plaintiff possessed a very good ability to follow work rules and good to very good ability to relate to co-workers and supervisors, deal with work stresses and maintain concentration and attention. (Tr. 675-80).

In a written daily activities questionnaire completed on May 29, 1997, plaintiff's estranged husband stated that she has trouble dealing with people, that her social activities have decreased, that she is very annoyed by noise and lights, and that she becomes angry quickly with violent behavior to the point of "wanting to take someone's life." (Tr. 491).

Janelle Roethemeyer, M.D., on November 6, 1997, examined plaintiff for complaints of persistent bilateral hand and wrist pain. Plaintiff stated to the SSA that Dr. Roethemeyer was a new treating physician. (Tr. 682.) Dr. Roethemeyer noted plaintiff's bilateral wrist pain with only mild swelling of the wrists, diabetes, and hypertension. Plaintiff's medications included Naprosyn, Tranxene, Elavil, Zoloft, and Risperdal. On December 4, 1997, Dr. Roethemeyer noted plaintiff's diabetes was not under the best control and swelling in her hands limited range of motion. Nerve conduction studies were planned. (Tr. 685-92).

On October 16, 1997, plaintiff was seen at St. Mary's Health Center for complaints of "losing sight in both eyes." The diagnosis was intermittent left eye irritation. (Tr. 693).

Additional medical evidence was submitted to the Appeals Council, including a summary report from Dr. Roethemeyer to Missouri Department of Social Services stating that plaintiff was unable to provide adequate supervision for her children due to severe arthritis in both hands, hypertension, and diabetes. (Tr. 710).

N. Sallapudi, M.D., in an undated letter faxed on August 21, 1997, stated that plaintiff had bilateral wrist pain possibly secondary to neuropathy or carpal tunnel syndrome. (Tr. 653). He felt the pain was debilitating and kept her from doing many routine activities. (Tr. 653).

At the administrative hearing on September 4, 1997, plaintiff testified she was 44 years old. She lived with her three-year-old nephew, next door to her disabled husband. (Tr. 39). Plaintiff said she raised ten children who, at the time of the hearing, ranged in age from 18 to 29. (Tr. 65-66). Her daughters often took care of the nephew. (Tr. 66). Plaintiff testified to

finishing college, receiving a degree in business, and studying two years post-graduate in retail sales and management marketing. She said she had not worked since 1989. (Tr. 38-41).

Plaintiff said she suffered a heart attack in December of 1988. (Tr. 45). She said she was admitted to the Golden Regional Medical Center in Columbus, Mississippi, for the heart attack. (Tr. 45). She said the heart attack has left her weak, strained and sensitive to extreme heat and cold, which leaves her unable to breathe. (Tr. 51). She also said she had a stroke on August 10, 1993. She stated the stroke created problems with her left side, specifically her left leg, which continues to "spasm up." The stroke also left her with less clarity of thought and intermittent weakness in gripping with the left hand. (Tr. 46-47). She stated her diabetes was not under control and created dizziness, lightheadedness and yeast infections. (Tr. 48-49). The yeast infections were successfully treated with Monostat 3. (Tr. 50).

She stated that she has high blood pressure, which is not completely controlled and causes problems with her vision, as well as weakness. (Tr. 51, 53). Plaintiff lost her vision for five hours approximately a month before the hearing. (Tr. 54).

Plaintiff reported carpal tunnel syndrome in both hands that causes pain and numbness. (Tr. 55, 68). She takes Naprosyn and Elavil for the pain. (Tr. 56). She estimated the pain varied between eight and ten on a scale of one to ten, with ten being the greatest. (Tr. 57). It also causes weakness in her hands that could cause her to drop items. (Tr. 68). The condition makes it difficult to hold items and dress herself. (Tr. 68).

Plaintiff alleges she has difficulty dealing with people and complains of problems with her "nerves." (Tr. 64). She testified that she has suffered from these problems since 1970 and was

hospitalized for a full year but does not recall a lot of it. (Tr. 59). She declined hospitalization in April of 1997, although it had been recommended due to her desire to kill Dr. Santos' nurse. (Tr. 60). She planned to "choke [the nurse] still." (Tr. 61). The only thing plaintiff could think of was "breaking her neck, just taking her life." (Tr. 64). The nurse had started "screaming" at her. Plaintiff's husband saw a change come over plaintiff, and he took her to the emergency room for psychiatric evaluation. (Tr. 62-63). Plaintiff refused to be admitted to the hospital because of her prior experience in being institutionalized and "horrible things happen up there on the floors." (Tr. 63-64).

She is unable to care for her grandchildren or be with them for more than one hour because of the noise. (Tr. 67). Additionally, her nervous condition causes her to experience itching, irritability, and constant bowel movements that are sometimes cured by her medicine. (Tr. 65). She stated she was seeing Dr. Scott Jones in the psychiatric department of Lutheran Medical Center on a monthly basis but recently they had switched her to Dr. Hans. (Tr. 43).

Plaintiff can sit for over two hours unless her mental state is agitated. (Tr. 70). Her children take her shopping. She cannot pick up ten pounds of potatoes. (Tr. 71). She cooks simple meals. (Tr. 72). She can make her bed sometimes. (Tr. 68). She gets lost in familiar places. (Tr. 70). She said she has no problem walking but does not go on walks alone because she fears getting lost. (Tr. 70).

Plaintiff's estranged husband also testified at the hearing that plaintiff has had several instances of homicidal tendencies, other than with Dr. Santos' nurse. He testified that she angers

quickly. She no longer associates with other people. She was no longer active in church. (Tr. 78-79).

#### Discussion

The undersigned concludes that the decision of the ALJ is not based upon substantial evidence on the record as a whole.

First, the ALJ discounted Dr. Jones' opinion for legally insufficient reasons.

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. By contrast, "[t]he opinion of a consulting physician who examines a claimant once or not at all does not generally constitute substantial evidence."

Singh, 222 F.3d at 452 (citations omitted). See also 20 C.F.R. § 404.1527(d) (2000).

The ALJ discounted Dr. Jones' findings and opinions, in part, because he only saw plaintiff once, even though plaintiff testified to monthly sessions. (Tr. 19, 20). Such was also used to discredit plaintiff's testimony. (Tr. 19). The records submitted to the Appeals Council in fact show at least nine sessions with Dr. Jones and/or psychiatric medical personnel at Lutheran Medical Center between March 25, 1997, and March 31, 1998. (Tr. 699-709). Thus, one of the ALJ's primary reasons for discounting Dr. Jones' opinions, as well as discrediting plaintiff's allegations, is not supported by substantial evidence. The undersigned cannot conclude that, if the ALJ had all pertinent information before her, she still would have credited the opinion of a consulting physician, Dr. Jose, over that of a treating physician, Dr. Jones.

The ALJ also noted the absence of evidence to support the allegation of a heart attack in 1988. (Tr. 19). To the extent the ALJ used this to discredit plaintiff, such was improper. As noted above, much of the prior medical evidence is missing. However, the record of an EKG in July 1990 showed an "abnormal EKG with a 1st degree AV Block and age indeterminate [sic] inferior infarct with question of septal extention, also sinus bradycardia." (Tr. 294). This suggests a prior heart attack, supporting plaintiff's credibility.

Of greatest concern to the undersigned, however, is the ALJ's determination of plaintiff's residual functional capacity, the absence of non-exertional limitations on her ability to engage in substantial gainful activity, and the finding that she can return to her past relevant work as a cashier in retail sales.

It was the duty of the ALJ to determine plaintiff's residual functional capacity. 20 C.F.R. § 404.1546. Residual functional capacity is "what [a claimant] can still do despite limitations," based on the entire record. See 20 C.F.R. §§ 404.1545(a), 416.945(a). Relevant evidence may include plaintiff's description of her limitations, the observations of treating and examining physicians or psychologists, family, neighbors, or friends, and medical records. 20 C.F.R. §§ 404.1545(a)-(c), 416.945(a)-(c). A limited ability in responding appropriately to supervision, co-workers, and work pressures in a work setting may reduce a claimant's ability to do past work and other work. 20 C.F.R. §§ 404.1545(c), 416.945(c). The ALJ is to consider the total limiting effect of the claimant's impairments and related symptoms. 20 C.F.R. §§ 404.1545(e), 416.945(e).

The ALJ must consider plaintiff's exertional as well as non-exertional limitations. 20 C.F.R. § 404.1569(a). Difficulty in

functioning due to nervousness, anxiousness, or depression is an example of a non-exertional limitation. 20 C.F.R. § 404.1569a(c).

The ALJ determined that plaintiff had no significant, non-exertional, mental limitations. (Tr. 22). However, in doing so, she relied on Dr. Shuman's consultative evaluation. Dr. Shuman classified plaintiff's ability to withstand stress and pressure to be variable. Other mental status examiners found that plaintiff had varying degrees of limitations in dealing with others, including co-workers and supervisors. Dr. Bailey noted a reduced frustration tolerance level and that "lowered pace/pressure/public contact would be helpful." Further, plaintiff was moderately limited in her ability to complete a normal workday and workweek, perform at a consistent pace, interact appropriately with the public, and get along with co-workers. Similarly, Dr. Jones found plaintiff could not be gainfully employed in a competitive work environment over a period of time. Dr. McGhee noted difficulty in relating, with the corresponding need for minimal contact with others.

Plaintiff's reports of activities, including lack of socialization, discontinuance of church related activities, as well as the reports of plaintiff's estranged husband, corroborate the limitation on her ability to interact with people. Her testimony, as well as her husband's, of homicidal ideas and instant anger also corroborates limitations on her ability to deal with people and tolerate the ordinary incivilities encompassed in the workplace or in dealing with the public. The observations of the disability hearing officer that she had trouble relating to people further supports the existence of such non-exertional limitations. Her threat to forcibly take medical records because of "static" from a nurse also evidences the inability to interact with others. Dr.

Rabun noted an irritable and sarcastic demeanor. Even going back to 1989 in psychiatric reviews, it was recommended that plaintiff have minimal interaction with others. (Tr. 133, 136).

In short, the undersigned concludes that the ALJ's decision, by not specifically addressing and discounting non-exertional limitations relating to the inability to interact with others and deal with frustration and pressure in the workplace, suggests that the ALJ did not consider the possibility of the presence of such non-exertional limitations. This matter should be remanded for the ALJ's consideration of, and acceptance or specific rejection of, such non-exertional limitations.

The ALJ also found plaintiff could return to her past relevant work as a cashier in retail sales. The ALJ must make explicit findings regarding the actual physical and mental demands of plaintiff's past work and compare them with her residual functional capacity. Salts v. Sullivan, 958 F.2d 840, 844 (8th Cir. 1992). This the ALJ did not do. But it is obvious that a retail sales cashier position involves contact with the public and possibly with co-workers. The record suggests that plaintiff never held these jobs for very long, which may be due to her inability to interact with others. (Tr. 286). In light of the ALJ's resolution of the presence or absence of significant, non-exertional limitations due to the inability to interact with others or deal with the frustration or pressure of the work environment, the ALJ may need to re-examine whether plaintiff can return to her past relevant work.

Further, if the ALJ credits significant, non-exertional limitations which diminish the full range of jobs listed in the guidelines, then she must solicit testimony of a vocational expert regarding whether or not there are other jobs in the national

economy that plaintiff can perform. Robinson v. Sullivan, 956 F.2d 836, 841 (8th Cir. 1992) (application of medical vocational guidelines appropriate only if claimant has exertional limitations; however, if claimant has non-exertional impairments which diminish capacity to perform full range of jobs listed in the guidelines, the Commissioner must solicit testimony of vocational expert about whether there are jobs in the national economy that plaintiff can perform).

**RECOMMENDATION**

For these reasons, it is the recommendation of the undersigned United States Magistrate Judge that the appeal of plaintiff Maggie Hairston be sustained. The final decision of the defendant Commissioner of Social Security should be reversed and the case remanded under Sentence 4 of 42 U.S.C. § 405(g) for further proceedings.

The parties are advised that they have ten (10) days in which to file written objections to this Report and Recommendation. The failure to file timely, written objections may waive the right to appeal issues of fact.

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**DAVID D. NOCE  
UNITED STATES MAGISTRATE JUDGE**

Signed this \_\_\_\_\_ day of September, 2001.