

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
SOUTHEASTERN DIVISION

SARAH MEARES,)
)
Plaintiff,)
)
v.) No. 1:02 CV 85 CAS
) DDN
JO ANNE B. BARNHART,)
)
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 denying plaintiff Sarah Meares's applications for disability insurance benefits under Title II of the Social Security Act (the Act), 42 U.S.C. §§ 401, et seq., and supplemental security income (SSI) benefits under Title XVI of the Act, 42 U.S.C. §§ 1381, et seq. The action was referred to the undersigned United States Magistrate Judge for a recommended disposition under 28 U.S.C. § 636(b). The undersigned recommends affirmance.

I. BACKGROUND

A. Administrative record

1. Documentary evidence

Plaintiff, who was born on June 18, 1947, applied for benefits on November 14, 2000, claiming she became disabled on June 15, 1990, at age 43. (Tr. 20, 122, 133-35.) Her work history report showed that she had been a cook at a restaurant from May 1993 to December 1994 and a housekeeper in a nursing home from June 1990 to May 1992. As a housekeeper, she had cleaned patients' rooms, did laundry, put up clothes and bed linens, and twice a month waxed

floors and cleaned walls. Each day she reportedly walked for six hours and stood for six hours; she sat, kneeled, and crouched for two hours each; and she lifted up to fifty pounds and frequently lifted twenty-five pounds. (Tr. 237-39.)

In a disability report, plaintiff claimed that digestive problems, depression, the inability to lift, and migraine headaches limited her ability to work and caused her pain. She indicated that her problems first bothered her on June 15, 1990, and caused her to become unable to work on May 16, 1992. After June 15 she reportedly changed from working as a nursing assistant (where lifting was required) to housekeeping, later worked only part-time, and after surgery was unable to work at all. (Tr. 245-46, 254.)

In a December 4, 2000, disability determination questionnaire, plaintiff wrote that she could not lift more than five pounds. She listed five medications that she was presently taking and wrote, "none" when asked to describe any side effects. She maintained that the only time she did not take her medications was when she could not afford them. She stated that she cared for her husband, "doing almost everything for him." In a supplement to the questionnaire, she added that she could not carry anything. (Tr. 191, 194-95.)

Plaintiff was admitted to St. Bernards Regional Medical Center (St. Bernards) on May 16, 1991, and underwent a total abdominal hysterectomy. She was discharged on May 22 with a diagnosis of moderately severe pelvic pain and dysfunctional uterine bleeding. It was noted that she smoked between 1 and 2.5 packs of cigarettes a day. (Tr. 400-04.)

On April 9, 1992, plaintiff went to Earl Montgomery, M.D., complaining that she had had pain in the left side and back for four months. The assessment was hormone replacement therapy, left pain, and adhesions. In November, she complained of left-side pain

and nervousness. The following April she complained of left-side pain and hot flashes. (Tr. 394-95, 397.)

On October 21, 1994, plaintiff went to the Monroe Clinic of Baptist Memorial Hospital (Monroe Clinic) on referral from her physician, Dr. Dennis D. Parten. She reported that, since her hysterectomy, she had experienced gradually increasing pain in the left upper quadrant and left flank area of the abdomen, and that over several years she had intermittent constipation, with some nausea and occasional vomiting. She admitted to smoking 1.5 to 2 packs of cigarettes per day for about thirty-five years. Her blood pressure was 150/84, she weighed 144 pounds, and in her abdomen there was mild tenderness in the left upper quadrant and left flank area but no palpable masses. The assessment was abdominal pain and pelvic pain, etiology unknown. She was to undergo a barium enema, an ultrasound, thyroid function studies, and an EKG. (Tr. 281-82.)

On November 9, 1994, a colon air contrast was performed but was of limited use because of abundant air in the colon. No intrinsic colon lesions were identified. At the Monroe Clinic on November 11 plaintiff claimed insomnia, decreased appetite, and occasional depression. An abdominal ultrasound was normal; a mammography revealed no radiographic evidence of malignant neoplasm; and her abdominal examination was normal. On December 2, she returned to the Monroe Clinic and was assessed with chronic pelvic pain, started on Zoloft, and directed to follow up in one month. When she returned in January 1995, she stated the Zoloft slightly improved her pelvic pain but caused nausea and vomiting, so she was switched to Trazadome. (Tr. 268, 271-72, 274-75, 278.)

Plaintiff was treated at St. Bernards from March 23 to 26, 1996. She had been having intermittent nausea, vomiting, and upper abdominal pain. An upper endoscopy was completely normal. In June Dr. Parten prescribed medications. In July plaintiff was evaluated at St. Bernards for repeated episodes of syncope (fainting). Test

results were normal. In November Dr. Parten indicated that plaintiff, who weighed 136 pounds, had abdominal pain, nausea, and vomiting. (Tr. 327-28, 372-73.)

Monette Family Practice Clinic notes from February 10, 1997,¹ include an impression of syncope, severe and recurrent headaches, menopause, generalized anxiety disorder, and a lesion. Pain medication was prescribed. (Tr. 323.)

On February 18, plaintiff, who weighed 138 pounds and stood 4 feet, 11 inches, went upon referral to a medical center, reporting lower left quadrant pain, headaches, passing out, decreased appetite, weight loss, and constipation. Her constipation was exacerbating the abdominal pain. Chest x-rays revealed no acute cardiopulmonary disease. In March, she went to a hospital complaining of lower left quadrant pain, which was not reproducible with a stethoscope and was believed to be constipation related. In April plaintiff underwent a barium enema. The conclusion was "inadequate examination of the colon," with a suggestion of pseudoobstruction. (Tr. 380, 382, 384-86, 389.)

In July 1997, plaintiff's anti-depressant medication seemed to be working. During a December checkup plaintiff was still very depressed and had a lot of left-side pain; she had been hit on the back of the head and felt pain shooting down her neck. Her medications were Effexor, Lorazepam, Premarin, a fluid pill, and potassium liquid. (Tr. 321, 366.)

On June 10, 1999, plaintiff complained of nausea and vomiting to Dr. Trent Lamb. He noted that she was having a lot of problems at home: her husband was an abusive alcoholic; her son had a drug problem; and her daughter was married to a man whom she believed was molesting her grandchildren. She reported that she had been on Zoloft, but that it made her sick to her stomach. Dr. Lamb's

¹Plaintiff interprets year as 1991.

assessment was anxiety with intractable nausea and vomiting. He gave her Reglan (along with refills) for the nausea, directed her to take Zoloft with her nighttime meal, and referred her to a psychologist for counseling. (Tr. 320.)

Dr. Woody Soonathakul examined plaintiff on November 28, 2000, upon referral from the state agency. She weighed 184 pounds; her blood pressure was 178/90; and her vision corrected by glasses was 20/200 and 20/100 on the right and left eyes, respectively. As to plaintiff's nervous system, the doctor checked a box to indicate evidence of neurosis, and diagnosed plaintiff with abdominal pain, probably caused by peptic ulcer diseases, hypertension, anxiety, depression, and cigarette abuse. He stated that she had abdominal pain and possible gastritis, and probably had some degree of chronic obstructive pulmonary disease given the cigarette abuse. Finally, he opined that she had a mental or physical disability which prevented her from engaging in employment or gainful activity for four to six months. (Tr. 358-59.)

On January 18, 2001, a medical consultant indicated the following in a physical residual functional capacity (RFC) assessment. Plaintiff could occasionally lift and carry fifty pounds, frequently lift and carry twenty-five pounds, stand and walk about six hours in an eight-hour work day, sit about six hours in such a work day, and had an otherwise unlimited ability to push and pull. She had no postural, manipulative, or communicative limitations. Visually, her near acuity and far acuity were limited; her vision while wearing glasses was 20/200 and 20/100, but she had not had a recent eye examination. She was to avoid concentrated exposure to fumes, odors, dust, gases, and poor ventilation because of her history of chronic obstructive pulmonary disease (COPD). No treating or examining source statements regarding plaintiff's physical capacities were provided to the consultant. (Tr. 201-08.)

On January 19, 2001, Holly L. Weems, Psy.D., completed a psychiatric review technique form, indicating that plaintiff has non-severe affective and anxiety-related disorders, i.e., depression and anxiety. She categorized the disorders as imposing "[m]ild" limitations on plaintiff's activities of daily living, maintaining social functions, and maintaining concentration, persistence, or pace. She noted no repeated episodes of prolonged decompensation. (Tr. 209, 212, 214, 219.) In prose somewhat difficult to decipher, the consultant states:

claimant does allege some depression. There is [a history] of anxiety/depression which has been controlled by [medications] per [doctor's] report [and] [claimant's] report. . . . The _____ evidence supports non-severe impairment [with] no [history] of complications.

(Tr. 221.)

Plaintiff went to the emergency room at St. Bernards on February 11, 2001, with dizziness, lightheadedness, and a headache. She was admitted for uncontrolled hypertension, as her blood pressure was at 246/143. She was placed on Labetalol and her blood pressure gradually decreased; it was 132/65 on February 14. Plaintiff underwent a battery of tests on February 16; she did not have atherosclerotic coronary disease. The diagnosis at discharge on February 17 was hypertension, chronic obstructive pulmonary disease, and left lower lobe pneumonia. Dr. Parten instructed her not to smoke. (Tr. 330-31.)

On April 16, 2001, plaintiff had blood pressure readings of 180/123 in the morning and 140/90 in Dr. Parten's office. She had been out of her hypertension medicine for three days. Dr. Parten, therefore, gave her a month's supply of samples. (Tr. 309.)

Plaintiff had been staying at St. Bernards with her hospitalized husband when, on May 5, 2001, she went to the emergency room with hypertension problems. She was diagnosed with hypertension not otherwise specified, headache, and vertigo. She

was prescribed Meclizine and Darvocet and instructed that she may return to work on Monday, May 7. A chest x-ray, taken May 6, was normal and showed improvement in her lungs since the previous February. (Tr. 295-96, 303.)

On May 15, plaintiff, weighing 178 pounds, went to Dr. Lamb, complaining of hypertension, chest pain, and intermittent shortness of breath but no real anginal type symptoms with it. She also complained of headaches, tinnitus, and intermittent epistaxis. Her blood pressure was initially 180/110, but it came down to 160/100. Dr. Lamb told plaintiff to quit smoking. He assessed her with hypertension and gave her a five-week supply of Atican. She returned on May 30, having passed out the previous day. Dr. Lamb's assessment was anxiety and crying, and hypertension with a blood pressure of 150/90. He gave her samples of hypertension medicines Aceon and Norvas. (Tr. 291-93, 295.)

When plaintiff returned to Dr. Lamb on June 28, her blood pressure was 188/100. He gave her medicine and within half an hour her blood pressure went down to 148/84. She had run out of medications the previous night and was very stressed; her husband was dying of COPD and her children were not helping. Dr. Lamb noted that the Aceon and Norvasc had been working; he gave her additional samples. He also prescribed Xanax. (Tr. 290.)

Plaintiff saw Dr. Lamb on October 29, 2001, with complaints of increased chest pain. He had her admitted into St. Bernards to rule out myocardial infarction. At the hospital, she had some diaphoresis (sweating), which was relieved with sublingual nitroglycerin. An echocardiogram showed no significant wall abnormalities; thus myocardial infarction was ruled out. Upon discharge, her medications were Norvasc, Premarin, Diovan, and Enteric-coated aspirin. Dr. Lamb strongly encouraged her to quit smoking. Another doctor assessed plaintiff with chest pain,

atypical with a history of normal coronary arteries; hypertension, stable on current medications; and tobacco abuse. (Tr. 256-60.)

2. Plaintiff's testimony

On March 1, 2002, the Administrative Law Judge (ALJ) held a hearing during which plaintiff testified as follows. She quit school in the tenth grade, owned a vehicle and drove it occasionally, lived with her son and his wife and two children, and weighed 146 pounds. For a while she weighed over 200 pounds, as a result of depression. Then, she lost weight down to 89 pounds, because she had gastritis and could not keep anything down. She started regaining the weight during the past couple of years. (Tr. 26-30.)

About two weeks per month plaintiff's colon caused her stomach and left side to swell such that she would have days when she could hardly walk because of pain. She also had difficulty with vomiting and nausea. During the hearing she did not have pain, but had it on the way to the hearing and the previous day. The pain was intermittent but could be as severe as labor pains; at times it would approach 100 on a scale of 1 to 100. She had problems lifting her grandchildren. (Tr. 33-37.) She never really recovered from her hysterectomy. Her doctors limited her lifting to five pounds and never released her to work. (Tr. 51-52.)

Plaintiff's physician told her she had an enlarged colon and she was told she had a tumor, but no surgery was recommended. It had been about two years since she last had an endoscope examination of the upper colon; her husband, who passed away in December 2001, did not like her "colored" doctor and would not let her return to him. Her condition had remained steady over the last two years. She believed her colon would cause her to miss at least four days of work a month. (Tr. 38-39, 45.)

In February 2001 plaintiff began suffering from hypertension, which caused headaches and dizziness every other day, depending on her stress level. Her blood pressure has been running from 164 to 190 over 80 to 102 the past couple of months. She took two types of blood pressure medication as directed. Her hypertension had not caused problems with her other organ systems. (Tr. 39-43.)

Plaintiff's next most severe problem, depression, made her apathetic and easily irritated. She was not seeing a psychologist or psychiatrist, but had in the past and had taken medications for it. The medications sometimes improved her mood, but not recently. Additionally, she suffered from anxiety, which caused her to get weak and angry. Emotionally, she had not recovered from her husband's death and she felt a strain from her living situation. (Tr. 43-46.)

Plaintiff suffered no side effects from her medications. She took hydroxide about once a week for nausea and vomiting, always took her hypertension medicine, and had other medications that were to be taken daily, but she got "tired of taking medicine" and did not always take them. (Tr. 55-56.) In addition, plaintiff's back still hurt from the residuals of a car wreck in 1972, but she had not had it investigated within the previous two or three years, and did not complain frequently to her doctor of back pain or wear a brace. (Tr. 77-78.)

Plaintiff took care of her personal needs, i.e., fed, bathed, and dressed herself, and did her own laundry. She did household chores for up to half a day, went grocery shopping with her daughter-in-law, occasionally went out to lunch, read books, watched television, prepared a large meal once a week, and walked nine blocks to visit her ex-daughter-in-law. About twice a week, she moved furniture to clean behind it and to rearrange it; she sometimes got on her hands and knees to perform dusting. She could not run, climb a ladder, stand, sit for over an hour, crawl well,

or squat. She was not on a bowling team because she could not get anybody to go with her. Up until one month before her husband died, she alone cared for him. In the previous thirty days, the heaviest thing she lifted was a sack of groceries weighing less than twenty pounds; she usually carried two or three sacks. (Tr. 47-50, 54-58, 72-73.)

Plaintiff last worked as a housekeeper in 1991, cleaning rooms, moving furniture, washing walls, and buffing floors. In her other position she was a short-order cook at a pit stop. She believed she could no longer work for eight hours a day, five days a week, and perform any service, because her "nerves" would not hold up; if she were around people she would probably break down and cry. In addition, she vomited once a day, could usually keep down only one meal per day, and took no nutritional supplements. She saw Dr. Parten about once a month. (Tr. 59, 65-68, 83.)

Financially, plaintiff received \$217 in food stamps for the five family members, had no income, and was rejected as ineligible when she applied for a Medicaid card. The past two times she visited her doctor he did not charge anything because of her financial situation and he gave her samples of medicine. She received information about getting medication cheaper through some program; she had received blood pressure and depression medication from the program. She purchased her "nerve medicine" in two-week quantities. (Tr. 68-70, 75-77.)

Although her doctor told her to quit smoking, plaintiff continued to smoke about a pack and a half per day. In the summer time her legs would swell and cause pain. She continued to suffer from COPD problems. She was told that she has blood clots in her legs and to stay off and elevate her feet. She takes blood-thinning medication. She could not see well with her glasses and needed new ones because her prescription was four years old. (Tr. 71-72, 79-80, 82, 87.)

The ALJ posed a few hypothetical questions to vocational expert (VE) Dr. Arthur E. Smith, who was present throughout the hearing. First, the ALJ asked whether plaintiff would be able to engage in any form of work activity if she were limited by her symptoms as she described them. The VE responded that several factors in and of themselves, e.g., the colon and headache problems, would preclude competitive work. Next, the ALJ asked the VE whether plaintiff would be able to return to her past work, assuming she had COPD disease and gastritis, which limited her to lifting no more than fifty pounds occasionally and 25 pounds frequently; that she could sit, stand, and walk, each, for six hours in an eight-hour workday; that she could not climb ladders, ropes, or scaffolding; and that she needed to avoid concentrated exposure to respiratory irritants such as fumes, odors, dust, gases, and poor ventilation. The VE replied that the work of cook would be contraindicated because of the fumes, but that she could work as a nurse and housekeeper, as those jobs are not considered hazardous to one with respiratory conditions. (Tr. 83-85.)

Finally, stating that 20/200 vision equals legal blindness, the ALJ asked whether plaintiff would be able to engage in work if her vision was correctable to no better than 20/200 and 20/100. The VE responded that 75 percent of sedentary occupations probably would be eliminated, as would all of her past work. (Tr. 89-90.)

B. The ALJ's decision

On April 11, 2002, after "a thorough evaluation of the entire record," the ALJ found the following in a lengthy decision. Plaintiff met the disability insured status requirements of the Act on June 15, 1990, and continued to meet them through September 30, 1997. She had not engaged in substantial gainful activity since June 15, 1990. She has medically diagnosed hypertension, and a history of chronic pelvic pain, lower left quadrant pain, synocopal

episodes, headaches, nausea and vomiting, anxiety, depression, chest pain, and a hysterectomy. But 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." (Tr. 19.)

Next, the ALJ determined that plaintiff's allegations of symptoms precluding all work were not credible based on inconsistencies in the record as a whole, i.e., her "scattered use of treatment and medication, the objective medical findings, her activities, her lack of work restrictions, and her appearance and demeanor were inconsistent with her alleged symptoms." Further, the ALJ concluded that plaintiff's work record was not particularly helpful on the issue of credibility because she had earned more in 1991--the year of her alleged disability onset date--than in any other year and she chopped cotton for two months per year from 1992 to 1994. (Tr. 18-19.)

Next, the ALJ determined that plaintiff had no exertional limitations and that she should avoid concentrated exposure to respiratory irritants, such as fumes, dust, odors, gases, and poor ventilation, but that her past relevant work as a nurse's aide and housekeeper was not precluded by such limitations. The ALJ found that plaintiff's "impairment"² did not prevent her from performing her past relevant work and is not severe. Finally, the ALJ concluded that plaintiff is not disabled. (Tr. 19-20.)

The Appeals Council declined further review. (Tr. 2-3.) Hence, the ALJ's decision became the final decision of defendant Commissioner subject to judicial review.

²"Impairment" is not defined by the Act or the regulations but is properly considered as any condition that deviates from normal health. See Doe v. Harris, 495 F. Supp. 1161, 1168-69 (S.D.N.Y. 1980). Here, the ALJ meant the condition described in his express Finding 3. (Tr. 19.)

In support of her complaint, plaintiff argues that the ALJ (1) improperly assessed her credibility; (2) did not properly evaluate her mental impairment; (3) did not base the RFC determination on substantial medical evidence; and (4) erred in determining that she could perform her past relevant work. (Doc. 15.)

II. DISCUSSION

A. Legal framework

The court's role on review is to determine whether the Commissioner's findings are supported by substantial evidence in the record as a whole. See Krogmeier v. Barnhart, 294 F.3d 1019, 1022 (8th Cir. 2002). "Substantial evidence is less than a preponderance but is enough that a reasonable mind would find it adequate to support the Commissioner's conclusion." Id. In determining whether the evidence is substantial, the court considers evidence that detracts from as well as supports the Commissioner's decision. See Prosch v. Apfel, 201 F.3d 1010, 1012 (8th Cir. 2000). So long as substantial evidence supports that decision, the court may not reverse it because substantial evidence exists in the record that would have supported a contrary outcome or because the court would have decided the case differently. See Krogmeier, 294 F.3d at 1022.

A five-step regulatory framework governs the evaluation of disability in general. See 20 C.F.R. §§ 404.1520, 416.920; see also Bowen v. Yuckert, 482 U.S. 137, 140-41 (1987) (describing the five-step process); Fastner v. Barnhart, 324 F.3d 981, 983-84 (8th Cir. 2003). Step One asks whether the claimant is engaged in "substantial gainful activity." 20 C.F.R. §§ 404.1520(b), 416.920(b). If she is engaged in such activity, disability benefits are denied. 20 C.F.R. §§ 404.1520(b), 416.920(b). If she is not, Step Two asks whether she has a "severe impairment," i.e., an impairment or combination of impairments which significantly

limit her physical or mental ability to do basic work activities. 20 C.F.R. §§ 404.1520(c), 416.920(c). If she does not have a severe impairment or combination of impairments, the disability claim is denied. 20 C.F.R. §§ 404.1520(c), 416.920(c). If the impairment is severe, Step Three asks whether the impairment is equal to an impairment listed by the Commissioner as precluding substantial gainful activity. 20 C.F.R. §§ 404.1520(d), 416.920(d). "If the impairment meets or equals one of the listed impairments, the claimant is conclusively presumed to be disabled." Bowen, 482 U.S. at 141. If the impairment is not one that meets or equals one of the listed impairments, Step Four asks whether the impairment prevents the claimant from doing work she has performed in the past. 20 C.F.R. §§ 404.1520(e), 416.920(e). If she is able to perform her previous work, she is not disabled. 20 C.F.R. §§ 404.1520(e), 416.920(e). If she cannot perform her past work, Step Five, the final step, asks whether she is able to perform other work in the national economy in view of her age, education, and work experience. 20 C.F.R. §§ 404.1520(f), 416.920(f). If she is able to perform other work, then she is not disabled. 20 C.F.R. §§ 404.1520(f), 416.920(f). If she is not able to perform other work, she is, generally, disabled and entitled to disability benefits. 20 C.F.R. §§ 404.1520(f), 416.920(f).

B. Credibility determination

Plaintiff's argument concerning the ALJ's adverse credibility determination is relevant to the determination, at Step Two, that she is not disabled. Substantial evidence supports this determination. In Polaski v. Heckler, 739 F.2d 1320, 1322 (8th Cir. 1984), the Eighth Circuit set forth several considerations for evaluating a claimant's subjective allegations of pain and disability. In addition to the medical evidence, the ALJ is required to assess a claimant's subjective complaints in light of

her prior work record and in light of observations by third parties and physicians relating to the claimant's (1) daily activities; (2) the duration, frequency, and intensity of the pain; (3) precipitating and aggravating factors; (4) dosage, effectiveness, and side effects of medication; and (5) functional restrictions. Id. An ALJ may not discount subjective complaints of pain solely because they are not fully supported by the objective medical evidence, but such complaints may be discounted based on inconsistencies in the record as a whole. Id. The record illustrates that the ALJ cited Polaski and performed a thorough analysis to determine the credibility of Meares's subjective pain complaints. It is unnecessary to rehash the entire analysis of the ALJ's eleven-page, single-spaced decision in order to find that substantial evidence supports the ALJ's conclusion as to plaintiff's credibility.

In short, the ALJ noted the lack of objective medical evidence of pain and found that plaintiff's work history did not help her credibility given that she earned more in the year her disability allegedly began than in any other year, and she chopped cotton during two-month periods in subsequent years. See Curran-Kicksey v. Barnhart, 315 F.3d 964, 969 (8th Cir. 2003) (claimant's participation in part-time work certainly was a matter for the ALJ to consider); Black v. Apfel, 143 F.3d 383, 386 (8th Cir. 1998) (considering claimant's relevant work history and absence of objective medical evidence to support subjective complaints of pain when assessing claimant's level of pain). The ALJ also noted that plaintiff engaged in several activities, such as nursing her terminally ill husband, caring for her personal needs, performing chores, shopping, visiting a relative, and driving an automobile occasionally. See Ramirez v. Barnhart, 292 F.3d 576, 581 (8th Cir. 2002) (affirming ALJ's discount of claimant's subjective complaints of pain where claimant had the "ability to drive, clean, shop and

care for children at least to some extent"); Pena v. Chater, 76 F.3d 906, 908 (8th Cir. 1996). Further, the ALJ found that plaintiff did not have severe side effects from her medications and her medication controlled her hypertension.³ See Roth v. Shalala, 45 F.3d 279, 282 (8th Cir. 1995) (if impairment can be controlled by treatment or medication, it cannot be considered disabling). Additionally, as the ALJ noted, the documentary record revealed no physician-imposed functional limitations. Moreover, the ALJ was permitted to consider Meares's appearance and demeanor at the hearing along with other factors. See Jackson v. Bowen, 873 F.2d 1111, 1114 (8th Cir. 1989); cf. Muncy v. Apfel, 247 F.3d 728, 736 (8th Cir. 2001) (failure to sit and squirm during the hearing is not dispositive of a claimant's credibility).

Plaintiff's argument that the ALJ should not have held her "scattered use of treatment and medication" against her, because she is of limited financial means and because the ALJ did not examine whether she had the ability to comply with a regimen of prescription medications (Doc. 15 at 19) is not persuasive. The medical records and the hearing transcript indicate that plaintiff received free samples and was enrolled in a program by which she received medications at a reduced cost. It follows from the ALJ's determinations that depression and anxiety did not impair plaintiff's daily activities, and that she had the ability to take her medications as prescribed. Cf. Kirby v. Sullivan, 923 F.2d 1323, 1326 (8th Cir. 1991) (remanding for other reasons but commenting that the ALJ should consider the claimant's subjective ability to comply with prescribed treatment regimens in part because claimant was an individual of borderline intelligence with mild to moderate memory impairment). Meares put it best: she grew "tired of taking medicine."

³Even plaintiff indicated that she did not suffer effects from her medications.

C. Mental impairment

Although plaintiff appears to argue in regard to her "mental impairment" that the ALJ should have ordered a consultative psychiatric or psychological examination, the undersigned believes that under the circumstances the ALJ adequately developed the record. See Nevland v. Apfel, 204 F.3d 853, 857 (8th Cir. 2000) (it is the duty of the ALJ to develop the record fully and fairly); Battles v. Shalala, 36 F.3d 43, 45 (8th Cir. 1994) (no bright-line test exists for determining when the ALJ has failed to develop the record; the determination must be made on a case-by-case basis).

The ALJ acknowledged that at times physicians had noted that plaintiff appeared anxious and depressed. However, the ALJ provided several reasons for finding that the record had not established a severe depressive or anxiety condition: plaintiff had not been hospitalized for any mental impairment; there was no evidence that she made or kept an appointment after Dr. Lamb referred her to a psychologist; the medication prescribed apparently helped, as she engaged in fairly normal daily activities; and the state agency psychologist came to the same conclusion upon reviewing the evidence. In addition, the 410-page administrative file, which includes a 91-page transcript of the hour-long hearing before the ALJ, demonstrates the extent to which the record was developed. See Battles, 36 F.3d at 45 ("Although length of a hearing is not dispositive, it is a consideration."). Further, the ALJ made an explicit adverse credibility determination regarding plaintiff's allegation of depression.

D. Plaintiff's other arguments

Because substantial evidence supports the ALJ's determination that plaintiff did not have any significant or severe impairment based upon the evidence of record, she is not disabled; and Steps Three, Four, and Five of the disability analysis, as well as her

challenges to the ALJ's decision as it relates to those steps, become superfluous. In other words, the ALJ's discussion of plaintiff's ability to perform past relevant work, RFC, and capability of performing other work may have been the result of overly cautious decision-writing, but was unnecessary. See Fastner v. Barnhart, 324 F.3d 981, 982 (8th Cir. 2003) (if the claimant "does not have a severe impairment or combination of impairments, the disability claim is denied"); Jones ex rel. Morris v. Barnhart, 315 F.3d 974, 978 n.2 (8th Cir. 2003) (the RFC procedure is only required when the claimant's condition is determined in Step Three not to meet or equal a listed impairment); cf. 20 C.F.R. § 404.1520(e) (if a decision cannot be made based on a claimant's current work activity or on medical facts alone, and a severe impairment exists, RFC and the physical and mental demands of a claimant's past work will be reviewed), (f)(1) (if a claimant cannot do past work because of a severe impairment, RFC and age, education, and past work experience will be reviewed to determine capability of doing other work); 20 C.F.R. § 404.1545 (the RFC assessment of remaining capacity for work is not a decision on whether a claimant is disabled).

In any event, the undersigned will address plaintiff's remaining arguments. Plaintiff criticizes the hypothetical question the ALJ asked the VE on the bases that (1) no treating physicians ever stated that she could lift up to 50 pounds occasionally and 25 pounds frequently, (2) the RFC assessment in the record "was performed by a doctor"⁴ who never personally

⁴Looking at the signature box of the RFC assessment form, the undersigned is unable to determine with certainty whether the individual who completed the assessment is a doctor. Because individual who signed the form drew a line through the words "Medical Consultant's Signature" before signing below those words and because plaintiff explicitly states that the individual is a doctor, the undersigned will not find to the contrary.

examined the plaintiff," and (3) the hypothetical did not take into account that she suffered from abdominal pain, nausea, and vomiting, and "may" suffer from a mental impairment. (Doc. 15 at 22-23.) These criticisms are not well taken.

More weight is generally given to the opinion of an examining source than to the opinion of a non-examining source. 20 C.F.R. § 404.1527(d) (1). But in this case there was no examining source who opined as to plaintiff's lifting capacities. Therefore, "[i]t was well within [the ALJ's] authority to rely . . . on the RFC provided by the agency consultant[]." Melton v. Barnhart, No. Civ. 4-03-CV-10053, 2003 WL 21976088, at *4 (S.D. Iowa Aug. 4, 2003); see 20 C.F.R. § 404.1527(f) (2) (i) (because state agency medical consultants and other program physicians are highly qualified physicians who are also experts in Social Security disability evaluation, ALJs must consider their findings as opinion evidence); SSR 96-6p, 1996 WL 374180 (July 2, 1996). Moreover, the ALJ's hypothetical did not need to mention abdominal pain, nausea, vomiting, and a possible mental impairment because, as has been discussed already, the ALJ properly discredited plaintiff's allegations related to those items. See Chamberlain v. Shalala, 47 F.3d 1489, 1495 (8th Cir. 1995) (an ALJ's hypothetical question must to the VE must sufficiently set forth the impairments the ALJ accepts as true).

Plaintiff's argument that the ALJ did not base his RFC decision upon "substantial medical evidence" with respect to whether she had the RFC to return to past relevant work (id. at 14-16) is also flawed. Although RFC is a medical question, it is not based on only "medical" evidence. See McGeorge v. Barnhart, 321 F.3d 766, 768 (8th Cir. 2003) (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 her limitations); Dykes v.

Apfel, 223 F.3d 865, 866-67 (8th Cir. 2000) (RFC is not determined based on medical evidence alone). The ALJ's RFC determination was based in part on medical evidence, i.e., the medical evidence used to discredit the severity of each alleged impairment. Further, the record revealed no specific physician-imposed limitations. See Anderson v. Shalala, 51 F.3d 777, 779-80 (8th Cir. 1995) (fact that no treating physician ever indicated claimant was unable to work for any 12-month period within the time encompassed by her alleged disability supported the ALJ's determination that she retained the capacity to perform a number of jobs).

RECOMMENDATION

For the reasons set forth above, it is the recommendation of the undersigned that the decision of the Commissioner of Social Security be affirmed under Sentence 4 of 42 U.S.C. § 405(g).

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.

DAVID D. NOCE
UNITED STATES MAGISTRATE JUDGE

Signed this _____ day of August, 2003.