UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

JAYNE A. MATHEWS-SHEETS, Plaintiff,	)	
v.	)	1:08-cv-1426-WTL-DML
MICHAEL J. ASTRUE, Commissioner of the Social Security Administration, Defendant.	)	

PLAINTIFF'S BRIEF

The Plaintiff, Jayne A. Mathews-Sheets, by counsel, C. David Little, herein files her Plaintiff's Brief in this cause.

JURISDICTIONAL STATEMENT

1. Jayne A. Mathews -Sheets, ("Claimant") appeals the decision of the Administrative Law Judge ("ALJ") which denied her claim for disability insurance benefits. That denial was rendered on or about January 30, 2008 (Tr. 19-31). The Appeals Council issued a denial of review on or about August 8, 2008 (Tr. 15-17). On October 8, 2008, the Claimant filed a Complaint for Disability Benefits in the United States District Court, Southern District of Indiana.

2. The Claimant, whose Social Security number is 309-76-1089, resides at 704 South East Street, Lebanon, IN 46052.

3. The jurisdiction of this Court is invoked pursuant to 42 U.C.S. 405(g) (and

42 U.S.C.1383(c)(3)) to review a decision of the Secretary of Health and Human Services denying Claimant's application entitling her to a period of disability or disability insurance benefits, and supplemental security income benefits under Sections 215(i) and 223 of the Social Security Act.

STATEMENT OF THE ISSUES

1. The ALJ used incorrect legal standards in assessing Claimant's disability, necessitating reversal and remand.

2. The ALJ did not apply the correct legal standard in determining whether to grant controlling weight to the medical opinions of Claimant's treating physicians and erroneously disregarded these opinions and in doing so, failed to recognize fibromyalgia as a debilitating disease in that the client's testimony of the severity of her disability was supported by medical evidence which precluded her from significant gainful activity.

3. The ALJ failed to use correct legal standards under SSR 96-8p to properly analyze the combination of Claimant's impairments, specifically the impact of her morbid obesity, at Step Three as well as other impairments including but not limited to bilateral plantar fasciitis, the swelling of her feet, recurrent venous thromboembolic disease, peripheral neuropathy, degenerative arthritis in the right knee and the affects of medication.

4. The ALJ erred in failing to find that the claimant met Step 5 of the Commissioner's Five Step Sequential Evaluation Process in determining that the claimant had sufficient residual functional capacity to maintain substantial gainful activity and work eight hours a day, forty hours a week.

5. The ALJ erred in improperly evaluating and weighing the credibility of Claimant's evidence as to her symptoms, pain, and activities of daily life pursuant to correct legal standards.

STANDARD OF REVIEW

1. This Court's review of the Commissioner's decision is governed by 42 U.S.C. 405(g):

“(t)he Court shall have the power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying or reversing the decision of the Commissioner of Social Security, with or without remanding the cause for rehearing.” 42 U.S.C. 405(g)(Supp. 1998).

2. This section of Title 42 provides for judicial review of a final decision of the Commissioner of the Social Security Administration. The reviewing court will uphold the Administrative Law Judge’s (ALJ) decision if the ALJ employed the correct legal standard and his ultimate conclusions are supported by substantial evidence. *Simpson v. Barnhart*, 91 Fed. Appx. 503 (7th Cir. 2004) and *Groskreutz v. Barnhart*, 108 Fed. Appx. 412 (7th Cir. 2004). Substantial evidence is defined as adequate, relevant evidence of record that a reasonable mind might accept to support a conclusion. Evidence is insubstantial if it is overwhelmingly contradicted by other evidence. A finding of no substantial evidence will be found only where there is a conspicuous absence of credible choices or no contrary medical evidence. 42 U.S.C. 405(g).

3. This Act also provides that an individual shall be determined to be disabled if ‘his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work, but cannot, considering the Claimant’s age, education and work experience, engage in any other kind of substantial gainful work which exists in the national economy. . . “ 42 U.S.C. 423(d)(2)(A).

Accordingly, the Social Security Regulations provide for a Five (5) step sequential method in the evaluation process of determining disability claims. Briefly stated, these are the required steps:

(A) Step One: If Claimant is engaging in work activity which is both substantial and gainful, a finding of "not disabled" is made. 20 C.F.R. 404.1520(b) and 416.920(b).

(B) Step Two: If a Claimant's impairment does not significantly limit his/her physical or mental ability to do basic work activities, a finding of "not disabled" will be made on the basis that the Claimant does not have a severe impairment. 20 C.F.R. 404.1520(c) and 416.920(c).

(C) Step Three: If a Claimant has an impairment which meets or equals those listed in the Listings of Impairments, a finding of disability will be made on medical factors alone. 20 C.F.R. 404.1520(d) and 416.920(d).

(D) Step Four: If a Claimant has a severe impairment, but his/her residual functional capacity does not prevent performance of past relevant work, a finding of "not disabled" is made. 20 C.F.R. 404.1520(e) and 416.920(e).

(E) Step Five: If a Claimant has a severe impairment which prevents performance of past relevant work, the ability to engage in substantial gainful activity must be determined based on: 1) the individual's residual capacity to perform work related functions, and 2) the individual's vocational capacities. 20 C.F.R. 404.1620(f) and 416.920(f).

4. Disability is defined as the inability to engage in any substantial gainful activity for at least Twelve (12) months due to a medically determinable impairment. 42 U.S.C. 423(d)(1)(A).

5. It is well established that an ALJ must give substantial weight to the testimony of the Claimant's treating physician, unless good cause is shown. A treating physician's opinion may be rejected if it is brief, conclusory, and unsupported by medical evidence. Before an ALJ can

disregard a treating physician's opinion, he must set forth specific, legitimate reasons. *Glenn v. Apfel*, 102 F. Supp. 2d 1252 (US Dist Kan. 2000).

6. While it is true that the ALJ may not ignore an entire line of evidence that is contrary to his/her findings, he/she also need not provide a complete written evaluation of every piece of testimony and evidence. *Henderson v. Apfel*, 179 F.3d 507 (7th Cir. 1999).

7. The reviewing court may evaluate the ALJ's decision with a skeptical eye where the Claimant's subjective complaints of pain are supported by treating physicians. *Glenn v. Apfel*, 102 F. Supp 2d 1252 (US Dist Kan. 2000). The ALJ must be careful not to succumb to the temptation to "play doctor" and avoid making their own independent medical assessments. *Schmidt v. Sullivan*, 914 F.2d 117, 118 (7th Cir. 1990).

8. If the evidence upon which an evaluation is based is found to be credible, then ALJ must explain why he/she has chosen not to accept a medical expert's diagnosis. *Baker v. Bowen*, 86 F.2d 289,291 (10th Cir. 1989).

9. A Social Security Disability hearing is non-adversarial, and thus, the ALJ bears the responsibility for ensuring that "an adequate record is developed during the disability hearing consistent with the issues raised" in the hearing. *Henrie v. United States Department of Health And Human Services*, 13 F.3d 359, 360-361 (10th Cir. 1993).

10. Courts will reverse the ALJ's denial of disability benefits if it is based on legal error or is not supported by substantial evidence, meaning "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." The ALJ must build an "accurate and logical bridge" between the evidence and his conclusions, and the court must confine its review to those reasons the ALJ supplied for the decision. *Steele v Barnhart*, 290 F.3d 936 (7th Cir. 2002) *as cited in Villano v. Astrue*, 556 F.3d 558 (7th Cir. 2009); *see Indoranto v. Barnhart*, 374

F. 3d 470 (7th Cir. 2004); *Zurawski v. Halter,* 245 F. 3d 881 (7th Cir. 2001). If an ALJ's decision contains inadequate evidentiary support or a cursory analysis of the issues, the court must reverse. *Collins v. Astrue*, 2009 U.S. App. LEXIS 9950 (7th Cir. 2009).

11. If an ALJ's decision "lacks adequate discussion of the issues," the case will be remanded. *Day v. Astrue*, 2009 U.S. App. LEXIS 9227 (7th Cir. 2009) *citing Villano v. Astrue*, 556 F.3d 558 (7th Cir. 2009).

MEDICAL EVIDENCE

The claimant, Jayne Mathews-Sheets, has multiple medical impairments, the most severe being fibromyalgia, chronic deep vein thrombosis and morbid obesity. Fibromyalgia gradually became worse until she could no longer work at the job as a nurse's assistant and a secretary at the Witham Hospital in Lebanon, Indiana. She was finally terminated, as not being able because of her illness and many absences, on June 28, 2004 (Tr. 719). The claimant had worked steadily since 1985, earning SGA in each year until 2004 (Tr. 71). She testified, too, that she worked very hard when she worked on a farm and then at Witham Hospital for fifteen years (Tr. 715-715). Her fibromyalgia is confirmed by a rheumatologist, Dr Veronica Mesquida, who stated on numerous occasions that she has multiple triggerpoints, or tender points, and that her conditions worsened throughout her body with pain in her hands, shoulders, knees, hips, lower back, neck, feet, as well as stiffness, weight gain and fatigue (Tr. 682, 535, 683, 684). In the claimant's testimony of her pain (Tr. 703, 706-710) she states that her whole body hurts all the time. She cannot take care of her grandson because of the pain and cannot chase after him (Tr. 81). Walking is very painful (Tr. 86) and she cannot go anywhere because of the pain and the inability to walk, and even has considerable pain when sleeping. Tr. 91 states that she worked

one to two days per week, about three hours each day, and was unable to finish the day, and since September 17, 2004, could not work even three hours a day for a couple days per week. A considerable complicating factor is her morbid obesity which exacerbates not only the fibromyalgia but all of her other medical impairments. Her various treating physicians repeatedly make note of this as a severe debilitating factor. She has even had consultation with a bariatric specialist, although bariatric surgery is not yet appropriate. Dr. Watt, who treated the claimant for seven years, stated that she has multiple medical problems and her long term prognosis is incredibly poor, secondary to weight (Tr. 482), and that she is a walking time bomb for thromboembolic or coronary events (Tr. 503).

She has been diagnosed over the years with bilateral plantar fasciitis, by Dr. Conard, an orthopedic surgeon. Dr. Watt, Dr. Abonour and Dr. Tuttle have all treated her for recurrent venous thromboembolic disease (Tr. 659, 685) and degenerative joint disease, (Tr. 613). Her attending physicians, Dr. Tuttle and Dr. Watt, recited a list of further impairments including restless leg syndrome, depression, peptic ulcer disease, hyperlipidemia and antiphospholipid antibody syndrome with multiple DVT's and pulmonary emboli, (Tr. 246, 541). She has further had severe tricompartmental degenerative arthritis with the right knee. The claimant testified also that her continued swelling of her feet, which requires rest and elevation throughout the day (Tr. 708) and her internal bleeding, which requires a shot every night (Tr. 705-706). She also states, and the record reveals in various doctor reports that she has shortness of breath.

ERRORS

Error One

The ALJ used an incorrect legal standard in assessing Claimant's disability, necessitating reversal and remand.

In this case, the ALJ denied disability benefits to Claimant, who presented medical and personal evidence that she suffers from pain and other symptoms associated with fibromyalgia, chronic deep vein thrombosis, morbid obesity, peptic ulcer, osteoarthritis, and bilateral plantar fasciitis. (Tr. 22). At Step Two of the determination, the ALJ found Claimant's fibromyalgia, morbid obesity, and chronic deep vein thrombosis to be severe impairments. (Tr. 26).

Yet at Step Three, the ALJ found no impairments or combination of impairments that met or equaled a listing. (Tr. 26). Specifically, the ALJ stated that there is no listing for fibromyalgia, so he used the listing requirements of 14.09 for inflammatory arthritis to evaluate Claimant's fibromyalgia. (Tr. 26). Since fibromyalgia is not the same as inflammatory arthritis, on its face, it is clear that the ALJ used the incorrect legal standard to deny disability benefits to Ms. Sheets.

Courts will reverse the ALJ's denial of disability benefits if it is based on legal error. *Collins v. Astrue*, 2009 U.S. App. LEXIS 9950 (7th Cir. 2009). Because the ALJ erred when he used an incorrect legal standard, namely the inflammatory arthritis listing, to assess Claimant's fibromyalgia, he committed a legal error, mandating reversal of this decision.

While there is no specific listing for fibromyalgia, the Social Security Administration does recognize fibromyalgia as a medically determinable impairment if there are specified signs and findings that are clinically established by the medical record which comply with the definition set forth by the American College of Rheumatology (ACR). *SSA Memo: Fibromyalgia, Chronic Fatigue Syndrome, Objective Medical Evidence Requirements for Disability Adjudication, May 11, 1998 at p.5*. These signs are primarily the presence of tender points. Specifically, the ACR defines fibromyalgia as "widespread pain in all four quadrants of the body for a minimum duration of 3 months and at least 11 of the 18 specified tender points

which cluster around the neck and shoulder, chest, hip, knew, and elbow regions. *Id.* As Judge Posner wrote in the flagship fibromyalgia case of *Sarchet v. Chater*:

> . . . of greatest importance to disability law, its (fibromyalgia) symptoms are entirely subjective. There are no laboratory tests for the presence or severity of fibromyalgia. The principal symptoms are "pain all over," fatigue, disturbed sleep, stiffness, and - the only symptom that discriminates between it and other diseases of a rheumatic character – multiple tender spots, more precisely 18 fixed locations on the body (and the rule of thumb is that the patient must have at least 11 of them to be diagnosed as having fibromyalgia) that when pressed firmly cause the patient to flinch. *Sarchet v. Chater*, 78 F3d 305 (7th Cir. 1996); see also *Elder v. Astrue*, 529 F3d 408 (7th Cir. 2008), *Groskreutz v. Barnhart*, 108 Fed. Appx. 412 (7th Cir. 2004), *Preston v. Sec'y of Health & Human Servs.,* 854 F.2d 815 (6th Cir. 1988), *Rogers v. Comm'n of Social Security,* 486 F.3d 234 (6th Cir. 2007).

Therefore, the proper Social Security analysis for the severity of fibromyalgia looks first for signs[1] that are clinically established by the evidentiary medical report which signal the presence of fibromyalgia. The word "signs" is used because objective medical tests

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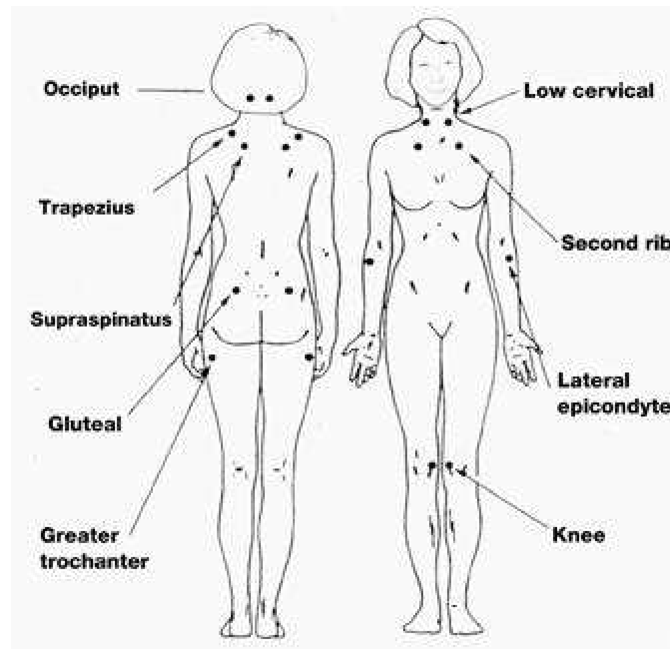
[1] Fibromyalgia (also called fibrositis or fibromyositis) is a syndrome of unknown causes that results in chronic, sometimes debilitating wide spread pain (it hurts everywhere) and fatigue.

Pain. The primary symptom of fibromyalgia is pain, the pain is *widespread* and in certain precise locations called *tender points*. The pain of fibromyalgia is often is described as follows:

- • The experience of widespread pain is similar to that of arthritis and has been described as stiffness, burning, radiating, and aching. Most patients report feeling some pain all the time, and many describe it as "exhausting." The pain can vary, depending on the time of day, weather changes, physical activity, and the presence of stressful situations. The pain is often more intense after disturbed sleep.

- • Tender point pain occurs in local sites (tender points), usually in the neck and shoulders, and then radiates out. It occurs specifically in areas where the muscles attach to bone or ligaments. There are no lumps or nodes associated with these points and no signs of inflammation (swelling, redness, heat). There are at least 11 of 18 specific areas called *tender points* on the body. The pain experienced when pressing on a tender point is very localized and intensely painful (not just tender). Tender points are found in the following areas:

identifying fibromyalgia simply do not exist: “By objective medical evidence, we mean medical signs and laboratory findings as defined in §404.1528 (b) and (c). 20 C.F.R. § 404.1529. [2]



The tender point definition of FMS was developed back in 1990 when much less was known about this disorder. Based on what we now know, tender point definition is an over-simplification of this condition which is best describes as a wide spread pain syndrome (it hurts everywhere), not discrete isolated tender points. Chronic Fatigue Syndrome/Myalgic Encephalopathy (CFS/ME) & Fibromyalgia Syndrome (FMS), 01/14/2007 at www.woodmed.com/CFS%20&%20FMS%20Handout.htm

[2] (b) *Signs* are anatomical, physiological, or psychological abnormalities which can be observed, apart from your statements (symptoms). Signs must be shown by medically acceptable clinical diagnostic techniques. Psychiatric signs are medically demonstrable phenomena that indicate specific psychological abnormalities, e.g., abnormalities of behavior, mood, thought, memory, orientation, development, or perception. They must also be shown by observable facts that can be medically described and evaluated.

(c) *Laboratory findings* are anatomical, physiological, or psychological phenomena which can be shown by the use of medically acceptable laboratory diagnostic techniques. Some of these diagnostic techniques include chemical tests, electrophysiological studies (electrocardiogram, electroencephalogram, etc.), roentgenological studies (X-rays), and psychological tests. 20 C.R.F. § 404.1528 (b) and (c).

Thus, the Social Security Administration's definition of 'objective medical evidence' includes 'signs' which constitute accepted diagnostic methods. Therefore, using SSA and ACR standards, consistent multiple tender points are objective medical evidence of fibromyalgia. At least one Federal Circuit has held that consistent findings of multiple tender points are considered objective medical evidence of fibromyalgia. *Brosnahan v. Barnhart*, 336 F.3d 671 (8th Cir. 2003). If this precedent from the Eighth Circuit is persuasive or the SSA or ACR definitions are conclusive, then Claimant's relevant argument shifts to the fact that her treating specialist, Dr. Veronica Mesquida, reported consistent findings of claimant's multiple tender points (Tr. 535, 682, 683, and 684), but the ALJ failed to follow established legal standards because he refused to recognize consistent evidence of multiple tender points as objective medical evidence of fibromyalgia. In this matter, the ALJ repeatedly called for objective medical evidence at the hearing, and denied disability benefits to Ms. Sheets because he could not find any objective medical evidence to establish a listed disability or its medical equivalent. Yet, if the ALJ had recognized consistent findings of multiple tender points as objective medical evidence of fibromyalgia, the award of disability benefits to Claimant is the only logical conclusion that he could have reached in this matter.

Yet in analyzing Claimant's fibromyalgia under the inflammatory arthritis standard, the ALJ wrote:

> The claimant has been diagnosed with fibromyalgia (Exhibit M at 3). She has reported pain and /or stiffness in her hands, shoulders, knees, hips, lower back, neck, and feet. Physical examination revealed multiple tender points. She has been prescribed steroids and pain medication (Exhibit M at 1-2, 4). (Tr. 25).

Further, Dr. Mesquida made note of Ms. Sheets' multiple tender points and worsening condition at least 3 times during the 34 months in which Dr. Mesquida treated her. (Tr. 535, 682, 683, and 684) Hence, Claimant's medical evidence included the 'signs' of fibromyalgia, and the ALJ properly found it to be a severe impairment even though he clearly used the wrong analysis and listing to do so. (Tr. 22).

Having found the fibromyalgia to be a severe disability, the ALJ moved on to determine whether the Claimant's evidence of record supported a finding that her fibromyalgia, by itself or in combination with other severe impairments or conditions, met or equaled one of the listed impairments. He wrote:

> There is no listing for fibromyalgia, but an evaluation of this condition has been performed using the criteria of the listing for inflammatory arthritis, Listing 14.09, and there is no section of that listing whose criteria or met or equaled. (Tr. 26).

At this point, two errors in the ALJ's analysis are clear:

1. The ALJ used an improper legal standard. Fibromyalgia is not correctly analyzed by using the inflammatory arthritis listing; and

2. Even if it was the proper standard, the ALJ's conclusory statement that Claimant's evidence did not meet or equal a listing is defective without more explanation and discussion of how and why he discredited or completely ignored the evidence of record. As discussed *supra*., if the ALJ had followed the SSA definitions, the ACR definitions, or precedent from the Eighth Circuit, the consistent evidence of multiple tender points conclusively established objective medical evidence of fibromyalgia.

Without more reasons detailed in his decision, it is impossible for anyone to determine what evidence the ALJ considered, how he weighed it, and why the ALJ found it deficient or chose to ignore it. For this reason alone, this determination must be reversed or remanded.

To correctly conduct a proper analysis for fibromyalgia, the ALJ tests the degree of pain, fatigue, and other subjective symptoms experienced by a claimant under 20 C.F.R. § 404.1529

and § 416.929 to determine the severity of the claimant's condition. *Ibid.* Once again writing for the Seventh Circuit, Judge Posner considered whether the severity of the claimant's conditions, including fibromyalgia, caused her such severe pain that she could not work full time. *Carradine v. Barnhart*, 360 F.3d 751, 2004 U.S. App. LEXIS 4707 (7th Cir. 2004). Posner wrote:

> Medical science confirms that pain can be severe and disabling even in the absence of "objective" medical findings, that is, test results that demonstrate a physical condition that normally causes pain of the severity claimed by the applicant. E.g., Dennis C. Turk & Akiko Okifuji, "Assessment of Patients' Reporting of Pain: An Integrated Perspective," 353 *Lancet* 1784 (1999); Paula M. Trief *et al.*, "Functional vs. Organic Pain: A Meaningful Distinction?" 43 *J Clinical Psych 219 (1987).* And so "once the claimant produces medical evidence of an underlying impairment, the Commissioner may not discredit the claimant's testimony as to subjective symptoms merely because they are unsupported by objective evidence." *Lester v. Chater*, 81 F.3d 821 (9th Cir. 1996) in *Carradine, Id.*

Here, Posner's first point in *Carradine* applies to Ms. Sheets in that once she presented medical evidence of her fibromyalgia, obesity, etc., the ALJ should not have been able to attack her credibility by asserting that her testimony about pain and symptoms was unsupported by objective evidence. Taken together, the evidence from the treating doctors and the claimant's testimony about pain and suffering should have formed an impenetrable barrier preventing the ALJ from discrediting Ms. Sheets' testimony about symptoms. The medical record is replete with years of treating physician testimony documenting the continued worsening of her total physical condition. The doctors' notes corroborate the Claimant's testimony as to her pain and inability to enjoy normal life activities. Thus, the ALJ's attack on Claimant's credibility was improper under the standard set forth in the *Carradine* decision.

Posner continued, writing that:

> "A claimant's subjective testimony supported by medical evidence that satisfies the pain standard is itself sufficient to support a finding of disability. Indeed, in certain situations, pain alone can be disabling, even when its existence

> is unsupported by objective evidence. *Foote v. Chater*, 67 F.3d 1553 (11th Cir. 1995) *as cited in Carradine, Ibid.*

Thus, Posner's second point suggests that regardless of the Social Security Administration's listings, the possibility exists for a finding of disability based on pain alone. Dr. Mesquida's notes indicate that Ms. Sheets' pain often equal ten out of ten possible pain points (Tr. 682), mitigated only by pain medications that made often made concentration and staying awake difficult. (See Claimant's testimony, Tr. 701-716). Thus, even without the objective medical evidence upon which the ALJ insisted, it was quite possible to find that Ms. Sheets suffered a disability based solely on the degree of pain she suffered under the standard set forth in *Carradine*.

Continuing, Posner concluded, noting that:

> Pain, fatigue, and other subjective, non-verifiable complaints are in some cases the only symptoms of a serious medical condition. To insist in such a case, as the social security disability law does not. . . that the subjective complaint, even if believed by the trier of fact, is insufficient to warrant an award of benefits would place a whole class of disabled people outside the protection of that law." *Cooper v. Casey*, 97 F.3d 914 (7th Cir. 1996); see 20 C.F.R. § 404.1529(b)(2) *as set forth in Carradine, Id.*

Here, Posner's third point definitively overrules the ALJ's continued insistence on objective medical evidence, even though it arguably did exist in this matter because of the multiple tender points, which the ALJ referred to, but did not satisfy his insistence on objective medical evidence such as laboratory tests and x-rays. Posner's opinion makes clear that pain, fatigue, and other subjective, non-verifiable complaints, the very definition of fibromyalgia itself, can very well be the foundation for a valid finding of disability. Thus, the objective medical standard is not the litmus test for disability even though this ALJ continued to persist to the contrary. Hence, all of Ms. Sheets' testimony as to pain, fatigue, suffering, and inability to enjoy the attributes of a normal lifestyle (Tr. 701-716) could be found to sufficiently support a

finding of disability regardless of whether or not one of SSA's listings has been met or equaled. The subjective signs, pain, fatigue and other subjective factors can be used to support a valid finding of disability, but instead of considering them in that light, the ALJ used them to discredit Ms. Sheets' testimony, concluding in the face of such evidence that the Claimant was not disabled. Patently, the ALJ's decision was reached by using the wrong legal standards in a merely cursory analysis where overwhelming evidence of record demanded a contrary result. As such, the ALJ completely failed to construct an accurate and logical bridge between the evidence of record and his conclusions. Therefore, the decision must be reversed and remanded.

In short, there were two paths which both led to a grant of disability benefits to Claimant. First, using SSA and ACR definitions, and/or Eighth Circuit precedent, consistent multiple tender points are objective medical evidence of fibromyalgia. Second, Claimant's testimony about pain, fatigue, and other subjective factors can be used to award disability benefits under *Carridine*. Yet, the ALJ chose not to use either of these approved paths. Because of his refusal to analyze Ms. Sheets' claim under these accepted legal standards, this determination is based on an improper legal standard and must be reversed and remanded.

Alternatively, when the ALJ used the inflammatory arthritis listing instead of the "signs, pain, and fatigue" standard at Step Three to determine whether the claimant's condition met or equaled a listing rather than properly considering whether the pain and fatigue associated with her fibromyalgia is severe enough to render her disabled, the ALJ failed to apply the relevant legal standard. Even using the erroneous inflammatory arthritis listing, the ALJ failed to articulate what evidence he considered, his reasons for rejecting it, and a sufficient articulation of his basis for concluding that Claimant's fibromyalgia did not meet or equal a listing. Accordingly, Claimant submits that if the record is analyzed using the proper "signs, pain, and

fatigue" fibromyalgia standard, a proper examination and discussion of the evidence will yield sufficient, weighty evidence showing that she is disabled and entitled to an award of disability benefits. Thus, the ALJ's errors in analyzing the evidence of Claimant's fibromyalgia and application of an erroneous legal standard entitles Claimant to reversal or remand pursuant to the proper legal standards as a matter of law.

Error Two

The ALJ did not apply the correct legal standard in determining whether to grant controlling weight to the medical opinions of Claimant's treating physicians and erroneously disregarded these opinions and in doing so, failed to recognize fibromyalgia as a debilitating disease in that the client's testimony of the severity of her disability was supported by medical evidence which precluded her from significant gainful activity.

As discussed above with reference to the *Sarchet* opinion, the diagnosis of fibromyalgia is made by doctors and is based on subjective factors. There are no objective medical tests for fibromyalgia although the accepted diagnostic sign to diagnose fibromyalgia is evidence of consistent multiple tender points which, as discussed *supra,* can arguably be considered objective medical evidence. In actuality, doctors diagnose the disease by locating at least 11 tender spots from 18 fixed locations (see Footnote 2 *supra.*) throughout the body. *Groskreutz v. Barnhart*, 108 Fed. Appx. 412 (7th Cir. 2004). A review of fibromyalgia disability cases shows that doctors reach the diagnosis of fibromyalgia by noting the presence of "multiple tender points" observed in examinations of their patients. *Groskreutz, Id., Rogers v. Comm'n of Social Security,* 486 F.3d 234 (6th Cir. 2007), and *Green-Younger v. Barnhart*, 335 F.3d 99 (2nd Cir. 2003).

a. Treating Physicians

The Claimant submits that the ALJ failed to consider the opinions of all of her treating doctors as to the severity of her physical conditions and their impact on her ability to work. A treating doctor's opinion regarding the nature and severity of a medical impairment is entitled to controlling weight if supported by medical findings and is consistent with substantial evidence in the record. *Groskreutz, Ibid. citing* 20 C.F.R. §404.1527(d)(2) and *Gudgel v. Barnhart*, 345 F.3d 467 (7th Cir 2003); *Bailey v. Barnhart*, 39 Fed. Appx. 430 (7th Cir. 2002), *Lovelace v. Barnhart*, 187 Fed. Appx. 639 (7th Cir. 2006), *Rogers v. Comm'n of Social Security,* 486 F.3d 234 (6th Cir. 2007), and *Green-Younger v. Barnhart*, 335 F.3d 99 (2nd Cir. 2003). This treating physician rule takes into account the treating physician's advantage in having personally examined the claimant and developed a rapport, *see Hofslien v. Barnhart*, 415 F. 3d 654 (7th Cir. 2005) *as cited in Oakes v. Astrue,* 258 Fed. Appx. 38 (7th Cir. 2007), while controlling for the biases that a treating physician may develop such as friendship with the patient, see *Dixon v. Massanari*, 270 F. 3d. 1171 (7th Cir. 2001).

Yet in this case, the ALJ's decision reveals a misunderstanding and misapplication of this rule. While he discussed Social Security Ruling 96-5p in his decision (Tr. 27), his determination of Claimant's RFC capacity failed to acknowledge, weigh, or discuss the opinions of her treating physicians. While the Commissioner makes the final determination about a claimant's residual functional capacity, and that determination must be "based upon consideration of all relevant evidence in the case record" (see Social Security Ruling 96-5p, 1996), the treating physician rule determines how the ALJ must weigh the opinion of treating physicians. If the opinion of the treating physician is supported by acceptable medical evidence and is not inconsistent with other substantial evidence in the record, it must be given controlling weight. 20 C.F.R.§ 404.1527(d)(2); *Schmidt v. Astrue*, 496 F. 3d 833 (7th Cir. 2007) *as cited in Oakes, Id.*

Here, the ALJ improperly rejected and gave no weight to the medical opinions of Claimant's treating doctors. Rather, the ALJ ignored the opinions of all of Claimant's treating physicians. In this case, Ms. Sheets submitted evidence about the nature and severity of her condition from treating physicians Dr. John Tuttle, Dr. Barth Conard, Dr. Robert Watts, and Dr. Veronica Mesquida, but the ALJ mischaracterized it or ignored it.

Dr. Robert Watts

Dr. Watts has treated Claimant for 7 years. His records offer the following evidence of her condition:

> Jan. 21, 2004: 40 year old white female with multiple, multiple medical problems who in my view, whose long term prognosis is incredibly poor secondary to weight . . . (Tr. 482).
>
> Jan 20, 2003: Her prognosis, in my opinion, is extremely poor. She is a "walking time bomb" for thrombotic or coronary events despite her young age. She will need to lose, in my view, approximately 200 pounds as well as extensive lifestyle modifications. (Tr. 503).
>
> Jan. 16, 2003: Obesity. A huge problem for Jayne and continues to increase her risk for cardiac and pulmonary emboli. (Tr. 506).

Dr. Veronica Mesquida

Dr. Mesquida saw Claimant from January 2005 until November 2007, when Dr. Mesquida moved to a practice near Chicago. Her records offer the following evidence of Ms. Sheets' condition.

Jan. 25, 2005: Fibromyalgia tender points. (Tr. 535).

July 7, 2007: The patient has a history of fibromyalgia. She states that she is not doing very well and she has developed worsening of her diffuse body, pain. She complains of pain in her hands, shoulders, knees, hips, lower back, neck, feet. She states that she noticed swelling of her hands on and off. She describes stiffness in her hands in the evening and stiffness involving patient complains of fatigue . . .The patient has progressively gained weight since her last visit in 3/05. At that time, her weight was 148 kg and today is 160 kg. The patient states that she is unable to exercise because of knee pain. . . she has multiple tender points. (Tr. 682).

June 28, 2007: The patient definitely has fibromyalgia. Her chronic myofascial pain can be exacerbated secondary to her problems to sleep, reconditioning and morbid obesity. (Tr. 683).

August 13, 2007: The patient has a long standing history of fibromyalgia, morbid obesity and she has recently developed bilateral hand pain. . . In addition to her pain, she has pain in the shoulders, knees, hips, lower back, neck and feet. . . She has multiple tender points. . . This patient most likely has a degree of osteoarthritis and fibromyalgia syndrome. (Tr. 684).

Dr. John Tuttle

Dr. Tuttle has been Claimant's primary care physician since November 2004. (Tr. 541). On November 11, 2005, he wrote an opinion letter in which he stated that "it is doubtful that

(Claimant) would be physically able to maintain substantial, gainful employment due to (her) medical conditions that limit her physical performance.” (Tr. 541).

Dr. Barth Conard

Dr. Conard is an orthopedic specialist. He began treating Claimant in January 2005 for shoulder, knee, hip and foot pain. At that time, his notes indicate that her primary problem was morbid obesity. He wrote: “Therefore, it will be difficult to help her feet.” (Tr. 562).

Presumptively, the opinions of treating physicians control unless the medical evidence contradicts them. As in *Oakes*, courts will uphold an ALJ’s decision not to give controlling weight to a treating physician’s opinion where that physician did not have the requisite expertise, familiarity with the patient, or longitudinal relationship, or where the opinion was inconsistent with objective medical evidence like x-rays. *Oakes, Ibid. citing White, Id., Skarbek v. Barnhart*, 390 F.3d 500 (7th Cir. 2004), and *Scheck v. Barnhart*, 357 F.3d 697 (7th Cir. 2004). Yet the ALJ did not explore these factors. He gave no reasons for failing to even mention the names of Drs. Watts, Conard, and Mesquida, let alone any reasons why he did not discuss their opinions, in his decision. As the *Oakes* Court wrote:

> However, in this case there is no evidence that Dr. Chambers lacked the requisite expertise or relationship with Oakes to render his opinion unworthy of deference. . . . Moreover, the MRIs, x-rays, and other diagnostic tests in this case support, rather than undercut Chamber’s opinion, and (Dr. Hutson, consulting witness) acknowledged that every test underlying Chamber’s opinion was medically acceptable. *Oakes, Ibid*.

Likewise, the ALJ in this matter set forth no reasons to ignore or discount the opinions of Drs. Watts, Conard and Mesquida. Because they treated Ms. Sheets for more than two years, they did not lack the requisite expertise or relationship to render their opinions unworthy. The

diagnostic tests used to determine fibromyalgia, namely the multiple tender points test, decidedly support the treating doctor's opinions. Thus, there was no cogent reason to discount the opinions of the treating doctors. Yet, the ALJ simply ignored them without providing any rationale.

In the similar case of *Green-Younger*, the court considered why the ALJ had rejected the opinion of a treating physician. There, the ALJ found that Green-Younger had fibromyalgia and degenerative disc disease, her impairments were severe, but did not equal or exceed a listed impairment, and she had the residual functional capacity to do sedentary work, involving six hours a day of sitting and two hours of standing or walking. The ALJ rejected the contrary opinion of Green-Younger's treating physician, Dr. Helfand, that her limitations were more severe. *Green-Younger,335 F.3d at 114.*

The *Green-Younger* Court acknowledged that the Social Security Administration recognizes a "treating physician" rule of deference to the views of the physician who has engaged in the primary treatment of the claimant. "A treating physician's statement that the claimant is disabled cannot itself be determinative." *Snell v. Apfel*, 177 F.3d 128, 133 (2d Cir. 1999) *as cited in Green-Younger,* 335 F.3d at 114. However, SSA regulations advise claimants that "a treating source's opinion on the issue(s) of the *nature and severity of your impairment(s)*" will be given "controlling weight" if the opinion is "well supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record." 20 C.F.R. § 404.1527(d)(2) (emphasis added). *Green-Younger, Id.*

In this specific instance of the claimant Jayne Mathews-Sheets, it is imperative under the Social Security Administration Rules that the ALJ adopt the treating source medical opinions. See 20 C.F.R. § 404.1527(d)(2) and 416.927(d)(2):

> This provision recognizes the deference to which a treating source's medical opinion should be entitled. It does not permit us to substitute our own judgment for the opinion of a treating source on the issue(s) of the nature and severity of an impairment when the treating source has offered a medical opinion that is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with other substantial evidence. 56 FR 36936 (1991) set forth is SSR 96-2p.

After reviewing the record, the *Green-Younger* Court held that:

> . . . the ALJ erred by failing to give controlling weight to the treating physician's opinion and effectively requiring objective evidence beyond the clinical findings necessary for a diagnosis of fibromyalgia under established medical guidelines. Dr. Helfand's opinion regarding Green-Younger's impairments meets the standard under the SSA regulations and should have been accorded controlling weight. Contrary to the government's contention, Dr. Helfand was not offering an opinion on the ultimate issue of legal disability, but rather on the "nature and severity of [Green-Younger's] impairment(s)." He opined that "her ability to function at a normal level because of the persistent, severe pain is markedly limited," noting specifically that she could not sit or stand for more than four hours a day, that she could not continuously sit or stand for 60 minutes without a rest period, and that it was difficult for her to sit for more than 30 minutes at a time. *Green-Younger,* 335 F.3d at 118.

Therefore in all cases, there remains a presumption that the opinion of a treating physician is entitled to great deference. SSR 96-2p. Thus, a physician's opinion regarding the nature and severity of an impairment will be given controlling weight if it is well supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the case. 20 C.F.R. § 404.1527(d)(2) as cited in *Shramek v. Apfel*, 226 F.3d 809 (7th Cir. 2000), *Moss v. Astrue*, 555 F.3d 556 (7th Cir. 2009), *Bauer v. Astrue*, 532 F.3d 606 (7th Cir. 2008), *Collins v. Astrue*, 2009 U.S. App. LEXIS 9950 (7th Cir. 2009), and *Day v. Astrue*, 2009 U.S. App. 9227 (7th Cir. 2009). In many cases, a treating physician's medical opinion will be entitled to the greatest weight and should be adopted, even if

it does not meet the test for controlling weight. *Rogers v. Comm'n of Social Security,* 486 F.3d 234 (6th Cir. 2007). Thus, if an ALJ's decision lacks adequate discussion of these issues, the case must be remanded. *Villano*, 556 F. 3d at 562.

Yet in the present case, the ALJ only addressed the opinion of one of Claimant's treating physicians. Specifically, the ALJ noted that Dr. Tuttle was Claimant's treating physician and wrote the following about Dr. Tuttle's opinion:

> Each physician (referring to Dr. Tuttle and non-examining consultant Dr. Farber) noted the claimant's ability to perform sedentary work activities. Dr. Tuttle's opinion is derived from clinical examination and ongoing treatment. His opinion is congruous with the medical evidence and is therefore entitled to significant weight. . . On the other hand, controlling weight or special significance is not give to Dr. Tuttle's notation regarding the claimant's inability to "maintain substantial gainful employment" as this addresses a matter that is reserved to the Commissioner pursuant to Social Security Ruling 96-5p. (Tr. 28).

Inexplicably, the record does not reflect any opinion of Dr. Tuttle which endorses claimant's ability to perform sedentary activities in any way. To the contrary, Dr. Tuttle wrote that Claimant was unable to maintain substantial, gainful employment because of her conditions. (Tr. 541). The ALJ completely misquoted or misunderstood Dr. Tuttle's letter. He simply did not write that Ms. Sheets could perform sedentary work activities. Instead, he wrote that it was "doubtful that Ms. Sheets would be physically able to maintain substantial, gainful employment due to her medical conditions that limit her physical performance." (Tr. 541). Thus, as in *Green-Younger*, the treating doctor offered an opinion on the nature and severity of claimant's impairment, and his opinion was entitled to controlling weight. The ALJ erred in failing to accord controlling weight to Dr. Tuttle's actual opinion as to the nature and severity of Ms. Sheets' impairment.

The claimant submits that the ALJ apparently misunderstood the meaning of Dr. Tuttle's letter to contradict Dr. Tuttle's actual opinion as to Ms. Sheets' abilities, and also ignored the

opinions of her other treating doctors. Thus, the only treating physician medical evidence (one out of four treating doctors of record) which the ALJ considered in making his determination is misquoted and completely erroneous. Dr. Tuttle's actual opinion, in direct opposition to the ALJ's conclusion, is that Claimant cannot work; a treating physician's opinion which the ALJ completely disregarded, although it is supported by ample evidence of the approved signs of fibromyalgia in concurrence with the corroborating opinions of other treating doctors.

Similarly, an ALJ rejected an opinion letter from the claimant's treating physician, finding it conclusory and an invasion upon the province of the Commissioner's decision making authority in *Cox v. Barnhart. Cox v. Barnhart*, 345 F.3d 606 (8th Cir. 2003). The *Cox* Court noted that if the letter "were the only available record from the treating physician, the ALJ would have been correct in giving it little weight due to its conclusory nature." *Cox v. Barnhart*, 345 F.3d 606 (8th Cir. 2003) *as cited in Forehand v. Barnhart*, 364 F.3d 984 (8th Cir. 2004). As here, however, that was not the case: Dr. Tuttle's letter was only part of a larger record that fully supported the opinion of the claimant's treating doctors as to her history of treatment for and experience of fibromyalgia. Therefore, Dr. Tuttle's opinion, as it was written in his letter, it should have been given controlling weight. Failure to do so is reversible error.

Therefore, as in *Day*, the ALJ failed to give the appropriate weight to the opinions of all of Claimant's treating doctors, misunderstood the opinion and weight of Dr. Tuttle's letter, and refused, without explanation, to even consider the opinions of Dr. Watts, Dr. Conard, and Dr. Mesquida. As the *Day* Court instructed, if an ALJ does not give the treating physicians' opinion controlling weight, he must offer "good reasons" for explaining how much weight he has given the physician's medical opinion. 20 C.F.R. § 404.157(d)(2) and *Schmidt v. Astrue*, 496 F. 3d 833 (7th Cir. 2007) *as cited in Day v. Astrue*, 2009 U.S. App. LEXIS 9227 (7th Cir. 2009). In *Day*,

where the Seventh Circuit reversed and remanded, the ALJ never explained his reasons for discounting the opinions of the treating doctors. Further, he never addressed, in accordance with Social Security regulations, whether the doctors' opinions were supported by medically accepted clinical and laboratory diagnostic techniques and not inconsistent with the other substantial evidence. *Day, Id. and Bauer v. Astrue*, 532 F.3d 606 (7th Cir. 2008) *citing Hofslien v. Barnhart, 439 F.3d 375 (7th Cir. 2006)*. The *Bauer* Court wrote:

> We expressed some puzzlement about the rule: "Obviously if [the treating physician's medical opinion] is well supported and there is no contradictory evidence, there is no basis on which the administrative law judge, who is not a physician, could refuse to accept it. *Hofslien at 376* in *Bauer, Id*.

Since the ALJ gave no reason for ignoring the opinions of Ms. Sheets' other three treating physicians, and the ALJ had no authority to "play doctor" (*See Schmidtt v. Sullivan*, 914 F.2d 117 (7th Cir. 1990), the opinions of her treating doctors must be given prevailing weight. Thus, the unrebutted opinions of all of Ms. Sheets' treating doctors as to the severity of Claimant's pain, the credibility and actual existence of her pain, difficulties with daily activities, the aggravating and disabling effect of her morbid obesity, and her inability to routinely work at gainful employment are controlling. Given the weight of this evidence, the ALJ's contrary conclusion cannot stand.

As in *Collins*, where the Seventh Circuit reversed and remanded, the ALJ failed to provide "good reasons" that were "sufficiently specific to make clear to any subsequent reviewers the weight the adjudicator gave to the treating source's medical opinion and the reasons for that weight. *Collins v. Astrue*, 2009 U.S. App. LEXIS 9950 (7th Cir. 2009) *citing Wilson v. Comm'r of Soc. Sec.*, 378 F.3d 541, (6th Cir. 2004). As the *Collins* Court wrote:

> Specifically, the administrative regulations instruct an ALJ when determining how much weight to give a treating physician's opinion to consider the length, nature, and extent of the physician-applicant relationship, whether the physician is a specialist in the applicant's condition, the degree of consistency between the opinion and other evidence in the record, and the extent to which the physician supported his opinion with medical findings. 20 C.F.R. § 404.1527(d); *Elder v. Astrue*, 529 F.3d 408, 415 (7th Cir. 2008). The ALJ did not apply these regulations. In deciding to not give "any significant weight" to Dr. Olson's opinion, he made no mention of the nature of Dr. Olson's relationship with Collins (Dr. Olson had evaluated Collins at least fifteen times over three years) or the fact that Dr. Olson was an orthopedic specialist. *See* 20 C.F.R. § 404.1527(d). *Collins, Ibid*.

Likewise, the ALJ did not give adequate reason for his interpretation of Dr. Tuttle's opinion and why he ignored the opinions of the other three treating doctors. As in *Moss*, where the Seventh Circuit reversed and remanded, the ALJ altogether failed to address whether the medical opinions of Claimant's treating doctors were supported by medically acceptable clinical and laboratory diagnostic techniques. *Moss v. Astrue*, 555 F.3d 556 (7th Cir. 2009). Yet, an ALJ's conjecture is never a permitted basis for ignoring a treating physician's views. *Moss, Id. citing Gudgel v. Barnhart*, 345 F. 3d 467 (7th Cir. 2003) *and Rohan v. Chater*, 98 F. 3d 966 (7th Cir. 1999). If an ALJ rejects the opinion completely, he must then give specific, legitimate reasons for doing so. *Watkins v. Barnhart*, 350 F.3d 1297 (10th Cir. 2003) *as cited in Wade v. Astrue*, 268 Fed. Appx. 704 (10th Cir. 2008).

In discounting the medical opinions of all of Claimant's treating physicians, the ALJ failed to apply the correct legal standard, to follow the administrative regulations, to explain why he rejected the treating physicians' opinions, and to support his decision with substantial evidence. In ignoring the corroborative opinions of the treating physicians without giving any explanations whatsoever as to why he ignored them, the resultant decision is patently deficient. Because the ALJ both applied an erroneous legal standard and failed to articulate any good reason for significantly discounting the opinions of Claimant's treating doctors, his decision is not

supported by substantial evidence. *Collins, Id.* As the *Moss* Court explained, the ALJ's decision to accept one physician's opinion over another's without any consideration of the factors outlined in the regulations is reason for reversal. *Moss v. Astrue at 561*. Moreover, the *Rogers* Court held that the ALJ's decision was not supported by substantial evidence because the ALJ failed to provide "good reasons" in accordance with the administrative regulations for the weight he gave to the treating physician's opinion. *Rogers at 245-246*. While the ALJ's flaws in reasoning might be dissipated by a fuller and more exact engagement with the facts (*see Carradine v. Barnhart*, 360 F.3d 234 (6th Cir. 2007), this is a matter for remand.

Thus, Ms. Sheets submits that this decision cannot stand where the weight of the evidence does not substantially support the ALJ's conclusion because the unrebutted treating physician evidence directly and overwhelmingly contradicts the ALJ's conclusion, but it was completely ignored without explanation. For this reason, the ALJ's determination must be reversed or remanded.

b. Dr. Mesquida

Perhaps the more serious error committed by the ALJ is his treatment of Dr. Mesquida. Her opinion is entitled to even more weight than the opinions of the other treating physicians. Dr. Mesquida is a board certified rheumatologist. Since fibromyalgia is a rheumatic disease, the relevant specialist is a rheumatologist. *Sarchet v. Chater*, 78 F3d 305 (7th Cir. 1996), *Rogers v. Comm'n of Social Security,* 486 F.3d 234 (6th Cir. 2007) and *Howell v. Astrue*, 248 Fed. Appx. 797 (9th Cir. 2007).

Where a doctor was not only the treating source, but also a rheumatologist, her opinion as to the onset and severity of the claimant's fibromyalgia was entitled to special deference because rheumatology is the relevant specialty for fibromyalgia. *Howell, Id.*

citing Benecke v. Barnhart, 379 F.3d 587 (9th Cir. 2004). Each rheumatologist's opinion is given greater weight. . . because it is the opinion of a specialist about medical issues related to his or her area of specialty. Specialized knowledge may be particularly important with respect to a disease such as fibromyalgia that is poorly understood within much of the medical community. As in *Benecke*, the explanation offered by the ALJ in *Howell* for discounting the specialist's opinion – i.e. that the opinion was not supported by objective medical tests and was inconsistent with Howell's reported activities of daily living – was insufficient. *Howell, Ibid.*

Further, where the opinion of a specialist is in conflict with a treating doctor who is not a specialist in the relevant medical area, the specialist's opinion is entitled to greater weight and trumps the opinion of any other doctor. The opinion of a specialist cannot be undercut by any other doctor. *Moss v. Astrue*, 555 F.3d 556 (7th Cir. 2009).

Therefore, Dr. Mesquida's opinions about the Claimant's condition and abilities are entitled to great controlling weight. In sum, her repeated examinations found that Claimant had multiple tender points with worsening diffuse body pain, stiffening and fatigue, all exacerbated by morbid obesity. (Tr. 535, 682, 683, 684). In contrast, the ALJ never mentioned Dr. Mesquida at all, although he did generically refer to her findings. (Tr. 25). Therefore, the weight of the evidence tips in favor of Dr. Mesquida's opinions, and the ALJ's determination is without substantial evidentiary support because he gave no reasons for discounting the opinion of Dr. Mesquida, not only a treating physician, but a specialist in fibromyalgia. Hence, this ruling must be reversed or remanded because it does not follow the Social Security Administration's admonition to afford great weight to the opinion of a medical specialist and offers no explanation as to why this evidence was completely ignored.

c. Nonexamining Source Medical Opinions

In this case, Dr. Kennedy and Dr. Farber provided testimony based on a review of Claimant's medical records, but never examined her. Thus, their opinions are nonexamining source medical opinions.

More weight should be given to the opinion of a treating source than to the opinion of doctors who do not treat the claimant. *Benton v. Barnhart*, 331 F. 3d 1030 (9th Cir. 2003). In fact, where SSA consulting physicians did not examine the claimant, their reports were not considered substantial evidence. *Green-Younger v. Barnhart*, 335 F.3d 99 (2nd Cir. 2003). Further, a contradictory opinion of a non-examining physician does not, by itself, suffice to provide the evidence necessary to reject a treating physician's opinion. *Gudgel v. Barnhart*, 345 F.3d 467 (7th Cir. 2003) *as cited in Oakes v. Astrue,* 258 Fed. Appx. 38 (7th Cir. 2007).

Here, the ALJ based his determinations completely upon the opinions of Dr. Michael Kennedy and Dr. Mark Farber, non-examining consultants, over the opinions of Ms. Sheets' treating doctors, including specialist Dr. Mesquida. He wrote:

> In evaluating the medical opinions of record, considerable weight has been given to the opinion of Michael W. Kennedy, M.D., a consultive examiner who noted the claimant's ability to fully use her bilateral upper extremities for grasping, pushing, pulling, manipulating objects and operating foot controls. However, Dr. Kennedy's assessment regarding the claimant's s ability to work eight hours a day in a seated, standing, or ambulatory position in view of the effects of her morbid obesity is not followed. Such an opinion – that one cannot work due to extreme obesity – is, in essence, a revival of the now defunct obesity regulation. As noted above, a function by function assessment is necessary to determine what work activities a disability claimant can perform. . . . The residual functional capacity herein is consistent with the opinion of . . . Mark Farber, the medical expert. . . .Dr. Farber's opinion is based upon a recent and comprehensive review of the objective medical evidence and is highly consistent therewith. As such, considerable weight is assigned to his opinion as well. (Tr. 28).

Yet this is the only evidence that the ALJ cited as to claimant's ability to work even though the opinions of the treating physicians all negate it. Since the opinions of treating doctors are entitled to greater weight, a consultive examiner's opinion cannot be considered substantive evidence, a consultive examiner's opinion cannot have more weight than the opinions of treating doctors, particularly a specialist, and no other explanation was given by the ALJ as to why he did not conclude that Ms. Sheets was disabled. For this reason, the ALJ ignored the prevailing legal standards and his conclusion is without substance as a matter of law, necessitating reversal.

Additionally, the interchange during the oral hearing between Dr. Farber and the ALJ is informative as to how far off from the relevant legal standards necessary to evaluate fibromyalgia the ALJ's inquiry really was. In fact, it calls into question whether the ALJ truly considers fibromyalgia as a debilitating disease for which a person can be determined to be disabled. Dr. Farber, a non-examining consultant, sought to show the ALJ why objective medical evidence was the wrong legal standard to evaluate fibromyalgia. The transcript from the hearing shows that Dr. Farber tried to correct the ALJ, but the ALJ cut him off at different times, preventing Dr. Farber from giving a full explanation of the questions that the ALJ was asking.

> Q:. . . So I'm going to have to ask you in terms of the entire record, what impairments, and when I say impairments, I mean, conditions, medical conditions, that are shown to exist by objective medical means for a term of 12 months or more? So in terms of impairments, what impairments did you find?
>
> A: Well, I think these are all documented in some of the later notes from Dr. Mesquida who saw her in July. And we have – she's had chronic deep venous thrombosis and is on chronic anti-coagulation. She probably has obstructive sleep apnea, but I didn't see a sleep study although it was recommended. She has fibromyalgia. She has morbid obesity. She's had gastroesophageal reflux disease, a peptic ulcer, and she had an injury to her knee with a meniscal repair surgically. (Tr. 694)
>
> Q: Right. Okay. And, well, you mentioned fibromyalgia. Is there evidence in this – in the record of the – is this – we see two diagnosis of fibromyalgia here on –

A: Well, Dr. –

Q: - a fairly regular basis. One is where it's just thrown out as a diagnosis and the one don't - diagnosis in one actually where a physician actually does the trigger point test.

A: Well, Dr. Mesquida did that on her exam in July.

Q: Okay.

A: And on the new reporting, she even talks about the positive findings in the hand and the many trigger points and all the positivity. And she even says there's definitely fibromyalgia. Dr. Mesquida is a rheumatologist –

Q: Okay.

A: And then she repeats that on her August exam. So I think, you know, as far as fibromyalgia concerned is adequate documentation –

Q: All right.

A: - which takes us into the pain aspect.

Q: - what's in the - what objective medical evidence shows and what's in the medical record?

A: That's exactly right and that's what I found. (Tr. 697-698).

Q: And if the triggerpoints and the fibromyalgia. . . I know you said fibromyalgia can be a debilitating disease. Would that be a fair statement?

A: Well, I think once again, it's, you know, so it can be but Social Security has not chosen to list it so –

Q: Right.

A: - it's up to the judge now to accept – either to accept the diagnosis and evaluate this – the subjective debilitation because there's no way for me to actually assess that –

Q: Okay.

A: - just as it wasn't for the people who did the FCE.

Q: Right.

A: Yes. I believe that fibromyalgia is a real disease and can be debilitating. (Tr. 701).

In this case, the consultant, Dr. Farber, tried to interject the correct subjective fibromyalgia standard into the hearing proceedings. Yet, the ALJ 'backdoored' the requirement for objective medical evidence for fibromyalgia by asking the consultant, Dr. Farber, to assess Plaintiff's fibromyalgia claim through the lens of objective medical evidence. Then, the ALJ relied on those statements, taken out of context, in order to deny disability benefits to Claimant. Dr. Farber simply followed the question put to him when he stated that there were no objective medical findings to support a diagnosis of fibromyalgia. Of course, as discussed supra., if the SSA and ACR definitions or the Eighth Circuit precedent is used, then multiple tender points are sufficient objective medical evidence to establish fibromyalgia. But, as Dr. Farber explained, there could not be objective medical evidence, as it is thought of in the conventional sense of blood tests, MRI or CAT scans or x-rays, because fibromyalgia cannot be proven objectively. Rather, fibromyalgia's existence is determined first using subjective, medically accepted signs, called multiple tender points, as discussed *supra*., and then the claimant's testimony about symptoms and pain is evaluated for intensity, persistence and limiting effects. Also, Dr. Farber, an internist, noted that fibromyalgia is a rheumatologic disorder, not a neurological one, so Dr. Mesquida, as a rheumatologist and therefore a specialist in fibromyalgia, was in a better position to evaluate the Claimant's condition than any other testifying entity. Additionally, he noted that Dr. Mesquida had recorded the requisite multiple tender points for an accepted fibromyalgia diagnosis and that he believed that fibromyalgia could be a disabling condition.

Regardless of these statements, and their inherent attempt to clarify the correct legal standard for fibromyalgia, the ALJ relied on Dr. Farber's answers, as filtered through the

objective medical evidence requirement inherent in his questions to Dr. Farber. Thus, he used Dr. Farber's opinion to deny disability benefits to Claimant, concluding that:

> At the hearing, Dr. Mark Farbar (sic) testified that the claimant's impairments do not meet and /or equal any listings. Dr. Farber's opinion is found to be consistent with the overall medical and other evidence of record and therefore entitled to considerable weight. (Tr. 26).

Yet the point is that Dr. Farber, as a consultive witness, tried to set the record straight: there is no listing for fibromyalgia even though Social Security recognizes it and provides for its evaluation, and objective medical evidence in the traditional sense of x-rays and lab tests, is not relevant to a diagnosis of fibromyalgia or an assessment of its severity. Therefore, the ALJ shaped Dr. Farber's testimony to support his incorrect outcome - denial of benefits to Claimant – even where Dr. Farber's words actually support an award of benefits to Claimant.

Most importantly, as a non-examining consultive witness, Dr. Farber's testimony cannot supply the needed substantial evidence to withstand the scrutiny of this judicial review. When evidence from treating doctors stands toe to toe with testimony from a non-examining consultant, the treating doctor evidence prevails. Therefore, the ALJ's determination cannot be sufficiently supported by substantial evidence where he relied only on non-examining consultive testimony in the face of specialist and treating physician evidence to the contrary. Hence, this decision must be reversed or remanded as a matter of law because it is not sufficiently supported by the evidence of record.

Error Three

The ALJ failed to use correct legal standards under SSR 96-8p to properly analyze the combination of Claimant's impairments, specifically the impact of her morbid obesity, at Step Three as well as other impairments including but not limited to bilateral plantar fasciitis, the swelling of her feet, recurrent venous thromboembolic

disease, peripheral neuropathy, degenerative arthritis in the right knee and the affects of medication.

Even where a claimant does not identify obesity as an impairment, the ALJ is obligated to consider excessive weight if the record should have alerted the ALJ that weight might be a contributing factor to claimed impairment. *Clifford v. Apfel*, 227 F.3d 863 (7th Cir. 2000) *as cited in Hilmes v. Barnhart*, 118 Fed. Appx. 56 (7th Cir. 2004). In the case at hand, the evidence submitted by Ms. Sheets' treating doctors clearly shows her morbid obesity and the impact it has on her overall physical condition.

An ALJ must give adequate consideration to the effect of a claimant's obesity in combination with other severe impairments. *Barrett v. Barnhart*, 355 F. 3d 1065 (7th Cir. 2004) *as cited in Gentle v. Barnhart*, 430 F.3d 865 (7th Cir. 2005). In *Gentle*, the court said:

> Conditions must not be confused with disabilities. The social security disability benefits program is not concerned with health as such, but rather with ability to engage in full time gainful employment. A person can be depressed, anxious, and obese, yet still perform full time work. This point is obscured by the tendency in some cases to describe obesity as an impairment, limitation or disability. (Citation omitted). It is none of these things from the standpoint of the disability program. It can be the cause of a disability, but once its causal efficacy is determined, it drops out of the picture. If the claimant for social security disability benefits is so obese as to be unable to bend, the issue is the effect of that inability on the claimant's capacity for work. E.g. *Skarbek v. Barnhart*, 390 F.3d 500(7th Cir. 2004) *as cited in Gentle, Id*.

Yet sometimes, as in *Gentle*, *supra.*, obesity or some other health condition merely aggravates a disability caused by something else; it still must be considered for its incremental effect on the disability, as the ALJ failed to do in *Gentle, supra*. The court held that:

> . . . in considering the credibility of the obese woman's narrative of her ability to stand, sit, etc., the administrative law judge would have to determine the effect of her obesity on that ability. Thus, as we said in an analogous case,. . . "Even if Barrett's arthritis was not particularly serious in itself, it would interact with her

> obesity to make standing for two hours at a time more painful than it would be for a person who was either as obese as she or as arthritic as she, but not both." *Barrett v. Barnhart*, 335 F. 3d at 1068 *as cited in Gentle, Ibid*.

Thus, an ALJ is required to discuss the effect of obesity on a claimant's other impairments in combination with her other impairments[3] and in assessing RFC. *Prochaska v. Barnhart*, 454 F.3d 731 (7th Cir. 2006) and *Clifford, Id. as cited in Hernandez v. Astrue,* 2008 U.S. App. LEXIS 10376 (7th Cir. 2008) and *Sienkiewicz v. Barnhart*, 409 F.3d 798 (7th Cir. 2004).

In *Villano v. Astrue*, the court held that in determining an individual's RFC, the ALJ must evaluate all limitations that arise from medically determinable impairments, even those that are not severe, and may not dismiss a line of evidence contrary to the ruling. SSR 96-8p, 1996 SSR LEXIS 5, *Golembiewski v. Barnhart*, 322 F.3d 912 (7th Cir. 2003) *as cited in Villano*. In *Villano*, the ALJ's cursory analysis did not give the Seventh Circuit confidence that he had appropriate reasons for rejecting the limitations Villano alleged where the ALJ failed to analyze the combined effect of Villano's obesity and her other impairments, drew improper inferences about Villano's ability to sit based solely on a lack of objective medical evidence, and failed to discuss Villano's depression. Accordingly, the *Villano* decision was reversed and remanded. *Villano, Id.*

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[3] The policy interpretation portion of SSR 02-01p indicates that:

> Because there is no listing for obesity, we will find that an individual with obesity "meets" the requirements of a listing if he or she has another impairment that, by itself, meets the requirements of a listing. We will also find that a listing is met if there is an impairment that, in combination with obesity, meets the requirements of a listing. For example, obesity may increase the severity of coexisting or related impairments to the extent that the combination of impairments meets the requirements of a listing. This is especially true of musculoskeletal, respiratory, and cardiovascular impairments. It may also be true for other coexisting or related impairments, including mental disorders. SSR-02-01p.

In this case, the Claimant set forth morbid obesity as a disabling impairment. Further, her treating physicians referred to her morbid obesity and noted its exacerbating effects on her overall condition. For example, Dr. Watts said that obesity made Claimant a "walking time bomb." (Tr. 503). Dr. Mesquida wrote that the fibromyalgia pain throughout Claimant's body was exacerbated by morbid obesity. (Tr. 683). Dr. Conard wrote that as long as claimant was so obese, not much could be done to help her foot pain, presumptively because the excessive weight placed a terrible burden on the joints and bones of her feet and legs. (Tr. 562). This conclusion comports with both medical science and caselaw. Obesity may aggravate problems with joints because obesity places additional stress on joints [4], and Claimant has alleged a problem with her knees. As Judge Posner set forth in *Johnson v. Barnhart*:

> The heavier you are, the more stress is placed on your spine, hips, knees and ankles. Also, heavier people tend to resist exercise, resulting in another risk factor – weak muscles, particularly in the thigh. Weakness in the thigh, in turn, places extra stress on the knees. *Johnson v. Barnhart*, 449 F.3rd 804 (7th Cir. 2006).[5]

Where both the claimant and her doctors testified that her obesity aggravates her fibromyalgia, the ALJ should have considered how obesity affected her functionality. Here, the ALJ had evidence even from Dr. Kennedy, a non-examining consultant, that Claimant's obesity interfered with her ability to work, but the ALJ incorrectly rejected it, writing that:

> Such an opinion – that one cannot work due to extreme obesity – is, in essence, a revival of the now defunct obesity regulation. As noted above, a function by function assessment is necessary to determine what work activities a disability claimant can perform. (Tr. 28).

Thus, the ALJ's words reveal that he did not understand the task before him.

[4] 1 William J. Koopman & Larry W. Moreland, Arthritis and Allied Conditions: A Textbook of Rheumatology 27-28 (15th ed. 2005) as cited in *Johnson v. Barnhart*, 449 F.3rd 804, U.S. App. LEXIS 13793 (7th Cir. 2006).
[5] *Johnson, Id*. citing Jayne E. Brody, "Personal Health: Arthritis: Your 'Reward for Wear and Tear," *New York Times*, July 30, 2002, p.F7

This type of failure to consider all impairments, singly and in combination with other impairments, is reversible error under SSR 02-01p[6]. The ALJ must consider all of the available medical evidence and assess with a thorough and reasoned analysis the effect of all of claimant's impairments. *Fleetwood v. Barnhart, 211 Fed. Appx. 736 (10th Cir, 2007)*. Because the ALJ did not assess this matter with a thorough and reasoned analysis, particularly as to the impact of morbid obesity on fibromyalgia, this decision must be reversed or remanded.

The Judge also failed to mention other impairments, although some not as severe, that also play a factor in the ability of the claimant to work full time. She had been diagnosed with bilateral plantar fasciitis by Dr. Conard, accompanied by an MRI that shows that the plantar fasciitis is moderately severe (Tr. 152–156). Dr. Christopher Moon, a podiatrist, also diagnosed the claimant with plantar fasciitis and difficulty in walking (Tr. 414-416). Complimenting this diagnosis is a report by Dr. Abonour indicating that she has significant peripheral neuropathy and that she has severe pain in the dorsum of her bilateral feet (Tr. 662-663). Obviously, her morbid obesity and weighing over 300 pounds would be an aggravating factor to this impairment, as well as increase her difficulty in walking. An MRI of the right knee divulged that she has moderately severe, tricompartmental degenerative arthritis in the right knee (Tr. 393, 395). She has been diagnosed and treated for recurrent venous thromboembolic disease or deep venous thrombosis and continued to be treated for the same (Tr. 685-690). See the radiology report (Tr. 655) and the reports from Dr. Emhta (Tr. 659-661). See also Tr. 571, 576. Claimant also testified about her internal bleeding and her bruising and problems with clots in her testimony at the beginning (Tr. 704-705). Dr. Robert Watt, who has been her doctor for several years stated that she has "multiple medical issues" (Tr. 258) and that she is "a very complicated

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[6] See also *Salazar v. Barnhart*, 468 F3d 615, 621, 622 (10th Cir. 2006) as cited in *Fleetwood v. Barnhart*, 211 Fed. Appx. 736, 2007 U.S. App. LEXIS 199 (10th Cir. 2007).

40 year old white female" (Tr. 250). Dr. Watt's reports are recited in the record, beginning at Tr. 246 through Tr. 288. Among the conditions she has been diagnosed, although not inclusive, was a long history of antiphospholipid antibody syndrome, osteoarthritis, shortness of breath, morbid obesity, terrible dyslipidemia and hypercholesterolemia. Her medications (Tr. 541, 570) may reduce her pain from a level of five instead of level 10, but it makes her drowsy and sleepy and slower to think and not want to do anything and disturbs her ability to concentrate on something for a period of time (Tr. 707). The ALJ does mention some of these impairments on Tr. 25, but states that taken collectively, these conditions have not lasted for more than a 12 month period and only have a minimal effect on her functional ability. We submit that the medical record refutes that, as she has had bilateral plantar fasciitis for several years, her recurrent venous thromboembolic disease has been mentioned many times throughout her medical history by Dr. Watt, Dr. Abonour and Dr. Tuttle and degenerative joint disease infers that the condition would not improve, but become worse. Without referring to every single reference, the reading of the record with clearly indicate the references of these conditions over and over again and which continue to the date of her testimony. Given all the medical impairments, both the severe and non-severe and the combination of those, particularly the morbid obesity, claimant submits that it would be impossible for her to maintain substantial gainful activity and any kind of employment and that she should be determined to be disabled.

Error Four

The ALJ erred in failing to find that the claimant met Step 5 of the Commissioner's Five Step Sequential Evaluation Process in determining that the claimant had sufficient residual functional capacity to maintain substantial gainful activity and work eight hours a day, forty hours a week.

As pointed out in the Standard Review, Step 5 of the Commissioner's Five Step Sequential Evaluation Process requires the Commissioner to have the burden of proof in establishing that the Claimant cannot perform past relevant work or engage in substantial gainful activity.

In step 5 of the Commissioner's Five Step Sequential Evaluation Process (20 C.F.R., Section 404.1520(f)) states as follows:

"If a Claimant has a severe impairment which prevents performance of past relevant work, the ability to engage in substantial gainful activity must be determined based on (1) the individual's residual capacity to perform work-related functions, and (2) the individual's vocational capacity."

Substantial gainful activity is defined in Social Security Ruling 82-53 as "the performance of significant physical or mental activities in work for pay or profit, or in work of a type generally performed for pay or profit. 'Significant activities' implies not only that the activities are useful in the accomplishment of a job or the operation of a business, but also that they are the kind normally done for pay or profit." Disability is the inability to engage in any substantial gainful activity for at least twelve (12) months due to a medically determinable impairment. 42 U.S.C.S. § 423 (d)(1)(A).

The Court of Appeals of the 10th Circuit in *Adkins v. Joanne Barnhart, 80 Fed. Appx. 44, 2003 U.S. App. (2003)* stated "at step five, the ALJ has the burden to prove that the claimant retains the RFC to perform work other than his past relevant work *Thompson v. Sullivan, 987 F.2d 1482, 1487 (10th Cir 1993)*. It is not [the claimant's] burden to prove he cannot work at any level lower than his past relevant work; it is the [agency's] burden to prove that he can."

> "The ALJ must make specific findings as to RFC, *Winfrey, 92 F.3d at 1023*, and these findings must be supported by substantial evidence." *Adkins, supra*.

The Claimant testified in the beginning on page 708, that her feet are always swollen and that she has to lay down for a couple of hours to get relief when she has been standing or sitting. She testified about her constant pain throughout her body, that she has to tell her five year old grandson to get off of her lap because of the pain, it is painful to sit for more than 20 to 30 minutes and that her legs start going to sleep, that she can only walk a couple of blocks before she is out of breath, she can probably stand for a half hour to forty-five minutes and then has to sit down and rest for a half hour or so (Tr. 708-710). The claimant basically testified of the effects of all of her medical impairments, both severe and non-severe which have been discussed in this brief. The ALJ, in questioning vocational expert, Robert Barber, on Tr. 721 as to whether or not some allowance can be made for a person not to be able to work a full time schedule and would there be any jobs available in the economy for that individual, the vocational expert said "No." The vocational expert testified that the jobs that the claimant had been doing in the past were SVP of 4 and SVP of 5. However, he failed to mention any jobs, nor did the Judge ask the vocational expert any questions about any jobs that were available in the market that which the claimant could perform. Dr. Tuttle, having directed a functional capacity evaluation by Mary Ping, (Tr. 537-540), stated on Tr. 541 her past medical history of restless leg syndrome, morbid obesity, fibromyalgia / chronic pain syndrome, depression, peptic ulcer disease, hyperlipodemia, antiphospholipid antibody syndrome, thromboembolic and a list of her medications stated as follows "It is doubtful that Ms. Sheets would be physically able to maintain substantial gainful employment due to the above medical conditions that limit her physical performance. Please see attached Functional Capacity Evaluation. This study is an excellent tool in determining a patient's physical limitations and disabilities"

It is significant to note, however, that the claimant has worked hard and earned considerable income from 1985 to June 28, 2004 (Tr. 71), when she could no longer work. She received benefits after that date but did not work significant gainful activity. She testified on Tr. 714 how she worked hard on the farm and was always very active. It does not make sense for a person who has worked hard most of their life, for almost twenty years, to suddenly quit work, file for disability and wait two years for an uncertain determination as to whether or not she is eligible or not eligible to receive benefits. Logic tells us that people who have worked continuously and want to continue to work and be productive. They stop working because they can no longer do the job and work as they have in the past and maintain substantial gainful activity because of mental or medical impairments. Such is the case of Jayne Mathews-Sheets who has testified on Tr. 715 that she had missed too many days due to her illness and was finally terminated and that she was not able to perform the job even on a part time basis. The last day she worked full time was June 28, 2004 and claimant amended her onset date to that date (Tr. 719). Certainly, there is sufficient medical evidence submitted in the record to corroborate claimant's testimony that she is unable to work full time. The ALJ failed to meet step five of the commissioner's five step sequential evaluation process and has failed to meet his burden of proof that there are jobs in sufficient numbers that can be performed by the claimant. Accordingly, this matter should be reversed or remanded.

Error Five

The ALJ erred in improperly evaluating and weighing the credibility of Claimant's evidence as to her symptoms, pain, and activities of daily life pursuant to correct legal standards.

Here, the ALJ held that:

The claimant's daily activities, in contrast to her hearing allegations, illustrate a moderate level of activity. In January 2005, she reported only a mild reduction in her activities of daily living (Exhibit A at 13). She independently attends to her personal hygiene, prepares meals, performs household chores including laundry, and does yard work, albeit at a slower pace (Exhibit 1E at 18). She shops for groceries and assists in the care of her grandchildren (Exhibit 1E at 18; Exhibit M at 6). This evidence demonstrates that the claimant's capacity to engage in a considerable amount of activity despite her symptoms. Although the ability to engage in activity in a non-work setting is recognized as not the equivalent of performing the same activities in a work setting on an eight-hour-a-day and five-day-a-week basis, neither can the daily activities simply be ignored because they are not performed eight hours a day. The claimant's daily activities affirmatively demonstrate that she is capable of some physical activity . . . (Tr. 29).

Actually, Ms. Sheets testified to the following:

Q: Ms. Sheets, tell us, had you and I discussed, when we talked in preparation for this hearing – tell us the physical impairments that you suffer from, you know, beginning with – now you've heard the doctor's testimony, tell us about the -- start with the fibromyalgia –

A: Okay.

Q: - and how that affects you and where.

A: Well, I hurt all over. All of my joints hurt. My head hurts, my neck hurts. My neck is stiff and it – I have headaches from it and my shoulders hurt and my elbow and my hands and my fingers, my back and my hips and my knees, my legs, my ankles. My legs well really bad because of the blood clot that I had, the several blood clots that I had in my left leg. And the blood thinners that I'm on, when I'm on the Coumadin it either is too thick or too thin. If it's too – if my blood is too thick, I get blood clots. If it's too thin, then I bleed internally somewhere or if I -- . . . (Tr. 703).

Q: . . . when did it start being to the point where it was so sensitive to the touch, the trigger points we're talking about?

A: Well, this all kind of started in '04, but the last, even the last two years, it's gotten increasingly worse and it's more joints. Like in '04, it was my legs and my hip and in my back. But in the last year to two years, it's been my shoulders and my elbow. In the last year, it's been my hands and my neck and my right here in front.

Q: Front of your neck?

A: I mean, my chest area.

Q: Chest area.

A: and my shoulders.

Q: And during the course of a day, do you experience pain in these different joints?

A: I experience pain all the time.

Q: When you have – do you take medicine for this pain?

A: Yes.

Q: When your medicine is at its peak or so on, what kind of pain level would you say on a scale of one to 10?

A: At the peak level, when I take my medicine like I'm supposed to, it may manage to be at a level Five instead of a level Ten. But then when I have this medicine, I'm so drowsy and sleepy and I'm slower to think and I just I don't want to do anything.

Q: And you take this medicine every day?

A: I take this medicine every day, yes, and the --

Q: And this is basically an effect of the -- you feel is the effect of the medication?

A: Yeah.

Q: – that makes you –

A: Yes.

Q: What about concentration, being able to concentrate on something for a period of time?

A: Oh, well, if I don't fall asleep, I mean, my concentration is very low. And then he just put me on a – the fentanyl pain patch so it can – I mean, he's – the doctor is trying to get it where it's a little more steady instead of having this high and low dosage.

Q: When you – when your medicine starts running out or it starts not being, you know, it starts to not be as effective, what type of level of pain do you have? What –

A: Oh, it's level ten.

Q: And what part of the body?

A: It's all over my whole body. It's just all over. (Tr. 706-707).

Q: And you say that any part of your body touch – hurts you?

A: Yes.

Q: And any particular points or any part of the body?

A: It's any part of the body. It's a lot of my upper torso and my legs. I mean, it's to the point where I have a five year old grandson that I pretty much have to tell him to get off my lap because I can't stand for him to be on me.

Q: And sitting is – your grandson sitting on your lap causes the pain?

A: Yeah.

Q: And does it cause anything else, swelling or numbness or anything?

A: No. It just is pain.

Q: Pain. How long can you sit for a period of time without having to --

A: Oh, probably for 20, 30 minutes, but it's painful to sit and my legs start going to sleep. . .

Q: And how far – how long can you walk or how long can you walk or how far can you walk?

A: Oh, I could walk a couple of blocks.

Q: Then what?

A: Well, I would be out of breath and I would not want to walk anymore because my hips and my back and my legs would hurt, my feet would hurt. (Tr. 708-709).

Q: How long can you stand?

A: Oh, I could probably stand for half an hour or 45 minutes.

Q: And then what happens?

A: Then I would be done standing. I would need to go do something else, probably sit down or --

Q: How long would you have to sit down or rest in order before you could stand again?

A: Oh, probably a half an hour or so.

Q: Would you have to sit down or lay down or something if you're standing that long?

A: Well, I would have to sit down but laying down would be better because even if I sit down, it's still cutting off the circulation in my legs and it really wouldn't do any good. But it – I mean, I would be resting but my legs would still be bothering me. But them my legs bother me so bad and with that restless leg syndrome that I just feel like I have lightning bolts in my legs and they're just real restless and – (Tr. 710).

Q: How often, going back to the leg, how often is the pain in the leg that you described, how often does that occur?

A: That's all the time.

Q: Every night?

A: Every night. Sometimes when I sit down – I mean, even if I sit down, I still have it.

Q: Do you drive?

A: I do drive. I drive short distances. (Tr. 714).

Q: And you understand what full time work is all about, don't you?

A: Oh, yeah, I'd worked full time work for 20 some years. I worked raising my first son. I worked. I was a single parent and I worked three jobs.

Q: And with the condition you have now, is there any way you feel that you can work eight hours a day, 40 hours a week at any kind of job even if it's a very light or a sitting job ?

A: I don't feel like I could.

Q: And why not?

A: I couldn't sit long enough for them to – I mean, for my – the required time that they – I would have to do something. And I couldn't be on my feet (f)or that long. And with the medicine I take, I'm drowsy or my thinking process is slower. And I get sick. Like if I bruise or something and it gets infected, then it pretty much just

kind of shuts my whole body down and then, I mean, I just wouldn't be reliable. I would just – I would be fired repeatedly.

Q: Would you with your medical condition keep you from going to work at least one day or two days a month?

A: I believe it would just because I wouldn't be able to stand to do a standing job or sit long enough – (Tr. 716).

Nevertheless, the ALJ concluded that:

> While there can be no doubt that the claimant has some pain and discomfort associated with her impairments, the overall evidence does not substantiate the extreme symptoms to which she testified. (Tr. 29).
>
> After considering the evidence of record, the Administrative Law Judge finds that the claimant's medically determinable impairments could reasonably be expected to produce the alleged symptoms, but that the claimant's statements concerning the intensity, persistence, and limiting effects of these symptoms are not entirely credible. (Tr. 30).

Yet this view overstates Claimant's abilities to perform her daily activities as shown by her testimony *supra.* Most tellingly, the ALJ does not show how and why the evidence does not substantiate the symptoms to which Ms. Sheets testified. The plain meaning of her words *supra*. do indicate extreme pain and discomfort that afflicts her all the time, limiting her ability to stand, walk, drive, hold her grandson, etc. for more than a half an hour at the most. Thus, it is unclear where and why the ALJ found that her activities were not consistent with her subjective complaints of pain. A claimant's ability to perform limited and sporadic tasks does not mean that she is capable of full time employment. *Groskreutz v. Barnhart*, 108 Fed. Appx. 412, (7th Cir. 2004), citing *Carradine v. Barnhart*, 360 F.3d 751, 2004 U.S. App. LEXIS 4707 (7th Cir. 2004), *Clifford v. Apfel*, 227 F.3d 863 (7th Cir. 2000) and *Shramek v. Apfel*, 226 F. 3d 8090 (7th Cir. 2000).

While credibility determinations regarding subjective complaints rest with the ALJ, those determinations must be reasonable and supported by substantial evidence. The decision must contain specific reasons for the finding on credibility, supported by the evidence in the case record. The decision must be sufficiently specific to make clear to the individual and to any subsequent reviewers the weight the adjudicator gave to the claimant's statements and the reasons for that weight. *Rogers v. Comm'n of Social Security,* 486 F.3d 234 (6th Cir. 2007). Here, the ALJ fails to show why he believed that the connection between Ms. Sheets' testimony and the other evidence is broken, making his decision defective. In fact, when fairly viewed, the Claimant's testimony is in perfect accord with the objective evidence of fibromyalgia and the evidence offered by her treating doctors as to her condition. There is substantial evidence to support Ms. Sheets statements. The ALJ's determination to the contrary is without substantial evidential support or explanation and must fall as a matter of law.

In determining credibility, an ALJ must consider several factors, including the claimant's daily activities, her level of pain or symptoms, aggravating factors, medication, treatment, and limitations, *see* 20 C.F.R. § 404.1529(c); S.S.R. 96-7p, 1996 SSR LEXIS 4, and justify the finding with specific reasons, *see Steele v Barnhart*, 290 F.3d 936 (7th Cir. 2002) as cited in *Villano v. Astrue*, 556 F.3d 558 (7th Cir. 2009). Additionally, under S.S.R. 02-1p, 2002 SSR LEXIS 1, the ALJ must specifically address the effect of obesity on a claimant's limitations because, for example, a person who is obese and arthritic may experience greater limitations than a person who is only arthritic. *Barrett v. Barnhart*, 355 F.3d 1065, 1068 (7th Cir. 2004) *as cited in Villano, Id*. Failing to acknowledge this effect may impact the ALJ's credibility determination. *Gentle v. Barnhart,* 430 F.3d 865, 868 (7th Cir. 2005). Furthermore, the ALJ may not discredit a claimant's testimony about her pain and limitations solely because there is no objective medical

evidence supporting it. S.S.R. 96-7p, 1996 SSR LEXIS 4; 20 C.F.R. § 404.1529(c)(2); *see Johnson v. Barnhart,* 449 F.3d 804, 806 (7th Cir. 2006); *Clifford v. Apfel*, 227 F.3d 863, 871-72 (7th Cir. 2000) *as cited in Villano, Ibid.* Here, the ALJ did not discuss the effect of Ms. Sheets' morbid obesity on her daily activities or on her ability to work.

In *Villano*, the ALJ failed to build a logical bridge[7] between the evidence and his conclusion that Villano's testimony was not credible. First, the ALJ did not analyze the factors required under SSR. 96-7p, 1996 SSR LEXIS 4: although he briefly described Villano's testimony about her daily activities, he did not, for example, explain whether Villano's daily activities were consistent or inconsistent with the pain and limitations she claimed. Nor did the ALJ analyze what effect Villano's obesity had on her arthritis under SSR 02-1p, 2002 SSR LEXIS 1. Though a failure to consider the effect of obesity is subject to harmless-error analysis, *see Prochaska v. Barnhart,* 454 F.3d 731, 736-37 (7th Cir. 2006); *Skarbek v. Barnhart*, 390 F.3d 500, 504, 105 Fed. Appx. 836 (7th Cir. 2004), the *Villano* Court was not persuaded that the error was harmless, given the other flaws with the RFC analysis and the analysis of Villano's ability to perform other jobs. The ALJ said he disbelieved Villano's testimony about her inability to sit (albeit in the course of his RFC analysis) because no medical evidence supported such a limitation, but as the court noted, a lack of medical evidence alone is an insufficient reason to discredit testimony. *See* SSR 96-7p, 1996 SSR LEXIS 4; *Clifford,* 227 F.3d at 871-72 *as cited in Villano, Id*.

As in *Villano, supra*., the ALJ wrote that "the overall evidence does not substantiate the extreme symptoms to which she (Sheets) testified" (Tr. 29), but he did not explain whether Sheets' daily activities were consistent or inconsistent with the pain and limitations she claimed.

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[7] The ALJ is not required to discuss every piece of evidence, but must build a logical bridge from evidence to conclusion. *Steele v Barnhart*, 290 F.3d 936 (7th Cir. 2002) *as cited in Villano v. Astrue*, 556 F.3d 558 (7th Cir. 2009); *see Indoranto v. Barnhart*, 374 F. 3d 470 (7th Cir. 2004); *Zurawski v. Halter,* 245 F. 3d 881 (7th Cir. 2001).

Nor did the ALJ analyze what effect Sheets' obesity had on her fibromyalgia under SSR 02-1p, 2002 SSR LEXIS 1. In actuality, Sheets' testimony about having pain all over and fatigue that was worse on some days, but better on others is completely consistent with her statements to her treating doctors since 2003 as well as to the characteristics familiarly associated with fibromyalgia. A person who has a chronic disease, whether physical or psychiatric, and is under continuous treatment for it with heavy drugs, is likely to have better days and worse days. *Bauer v. Astrue*, 532 F.3d 606 (7th Cir. 2008).

Thus, there was no contradiction between Sheets' testimony and the evidence of record, but both contradict the ALJ's decision. Further, in reading the ALJ's decision, there is no way to decipher how or why he determined that the evidence did not substantiate the symptoms that Sheets has reportedly suffered for years. Thus, the ALJ did not construct the required bridge between the evidence and his conclusion. The evidence supports a contrary conclusion, and without a recitation of the ALJ's reasoning to the contrary, there is no adequate discussion of the issues. As such, remand is required. *Villano, Ibid.*

An ALJ's credibility determination will be upheld only where the ALJ gave specific reasons for the finding that are supported by substantial evidence. *Moss, Id., citing Arnold v. Barnhart*, 473 F.3d 816 (7th Cir. 2007). But as the regulations state, an ALJ cannot disregard subjective complaints of disabling pain just because a determinable basis for pain of that intensity does not stand out in the medical record. See SSR 96-7p; *Johnson v. Barnhart*, 449 F.3d 804 (7th Cir. 2006) *as cited in Moss, Ibid. and Day v. Astrue,* 2009 U.S. App. LEXIS 9227 (7th Cir. 2009). In determining a claimant's credibility, the ALJ must consider his level of pain, medication,

treatment, daily activities, and limitations and must justify its credibility finding with specific reasons. *Day, Id.*

While the ALJ wrote that "the overall evidence does not substantiate the extreme symptoms to which she (Sheets) testified" (Tr. 29), he had the duty to set forth specific reasons or continue to develop the record. Here, Ms. Sheets' testimony clearly shows that she suffers level ten pain almost all the time (unless medicated, which makes her foggy and sleepy), she can't sit or stand for more than a half an hour, and most of the time, she isn't well enough to do much of anything. *Supra*. Yet if anything about Ms. Sheets' testimony or the evidence of record was unclear to the ALJ, he had the obligation to get more evidence. As in *Moss, supra*., if the medical record does not corroborate the level of pain reported by the claimant, the ALJ must develop the record and seek information about the severity of the pain and its effects on the applicant. *Clifford v. Apfel*, 227 F.3d 863 (7th Cir. 2000) as *cited in Moss, Id.* In *Moss*, the ALJ simply marginalized doctor opinions without a sound explanation and then went on to conclude that neither Moss' own testimony nor the remaining medical evidence supported her subjective complaints of pain. *Moss, Ibid*.

Similarly in *Day, supra*., the ALJ discounted the treating physicians' opinions and went on to conclude that Day's "statements concerning the intensity, duration, and limiting effects of his (injury) are not entirely credible: because he could do housework, attend movies, walk five blocks, sit for 45 minutes, stand for about 25 minutes, and was looking for a job." *Day, Ibid.* However, the *Day* Court cautioned against placing undue weight on a claimant's household or outdoor activities in assessing his ability to work full time. *Day, Id*. In the context of fibromyalgia cases, the ability to engage in activities such as cooking, cleaning, and hobbies does

not constitute substantial evidence of the ability to engage in substantial gainful activity. *Brosnahan v. Barnhart*, 336 F.3d 671 (8th Cir. 2003).

Likewise, the ALJ ignored Sheets' treating doctor opinions and concluded that neither the objective medical evidence, such as he recognized it, nor Ms. Sheets' testimony supported her extreme claims of pain in order to discredit her without setting forth any sound reasoning. Therefore, just as the result in *Moss*, the ALJ's determination in this case must be reversed and remanded because he did not follow the required legal standards, explain how he reached his conclusions, or create a bridge between the evidence and his determination to discredit the Claimant's testimony. Simply stated, an ALJ may not discredit a claimant solely because her subjective complaints are not fully supported by objective medical evidence, *Brosnahan v. Barnhart*, 336 F.3d 671 (8th Cir. 2003), but in this case, the ALJ did not give the reader of his opinion any other reason for discrediting Ms. Sheets' credibility. For these reasons, the ALJ misapplied the proper legal standards to determine a claimant's credibility, and that mistake affected his decision, meaning that it cannot be premised on substantial evidence of record. Hence, this case must be reversed and remanded.

Conclusion

The Claimant submits that the ALJ has committed multiple errors in considering this case: application of incorrect legal standards and tests, inappropriately weighing the evidence, failing to even recognize and address treating doctor and specialist opinions that merited controlling weight, and misstatements about the evidence, resulting in a failure to support his conclusions with substantial evidence. Whether premised on one or all of these errors, Claimant believes that the ALJ's determination must be reversed because it was premised from incorrect

legal standards that were applied to the facts, and perhaps skepticism against an established against the well established axiom that fibromyalgia, particularly when exacerbated by the logical effects of morbid obesity, is recognized by the Social Security Administration as a compensable disability.

Case law in the Seventh Circuit has been clear since *Sarchet v. Chater* in 1996 that fibromyalgia cannot be evaluated by traditional objective medical evidence like lab tests and x-rays, but it is properly established where a claimant exhibits consistent multiple tender points as set forth by the SSA and ACR. Yet more than ten years after Judge Posner penned that decision, this ALJ still seemed to require some blood tests or x-rays or some objective medical evidence in the record, that conclusively established the severity of her physical condition. As for Ms. Sheets, it is improper to hold her to an evidentiary standard which cannot logically exist and is not required by SSA or any judicial circuit.

Moreover, the decision is merely conclusory in that it fails to discuss the evidence of record as a matter of law. The ALJ failed to explain why he ignored evidence or why he did not set forth any reasons for making unfavorable judgments about credibility of the Claimant's subjective testimony, which was corroborated by her medical complaints over several years and the nature of her afflictions, as well as the medical opinions of treating doctors and a specialist. From the ALJ's words, it is impossible to know his reasons. Since such explication is required upon pain of reversal and remand, and it is lacking in this matter, this decision cannot stand.

On the other hand, a thoughtful consideration of the record, in light of the proper standards and tests which are used to evaluate fibromyalgia, yields a very different result. Claimant has set forth substantial evidence which merits receipt of disability payments. She has suffered from fibromyalgia for many years, and the resultant pain and fatigue is only worsened

by the effects of morbid obesity. While the fibromyalgia alone is often reason enough to prevent claimants from gainful employment, the wear and tear on Ms. Sheets' body because of the excessive weight just makes her situation more impossible. Although she takes medication intended to help her, it often has the effect of clouding her mind or sedating her, making her impossible situation even more unbearable.

In their reports, the treating doctors paint powerful pictures with words like "walking time bomb" and statements that Ms. Sheets can't be helped because she is so heavy although her condition continues to worsen as they stand by, unable to assist, leaving her in a hopeless state, particularly when she has no means to support herself and she is physically unable to work.

Ms. Sheets has presented substantial evidence of her severe disability of fibromyalgia, as exacerbated by the effects of morbid obesity, which is a medically determinable disability that is eligible for compensation as a matter of law as demonstrated in this brief.

The ALJ, furthermore, did not meet step five of the five step sequential process in determining that the claimant had residual functional capacity to perform significant gainful activity and failed to discern any jobs that were available in significant numbers that she could perform. On the contrary, the vocational expert indicated, based on the question from the ALJ, that there are no jobs available in the market that Ms. Sheets could perform. The ALJ further failed to delineate adequately clear and cogent reasons why he ruled that the claimant was not fully credible.

For all of the reasons stated above, claimant submits that she should be determined to be disabled and that the cause should be reversed and remanded with instructions that the claimant is entitled to disability payments beginning from her amended onset date.

Respectfully submitted,

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Certificate of Service

I certify that on the ___ day of _______, 2009, service of a true and complete copy of the above foregoing pleading or paper was made upon Thomas E. Kieper by the Court's CM/ECF delivery system as well as by first class mail, postage prepaid.

POWER, LITTLE & LITTLE

BY:________________________
C. David Little