IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF DELAWARE

BILLIE E. SIMMONS	)	
	)	
Plaintiff,	)	
	)	
v.	)	Civil Action No. 02-1539-KAJ
	)	
JO ANNE B. BARNHART,	)	
Commissioner of Social Security	)	
	)	
Defendant.	)	

MEMORANDUM OPINION

Gary L. Smith, 1400 Peoples Plaza, Suite 110, Newark. DE 19702; Counsel for Plaintiff.

Colm F. Connolly, United States Attorney, District of Delaware; Douglas E. McCann, Assistant United States Attorney, 1007 N. Orange Street, Suite 700, Wilmington, Delaware 19899; Counsel for Defendant.

Of Counsel: Patricia M. Smith, Acting Regional Chief Counsel; Kenneth DiVito, Asst. Regional Counsel, Office of the General Counsel, Social Security Administration, Philadelphia, Pennsylvania.

October 12, 2004
Wilmington, Delaware

JORDAN, District Judge

I. INTRODUCTION

Billie E. Simmons ("Plaintiff") brings this action for review of the Commissioner of Social Security's ("Commissioner") decision to deny supplemental security income ("SSI") and disability insurance benefits ("DIB") to Plaintiff under Titles II and XVI, respectively, of the Social Security Act (the "Act").[1] Presently before the Court are Plaintiff's Motion for Summary Judgment (Docket Item ["D.I."] 14) and the Commissioner's Cross-Motion for Summary Judgment (D.I. 18). The Court has jurisdiction to review the Commissioner's decision under 42 U.S.C. § 405(g). For the reasons that follow, Plaintiff's Motion for Summary Judgment will be denied and Defendant's Cross-Motion for Summary Judgment will be granted.

II. BACKGROUND

Plaintiff was born on December 4, 1943. (D.I. 10 at 70.) She has a high school education. (*Id.* at 135.) She has worked in the past as a nurse's aid and a clerk at a flower shop. (*Id.* at 143.) Plaintiff claims that she is "disabled" under the regulations because of total hip replacement, low back pain, diabetes mellitus, high blood pressure, chronic bronchitis, headaches, and depression. (*Id.* at 125, 127-28, 131, 139.)

[1] 42 U.S.C. §§ 401-433, 1381-1383f.

A. MEDICAL HISTORY

In August 1991, an EMG study of Plaintiff's lower extremities showed acute mild[2] left L5 radiculopathy. (*Id*. at 212.) In October 1991, Plaintiff underwent a total left hip replacement performed by Andrew J. Gelman, D.O. (*Id*. at 324-25.) The results of the surgery were successful. (*Id*. at 266-68, 316, 319, 343.)

Plaintiff was also evaluated for a neurological basis of a voice change in 1991. (*Id*. at 303-304, 318, 374-85.) According to a medical report, she had a strangulated nasal voice and some diminished pinprick sensation on her right side. (*Id*. at 384.)

In March 1992, Dr. Gelman permitted Plaintiff to return to work after recovering from hip replacement. (*Id*. at 319.) In July 1992, Dr. Gelman stated that Plaintiff had recovered well and had regained a physical and functional lifestyle. (*Id*. at 316.) In September 1992, Plaintiff had a normal pulmonary functioning test. (*Id*. at 390, 541, 548.)

In December 1992, John B. Townsend, M.D., examined Plaintiff to determine the source of Plaintiff's voice changes. (*Id*. at 374.) Despite improvement of her voice, he stated that Plaintiff most likely had a mild pseudobulbar palsy, but be acknowledged that nothing from her evaluation actually supported such a finding. (*Id*.)

From 1992 to 1993, three different physicians from the Delaware Disability Determination Services performed residual functional capacity assessments of Plaintiff. (*Id*. at 173-200.) Dr. Borek found that Plaintiff was capable of occasionally lifting fifty pounds; frequently lifting twenty-five pounds; standing and/or walking for about six

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[2]To the medically untrained, like me, the use of this terminology may seem strange, but this was, in fact, the diagnosis.

hours in an eight-hour workday; sitting for about six hours; and pushing/and or pulling without any limitation. (*Id*. at 178.) Dr. Borek also determined that Plaintiff should be limited in undertaking climbing, balancing, stooping, kneeling, crouching, and crawling. (*Id*. at 179.) He noted that Plaintiff should avoid concentrated exposure to extreme cold, extreme heat, wetness, humidity, vibration, fumes and hazards. (*Id*. at 181.) A second physician, Lynn Clark, M.D., made similar findings, except that Plaintiff was not restricted by any environmental limitations except for even moderate exposure to hazards. (*Id*. at 189.) Finally, a third physician, Adele Noznisky, M.D., found that Plaintiff should avoid all exposure to hazards and concentrated exposure to extreme cold, extreme heat, and fumes, but not wetness, humidity, noise, or vibration. (*Id*. at 197.) In January 1993, Dr. Gelman reported that, in his opinion, Plaintiff was not disabled. (*Id*. at 266.)

Plaintiff underwent a cardiac catheterization to evaluate the cause of ongoing chest pain in April 1993. (*Id*. at 417-18.) The results revealed mild non-obstructive coronary artery disease, normal systolic left ventricular functioning, and normal resting left ventricular and diastolic pressure. (*Id*. at 418.) The treating physician concluded that Plaintiff's chest pain was of a non-cardiac etiology. (*Id*.) In May 1993, an x–ray of Plaintiff's lumbar spine showed marked degenerative arthritic changes of the bilateral L4-L5 and L5-S1 facet joints. (*Id*. at 285.)

In August 1995, an MRI of Plaintiff's lumbar spine was unremarkable, except for facet joint arthritis and a mild bulging disc at L4-5. (*Id*. at 455.) In October 1995, Plaintiff began a treatment of epidural steroid blocks for her back pain. (*Id*. at 456.)

Emmanuel Devotta, M.D., reported that Plaintiff responded well to the treatment, but still had some element of pain. (*Id*. at 457.)

In September 1995, Plaintiff was referred to Richard G. Ivins, Ph.D., for a neurological and psychological evaluation. (*Id*. at 449-53.) Dr. Ivins reported that Plaintiff had an average range of intelligence and her verbal-expressive abilities were consistent with her nonverbal problem-solving skills. (*Id*. at 450, 452.) Dr. Ivins concluded that Plaintiff appeared to have "some type" of cognitive impairment. (*Id*. at 450-52.) He also noted that Plaintiff's memory skills were impaired, and she showed signs of emotional difficulties as a result of hip surgery and head injuries sustained during childhood. (*Id*. at 450-52.) Dr. Ivins stated that "[Plaintiff] is not presently able to perform any suitable gainful employment" and "[Plaintiff] is disabled." (*Id*. at 452.)

B. PLAINTIFF'S TESTIMONY

Upon Plaintiff's request *(*D.I. 10 at 94-95), an ALJ held a hearing on December 14, 1994, at which Plaintiff testified while represented by counsel. (*Id*. at 30.) According to notes taken by the ALJ, Plaintiff testified that she went out to dinner with friends, went shopping and was active in her church, singing in the choir. (*Id*. at 24.) Plaintiff also stated that she shopped for groceries by walking to the market with her grocery cart. (*Id.* at 24, 60.) She testified that she occasionally baked; she sewed; and she exercised. (*Id.*) She also stated that she is better off keeping active during the day. (*Id.*) According to the record, the ALJ ruled against Plaintiff's claim on May 22, 1996. (*Id*. at 30.) Because the tape recording of this hearing was defective, however, the Appeals Council remanded the case for a second hearing. (*Id*.)

A second hearing before an ALJ occurred on December 3, 1998, at which Plaintiff testified and was represented by the same counsel. (*Id*. at 28-69.) When questioned about the accuracy of the ALJ's notes from the first hearing, Plaintiff acknowledged that they were correct. (*Id.* at 60-64.) According to her testimony at the second hearing, Plaintiff suffered from migraines, weakness in her hands, and back pain. (*Id.* at 47.) She also claimed that she was depressed, but admitted that she improved as a result of psychotherapy with Dr. Dettwyler, her psychologist. (*Id.* at 49.) Among other things, she stated that she has difficulty doing most household chores, has a hard time cooking, and cannot go shopping by herself. (*Id.* at 54-59.)

C. PROCEDURAL HISTORY

Plaintiff filed for DIB on March 26, 1992 and SSI on November 23, 1992, alleging disability since October 14, 1991.[3] (*Id*. at 70-76.) The applications were denied initially and upon reconsideration. (*Id*. at 77-80, 81-84, 87-89, 90-93.)[4] After the second hearing before the ALJ, a decision was issued on May 3, 1999. (*Id*. at 27.) The ALJ found that although Plaintiff had not engaged in substantial gainful activity since the date of her alleged disability, and she had severe degenerative joint disease, Plaintiff still retained the residual functional capacity to perform work-related activities except for work involving repeated bending, stooping, squatting, kneeling, crouching, crawling or

[3] Plaintiff was last insured for purposes of entitlement to DIB on December 31, 1996. (D.I. 10 at 26.)

[4] The history, in sum, is as follows: First hearing on December 14/1994; ALJ rendered unfavorable decision on May 22, 1996; case appealed, then Appeals Council remanded case to ALJ on July 30, 1998 due to defective tape recording; second hearing held on December 3, 1998.

climbing. (*Id*. at 26-27.) Accordingly, the ALJ held that Plaintiff could perform her past relevant work as a sales clerk in a flower shop, and was therefore not "disabled" for purposes of eligibility for SSI or entitlement to DIB. (*Id.*) Plaintiff requested review of the ALJ's decision (*id*. at 8-11), but relief was denied by the Appeals Council on May 21, 2002. (*Id.* at 8-9.) Plaintiff then filed the present action.

III. STANDARD OF REVIEW

This Court reviews a decision of the Commissioner to determine whether the decision is supported by substantial evidence in the record and whether correct legal principles have been applied. 42 U.S.C. § 405(g); 5 U.S.C. § 706(2)(E); *see also Richardson v. Perales*, 402 U.S. 389, 390 (1971); *Monsour Med. Ctr. v. Heckler*, 806 F.2d 1185, 1190 (3d Cir. 1986). The Supreme Court has defined "substantial evidence" as "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson*, 402 U.S. at 427. It is less than a preponderance of evidence and more than a mere scintilla*. Id.*

The standard of review in this Court when deciding an appeal from the Commissioner is not *de novo*. *See Limerick Ecology Action v. United States Nuclear Regulatory Comm'n*, 869 F.2d 719, 753 (3d Cir. 1989). The Court is obliged, therefore, to affirm the decision of the Commissioner if the weight of the evidence substantially supports the decision, regardless of whether the Court may have decided the case differently if it were before it on first impression. *Richardson*, 402 U.S. at 401; *Monsour*, 806 F.2d at 1191.

IV. DISCUSSION

A. INTRODUCTION

The Act defines disability in terms of the effect an impairment has on a person's ability to function in the work place. 42 U.S.C. § 1382c(a)(3)(A), (3)(B); *Heckler v. Campbell*, 461 U.S. 458, 460 (1983). The responsibility for determining whether Plaintiff is disabled under the Act is reserved to the Commissioner. 20 C.F.R. §§ 404.1527(e), 416.927(e) (2004). The five-step evaluation process for determining disability requires the Commissioner to consider, in sequence, whether a claimant (1) is working; (2) has a severe impairment; (3) has an impairment that meets or equals the requirements of a listed impairment; (4) can return to her past relevant work, and (5) if not, whether she can perform other work in the national economy. 20 C.F.R. §§ 404.1520, 416.920. Here, the ALJ, in accord with the Commissioner's order, determined that Plaintiff was not working and had a severe impairment that did not meet or equal a listed impairment. (*Id*. at 26.) At step four of the sequential evaluation process, the ALJ found that Plaintiff could return to her past relevant work as a sales clerk in a flower shop. (*Id*. at 27.) Thus, the ALJ concluded that Plaintiff was not disabled under the Act. (*Id.*)

B. THE ALJ'S RELIANCE ON EVIDENCE OUTSIDE THE RECORD

Plaintiff first argues that the ALJ improperly used "personal notes" from Plaintiff's testimony at the first hearing to assess her disability status. (D.I. 15 at 8-9.) As a result, Plaintiff contends that the case should be remanded, because these notes were "outside the record and there is no way to confirm or deny the accuracy of [Plaintiff's] account." (*Id.*) As explained by Plaintiff (*id*. at 9), the Ninth Circuit in *Burkhart v. Bowen* provides the general proposition that an ALJ cannot rely on evidence outside the record

in making a disability determination if doing so would effectively deprive the claimant of her opportunity to "cross-examine a witness or rebut testimony." 856 F.2d 1335, 1341 (9th Cir. 1988) (acknowledging that such a determination would be made contrary to the standard procedure of the courts). In the present case, however, the record fails to show that Plaintiff has been precluded from cross-examination or rebuttal of the evidence. In fact, the same counsel represented Plaintiff at both hearings before the ALJ. (D.I. 10 at 30.) Plaintiff and her counsel were completely aware of the testimony and evidence presented at the first hearing. As such, Plaintiff was never prevented from cross-examining any witness or rebutting the evidence.

The record also indicates that Plaintiff expressly confirmed all testimony from the first hearing relied upon by the ALJ. Although Plaintiff claimed a decrease in her daily activities since the first hearing, Plaintiff did acknowledge that the ALJ's notes from the first hearing regarding her daily activities were correct. (*Id*. at 60-65.) When asked whether she remembered making certain statements at the first hearing, Plaintiff specifically acknowledged doing so at the second hearing and Plaintiff's counsel never contradicted the ALJ's findings. (*Id.*) The ALJ did not rely on any evidence without first acquiring confirmation from Plaintiff of its accuracy. (*Id*. at 24, 60-65) Accordingly, the ALJ was not precluded under *Burkhart* from relying on Plaintiff's testimony from the first hearing.

C. THE WEIGHT ACCORDED TO DR. IVINS' OPINION

Plaintiff argues that the ALJ, in weighing Dr. Ivins' medical opinion, erred first in denying the opinion significant weight. (D.I. 15 at 9-12.) The record indicates that the ALJ specifically stated: "I do not afford [Dr. Ivins'] conclusions significant weight though I do note the test results." (D.I. 10 at 18.) Plaintiff claims that, in making this statement, the ALJ improperly substituted her own opinion for the opinion of a medically-certified neuropsychologist regarding Plaintiff's claim of mental disability. (D.I. at 9.) According to Plaintiff, Dr. Ivins' statements that "[Plaintiff] is not presently able to perform any suitable gainful employment" and "[Plaintiff] is disabled" should have been granted greater weight in assessing Plaintiff's disability status. (*Id.*)

Contrary to Plaintiff's argument, the ALJ gave proper weight to Dr. Ivins' conclusions regarding Plaintiff's ability to work. First, Dr. Ivins' conclusory statements that Plaintiff was completely unable to work is not determinative in this case. Under the regulations, a statement by a medical source that a claimant is "disabled" or "unable to work" is not determinative of a claimant's disability status. 20 C.F.R. §§ 404.1527(e)(1), 416.927(e)(1). The ALJ, and not the medical source, is responsible for determining whether a claimant is disabled under the Act. *See Id.* "Disability" in this context is not a medical question, but a question of law. *See Id*. Therefore, the ALJ, as finder of fact, was not required to give Dr. Ivin's conclusory statements determinative weight in this case.

Moreover, the ALJ properly weighed Dr. Ivins' opinion according to factors set forth under the regulations. Under the regulations, an ALJ must examine the following factors in determining the weight to give a medical opinion: 1) the length of the treatment relationship with the claimant and the frequency of examination, 2) the nature

and extent of the treatment relationship, 3) the supportability of the medical opinion, 4) the consistency of the opinion with the record as a whole, and 5) the specialization of the physician. 20 C.F.R. §§ 404.1527(d)(2), 416.927(f)(2)(I). Here, the ALJ properly examined these factors in light of the evidence of record.

Most importantly, the ALJ emphasized that Dr. Ivins' opinion lacked support and was inconsistent with even his own clinical findings. (D.I. 10 at 18.) Despite a finding by Dr. Ivins that Plaintiff suffered from "some type" of cognitive impairment, the medical evidence suggests that Plaintiff actually had average intelligence. (*Id*. at 450, 452.) Dr. Ivins himself stated that Plaintiff "was found to be functioning in the Average range of general intelligence" and "her Verbal and Performance I.Q.'s were comparable." (*Id*. at 450.) He noted that her expressive word language skills were also in the average range. (*Id.*)

Although Dr. Ivins found that Plaintiff had visual perception, cognitive flexibility, and emotional limitations as a result of a head injury incurred during childhood (*id*. at 451), the evidence further indicates that these problems did not functionally impede her ability to perform gainful activity as an adult. Plaintiff worked for seventeen years as a nurse's aide before her alleged onset of disability. (*Id*. at 36, 143.) She also worked as a clerk in a flower shop for two years prior to allegedly becoming disabled. (*Id*. at 143.) There is no indication from the record that Plaintiff's mental disorder worsened since childhood.

On the other hand, the evidence indicates that Plaintiff actually is capable of performing work as an adult. Dr. Gelman, who treated Plaintiff on several occasions, stated that Plaintiff was not disabled as of January 1993, two years after her alleged

onset of disability. (*Id*. at 266.) Plaintiff also maintains a lifestyle that is inconsistent with Dr. Ivins' diagnosis of a severe mental disorder. According to the ALJ's notes, she testified that she socializes with friends and family several times a week; she cares for her personal needs and the needs of her pets; she performs housekeeping chores; she engages in physical exercise; and she reads and watches television. (*Id*. at 24, 60-64.) Plaintiff even testified that, in her opinion she is better off keeping busy throughout the entire day. (*Id.* at 160.) That Plaintiff was capable of successfully working many years after sustaining her childhood injury is evidence supporting the conclusion that she is now functionally capable of working as an adult.

The ALJ also examined the extent of Dr. Ivins' treatment relationship with Plaintiff in determining the amount of weight to give Dr. Ivins' opinion. The ALJ noted that Plaintiff was only seen once by Dr. Ivins throughout her seven years of alleged disability. (*Id*. at 17-18.) The opinion rendered by Dr. Ivins on the basis of an isolated visit thus warranted less weight than would the opinion of a treating physician, *see* 20 C.F.R. §§ 404.1527(d)(2), 416.927(f)(2)(I), such as Dr. Gelman, who found Plaintiff capable of working. (*Id*. at 266.) In light of the ALJ's extensive review of the record, her refusal to give Dr. Ivins' opinion significant weight is warranted in this case.

Next, Plaintiff's assertion that the ALJ incorrectly failed to further develop evidence pursuant to §§ 404.1512(e)(1), 416.912(e)(1) is without merit. (D.I. 15 at 12.) Plaintiff believes that the ALJ should have re-contacted Dr. Ivins upon finding his opinions inconsistent with the other evidence. (*Id.*) Contrary to Plaintiff's argument, the ALJ is only required to further develop the record when "the evidence we receive from your treating physician or psychologist or other medical source is *inadequate* for us to

determine whether you are disabled." 20 C.F.R. §§ 404.1512(e)(1), 416.912(e)(1) (emphasis added).

Here, the ALJ was not required to re-contact Dr. Ivins in order to reach a decision. Because other evidence found in the record was adequate to determine whether Plaintiff was disabled, the ALJ did not need further information or clarification from Dr. Ivin. As noted above, evaluations performed by treating physicians such as Dr. Gelman, Plaintiff's testimony as to her daily activities, and the medical record as a whole provide substantial evidence that Plaintiff is capable of performing her past relevant work. Accordingly, the ALJ was not required to develop the record any further and was justified in rejecting Dr. Ivins' opinion.

D. THE ALJ'S CONCLUSIONS REGARDING PLAINTIFF'S PAST MEDICAL TREATMENT

Plaintiff next contends that the ALJ incorrectly determined that her "doctors have found nothing to substantiate her complaints [and] that she does not take any medication [...]" (D.I. 15 at 14.) In making this argument, Plaintiff notes that, contrary to the ALJ's findings, Plaintiff suffered from a strangulated nasal voice, heart problems, severe leg pain, and degenerative disc disease/degenerative arthritic changes. (*Id*. at 13-14.) Hence, Plaintiff urges the court to remand the case so that these findings can be considered when evaluating Plaintiff's disability status. (*Id*. at 14.)

Despite Plaintiff's belief, the record indicates that the ALJ did adequately consider all of Plaintiff's credible limitations in assessing Plaintiff's functional capabilities. Regarding Plaintiff's vocal problems, the evidence shows that no doctor

found any objective signs for abnormalities which might have produced her complaints. Dr. Townsend noted that the cause of Plaintiff's vocal changes "remained obscure." (*Id.*) He added that, in any event, Plaintiff's condition was "improving" and the only medical "possibility" in support of her complaint was small infarcts. (D.I. 10 at 374.)

The evidence of Plaintiff's leg and chest problems also provide little support for her claim of disability. The ALJ was justified in finding these impairments insignificant, because the evidence indicates that they had little effect on her ability to work.[5]

Finally, the ALJ gave proper credit to Plaintiff's allegations of degenerative disc disease. The ALJ expressly noted that, upon review of the record, the medical evidence established that Plaintiff has, *inter alia*, "degenerative arthritic changes in the L4-5 and L5-S1 facet joints bilaterally." (*Id*. at 26.) In light of Plaintiff's testimony as to her daily activities, however, the ALJ found Plaintiff capable of performing gainful activity despite degenerative disc disease and other impairments. (*Id*. at 25.) Because this finding is based on substantial evidence, as shown above, Plaintiff's argument that the ALJ improperly disregarded her symptoms of degenerative disc disease is without merit.

According to Plaintiff, the ALJ also failed to acknowledge that she took a myriad of "prescribed" medications, including Wellbutrim, Oxapam, Tylenol with Codeine,

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[5] Regarding her chest pain, a Dr. Hopkins specifically stated that examination provided no evidence for coronary vasospasm. (*Id*. at 418.) As noted, examination only showed signs of "mild" non-obstructive coronary disease. (*Id*. at 418, 426.) Dr. Hopkins concluded that, in any event, Plaintiff's chest pain syndrome was of non-cardiac etiology. (*Id.*) In regards to her leg pain, Dr. Fellows opined that there was no vascular etiology for her complaints. (*Id*. at 302.)

Propoxyphene, Anaprox, Diabeta, Trental, Zestril, and Cardizem. (*Id*. at 14.) This argument, however, is without merit. The ALJ did expressly acknowledge that Plaintiff was taking medicine. (*Id*. at 25.) Whether or not the medicine is prescribed rather than over-the-counter is irrelevant under the regulations; the main consideration in determining a claimant's ability to perform gainful activity is the side-effects caused by the medicine. *See* 20 C.F.R. §§ 404.1545, 416.945. Because there is no evidence to contradict the ALJ's conclusion that "Plaintiff suffers no adverse side-effects from her medication" (D.I. 10 at 25), Plaintiff's medical treatment was properly considered under the regulations.

E. THE ALJ'S EVALUATION OF PLAINTIFF'S ABILITY TO PERFORM HER PAST RELEVANT WORK

Finally, Plaintiff argues that the ALJ should have found Plaintiff unable to perform her past relevant work as a sales clerk at a flower shop due to her alleged mental impairment and environmental limitations. (D.I. 15 at 14-16.) Plaintiff claims that the ALJ erred by determining that her mental impairment resulting from depression was non-severe and had no effect on her ability to perform basic work activities. (*Id*. at 15.) Contrary to this argument, however, the ALJ correctly concluded that Plaintiff's mental impairment was not "severe" under the Act and did not "significantly" limit her ability to perform basic work activity. (*Id.* at 18.)

While evidence of depression was present in this case, Plaintiff's mental disorder did not rise to the level of a severe mental impairment that *functionally* precluded Plaintiff from performing her past relevant work. There was no evidence from any of

Plaintiff's treating physicians that Plaintiff had any mental limitations that precluded her from working. Furthermore, evidence of Plaintiff's daily activities indicates that Plaintiff was mentally and emotionally capable of performing her past relevant work. As noted above, Plaintiff actively engaged in social gatherings, she cared for herself, she exercised, and read and watched television. As stated by the ALJ, this evidence shows only minor restriction in Plaintiff's "activities of daily living, in her social functioning, and her ability to concentrate." (D.I. 10 at 18.) Hence, substantial evidence supports a finding that Plaintiff's mental and emotional impairments are not "severe" under the Act.

Also, Plaintiff asserts that controlling weight should have been given Dr. Borek's opinion that Plaintiff must avoid concentrated exposure to wetness and humidity. (D.I. 15 at 15.) Despite Plaintiff's argument, however, the ALJ was correct in giving little weight to Dr. Borek's opinion under 20 C.F.R. §§ 404.1527(d)(2), 416.927(f)(2)(I). As noted by the ALJ, Dr. Borek's opinion is inconsistent with the evidence as a whole. First of all, Plaintiff never even mentioned that she was affected by such an environment and provided no evidence in support of such an allegation. Also, two other state agency physicians concluded that Plaintiff had no reason to avoid humidity at all; only one found that Plaintiff should limit exposure to wetness, but gave no reason for drawing such a conclusion. (D.I. 10 at 189, 197.) Nor is there any medical evidence from any treating physician indicating that Plaintiff should avoid exposure to wetness and humidity. Therefore, the ALJ was justified in giving little weight to Dr. Borek's opinion under the regulations.

V. CONCLUSION

Accordingly, for the reasons set forth herein, the Defendant's Motion (D.I. 18) will be granted and Plaintiff's Motion (D.I. 14) will be denied. An appropriate order will follow.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF DELAWARE

BILLIE E. SIMMONS, Plaintiff, v. JO ANNE B. BARNHART, Commissioner of Social Security Defendant.	)	Civil Action No. 02-1539-KAJ

ORDER

For the reasons set forth in the Memorandum Opinion issued on this date,

IT IS HEREBY ORDERED that Plaintiff's Motion for Summary Judgment (D.I. 14) is DENIED, and the Commissioner's Cross-Motion for Summary Judgment (D.I. 18) is GRANTED.

Kent A. Jordan
UNITED STATES DISTRICT JUDGE

October 12, 2004
Wilmington, Delaware