NONPRECEDENTIAL DISPOSITION
To be cited only in accordance with FED. R. APP. P. 32.1

United States Court of Appeals

For the Seventh Circuit
Chicago, Illinois 60604

Argued October 3, 2023
Decided November 30, 2023

Before

MICHAEL B. BRENNAN, *Circuit Judge*

MICHAEL Y. SCUDDER, *Circuit Judge*

AMY J. ST. EVE, *Circuit Judge*

No. 22-2975

NATHAN F. PATTEE,
Plaintiff-Appellant,

v.

KILOLO KIJAKAZI,
Acting Commissioner of Social Security,
Defendant-Appellee.

Appeal from the United States District Court for the Northern District of Indiana, Fort Wayne Division.

No. 1:21CV179-PPS/SLC

Philip P. Simon,
Judge.

O R D E R

Nathan Pattee, who suffers from several medical ailments, including dizziness and low blood pressure when he stands up, challenges the denial of his application for a period of disability insurance benefits. An administrative law judge (ALJ) found him not disabled and denied benefits. Pattee argues that the ALJ's assessment of his limitations, particularly in light of more recent test results, was improper. But because substantial evidence supports the decision, we affirm.

Background

Pattee, who is now 48 years old, worked several jobs requiring medium to heavy exertion until September 6, 2018, when he says he became unable to work. In November 2018, he applied for Disability Insurance Benefits under Title II of the Social Security Act, 42 U.S.C. § 423(d), based primarily on breathing problems. At this stage, however, his arguments relate primarily to symptoms of fainting, dizziness, hypotension, and irregular heartbeat, especially when he changes position from sitting to standing.

Pattee visited the emergency room several times between August 2018 and July 2019, reporting symptoms such as lightheadedness, tingling extremities, chest pain, and shortness of breath. Tests showed emphysema and other conditions that doctors assessed as low-risk, as well as chronic obstructive pulmonary disease (COPD). Otherwise, Pattee had normal cardiac, pulmonary, and neurologic function. Doctors twice recommended that Pattee take a statin for high cholesterol, but he declined, and he also reported not using the inhaler he was prescribed for COPD.

Between August 2018 and May 2020 Pattee complained often of chest pain, trouble breathing, and/or dizziness, but doctors repeatedly noted that his reports were inconsistent with, or disproportionate to, their objective findings. One cardiologist stated: "I do not feel that [Pattee] has ever had any true cardiac symptoms or problems." Multiple other doctors who examined Pattee attributed his symptoms to depression, anxiety, and hyperventilation caused by panic attacks. One pulmonologist, after finding normal pulmonary function, offered to refer him to an ear, nose, and throat doctor, but he declined. Pattee later revisited the pulmonologist and reported improvement from using his inhaler.

A state agency physician reviewed Pattee's medical records in January 2019 and determined that Pattee had the medical impairment of COPD. The doctor opined that Pattee was not disabled: He could perform medium exertional work, and could stand, walk, or sit for about six hours in an eight-hour workday and required no postural limitations, but should avoid concentrated exposure to fumes, odors, dust, and gases. The doctor noted that Pattee had not alleged any severe mental impairment at that time.

Three months later, though, Pattee was diagnosed with Major Depressive Disorder after a psychiatric evaluation and prescribed an antidepressant. He later reported that he was unable to tolerate the medication. At some point, he was prescribed a different antidepressant, but he did not take it in part because "he ha[d]

been sober for a year and [was] not going to risk his sobriety." Pattee began therapy for depression, and the therapist noted improvement while continuing to recommend antidepressant medication.

In September 2019, Pattee had a consultative psychological examination. The psychologist assessed his cognitive ability as "low average." She noted that Pattee had some limitations with memory, concentration, and interpersonal relationship but "may have the cognitive ability to perform comparable jobs" to his past work.

Another state agency physician reviewed Pattee's medical records when his claim was being reconsidered, and by then, Pattee had been diagnosed with and begun treatment for depression. The doctor identified COPD and depression as medical impairments. She noted that the medical record did not support the diagnostic criteria of a disabling mental disorder. She found no extreme mental limitations and only a "moderate" limitation in his ability to maintain concentration, complete a normal workday without unreasonable interruptions, and interact appropriately with the general public. She agreed with the previous reviewing physician's determinations regarding Pattee's exertional and environmental limitations, recommended no postural limitations, and concluded that Pattee was not disabled.

In November 2019, Pattee saw a neurology nurse practitioner. He told her that his sleep medicine specialist had taken him off his antidepressant. The nurse practitioner noted some cognitive issues but speculated that they were "due to his lack of effort." She also expressed concern about "possible depression" and requested a neuropsychological evaluation.

Pattee's internist diagnosed him with orthostatic hypotension (low blood pressure after standing up) in December 2019, and six months later he completed a tilt-table test to measure how his heart rate and blood pressure responded when he moved from a horizontal to vertical position. During the test, Pattee lost consciousness and experienced decreased heart rate and blood pressure. The administering doctor diagnosed neurocardiogenic syncope (loss of consciousness accompanied by drop in heart rate and blood pressure). Three days later, Pattee's cardiologist confirmed the diagnoses of orthostatic hypotension and neurocardiogenic syncope and also diagnosed autonomic dysfunction (improper regulation of the body's system for balancing). The cardiologist made no changes to Pattee's medications, which were proving effective, and noted that Pattee was no longer experiencing lightheadedness or any recurrent syncope or near-syncope.

Soon after, Pattee saw a neuropsychologist who performed a series of tests to measure his cognitive ability. But the doctor disavowed the results because "multiple measures of effort and symptom validity suggested suboptimal effort and task engagement or potential attempts at symptom magnification" by Pattee. He opined that this was consistent with depression and anxiety.

Pattee visited his sleep specialist in May 2020 and reported that his dizziness and shortness of breath had resolved with medication. When he visited another nurse practitioner in August 2020, he reported chest pain and requested an increased dosage of his blood-pressure medication "because it ha[d] helped him." He also reported that he felt faint when his wife tried a carotid massage on him. Still, the nurse practitioner reported normal findings, other than noting that Pattee had a depressed mood.

Some of Pattee's medical providers expressed that Pattee and his wife were hindering his treatment by refusing to accept certain diagnoses, insisting that he had various other conditions, and declining medications. One provider noted that Pattee's wife did most of the talking, and others described her as "confrontational," "demanding," and "extremely anxious." Pattee and his wife repeatedly told doctors, without corroboration, that he had experienced respiratory or cardiac arrest. And Pattee's wife repeatedly expressed her disagreement with the treaters' diagnoses. In one such instance, Pattee's wife asserted to the neuropsychologist that Pattee had suffered a hypoxic brain injury, but the doctor concluded otherwise based on a negative MRI. This doctor repeatedly opined that depression likely caused Pattee's symptoms.

Pattee had a hearing before an ALJ in October 2020. He testified that he was able to stand for "maybe five, ten minutes" without getting dizzy. He further testified that his lightheadedness required him to do exercises five to six times per day, take salt tablets, and drink plenty of water to increase his blood pressure. He added that medication had helped reduce his lightheadedness and dizziness. Pattee testified that he felt "irritable and moody[,]" but that therapy and medication helped his depression. A vocational expert also testified, opining that a claimant with Pattee's background and various limitations the ALJ described could not perform Pattee's past relevant work but could do other jobs that exist in significant numbers in the national economy.

The ALJ determined that Pattee was not disabled and therefore denied benefits. Applying the five-step analysis, *see* 20 C.F.R. § 404.1520(a), the ALJ determined first that Pattee had not engaged in substantial gainful activity since September 2018; second, that his neurocardiogenic syncope, orthostatic hypotension, and autonomic dysfunction

(among other conditions) were severe impairments; third, that no impairments met or medically equaled a listed impairment; fourth, that he retained the residual functional capacity (RFC) to perform medium work (with limited exposure to pulmonary irritants and additional postural and mental limitations); and fifth, that, considering Pattee's background and RFC, there were sufficiently abundant jobs in the national economy that he could perform.

The Appeals Council denied Pattee's request for review, and he then came to federal district court, where a judge upheld the ALJ's decision. Pattee now appeals.

Analysis

Pattee challenges the ALJ's determinations that his conditions did not meet or medically equal a listed impairment and that he had a residual functional capacity to work at the medium exertional level with few limitations. Our review is deferential. If substantial evidence supports the ALJ's decision, we will affirm. *Surprise v. Saul*, 968 F.3d 658, 661 (7th Cir. 2020). Substantial evidence means simply that the administrative record contains relevant evidence from which a reasonable mind could reach the same conclusion. *Biestek v. Berryhill*, 139 S. Ct. 1148, 1154 (2019).

Pattee first argues that the ALJ impermissibly played doctor by interpreting the results of his tilt-table test (which occurred before the hearing) without the help of a medical expert. According to Pattee, the ALJ therefore failed to ascertain that Pattee suffers from postural orthostatic tachycardia syndrome (POTS), a blood circulation disorder that can cause symptoms including lightheadedness, dizziness, and fatigue. But two physicians analyzed Pattee's test results, and neither concluded that he had POTS. The doctor who performed the test observed neurocardiogenic syncope; Pattee's cardiologist agreed and added that he had autonomic dysfunction and orthostatic hypotension. The ALJ's findings were consistent with these diagnoses. Thus, the ALJ deferred to medical professionals rather than independently evaluating the result, so contacting a medical expert was not required. *See Bakke v. Kijakazi*, 62 F.4th 1061, 1067 n.2 (7th Cir. 2023); *Durham v. Kijakazi*, 53 F.4th 1089, 1094–95 (7th Cir. 2022). The ALJ then appropriately relied on the same records in accepting the opinion of Pattee's treating cardiologist that medication largely controlled his condition after the tilt-table test. *See Durham*, 53 F.4th at 1094–95.

Nevertheless, Pattee maintains that the ALJ erred by not assessing whether his impairments met or medically equaled the listing for "recurrent arrhythmias."

See 20 C.F.R. Pt. 404, Subpt. P, App. 1, § 4.05 (effective May 22, 2018, to September 23, 2019). As the claimant, however, Pattee had the burden of showing that his impairments satisfied the listing's criteria. *See Filus v. Astrue*, 694 F.3d 863, 868 (7th Cir. 2012). To meet Listing 4.05, Pattee needed evidence of "recurrent" episodes (meaning at least three times within 12 months) "of cardiac syncope or near syncope" (meaning "a loss of consciousness" or "a period of altered consciousness"), "despite prescribed treatment." *See id.* §§ 4.00A3c, 4.05. But the record contains only one documented instance of syncope, and Pattee's cardiologist later stated that medication appeared to solve the problem; therefore, Pattee's syncope was neither "recurrent" nor occurring "despite prescribed treatment." *See id.* So Pattee was not prejudiced by the ALJ considering only other listings that were more consistent with the record. The ALJ supported her conclusion that Pattee did not meet any cardiovascular listing, and she was not required to explain separately her findings of non-equivalence. *See* Social Security Ruling 17-2p, 2017 WL 3928306, at *4 (March 27, 2017). In any case, all impairments—including those that do not meet or equal a listing or are not severe—must be considered at step four, so the ALJ's analysis of Pattee's syncope did not end with the listings. *See Murphy v. Colvin*, 759 F.3d 811, 820 (7th Cir. 2014); *Terry v. Astrue*, 580 F.3d 471, 477 (7th Cir. 2009).

Regarding step four, Pattee argues that the ALJ's failure to obtain an expert medical interpretation of the tilt-table results caused a flawed determination of his RFC. The test results, he insists, "changed the picture so drastically" as to render the other evidence too "stale" to support the RFC. True, ALJs should not rely on the outdated assessments of a reviewing physician if later evidence of a new diagnosis "reasonably could have changed the reviewing physician's opinion." *Bakke*, 62 F.4th at 1066–67. But an ALJ may continue relying on assessments that are reasonably consistent with a new diagnosis. *Id.* at 1067. Here, Pattee's tilt-table test results did not produce the "new diagnosis" of POTS that Pattee has self-assessed. *See id*. The administering doctor and Pattee's cardiologist interpreted the results to show other causes of his lightheadedness, low blood pressure, and related symptoms. After this, Pattee's family nurse practitioner found his cardiovascular, pulmonary, and neurological function to be normal. Furthermore, the ALJ did not simply continue relying on stale medical opinions to craft the RFC. Based on the tilt-table test, the ALJ assigned postural limitations that went beyond what the reviewing physicians had recommended earlier. And Pattee does not explain what additional limitations would better describe his capacity for work.

Pattee seems to make two further, related arguments about his RFC. First, he argues that the ALJ erred by making adverse credibility determinations against him and

his wife. He asserts that his wife's involvement with his treatment was caused by her concern that doctors were not identifying the correct cause of his symptoms. But the ALJ's minimal remarks about Pattee's wife simply recounted doctors' accounts of their difficulties with her meddling and her insistence that Pattee had conditions for which there was no evidence. This was relevant to assessing her third-party report, which the ALJ found minimally persuasive because "[t]he overall record [did] not support her vast and varied allegations," and she was not a medical expert. It was not the ALJ's opinion, but that of Pattee's doctors, that drove this assessment.

Likewise, the ALJ provided an appropriate explanation for not accepting Pattee's subjective account of his limitations: Pattee repeatedly reported symptoms or conditions that were not backed up by examinations and tests, which produced largely normal results. He had also told doctors that he had experienced cardiac arrest, a statement unsupported by his medical records. And his neuropsychologist suggested he was magnifying his symptoms. In sum, Pattee does not demonstrate that the ALJ made a "patently wrong" credibility determination. *See Grotts v. Kijakazi*, 27 F.4th 1273, 1279 (7th Cir. 2022). Instead, he appears to ask us to reassess his and his wife's credibility, but that is beyond our scope of review. *See Reynolds v. Kijakazi*, 25 F.4th 470, 473–74 (7th Cir. 2022) (citing *Gedatus v. Saul*, 994 F.3d 893, 900 (7th Cir. 2021)).

Second, Pattee contends that the RFC is flawed because the ALJ ignored evidence that the symptoms doctors had attributed to depression were caused by his POTS. He emphasizes that his neuropsychologist's opinion about his depression left room for a physiological cause. But that is a far cry from supporting Pattee's hypothesis that POTS—a condition with which no doctor has diagnosed him—caused his symptoms. It is no more appropriate for a claimant to "play doctor" than it is for an ALJ: An impairment "must be established by objective medical evidence." 20 C.F.R. § 404.1521. The tilt-table test results are such evidence, but only Pattee's speculation connects those results to POTS, and the two doctors who reviewed the test results drew other conclusions. In any case, Pattee makes the mistake of equating a diagnosis (be it POTS or the conditions the doctors identified) with an impairment. *See Gentle v. Barnhart*, 430 F.3d 865, 868 (7th Cir. 2005). No matter the cause of his symptoms, he must show that they limit him physically or mentally in ways that render him unable to engage in full-time gainful employment. Even if Pattee has a new explanation for his symptoms, he has not pointed to medical evidence that those symptoms are disabling. *See Reynolds v. Kijakazi*, 25 F.4th 470, 474 (7th Cir. 2022).

AFFIRMED