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THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

Appeal from Charleston County
Court of Common Pleas

J.C. Nicholson, Jr., Circuit Court Judge

Appellate Case No. 2016-000419
Circuit Court Case No. 2013-CP-10-03251

Rosemary Connelly,

Respondent,

v.

Winsor Custom Homes, LLC,

Appellant.

RECORD ON APPEAL
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YOUNG CLEMENT RIVERS, LLP
Stephen L. Brown (SC Bar No. 66468)
Russell G. Hines (SC Bar No. 72100)
25 Calhoun Street, Suite 400
Charleston, South Carolina 29401
P.O. Box 993 (29402)
(843) 720-5488

Attorneys for Appellant
Winsor Custom Homes, LLC

WILLS MASSALON & ALLEN, LLC
Christy Ford Allen (SC Bar No. 15649)
John A. Massalon (SC Bar No. 10279)
P.O. Box 859
Charleston, South Carolina 29402
(843) 727-1144

Attorneys for Respondent
Rosemary Connelly

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[2] Plaintiff's Exhibit 7 consists only of Bates No. 302; Defendant's Exhibit 1 consists of Bates Nos. 302-303.

[3] Plaintiff's Exhibit 8 consists only of Bates No. RMC 96; Defendant's Exhibit 2 consists of Bates Nos. RMC 93 and 96.

[4] Certain pages, i.e., entire pages, of this exhibit were redacted at trial. The entirely redacted pages are omitted from this record.

[5] As noted above, the three (3) depositions transcripts which comprise Court's Exhibit 1 are grouped with the other transcripts in this record.

Q. Very good. Take a look at -- towards the back of Exhibit No. 2, we have the record that is Bates stamped RMC Production 169.

A. I'm on that page.

Q. Okay. And who is this record signed by?

A. Dr. Dozier.

Q. Do you know Dr. Dozier?

A. Very well.

Q. Is Dr. Dozier qualified to give one of his patients a smell test?

A. Yes.

Q. Is Dr. Dozier qualified to diagnose one of his patients in terms of what the cause of any disturbance in their smell may be?

A. As qualified as anyone.

Q. Okay. Let me ask you just to take a look at this. And it looks like the date is January 16, 2015. Do you see that --

A. Yes.

Q. -- at the top?

And it's for Rosemary Connelly; correct?

A. Correct.

Q. And it says: "She comes in today to take a University of Pennsylvania Smell Identification Test.

Review of the ENT and allergy systems is otherwise negative."

Have I read that correctly?

A. Yes.

Q. Okay. First of all, do you know what the University of Pennsylvania Smell Identification Test is?

A. I mean, not -- back in the day of -- you know, a primitive ENT, a primitive smell test is pretty simple, really. You just take some commonly available substances such as some coffee and some spice and some oregano, and then to make sure the patient's not malingering, you take some ammonia or some alcohol. And if a patient has normal smell, then they say it's vanilla, coffee bean, and ammonia. If the patient is not malingering and has true anosmia, then they will say they don't smell anything to the coffee, but when you stimulate them with the ammonia, the sensation, the perception, the experience for a patient who breathes ammonia is not manifest and does not depend on the first cranial nerve, the olfactory nerve. The trigeminal nerve, the fifth nerve, which gives you your intranasal sensation, will be traumatized and stimulated by the smell of the ammonia, and a nonmalingering patient will say, "Whoa, I smell that."

Now, whereas if a patient is malingering, when you --

Q. "Malingering" meaning faking?

A. "Malingering" meaning faking and trying to get -- you know, win a lawsuit, or blame their ex-husband, or whatever.

Then when you hold the ammonia in front of them, they'll startle, but they'll say, "Oh, no, I don't smell anything."

And that's basically the premise, you know, of a smell test. University of Pennsylvania is a big center for rhinology and science of noses and stuff, and so probably what this is it's probably the current widely held standard. Probably costs 500 bucks. And so the place the size of Charleston ENT probably went out and purchased it, and they probably are some tests that show that it works a little better and a little more sensitive than those more primitive things.

But, you know, the fact that there's 40 in there now, that's more than we used to use at the Medical University of South Carolina 20 years ago, but it kind of gives you the same result.

Q. Perfect. And I wanted to ask you, if you see underneath -- well, before we get to that, let me ask

you: It says: "Review of the ENT and allergy systems is otherwise negative."

Do you see where it says that?

A. I do.

Q. In your view, is it important for treating doctors to take sort of a history?

A. Yes.

Q. All right. And is it important for doctors to do physical examination before giving a diagnosis of the patient?

A. Yes.

Q. All right. And is it important for doctors to do physical examination before giving a diagnosis?

A. Yes.

Q. All right. Under special testing, it says, if you read along with me: "A small identification test was performed. It was scored according to the answer key provided, and she got 13 out of 40 test items correct, which is consistent with anosmia, but not suspicious for malingering."

Let me ask you, Doctor, what's your interpretation of that?

A. In the, you know, the test I just described, instead of testing for 40, we would test for two or three items. And so what I would see is that she -- the

majority of the time she could not -- I mean, 27 out of 40 times she could not smell the item, but then when they did the test for malingering with the ammonia or alcohol, then she, I guess, honestly reported that she could smell it.

Q. And what was Dr. Dozier's conclusion as a result of that smell test that he listed in the record?

A. His assessment was that she had anosmia, and he indicated that at this point, being several years out from the injury, that it was unlikely to improve.

Q. Do you have any doubt, based upon that record, first of all, that Rosemary Connelly has anosmia?

A. No.

Q. Okay. Okay. I want to go back to your chart, sir, and let's see if we can do it this way. About the middle of your chart, there is a record that's dated 5/28/2013, and let me know when you've gotten there.

A. Since you guys put these chronologically, it's going to be towards the back; right?

Q. Yes. After the surgery notes we were discussing. It says "patient note" at the top.

A. 5/28/13?

Q. Yes, sir.

A. Sorry. I'm having a hard time finding it here.

Bingo.

Q. All right. Does it appear that you saw Rosemary Connelly in your office on May 28, 2013?

A. Yes.

Q. Okay. It says: "She mentioned that she has had hyposmia since the injury."

Tell us what that word means.

MR. HINES: Objection.

A. Hyposmia is a reduction in the sense of smell. Anosmia is total absence of smell.

Q. Okay. And I think I did it again, and I just want to make sure that for the record we've got a proper question before you.

If you look at the second sentence of your patient note, what does it indicate that Rosemary Connelly said to you?

A. The second sentence of my patient note?

Q. The second sentence of your patient note, beginning with "she."

A. Okay. That's, like, the fourth sentence, but it says: "She has seen a couple of ENT" --

Q. Sorry. The second sentence, where it says: "She mentioned."

A. "She mentioned that she has had hyposmia since

her injury."

Q. Okay. And, again, what is hyposmia?

A. Diminished sense of smell.

Q. Okay. And then let me ask you, you said -- you've got some notes here about her being worked up by Charleston ENT and so forth, but what I want to ask you about is here is the second paragraph.

And it indicates: "Using an artificial skull as a teaching aid, I explained to Rosemary the anatomy of the cribriform plate and explained how a frontal injury may sometimes result in some disruption in some of the branches of the olfactory nerve."

Do you see where I've read that from?

A. Yes.

Q. Have I read that correctly?

A. Yes.

Q. All right. What I'd like you to do, Doctor, is sort of tell us -- walk us through what you did with Rosemary and sort of that whole mechanism. And we've got a board back there that I think may be helpful for you to explain it to the jury. So with that, maybe we'll take just a moment off the record to go ahead and bring this board up. Okay?

THE VIDEOGRAPHER: And I have about five

minutes remaining, so --

MR. GRUENLOH: Okay, yeah, that makes sense.

THE VIDEOGRAPHER: This is the end of Tape No. 1 in the videotaped deposition of Dr. Thomas Funcik. The time is 6:04 p.m. We are off the record.

(Recess from 6:04 p.m. until 6:09 p.m.)

THE VIDEOGRAPHER: We are back on the record. The time is 6:09 p.m. This is the beginning of Tape No. 2 in the videotaped deposition of Dr. Thomas --

THE WITNESS: Funcik.

THE VIDEOGRAPHER: -- Funcik.

BY MR. GRUENLOH:

Q. All right. I promise, Doctor, we're going to move this along and we're getting to it, and I appreciate your time very much.

Incidentally, you've not been hired by the plaintiff in this case, have you?

A. Correct.

Q. All right. Let me ask you: I put a board in front of you, and if you take a look at the board, can you tell me, is that a fairly accurate depiction, kind of the same question I asked you before about the cutout?

A. The same. It's a valid teaching aid.

Q. Okay. Do you believe that that will help you or assist you in explaining the mechanism of how a trauma can cause anosmia to the jury?

A. Yes.

Q. All right. If you would, we were talking about this May 28, 2013, note where Ms. Connelly mentioned that she -- to you that she had this issue with her sense of smell since her injury, and then you talked about how -- you wrote how you used an artificial skull and showed her how a frontal injury can cause the loss of sense of smell.

And my question to you with all that is, can you please explain to the jury what you explained to Rosemary Connelly?

A. Yes. Okay. So this is a two-dimensional representation that's comparable to the teaching aid that we used earlier where the patient's head has been basically kind of sawed in half vertically, a little bit more than in half, because the nasal septum, the wall between the halves of the nose, has been removed. In this case, we're looking at the left sidewall of the nose. We talked --

Q. I don't mean to interrupt you, but I just wanted to let you know, I'm the one that put that up

there, and I'm not sure how stable it is, so if you touch it, it may be in your lap.

A. Okay. So we'll see how good I am with the instrument here.

Okay. So here's her turbinates, this patient's turbinates, the inferior, middle, and then superior turbinate, and then the artist's interpretation of the olfactory nerve is as follows: So here's the brain, and then here's the first cranial nerve. There's a pair. There's one on each side. And then the olfactory nerve filaments go through this little section of the bony floor of the cranial vault through a little sieve, which is called the cribriform plate, and extending through the cribriform plate are these tiny little fibers of nerves, and they're responsible for the sense of smell. So it's really a piece -- an extension of the brain that extends outside of the cranial vault into the nasal cavity.

And this is a pretty accurate representation, but, in reality, if you draw this is meant for teaching purposes. And, to scale, the nerves are actually not this big. I mean, if the nerves were actually this big, then they could be visualized at surgery, but the nerves are so small and really delicate, so small that they

can't be visualized with the naked eye or even with, you know, magnification that we use in surgery. It would take probably a microscope and special stains that stain mucosa, different than submucosa, different than periosteum, different than nerves, in order to visualize them. The actual nerves are much smaller and more numerous than this.

But they basically extend through this little cribriform plate. And so the mechanism of injury in a case of trauma, of anosmia, is -- we were talking about the boxer the other day, or the other minute, where a lot of times a knockout punch is a combination punch where you punch the fellow with the right cross and his head starts traveling in that direction, and then suddenly you reach around with the left arm to him in the opposite way. So there's momentum in the brain, and the brain -- fluid around the brain, the skull, is traveling in that direction, and then when you stop, it's like a head-on collision with a semi, and the brain impacts the opposite inner side. That causes such an injury to the brain that it causes sudden loss of consciousness.

And so the traumatic mechanism of anosmia is the sudden either posterior acceleration or a sudden

rapid deceleration, either a bang this way or else you push the head forward and suddenly stop it. And when that happens, the brain has a little bit of space around it here from the cerebral spinal fluid, and the brain can shift a little bit. And there's no room for error. There's no slack, like an extension cord, in this area. When that happens, some or all of these fibers get -- can get disrupted and cut.

Peripheral nerves sort of can heal and regenerate, but central nerves tend not to. Brain and spinal cord injuries are kind of irreversible. If someone has a stroke and you look at their brain, there's actually just a hole here. No scar tissue. Just a big hole. Like a Swiss cheese hole. The spinal cord is severed. It doesn't grow back.

Peripheral nerves have, you know, somewhat of a capacity to partially regenerate, but central nervous tissue tends not to regenerate.

Q. Let me ask you just a couple questions. You mentioned loss of consciousness. Does somebody have to have a loss of consciousness in order for those olfactory nerves to be severed?

A. No.

Q. All right. At some point you talked to us

about the cribriform plate and how those nerves go through the cribriform plate. Can you talk to us a little bit about that, explain what that cribriform plate is, what it looks like?

A. If we had an actual skull -- last time in the deposition we had a plastic skull, which is a simplified version, but if we had an actual skull, a lot of times for teaching purposes you have all the soft tissue, the brain, muscles, has all been removed. A lot of times they'll take a saw and they'll remove the top, and you can take that off and you can look down into the brain.

And so if I had somebody's -- if I had a skull specimen here and the nose was pointing up this way, I was holding the two ears and I was looking into the floor of the cranial vault, it would be pretty apparent. You could actually see the cribriform plate.

And what it is, it has a little divider in the middle, and that divider is sort of in line with the nasal septum as a midline partition, and then on either side of it there would be these -- this tiny little opening, which would be smaller -- like, if you took a small Tic Tac and stretched it out. It's about an -- it's sort of an oval configuration. And you would see these two little openings, and you could actually see

some of the tiny little holes. They're very, very small holes. The holes are -- would not admit a pin. They would admit the tip of a pin, like a pin when you get a new shirt or something like that, it would admit the tip of a pin, but it wouldn't -- you couldn't put the whole shaft of a pin in there without, you know -- some of the holes might be big enough to emit a pin maybe, but most of the holes are smaller. They would just barely admit the tip of a pin.

Q. Okay. And so if we look up on the board, for example, the cutout, the circle, you see where it has the cribriform plate noted?

A. Yeah, these are the pin holes.

Q. Got it.

A. And, like I said, they're just -- it's not really to scale. You know, the holes are smaller than that.

Q. And those white fibers that are going down through the cribriform plate, what are those?

A. The extensions of the olfactory nerve. The olfactory nerve filaments.

Q. I think you've already touched upon this, but, I mean, how big are they? Are they fragile?

A. Yeah, super tiny.

Q. And are they fragile?

A. I mean, are they fragile? You know, nerve tissue is kind of tough in the sense that, like, if a -- just a grizzly bear swatted you, you know, and tore your flesh and tore your muscles, nerves are actually kind of tough. They're kind of fibrous and stuff.

But the reason that this injury occurs is just mechanical. It's a simple mechanical principle. You know, the brain has a little bit of mobility within the skull, but this is fixed right here, and so just a little bit of movement without a lot of play and tethering in there, that's how anosmia occurs as a result of trauma. Just a forward injury.

You know, and I -- Mary's case was a long time ago, and I was responsible for, as the patient, really principally, you know, for the nasal fracture and stuff. I mean, I had awareness, and I haven't reviewed it that much, and it's been a long -- I mean, I couldn't -- I mean, I believe that this was the time and so forth, and as we've talked about the cases, things have come back to me.

And if I look at her nose right here, I mean, the main area of swelling I see is an area about an inch above her cribriform plate and about an inch below her

cribriform plate. So if the degree of swelling -- and it wasn't the most swollen nose I've ever seen. I've seen people fall from three stories. I've seen people in semi collisions. You know, I've seen the face be a bag of bones. I've seen the brain extrude. I've seen worst traumas.

But this is some very significant swelling, and the main focus -- I don't know if she fell on concrete or whatever, but there's a main focus of injury here, a main focus of injury here, and it looks like a frontal injury. And so the pattern of swelling, the pattern of the point of impact, just seems sort of very consistent and intuitive that absolutely this injury could cause anosmia.

And after we had our last deposition, like I said, if somebody looked in the Yellow Pages for somebody to see for a smell disorder, I probably wouldn't be the first doc in town, but after I spent time with you guys and I wasn't anticipating that we were going to get into the whole anosmia thing that much, I did do a brief online literature review to see if I was missing anything, if the testimony that I gave was, you know, consistent with the state of the literature.

And even since then, today when we met today before the deposition and you explained to me about the way that -- the refrigerator episode where Mary became aware of the anosmia when her daughter noticed that the refrigerator smelled to high hell and she didn't notice it, the more time I spend on this case, the more clear it is to me that, yeah, anosmia can be caused by horrendous sinus infection and by surgical mishap, and by medications, and iatrogenic, but as time goes on and we revisit these facts and memories come back to me, I think the three leading causes of her anosmia are trauma, trauma, and trauma.

MR. HINES: Let me just interpose for the record an objection and motion to strike about the refrigerator reference and those issues. I mean --

MR. GRUENLOH: Just let me make sure I understand what your objection is. You just want to move to strike the refrigerator issue?

MR. HINES: Because I'm -- this is a legal issue. I don't mean to derail his testimony. As I understand it, what he was saying is that on the basis of a conversation and information that you provided to him, that I don't think that's proper basis for his opinion in the sense that -- well,

heck, maybe this is something I need to ask him, and I will, but I would be -- I understand experts can rely on things that aren't admissible evidence, but hearing something sort of, you know, secondhand that someone else said, you know, what I'm saying, I don't think that's a sufficient basis for an opinion. That's my concern. And I don't think that could come in even in that way. I don't know if it forms part of his opinion.

MR. GRUENLOH: Sure. And I -- just to respectfully disagree with you, because we don't have a transcript of what Mary testified to just this morning, and so I shared with the doctor what Mary testified to this morning. And I think that experts all the time base their opinions upon something the attorney said, and if what the attorney said is not consistent with the facts, then that's obviously a problem and that's fair game for cross-examination, or even exclusion of the opinion if it was based upon it. But I've got no other way to give him this information that we got this morning other than to give it to him.

And so if you want me to go back on the record -- I was actually intending on doing this --

and saying, "Doctor, you and I had a conversation this morning about Mary's testimony as it relates to your understanding of when the anosmia occurred in Rosemary," and so forth, and I can do that, and I'm happy to do that, and I think I should based upon your objection at this point --

MR. HINES: Yeah, and --

MR. GRUENLOH: I think it's perfectly proper for me -- for an attorney to do that. If there was a better way for me to have done it, I would have given him a transcript.

MR. HINES: Sure. And I guess -- well, as I understand, what we're doing now is we're just sort of going through the process now of, sort of, putting some things on the record so we'll have done it, because I'm not -- obviously I'm not trying to --

MR. GRUENLOH: Sure.

MR. HINES: For one, I'm not suggesting anything nefarious. I'm just talking about admissibility. You know, you get me. I'm saying this is a legal objection, not a -- I'm not, you know, upset with it or saying there's any wrongdoing. Furthermore, I may well be wrong in my

legal analysis. So I'm just -- I just think I need to at least preserve the objection about -- I guess beyond objections, since he mentioned, the motion to strike, you know, the portion of his testimony.

Perhaps, if we're going to get into this further, I have to disagree about it being acceptable for him to testify about what he was told, because this is -- again, this is by no means accusing anything. If I was to tell him what Mary said in her deposition this morning, that wouldn't be what Mary said at her deposition this morning. It would be what Russ understands Mary to have said at her deposition this morning. You get -- so I'm not -- you know, I'm saying I couldn't even do it.

MR. GRUENLOH: Sure. So let me just make sure before we move on. Your objection with respect to what he said and what you'd like to move to strike is simply the portion of the testimony where he talked about the refrigerator incident and what I shared with him?

MR. HINES: Yeah, and I think, for instance, he said -- he said, "Smelled to high hell." Like, I don't think that's exactly what the transcript is going to say.

MR. GRUENLOH: Okay.

MR. HINES: You know what I'm saying? I'm not trying to be a real pain in the neck about it, and I can appreciate the practical issue that we have, and I don't even think it's all that significant of an issue, to be honest. I mean, I think it's probably a pretty minor point, just meaning, again, perhaps overly worrisome, because, by nature, I just wanted to make that objection.

MR. GRUENLOH: I think it's fair. Let me -- let's go back on the record and I'm going to ask him some questions specifically about what's been shared with him with respect to the testimony, and maybe the way to do it, because you ask experts this all the time, and one way that we can completely avoid all of this is for me to say, "Doctor, I want you to assume that Rosemary Connelly could never smell anything after the accident and that at some point she noticed it, but she never had a sense of smell from the accident on," and that is consistent with her testimony and her daughter's testimony.

And if you've got an issue with that, I think that you can bring that before the court or bring it in cross-examination, but I think that that's the

way that I'll do it, and -- because I was going to hit this timing issue anyway, and I'll ask him to accept that understanding. Because, I mean -- and if I wasn't -- if I didn't feel comfortable that's what she had testified and that's what Mary had confirmed today, I wouldn't do it, because I risk losing the opinion, but that's -- I mean, that's essentially what the testimony has been and will be.

MR. HINES: Listen, I have -- testifying by way of, you know, "Doctor, please assume for this," it's essentially a hypothetical, and your intention is to have the hypothetical be exactly consistent with what the evidence is, what will be presented. I get that.

MR. GRUENLOH: Right.

MR. HINES: But I think you were just explaining to me your hypothetical was going to be consistent. Like you weren't going to say, "Doctor, assume this. This is consistent with her testimony." Right? My point is, that's not going to be a tail of the hypothetical? It will be, "Doctor, assume these." You see what I'm saying?

MR. GRUENLOH: Yes.

MR. HINES: Yeah, because, I guess what I mean

is, I won't -- I would object to the sort of seal of approval, so to speak, that that hypothetical is consistent with the testimony, because I don't know that that's really fair commentary for the lawyer to make directly to a jury. I mean, you can certainly tell the judge, "Judge, the hypothetical is consistent with the testimony."

MR. GRUENLOH: Well, and now I've pulled my fingernail off like I always do in depositions. Let me see what I can do. And, you know, if you object, let's not have another long one of these conversations. You object and we'll move on and we'll deal with it with the judge.

MR. HINES: Okay.

MR. GRUENLOH: All right. So let's go -- are we -- we're back -- we're on the record; right? We never went off. Okay.

BY MR. GRUENLOH:

Q. Okay. Doctor, let me ask you, before we -- I want to talk to you about the timing situation that we've just been discussing off the record, but before I do that, let me just ask you a couple questions.

Is it your opinion that based upon the -- what you know about the fall, the point of impact, as you've

just testified, that the mechanism of shearing those olfactory nerves as a result of the blow to the head is consistent with what happened in Rosemary Connelly?

A. Yes.

Q. All right. Now, there were some questions in your -- well, and before I go there, do you -- are you aware of situations where people have reported anosmia by virtue of being hit by an air bag?

A. Yes.

Q. Are you aware of situations where people have reported anosmia by virtue of being shellshocked? Veterans, for example?

A. Yes.

Q. Okay. So would it be fair to say that you don't even need a blow to the head in order to cause that anosmia?

A. Yes.

Q. All right. What is it? Is it the movement of the brain then that's really what's causing that?

A. The nerves and the -- the filaments of the nerves as they exist within the fixed holes of the cribriform plate remain stationary in space and time and the brain moves forward and the nerves tear off at the entry point of the cribriform plate.

Q. Is that what you told Rosemary Connelly when you sat with her in May of 2013?

A. Yeah. I was trying to explain to her the -- how it could be related.

Q. To a reasonable degree of medical certainty, can you testify today that that is what you believe, in fact, happened with Rosemary Connelly and is the cause of her anosmia?

A. Yes.

Q. All right. Let me ask you a couple questions on timing. We were having this conversation at your deposition about, well, when did she report it to her doctors versus when did she notice it. And I've shared some information with you, some testimony with you, since that time, and we also had a conversation before the deposition began today because we had the testimony of Ms. Connelly's daughter, which we don't have a transcript of yet.

And so what I'm going to do to keep this clean is I'm just going to ask you to make an assumption with respect to the timing. And the assumption is simply this: I want you to assume that Rosemary Connelly did not have a sense of smell at any point in time after the accident but that she did have a sense of smell prior to

the accident. Okay?

And I want you to assume that after the accident that sense of smell, that disruption, was continuous until today, but that it took her a while before she noticed it. Okay? I want you to assume that that is going to be the testimony in this case from the plaintiff and from her daughter. Are you with me?

A. Yes.

Q. Okay. So with that understanding, and also with the understanding, as we've just discussed throughout the course of this deposition, that she had a blow to the front of her head, which is, in your words, consistent with the mechanism that can cause anosmia, that she had a concussion, and that she had a nasal fracture, do you have an opinion to a reasonable degree of medical certainty what caused the anosmia that Rosemary has today?

A. I believe it was the fall.

Q. All right. Do you hold that --

MR. HINES: I was trying to let you let him answer. I just want to make sure we're preserved. I mean, I'm trying to let you go. I'm preserved on my objection on his ability to give that opinion. I mean, I've been sort of waiting. The point is, as

opposed to objecting, I'm trying to help your record be cleaner so we can -- I don't intend to say anything other than I already have, you know, for my reasons. I'll examine him with cross-examination and get some more things in, but the point is, my thinking was to allow you to go through particularly those questions just then uninterrupted for the purpose of being uninterrupted for editing purposes and whatnot.

I mean, we've already talked at the beginning of this deposition how you anticipate my objection to his ability to make certain -- offer certain opinions in the case; correct?

MR. GRUENLOH: Yeah, I get that you've got an objection. I mean, I'm not going to say that it's preserved. I think that you need to make the objection for the question. So --

MR. HINES: I will say I think that's entirely inconsistent with our earlier talk on the record today in this case, and that, I will say, is, you know, well, it's -- that's upsetting to me.

MR. GRUENLOH: Well, I do understand that you have an objection as to that issue.

MR. HINES: And you understood way before you

asked those questions that we've been sitting here and you asked me not to continue to have long discussions like this, so, I mean, that is offensive. And so I'm going to put that on the record, that the idea that you're suggesting that there needed to be an objection made prior to those two questions, when solely as a courtesy and efficiency that I think that's --

MR. GRUENLOH: Let me stop you, Russ, because I'm not going to play gotcha with that. I haven't throughout this case. I do believe that you need to make objections after I've asked the question, but I understand that you have an objection on that issue, and so I am not going to cry foul if you stand up in front of the judge and argue that you want to make an objection as to those questions on that issue. Okay?

MR. HINES: Perhaps I understood it the wrong way when you said, "I'm not going to agree you're preserved on it." I'm not talking about a technical question of law for -- from an evidence professor. I'm asking between you and me, the way we've been handling this whole proceeding today, are you agreeing with me, as you just now, and maybe I can

settle down, explained to me that you're not going to cry foul. I'm not trying to write an AmJur article. I'm just asking about --

MR. GRUENLOH: I'm not -- on -- I don't know whether you're going to come back and whether you're going to say my objection was preserved on all these things even though I didn't make an objection, but for the issue of specific causation as it relates to Rosemary, I understand you made that objection before we started, you made that objection once today, and I understand that you're going to have a right to argue that before the judge, and I'm not going to preclude -- to the extent that I could, I'm not going to attempt to preclude you from doing that. Okay?

MR. HINES: Thank you.

MR. GRUENLOH: All right.

BY MR. GRUENLOH:

Q. All right. Doctor, we -- at your deposition, you were asked a number of questions by Mr. Hines regarding timing, and at one point, I think, in your deposition you said that that issue gave you cause -- pause, excuse me -- with respect to some of the timing questions that he has asked you. Does --

A. I think he said that it gave me pause.

Q. Right. Right. Does the understanding that Ms. Connelly's sense of smell has been absent from her from the time of the accident and has never come back at any point since the accident help alleviate that pause?

MR. HINES: Objection.

A. Yes.

Q. I think one of the issues that you --

A. Well, you just asked me -- you just asked me to assume that. You took me through that hypothetical.

Q. Sure.

A. So I'm still in that hypothetical. Am I still -- I was still in that hypothetical.

Q. Sure. And do you -- you're willing to accept that hypothetical that -- the assumption of that fact that I've given you, that being that Rosemary Connelly has indicated and will indicate at trial that her disruption of sense of smell has been continuous since the accident?

MR. HINES: Objection. Leading. Argumentative. Compound question.

MR. GRUENLOH: I'll withdraw the question. I think that what we can do is we can probably move on to a different subject.

BY MR. GRUENLOH:

Q. All right. One of the other things, I think, that gave you a bit of pause at your deposition is we didn't, in fact, have the written record showing that she had anosmia. Do you recall that?

A. Yes.

Q. Okay. I want, if we could, to go back to Exhibit No. 2, which is the Charleston ENT records, and I'm just going to ask you to go back to the same record that we were looking at before, which is sort of towards the end.

A. January 16th?

Q. Yes, sir. All right. And as you read into the record earlier, Dr. Dozier indicated that he discussed with Ms. Connelly in detail the results of her tests, and he indicated: "I suspect at this point, being several years out from the injury, this is unlikely to improve. She'll follow up on an as-needed basis."

Do you recall we went over that before?

A. Yes.

Q. All right. First of all, that pause that you had in your deposition with respect to whether or not she had anosmia or did not have anosmia, has that been cleared up by this record?

A. Yes.

Q. Okay. And I think you testified you don't have any doubt that she has anosmia, do you?

MR. HINES: Objection. Leading.

MR. GRUENLOH: I'll withdraw the question.

Q. The portion of the doctor's note that you read before and that we just read, "I suspect at this point, being several years out from the injury, this is unlikely to improve," do you have an opinion as to whether or not Rosemary Connelly's sense of smell is going to come back?

MR. HINES: Objection to his qualifications and ability to answer that question.

Q. My question, sir, is --

A. I apologize. It's been a long day. I've done a lot of surgery today.

And I understand how this works, that he has to do that, I don't hold it against him, but sometimes that distracts me, and I so apologize. I'll try to -- I'll try to just block out these objections to form and leading.

MR. HINES: Doctor, just to explain myself a little more clear, that's part of the reason why I've been -- why a moment ago I had a little bit of

discussion where I expressed some upset about perhaps me being under a misconception about, sort of, the way these type of things would be handled. My proposal would be, and an idea would be, is that typically when you give a deposition, that objections other than to the form of the question are preserved for the time of trial, and I don't know why, candidly, that wouldn't be any different even in the context of a deposition like this.

But out of an abundance of caution, and not to be a pain in the neck, I've become concerned to or at least wanting to, you know, make sure I'm not going to have a problem with legal points, because that's what they are. So I'm not trying to cause you any -- to be distracting or annoying at all. I just find myself in a situation where I feel, you know, compelled to voice the objection. With that being said, would -- you know, don't want to be unduly obstreperous.

THE WITNESS: Oh, I know you're not trying to distract me, but it is distracting me a little bit.

MR. GRUENLOH: Let me --

THE WITNESS: So I'm just going to -- and so if that happens, I'll try to focus on the question and

so it doesn't happen as much, but I'm just going to ask so that I can answer the question honestly and accurately, I want you to repeat the question, and you can say whatever legally is required to be said, and I'll --

MR. GRUENLOH: Perfect.

BY MR. HINES:

Q. Do you have an opinion to a reasonable degree of medical certainty as to whether or not Rosemary Connelly's anosmia is permanent?

MR. HINES: I have to object to that question.

A. Okay. And I think it is permanent, and my basis for that is 30 years of practicing medicine, medical study, having had peripheral nerve injuries. I've had four paralyzing neck injuries. I know that peripheral nerves have a capacity to return on a limited basis. The other cranial nerve, the facial nerve, I deal with trauma from that.

When a nerve injury occurs towards the periphery, it tends to have some capacity to improve, but it typically happens about within a year. As I said, most healing takes place within a year. Whereas central lesions, like spinal cord lesions and central lesions, whereas central lesions such as the retina, the

olfactory nerve, they tend not to recur.

And so if she had a smell test on January 2015, which is, like, almost four years out from her injury, I think it would be a medical miracle if she recovered her sense of smell. I feel comfortable medically as a physician, you know, making that conclusion.

Q. In the -- I think you said --

A. There's not that many doctors that have much experience with anosmia, because once it's established, if it's not litigation, then there's no point in going to a doctor again. So it's usually a one-visit thing. So there's not a doctor in America who's seen 200 cases of anosmia and said, "Okay, let's do some smell therapy and give you" -- "have you repeatedly stick your head in this aromatic thing and" -- nobody does a study. Nobody does intervention. Nobody says, "Oh, we've got a new medicine for anosmia," with -- you know, so --

Q. We've talked about the turbinates. We've talked about your surgery. You were asked some questions at your deposition about Rosemary Connelly's sinuses, and I'm just wondering, in the dozen or 15, or whatever you said it was earlier, times that you have seen her, have you ever seen any sinus condition that was so serious that you believed that it could cause a

disturbance of her smell?

A. No.

Q. Is there anything else that you're aware of with respect to Rosemary Connelly on the basis of your review of her records, on the basis of your examination of her through the years, that could be a cause of the anosmia other than the trauma?

A. No.

Q. I'm going to ask you one more time, Doctor, just because we had a bit of back-and-forth when I asked you before, do you have an opinion as to what has caused Rosemary Connelly's permanent anosmia?

MR. HINES: I have to object to that for the reasons I think that I've stated.

MR. GRUENLOH: Sure.

A. My opinion is that her anosmia was caused by this injury.

Q. "This injury" being the trauma on June 6, 2011?

A. Yes.

Q. Do you hold that opinion to a reasonable degree of medical certainty?

A. Yes.

Q. More likely than not?

A. Yes.

MR. HINES: Same objection.

MR. GRUENLOH: Thank you for your testimony. Mr. Hines is going to have a few questions for you. I think it might be a good idea for us to go off the record and just sort of clear the room for a moment.

MR. HINES: Yeah, that's fine. Listen -- and I've probably --

THE WITNESS: And I apologize. Man --

MR. GRUENLOH: We're off the record.

THE WITNESS: If I --

MR. HINES: Let him get us off.

THE VIDEOGRAPHER: The time is 6:43 p.m. We are off the record.

(Recess from 6:43 p.m. until 6:46 p.m.)

THE VIDEOGRAPHER: We are back on the record. The time is 6:46 p.m.

MR. GRUENLOH: Russ, before you jump into it, just I wanted to move Exhibits 1, 2, and 3 into evidence.

MR. HINES: And on that point, just to make our record, I'm not able to consent to the admission of all those. I guess the point at this time I want to make is I don't have a disagreement or argument about authenticity of those documents or a

foundation issue. My concern is I just at least want to reserve the right to take up the legal question about any documents in there that, really, in particular, are redactions, but I suspect there could be a document that needs to be taken out, on the basis of subjective opinions that are contained therein that aren't -- well, essentially, my -- I want to be able to at least table that issue and discuss it. It may be one that is a nonissue once I -- once I go through those page by page.

That being said, we could sit around here right now and do it page by page if that's the position that is taken that we need to do, but what I'm thinking is, since there's a -- you know, his full chart is in there, a number of records, we're not over here fighting about foundational issues. The question of admissibility of the documents on the basis not -- again, not as -- not genuine or authentic, but as to the subjective opinions and judgments that may be in them, and also, well, you know, Rule 403, an objection of undue prejudice, you know, with regard to undue prejudice.

So unless there's any more commentary on that, that's what I've got to say for the record on that.

MR. GRUENLOH: Yeah, and the only commentary that I have on it is, I certainly understand preserving any objections as it relates to redactions that need to be done or whether or not the chart is complete. In terms of an objection as it relates to some specific opinion that's in the record, I can't agree that that should just be preserved, because I don't know what you're talking about and I don't know what opinions you're talking about, and I think that we don't need to hash them out, but I think that in order to preserve them, you ought to note for the record which documents you're talking about.

MR. HINES: Sure. Then let me sit right here and do that.

MR. GRUENLOH: That's fine.

MR. HINES: For the record, I suppose, this is not an -- it's not a case of not having a familiarity with the documents, it's a case of take this deposition for use at trial and not knowing necessarily what documents were going to be presented to be admitted --

MR. GRUENLOH: Sure.

MR. HINES: -- at this time. We're also

working on the fly with this.

MR. GRUENLOH: Absolutely.

MR. HINES: So my suggestion was born of -- well, what I -- what I would hope to be, I guess, pragmatism, but --

MR. GRUENLOH: I tend to agree with you, Russ, but, again, that sort of leaves open the possibility that you're going to come in and object to every -- I know you won't do that, but I need to understand, if you've got an objection as it relates to a specific issue on an opinion, I think we ought to at least know the document that you're talking about.

MR. HINES: As I go through these, I guess I also want to say my intention is to -- well, my hope is that this will be -- there will be no issues.

By the way, I don't need to do this on the record, so I don't know if we need to be read off or not, but what I mean is, when I have an objection, I'll -- I mean, I can save all that, you know, for the purposes of saving tape, but not now.

MR. GRUENLOH: Do you want to -- here. Here's a thought. Why don't we go ahead and go forward with the doctor so that, you know, we're not wasting his time with you looking through the records, and

then we'll keep the record open after he leaves. Does that make sense? And if you want to go back and identify the specific pages that you've got objections to, we can do it that way.

MR. HINES: That's fine. I mean, I'm certainly happy to --

MR. GRUENLOH: So that we don't -- we're not killing Funcik.

MR. HINES: Listen, I certainly don't want a dollar waiting on a dime, as they say, so I am fine with that. And, of course, I'll give these records back to you now, Doctor, so you'll have them as we go through this. Again, really, the place I'm coming from is a place of, well, I guess you could call it, in the most positive light, due diligence, in the most negative, perhaps paranoia, but I just don't want to have something in there that I'm kicking myself over, saying, "Sure, let it in."

CROSS-EXAMINATION

BY MR. HINES:

Q. Well, Dr. Funcik, if -- we're on. I suppose we're ready to go. Everyone's ready.

Dr. Funcik, again, my name is Russ Hines. I'm here for the defendant, Winsor Custom Homes. And let

me, well, try to move through this the most quick -- as quick as I can, but I do want to just touch upon a few things.

First of all, I want to get to make sure I understand what you have been provided for your review in terms of, I mean, what you have in front of you as Exhibits 1, 2, and 3 to this deposition now, you know, I think is your medical chart, some records from Charleston ENT, and also the photograph. Is it just one photograph?

A. Correct.

Q. What else in terms of documentary material has been provided to you, if anything, for review in terms of formulating any of the opinions in this case?

A. You said documents?

Q. Yes, sir.

A. I received an e-mail that had four attachments, and I didn't read -- I didn't have time, an opportunity, to read those attachments. You know, I'm busy every day clinically and it's been a busy week. And I believe that those attachments were my deposition and maybe Dr. Schlosser's deposition, and perhaps some others, but honestly, I didn't read them. I may have opened one of them briefly or -- I think I opened mine, and then I

realized how long-winded I tend to be, and it was kind of embarrassing, and I was busy on to other things, and --

Q. Okay. So you haven't read --

A. -- I read probably 10 words. I haven't -- and then before we came in here today Mark asked to meet with me across the hall in the exam room.

Q. Are you talking about, just so we're clear, you're talking about the plaintiff's lawyer?

A. Yes. And he showed me Dr. Dozier's note, the results of the Pennsylvania smell test, and then he told me that today -- or he told me today that he either today or recently took Ms. Connelly's and her daughter's deposition, and he related to me a story about, you know, his version. And I realize there's -- like, you said something about interpretation, you know, and I said smell to high hell. It's like that in an argument amongst spouses. You know, "You always do this." You know, there's accusations.

But the gist of what I got from that was, like, sort of an evolution of how the sense of smell, the anosmia, came --

Q. If I can, let me stop you right there. And I don't mean to do that at all rudely, but I want to make

sure.

So what you're saying is -- because I really want to first go with documents. In terms of the documents that you've had to review or that you have, I mean, is it essentially those Exhibits 1, 2, and 3 that are --

A. Yes.

Q. -- there?

A. Yes.

Q. So no depositions that have been taken in this case?

A. No.

Q. Okay.

A. I mean, I was provided them, but I didn't have an opportunity to read them. I just -- physically, I would have to stay up all night to read them.

Q. And you've spoken prior to -- in fact, just before this deposition today, you spoke with plaintiff's counsel --

A. Correct.

Q. -- and he provided some information to you?

A. Right.

Q. Okay. And, you know, you -- I thought I understood your testimony earlier is that you're not

a -- you're not here as a paid expert --

A. Correct.

Q. -- retained for -- for Ms. Connelly?

A. Correct. I mean, I was paid to -- yeah, I've never been, like, a hired expert in a -- in a court case or something like this. I don't like doing this. I don't like anything to do with court and stuff like that. But -- so when I -- I mean, I just try to avoid it.

So I was paid to do her rhinoplasty. I saw her for follow-up visits. I didn't charge her anything to do that. For that last deposition, largely to discourage -- largely because my overhead is $300 an hour just to keep the light bill on, when I do a deposition like this, in this case and any other, I ask for a payment of $500 an hour for my time.

Q. Sure.

A. So does that -- I don't know if that makes me a hired expert or hired gun, whatever, you know what I mean? I feel like it's just -- I mean, I'm getting -- at $500, I'm getting less compensation when I do my job, and this takes away from my productivity.

Q. Sure. And I guess maybe this is a way to ask you. I mean, is it accurate to say that you're a -- you

were -- your role with respect to Ms. Connelly and the fall that's the subject matter of this lawsuit is as a treating physician?

A. It's my primary role.

Q. Okay. And -- well, I'm correct in understanding, you've never treated Ms. Connelly for any loss of smell or loss of taste; is that right?

A. Correct. I mean, other than than to, like, kind of further her education. I mean, there's plenty of intelligent people running around that don't know what a cribriform plate is and don't understand it, and I enjoy teaching, and I spend a lot of time on patient teaching, so I did, you know, do that kind of explanatory thing.

Like I say, there's not any medical or surgical therapy for anosmia, so, really, no one ever really has treated her for anosmia. No one ever will until somebody discovers how to regenerate central nervous tissue or comes up with some miracle drug. So no one treated her. No one ever will.

MR. HINES: I move to strike the last -- the bit of that testimony about no one having treated her from -- well, that last bit of testimony, as being an improper opinion and nonresponsive and

beyond any qualifications of the expert.

BY MR. GRUENLOH:

Q. And, Doctor, forgive me. That's all stuff I have to do for the record because of the way we're doing this.

Because the point I'm trying to make is --

A. My point was just that she hasn't received any -- what treatment has she had? What treatment? Doctors treat by -- beyond education, we give drugs or surgery or physical therapy or other modalities. I don't think she's gotten any treatment from any doctor; Dozier, anybody. There is no treatment. Sadly, there is no treatment that I'm aware of.

MR. HINES: I'll object to that as, also for the same reasons as I mentioned, being nonresponsive and, in fact, responsive to a question that was not asked, and also beyond the witness's qualifications.

BY MR. HINES:

Q. Doctor, if you'll forgive me for just one moment.

A. Okay.

Q. Doctor, I want to hand you what your -- this is a copy of the sworn deposition that you gave in this case. It was back on May 21st of this year. If you

would, please, turn to --

A. Is this whole thing my deposition?

Q. Yes, sir, it is.

A. This 126 pages here? This is all me right here?

Q. Yes, sir.

MR. GRUENLOH: Is that entered as an exhibit?

MR. HINES: No, I just want him to have it so that he can be along with me.

BY MR. HINES:

Q. But, Doctor, I want you to look at page 66, line 16, please. Just let me know when you're there.

Do you see where the question picks up, it's at line 16?

"Have you treated Ms. Connelly for the loss of smell and taste issues she talked about?"

And your answer: "No."

"So that's not been part of your treatment at all?"

"No."

A. Yes, I can see that.

Q. Okay. I mean, that's -- that obviously was your testimony that you gave to me?

A. Right.

Q. And I want to go back to the idea being -- well, that's the point that I'm getting at here is that she saw Charleston ENT complaining of smell and taste issues, did she not?

A. Yes, she saw them for, like, a diagnosis. I guess it depends on your definition of treatment. Treatment means therapy.

Q. Well, Doctor, I guess what I'm getting at is, the question -- the word "treatment" was used in those questions during your deposition, and your answer, I thought, was -- well, it was short and -- it was "no." So we can move on, but --

A. Right, but I guess perhaps at the time, and this is 127 pages, but I guess the way -- did I render any therapy or advice. You know, I mean, she told me that she had an examination there. I don't know if I had -- I don't recall seeing any records. I don't think there's any records in my chart. But I didn't render any therapy or recommendations, which is maybe just explaining to her --

Q. Well, let me --

A. -- what -- how I honestly thought at that time it probably happened.

Q. Okay. Okay.

A. That's why I went into the cribriform plate explanation.

Q. Let me then maybe go back and do it this way: June 6, 2011, is the date of the accident --

A. Okay.

Q. -- that is the subject of this lawsuit. Now, on June 6, 2011, Ms. Connelly came to see you with having just then, you know, right before she came to see you, with a nasal fracture?

A. Correct.

Q. Now, at the time that she presented to your office, well, she -- you didn't know for sure actually that she had a nasal fracture, did you?

A. No, I knew -- I knew that she had a nasal fracture. You know, when -- for some kind of fractures, some kind of doctors, in some kind of clinical settings, you need an x-ray. I mean, if it's a small bone of the wrist or an ankle or something, you absolutely have to have an x-ray, and sometimes even an x-ray can't diagnose it. Sometimes you have to do an x-ray a week later or do an MRI to ascertain whether there's a fracture or not.

When you're accustomed and experienced and trained in treating nasal fractures, a facial plastic

surgeon typically does not obtain any x-rays whatsoever. Matter of fact, even an experienced ENT doctor will kind of chuckle at the idea of obtaining an x-ray. The diagnosis is a clinical one.

Now, we've talked several times about the degree of a nasal fracture. Technically, if there's a slight little crack that's not displaced and not even all the way through the bone, then that's a nasal fracture.

So I knew based on the magnitude of trauma and swelling that she had some cracks in her nasal bone and; therefore, she had a nasal fracture. What I couldn't ascertain and what I would not ordinarily be expected to ascertain is whether that nasal fracture was enough to cause a visible or a functional deformity and whether it would need therapy. But I felt -- I knew that she had a nasal -- I knew that she had a nasal fracture.

When she went to Nason -- well, I'm not --

Q. Doctor, this is -- I mean, it probably sounds like I'm being -- like I'm being rude.

A. I don't mind.

Q. I have to make an objection to that response as being nonresponsive.

And so -- but let me see what I can do to pick

up the pace here, because what my hope is, Doctor, is to ask questions that can really be answered yes or no.

A. Yes or no.

Q. And that if they're -- if you'd be -- I'm not trying to say don't explain, but if the question could be answered yes or no, what I'd like is a yes or a no and then an explanation, and then beyond that, of course, plaintiff's counsel can ask you a question.

A. I'll try to be so concise. I knew she had a nasal fracture. I would have been willing to bet that she had a nasal fracture the minute I saw her, I touched her.

Q. Let me ask you this way, maybe, what I'm getting at about the nasal fracture: Is it -- when -- when she came to see you immediately after this fall and -- your examination of her showed that her nasal bones were essentially stable, didn't it?

MR. GRUENLOH: Object to form.

A. I -- remember I haven't read that. That the bony pyramid was essentially stable. And what that means is, when I put my fingers on her bones, the bones did not, you know, glide freely with minimal resistance, that the bulk of the bones in that area were in that same position.

But as a practical real world matter, you only do a physical exam if it's going to change your therapy, I mean, if it's going to make a difference right then and there. And so if I knew that it was going to go to litigation and, you know, I had to know right that minute, I would have pushed really hard on her bone and found a part that wiggled a little bit, and she would have screamed, and I could -- I could have done that, but that's not something that we do, because -- because we're not going to rush her to -- it's not like this is a branch point where you say are we going to surgery or not, we need to know, is this appendix hot, is the person having a stroke, you know.

Q. Doctor, I don't mean -- again, I don't mean to cut you off, and this is one of those things where if we had a judge here, we'd get explanations from a judge. It's all kind of the reasons why this is a tough environment in which to take a deposition like this.

A. And I'm trying really hard. I'm trying so hard to answer your questions, you know.

Q. Listen, I appreciate that effort. I sincerely do. I sincerely appreciate everyone bearing with us, but I have to object to the nonresponsiveness of that answer. Again, I want to go back to, my intention is to

ask you a question that can be answered with a yes or a no.

A. Okay.

Q. And I would like for you to answer it with a yes or a no. If you feel that there is some responsive explanation that needs to be added, you know, I'm not -- I mean, that's -- then, you know, please add it.

A. Okay.

Q. But, you know, we'll be here for quite a while if we can't keep it moving along. And, furthermore, this is -- because this is for use at trial, and this goes along with my objection, you know, if -- you know, well, I'm sure that plaintiff's counsel will on redirect examination of you, you know, make any points that need to be made.

A. Do you want to do that last question over again?

Q. Yeah, let me just sort of --

A. Ask that question over. I'll try to give you a yes or no.

Q. And so that's the standpoint that I'm coming from. Again, you don't have the benefit of having a judge here to help. None of us have the benefit of having a judge here to help us along on those points.

All right. Let me go back and start all the way from here. Doctor, your medical practice is called --

A. Coastal Facial Plastic Surgery.

Q. Coastal Facial Plastic Surgery. So is it accurate to say that the focus of your practice is facial plastic surgery?

A. Yes.

Q. And prior to the time that Ms. Connelly came to see you after she fell on June 6th of 2011, you had a doctor-patient relationship with her for other -- well, just other matters that --

A. Yes.

Q. -- you had seen her for; correct?

A. Yes.

Q. So when she came to see you that day, obviously her -- the injury that brought her to you was the nasal -- you know, was a fall, was the fall, and -- and, I guess in particular, her nose; correct?

A. Yes.

Q. Was it important -- it was, of course, important to you at that time to evaluate her in terms of any sort of care that she may need in terms of a MRI or other things that she might have needed at that time

because of something that needed immediate attention that you needed to refer her to a hospital or to some other doctor?

A. Would you please -- I'm going to try really -- I'm trying really hard to give you yeses and nos. Would you repeat? Would you repeat that question, please?

Q. You know, I will. And you're trained -- you have a pretty significant amount of emergency room training, don't you?

A. Yes.

Q. And --

A. More experience than training.

Q. Experience. And the point is that I'm -- with that, obviously you understand the importance of determining if there's been a loss of consciousness --

A. Correct.

Q. -- when somebody -- after someone suffers a, you know, traumatic event?

A. Correct. It's very a significant clinical point.

Q. So, I mean, you were evaluating her for those types of emergent care needs --

A. Right.

Q. -- at the same time that -- when you saw her right after the --

A. Yes.

Q. And you didn't identify -- well, you know, nowhere in your record indicates that she had a concussion on your record from the June 6th, 2011, visit?

A. The words "concussion" do not appear in my records.

Q. And your record -- well, and after you saw her, did you indicate that she needed to go to the emergency room, or was -- did you determine that it was appropriate for her to, well, to go home, essentially?

A. I got to go outside the yes and no on this side. You know, man, every ER shift you would see a head injury, you know, somebody with an impact, and it's a pretty established standard of care, routine way of handling it. And, pretty much, if the patient experiences a loss of consciousness or is vague on the details of the event, then you need to determine whether they have a potentially lifesaving brain injury. And so in this country, in the standard of care, if there's a noted loss of consciousness or a vague recollection of the events, then you've got to image the brain to make

sure there's not intracranial hemorrhage, because the person can have complete loss of consciousness, go through a period of lucidity, and then all of a sudden the next thing that happens is they seize and their brainstem is herniated and they stop breathing and they die. I've done that hundreds of times.

And given that she had that history, I do not -- I think I appropriately said that brain imaging was not indicated. Now -- and it's unlikely -- I don't recall every word of that visit, but if you're triaging a case like this, I treat the whole patient. I'm not just a nose doctor. I'm responsible for the whole person and their safety, medically, legally, ethically, morally.

And so if there's been an impact to the head, depending upon the situation, I may or may not say, you know, "If you continue to have nausea or dizziness or something, then you need to call me or call your primary care doctor or go to the nearest emergency room."

Q. Doctor, if you will, will you turn to page 12 of the deposition transcript, your deposition transcript, and particularly line 13. Beginning at line 13.

And I -- well, this picks up when you're giving

a response about your -- the initial visit that she made to your office?

A. What lines do you want me to read here?

Q. On 13.

A. Line 13. "You know, so I would see trauma, and when you're" --

Q. Excuse me. Is this page 12?

A. Oh, I'm on the wrong page.

MR. GRUENLOH: I'm just going to object to asking him to read a portion of his answer. It's a pretty long answer.

A. "She looked pretty good to me."

Q. If you'll continue on. I said all the way to 24, please.

A. To 24? Okay. I'm going to need a minute to read.

MR. GRUENLOH: I'm sorry to interrupt, but the answer begins on page 11, at line 5, and it goes to page 13, line 6. So, again, just for the completeness sake, if you're going to read it in, you need to read in all of it. If I'm wrong on this, I can ask him on cross-examination.

MR. HINES: Yeah, and that's my -- that's my point too, since we're talking about legal

positions, is that you're welcome to ask him -- you're welcome to get into that on redirect.

MR. GRUENLOH: I won't interrupt you any more then. I'll just note my objection and see what the court wants to do about it. Go ahead.

MR. HINES: Sure.

BY MR. HINES:

Q. But -- all right. We're on page 12, line 13 through 24 if -- of your deposition, Doctor. If you'll just read that for me.

You know what? Let me give a little bit of a preamble, and I apologize, but what I was asking you about is -- well, this -- what we've been talking about is the first visit that Ms. Connelly had with you immediately after the -- the accident, and -- well, I'll tell you what.

Let's just go ahead, if you would, and go back to page -- well, page 10. I'm trying to figure out where -- where to start this just so we can include it all. If you would, go to page --

A. Ten.

Q. -- page 10. And then the question is this, beginning at page 10, line 12. And the question is kind of odd because it does pick up in the middle of a

discussion, but I think the -- it's appropriate to start it here on page 10, line 17.

"The first thing that it says on here, this is a note from June 6, 2011, 'Rosemary fell while jogging today.'

Could you tell me, is there any other information about the accident that you recall that may not be reflected in the note?

And let me append that enough to say I'm not asking this by way of any sort of criticism of the note itself. I'm saying, do you happen to remember something significant -- excuse me -- remember something that wouldn't necessarily be clinically significant but just a detail of the accident? Anything she might have said about how she fell or anything to describe the accident?"

Well, I tell what you, since we're doing this for the --

MR. GRUENLOH: Russ, for the sake of time, I'll withdraw the objection. If you want to just talk about that statement, it's fine. I can come back to it.

MR. HINES: Well, thank you for that. I'll just move on entirely.

BY MR. HINES:

Q. All right, Doctor. The first time you see Ms. Connelly after the fall was June 6th of 2011. It's -- you know, you saw her, and the bony pyramid of her nose was essentially stable; correct?

A. Correct.

Q. And she permitted reasonable palpation. Does that mean touching?

A. Yes.

Q. And at the time -- there was some discussion earlier about whether you thought from the very beginning that she would need open reduction of the nasal fracture. You might remember that earlier from your testimony?

A. Yes.

Q. Well -- but, in fact, initially you thought it was unlikely but possible that she may need open reduction of the nasal fracture; isn't that right?

A. I mean, you can read my note. I don't have my note open and, you know --

Q. You know, if you flip to it, I think it's part of one of those exhibits up there. I think it's Exhibit 1.

A. 6/6/11 is the date?

Q. Thank you.

A. So let me read what I wrote. What paragraph are you referring to?

Q. The final paragraph, the second sentence.

A. "It is unlikely but possible that she may need open reduction of the nasal fracture."

Q. So at the time when she came to see you, you thought it was unlikely, based upon your examination of her at that time, you thought -- you didn't expect that to be needed; isn't that correct?

A. No, I think that's incorrect. I think that's reading too much into my word "unlikely" here. I don't -- when I'm doing a clinic note like this, I don't do my words that precisely thinking that I'm going to be analyzing them four years later. And the reality is that when there's, as I said above, there's massive swelling, it's just not a determination to be made at that time. There's no need for the determination to be made at that time. It's not a decision that needs to be made at that time.

And so to -- for me to try to honestly weigh in between unlikely but possible, just you let the swelling go down and then you see how it heals, which is what

unfolded in this case. I let the swelling go down a little bit. She had some palpable and visible irregularities. And so it would -- later it became clear that it was indicated.

Q. Okay. But at least we agree that the note does say "it is unlikely but possible"?

A. The note does say that, yeah.

Q. That's the words of the note?

A. Yeah, yeah, obviously that's the words.

Q. We'll move on past that. And, of course, we'll -- you mentioned swelling, and the word is massive or fairly massive, but isn't it normal to have swelling when there's been a nasal fracture?

A. Yes.

Q. So that's -- when -- you're not saying there's anything that's all that unusual about swelling after a nasal fracture?

A. I mean, we're back where we -- fairly massive is what I wrote. I mean, maybe if I was, like, to rewrite it, I might say impressive, meaning that a lot of times there can be a nasal fracture and there can be less swelling. It's not the most. More than average from swelling from a fall --

Q. Okay.

A. -- is the way I would -- if I had to try to, like, you know, succinctly, accurately recharacterize it now, you know, to the best of my recollection four years earlier.

Q. Okay. But at the end of that visit, obviously, the result that, you know, she -- she leaves your office and she goes home with the idea being that she'll follow up in -- in a week; correct?

A. Correct.

Q. All right. Now, she comes back again. If you'll just flip with me with the notes, and maybe this will pick up the pace for us. It looks like the next visit was about a week later.

A. Correct.

Q. I think the date that's been identified was June the 14th, but, you know, about a week; is that right?

A. Correct.

Q. Now, as far as -- at this time you have had the benefit of some, well, some imaging information, I guess from -- from Nason Medical Center; correct?

A. The x-ray report, right.

Q. And I asked you earlier about -- just going back to that last note one more time, the first one,

about it didn't -- about there being a lack of certainty of there being a fracture as of the initial visit, and I want you to look at the third paragraph on this now on the -- on the -- on the second visit, the one about a week later on June 14th of '11.

Do you see where it says, "Our suspicion that there is a nondisplaced or minimally displaced nasal fracture has been confirmed"?

Do you see that, Doctor?

A. Yes.

Q. And I guess I want to be clear that the point I was trying to make is that, well, there may have been a suspicion of a break at least documented. It's indicating there was a confirmation of a suspicion that happened after the first visit as opposed to at the first visit it was known without any suspicion there was a break. Is that at least what this note says?

A. Yes.

Q. And the type of -- when we say fracture, I mean, as a layperson, that means a broken nose; right? Is that -- isn't that what that means?

A. Correct.

Q. And we look at -- you know, nondisplaced or minimally displaced, does nondisplaced mean that, well,

that the bones are in line or the bone is in line with -- is that what that means?

A. Substantially.

Q. And minimally displaced would mean that it's --

A. Slightly.

Q. And aren't there different types of fractures that a person can have or different types of -- you can break your nose and you can have a compound fracture? You can have a -- what is a compound fracture?

A. We've we've talked about this before. You know, a nasal fracture is just a wide variety of nasal fractures. It could just be just like a hard boiled egg. When we tap a hard boiled egg, it's still shaped like an egg but there's little cracks and there's little parts of it that are a little bit mobile and maybe shifted slightly, but it still sort of looks like an egg.

And then the whole egg could be fractured. Or -- or you can take an egg and you can smash it down, and when you palpate the nasal bones, the nasal bones could move over. They could be sticking out of the skin. They could be missing. All those are nasal fractures. There's a wide spectrum of --

Q. Of different types of fractures, is that what

you're saying there?

A. Right.

Q. Well, and on that spectrum, you know, like -- I think there's a word "comminuted." I mean, I will likely mess up plenty of terminology.

A. That's good. You said it right. That means multiple. Just if a bone just breaks in two pieces and boy, oh boy, they fit together like a puzzle, that's noncomminuted, and comminuted is busted up in a bunch of pieces.

Q. Comminuted is busted up in a bunch of pieces?

A. Right.

Q. You know, I don't have medical training, and so, you know, these words I will likely butcher, and so if you'll bear with me.

And I know this -- for the benefit of a jury, really what I'm trying to get is, when the word "fracture" is in there, that means break; right? We already talked about that; is that -- that's correct?

A. Yes.

Q. And nondisplaced is meaning that the bones are -- the bone, while broken, is substantially in line still?

A. Yes.

Q. And minimally displaced means that while broken, it is not, but a little bit out of line?

A. Correct.

Q. As opposed to comminuted, which is all busted up; right?

A. Yes, and maximally displaced.

Q. Yeah, I mean, just --

A. Open. Right.

Q. And the point I'm getting at is, you know, well, making the difference here, this wasn't an all busted up-type fracture?

A. I've seen more displaced and comminuted nasal fractures for sure.

Q. Now, I want to -- you get into this note, don't you, into talking about -- or this -- at the time of this visit, if you'll keep following with me into the third -- the fourth paragraph, rather, of your note, you get into talking about options of how to handle it now that you've confirmed your suspicions that you have a nondisplaced or minimally displaced broken bone in the nose.

And if you'll follow with me, do you see where it says: "We discussed her options. She has the option letting it heal conservatively versus a reduction of the

nasal fracture. Either way, she's likely to have some deformity in the area. If she were my wife, because it is minimally displaced, I'd allow it to just simply heal for about six weeks and perform some b.i.d." --

A. Twice a day.

Q. -- so that means twice a day -- "digital massage to try to make it as smooth as possible"?

A. That's what it -- that's what it says.

Q. And so that's -- you know, that's -- at the time, that's -- that's your assessment, isn't it?

A. Correct.

Q. Okay. And, again, you said b.i.d. means twice a day. And that's just -- that's Latin, isn't it, like p.i.d. is an abbreviation?

A. Correct.

Q. And digital massage just means with your hands or your fingers?

A. Push with your fingers.

Q. Your fingers. And the person who would be doing that would be the plaintiff, Ms. Connelly?

A. Ms. Connelly.

Q. And I'm sorry, Doctor, I don't mean to talk over you, but that -- what Ms. Connelly would be doing that?

A. Yes.

Q. Now, when -- now, when we go forward, I think that the next visit that she had to your office was about a month later on July 12, 2011. If you'll flip with me through that exhibit to where you get to your patient note, and let me know when you got to it, that would be great.

A. I have it.

Q. Now, by this time -- this is about a month later, and we just talked now about how the -- well, what your note indicates and what your opinion was about "if she were my wife."

And by the way, I want to make sure. What you're saying there is, you're simply saying, hey -- well, of course, I know you care about all your patients. You're saying -- what you're -- I think the sentiment or the thought you're expressing there is, "You know, I would tell somebody that I care about, as I do all my patients, this is the way I would handle it?"

A. Yes.

Q. Now, at this next visit a month later, the assessment and recommendation part of this note indicates, well, something -- something different; right? It indicates: "I would recommend proceeding

with open reduction of the nasal fracture"?

A. Correct.

Q. So in the month's time, there's been, well, a different plan that's now formulated?

A. Correct.

Q. Okay. Now --

A. Because more information is available now. When I saw her a week out, the skin, soft tissue, subcutaneous tissues, were swollen and dense and kind of, like, thick and leathery, and so when you put your fingers on something like that, if there's some bony irregularities that might be visibly or palpably prominent, that can't be ascertained at that time, but as the soft tissue swelling -- that's why this is the standard protocol for following nasal fracture. When the soft tissue swelling went down, at this point now I could feel some bony irregularities on the dorsum that were -- that no one could palpate, that no CT scan could show --

Q. Okay.

A. -- at that time.

Q. And that was -- well, and at that point the assessment and recommendation has now become an open reduction of the --

A. Correct.

Q. -- of the fracture?

A. Correct.

Q. Okay. Now -- no. Excuse me. Let's -- I think we can now go forward to your next note, which is, her next visit was a preoperative visit, as I understand it, on August the 9th of 2011; is that right?

A. Correct.

Q. You with me with that note, Doctor?

A. Yes.

Q. Thank you. Okay. Going through this note, well, obviously Rosemary comes in for her preoperative visit. She fractured her nose a short time ago. In addition to reducing the fracture -- and you know what, Doctor? While I'm -- while I'm there, reducing the fracture, does that mean just getting everything in line again --

A. Yes.

Q. -- at the bone?

So in addition to doing that -- and in this case, again, it was either nondisplaced or minimally displaced, so you're not talking about, you know, a lot of movement out of line; right?

A. Please repeat that question. Rephrase it.

Q. You know what? That's fine. I'll move on.

THE VIDEOGRAPHER: Counsel, we just have two minutes left.

MR. HINES: Sure, we can break. It's fine.

THE VIDEOGRAPHER: It would be a good idea. This is the end of Tape No. 2 in the videotaped deposition of Dr. Thomas Funcik. The time is 7:33 p.m. We are off the record.

(Recess from 7:33 p.m. until 7:38 p.m.)

THE VIDEOGRAPHER: We are back on the record. The time is 7:38 p.m. This is the beginning of Tape No. 3 in the videotaped deposition of Dr. Thomas Funcik.

BY MR. HINES:

Q. Thank you, Doctor. Where we are here is with your -- well, this is the preoperative visit that Ms. Connelly came in for August the 9th of 2011. I think you have that -- your note from it in front of you?

A. Yes.

Q. Thank you. Now, looking at the first paragraph of that note, I want you to look with me. It says that

"She fractured her nose a short time ago. In addition to reducing the fracture" -- and, again, we

just talked about what that means, to reduce the fracture -- "she wants to have some refinements, and we plan to take a hump down and to narrow her tip and elevate the nasal tip."

That's what it says?

A. Correct.

Q. And so -- well, again, the -- just to make sure that our jury understands this, reducing the fracture means -- that means fixing the broken nose; right?

A. Correct.

Q. And refinements, tell me, you know, is that -- well, that doesn't have to do with fixing the broken nose; right?

A. Correct.

Q. And is that -- I mean, that's -- it's a cosmetic -- well, the aim of that is cosmetic; is that right?

A. Correct.

Q. And then -- and you go on in the next sentence, I guess, to describe those refinements; right? Taking the hump down and to narrow the tip, narrow and elevate the nasal tip; right?

A. Correct.

Q. That's the tip of her nose?

A. Correct.

Q. And you would agree, I mean, well, that no nose is perfect before or after surgery; is that right?

A. Correct.

Q. Now, if -- when you go -- well, so just to recap a little bit, on the second visit from June of 2014 about a week after she came to see you originally -- excuse me. Not '14. I've gotten ahead of myself with the numbers.

When she came to see you about a week after the accident on June the 14th of 2011, the plan at that time was, you know, paraphrasing, but "If she were my wife, I'd recommend just letting it heal and massaging it a couple times a day with your fingers"; right?

And what I'm getting at, I'm just trying to show the evolution of it, because the next -- then you have that the plan changes with additional information that you got on about a month later?

A. Right, but the plan at one week is tentative, as it always is one week after a fracture.

Q. Sure. And so then the plan becomes the surgical plan as of, you know, sometime in the middle of July, that visit; right?

A. Right.

Q. And then within a couple, few weeks after that you get the preop. By the time of the preoperative visit, then the plan is to also include these refinements, the cosmetic aspects that aren't related to the --

A. Correct.

Q. -- broken nose; right?

A. Correct.

Q. Now, as far as the -- if you'll flip with me to the August 24th operative report.

A. Got it.

Q. And, again, that's August -- all of what we've talked about so far is the year 2011, just to make sure I'm --

A. Correct.

Q. -- my numbers didn't get away from me.

And so August 24th of 2011 is the day that the surgery happened; correct?

A. Correct.

Q. And there was -- I'm trying to go through this quickly, and -- nasal fracture. I think your testimony was that the open reduction of the nasal fracture, again, that was related to the fall and you were fixing that because of -- because it needed to be fixed; right?

A. Correct.

Q. Now, functional septoplasty, that was one I want to try to get into to make sure I understand this, about any relationship to the fall there. Now, that one, it -- well, you're certainly not saying that she would have had to have a septoplasty at that time -- or excuse me -- that -- I want to make sure this is right.

You're not saying that the fall caused her to have to have this functional septoplasty procedure; correct?

If you're having trouble with my phrasing, I'll do it again. Just let me do it.

A. Rephrase it.

Q. You're not testifying that the fall that -- let me see if I can think of a better way to ask this question so that it's not -- so that it doesn't end up getting confusing.

You're not saying that the accident caused her -- caused her to have -- to have a major, well, movement of her septum, are you? You're not saying that it really moved it out of place?

A. As I said earlier, she had a septal deformity, and it was partly, you know, developmental and aging, but the fracture contributed to it to a lesser extent,

probably, than the former two causes.

Q. So the fall's relationship to it was on the lesser end of in terms of --

A. The septal deformity.

Q. -- the septal deformity?

A. Yes.

Q. And that's -- that's -- you talked about that that's -- well --

A. Yes.

Q. So you're certainly not saying that that -- the procedure that's referenced there -- because there was a talk about -- obviously you've testified and obviously this report or this note is in reference to the surgical procedures that you performed on Ms. Connelly back on August 24th of '11.

And I guess the point I'm trying to make clear is that the -- well, is that -- well, you've talked about the factors that related to the septal -- the deformity of her septum, and you're not saying that the deformity of her septum was all caused by the fall?

A. Correct.

Q. In fact, you're saying that there were other causes more significant, even, than the fall?

A. Correct.

Q. Okay. I'm sorry for that. Having trouble getting -- this is --

A. That's okay.

Q. These medical words are a bear and trying to think through this and not sounding perhaps any more foolish is --

A. I don't even try to understand all your guys' jargon when you guys go back and forth.

Q. And then, of course, the bilateral inferior turbinoplasty, you talked with plaintiff's counsel about the inferior turbinates and, you know, a condition called hypertrophy, but the question I'm getting to is: As far as that procedure, that's -- that wasn't -- she didn't need to have that because of the fall; right?

A. Correct.

Q. So -- and then, of course, the rhinoplasty, I mean, is that -- the word "rhinoplasty" might sound a little bit -- I don't know if lay people know what that means.

A. A nose job.

Q. A nose job. Okay. And that's a cosmetic procedure?

A. Yes.

Q. And, again, not at all related to the fall?

A. Yes, correct.

Q. Correct. There was some talk earlier, when plaintiff's counsel was questioning you, about surgeries, and -- or the surgery you performed on August the 24th, and -- on Ms. Connelly. I mean, you had performed other procedures on her in the past --

A. Yes.

Q. -- unrelated to this fall and prior to the fall?

A. Yes.

Q. As part of your doctor-patient relationship you had?

A. Yes.

Q. Surgical procedures, I mean?

A. Correct.

Q. So it certainly was not -- well, it wasn't the first time that she'd had a surgical procedure --

A. Correct.

Q. -- that you had performed on her?

A. Correct.

Q. And as for the -- we've talked about, you know, what relates to and doesn't relate to the fall in terms of -- because -- well, I guess in lay terms, when you say surgery, that's perhaps a blanket term, and what we

just went through, and you testified to it earlier with plaintiff's counsel, was on your operative report where it talks about procedure, it includes, well, you know, the open reduction, the septoplasty, the turbinoplasty, and the nose job. Well, those are different things, aren't they?

A. Correct.

Q. And so the point is, you've already testified to, you know, how -- you testified as to how those various things relate or do not relate to the fall. What I want to focus on is, as for the things that don't relate to the fall, as for the procedures that don't relate to the fall, the cosmetic procedure, for instance, I mean, that's something that Ms. Connelly did voluntarily? She decided that that was something that she wished to do surgically; correct?

A. Correct.

Q. I think you already said earlier that you consider the -- your surgery -- the surgery you performed on Ms. Connelly to have been successful surgery; correct?

A. Yes.

Q. Now, after you performed a surgery on Ms. Connelly, I want to get into this -- there was some

testimony earlier, I guess, about the, sort of, after the surgery and what to expect, and I think the language that was used was something along the lines of -- and forgive me, I've written it down -- but it would take a year for things to settle out or something? That might have been plaintiff's counsel's language. I'm not sure whose language it was. But do you recall that general line of questioning earlier?

A. Yes.

Q. Now, I want to be clear about something. As I recall when you were testifying about that, you said, you know, you're talking about someone's nose, something they look at in the mirror, you know, every day, many times a day, likely; right?

A. Yes.

Q. And the point you were making is that you're talking about before the particular -- you're talking about the cosmetic aspects of a procedure like that, too, and when you -- when it is that you're going to, sort of, have the nose perhaps that you were hoping to have; right?

A. Yes.

Q. And so -- well, the point I'm trying to make is, I want to make clear this distinction, and as I do

it, let me make an objection -- make note of my preserving my objection for the record about the whole anosmia, because I need to get into asking you some questions about that, and I want to make clear again, I hope I've made it clear, that I'm asking this because I need to ask them in case this is something the judge rules in the plaintiff's favor on from an evidentiary standpoint, but I'm not trying to open any doors to anosmia from testimony from Dr. Funcik.

So with that being said, let me move on now to say, as for the testimony about it taking, you know, a year or so for the things to settle out, or whatever the word is -- and that's obviously not a medical term; right? That's just a lay term; correct, when we talk --

A. Correct.

Q. -- when we're using these terms "settle out" of whatever?

You're not talking about it takes a year for your nose and for the soft tissue to stop swelling so that you'll get your -- so that you'll -- it won't interfere with your sense of smell; right? You're talking about something different than this -- the smell settle -- a swelling issue of settling, aren't you?

A. Okay. If you want a yes or no, will you

rephrase that question, please?

Q. Let me see if I can get -- go through it a better way, because, again, the medicine is, well, in many ways beyond me, and what I'm trying to get through is perhaps simpler in my head than it is on my tongue.

But, for one, as far as anosmia is concerned, I think you've said this, perhaps, but I want to make sure it's clear, because I want to try to use the words smell and I want to use the -- also use the word taste. But anosmia, that means the loss of the sense of smell; right?

A. Correct.

Q. That's a medical term is what --

A. Correct.

Q. -- in the medical profession it would be called?

And so can we agree for the purpose of us talking about it, we're talking about, you know, loss of smell? I want to use smell --

A. Correct.

Q. -- just so that I can use a word I'm comfortable with. And, also -- primarily smell, because, you know, well, where you're coming from as far as the taste, any issues that the plaintiff may be

having with her sense of taste, that's, sort of, something that would be -- well, it would -- where you're coming from is you're looking at the smell issue, and then the taste issue, you know, would -- could perhaps follow that in some way because of the relationship between smell and taste; right?

A. Correct.

Q. But you're -- for instance, you're not saying that the olfactory, if potentially there was a traumatic injury to an olfactory nerve, or filament, or whatever the words you used are, you're not saying that -- it doesn't hurt your taste buds directly? It's -- you're talking about, you know, some relationship perhaps that could be between smell and taste?

A. An injury to the olfactory nerve would not directly affect the taste buds.

Q. Okay.

A. The subjective sense of taste could be modified by loss of sense of smell is, I guess, is what I would say.

Q. Yeah, and I guess, really, that's a way of me trying to get back around to, when I talk about smell, I mean, that's why I'm talking about smell, because if it makes -- it seems to me that your answer to this would

trace the thing back to, you know, the issue of lost sense of smell. And so the point I want to make is, you know, it's correct to say that you don't see cases of lost sense of smell very often in your practice; right?

A. It's true that I don't see that as a chief complaint very often in my practice. Almost never.

Q. Yeah. And it's true you've never done any --

A. I don't think anybody does, really. It would be a lonely practice.

Q. Well, and, again, I'll make an objection about that, again, just to preserve my -- for the nonresponsive part of it, and also just speculative, for the record.

But you -- what -- for instance, the University of Pennsylvania Smell Identification Test, I think I've heard it shortened to UPSIT, you've never administered that test, have you?

A. Correct.

Q. And, in fact, if someone -- typically, if someone complained to you -- if one of your patients complained to you about a lost sense of smell, wouldn't you refer them to some other office?

A. Probably Charleston ENT. They have 10 offices in town, and it's just a little more patient friendly

than the Medical University for, you know, something that's not a brain tumor wrapped around your eye or something complex.

Q. And, really, that gets back to -- again, I don't -- my earlier questioning to you about have you ever treated, and I don't mean to use that word in a way that's -- maybe the sense that I'm using it, you know, perhaps is a bit different than the sense that you're understanding it. But basically, I mean, you never had a situation where you provided medical care to Ms. Connelly where it was -- her chief complaint was -- was a smell issue like it was when she went to see the Charleston ENT folks?

A. That's correct.

Q. I mean, that's the distinction? She came to you for a broken nose; right?

A. Right, principally.

Q. Yeah. And she went to them for the smell and taste issue; isn't that right?

A. Principally.

Q. Okay. And if she had come to you, you know, with a chief complaint of broken nose, you would have said, "Go see Charleston ENT," or someone like that; right?

A. No, I would have treated a broken nose. But if she came to me for -- I think you said if she came to me for a broken nose.

Q. With a chief complaint.

Excuse me. If she'd come to you with a chief complaint of a smell and taste issue, as a general rule, you would have referred her to an outfit like Charleston ENT?

A. I mean, it would depend. I mean, if -- I mean, honestly, just if -- you know, my focus is facial plastic surgery, but if one of my office staff came to me, and they were on a vacation and they fell off a golf cart when they were in Costa Rica and then a month later they said that they couldn't smell, I would probably grab some coffee and grab a lemon and grab some perfume and test it, and I would do what Dr. Dozier did. I would look up there to make sure she didn't have a tumor. Then I would say, "Bummer, you lost your sense of smell and probably tore your olfactory nerves on your cribriform plate."

And then I would probably sit down and Google it to make sure I wasn't missing anything or just -- and then that would be -- I mean, I wouldn't then send her to Charleston ENT or send her to see anybody else.

Q. Okay. Now --
A. In this case, I think she had already gone there.
Q. That's right. And in this case, you didn't -- she -- this is another thing, I guess, I wanted to mention to you. You talked earlier -- could you go -- there was a note from May of 2013. Your note. It was May 28th. It should be among the papers that you have there.
A. May 28, 2013.
Q. And this note you talked about some with plaintiff's counsel. It says: "She mentioned that she has had hyposmia since her injury."
That's what that -- you know, what that note says; right?
A. Correct.
Q. And hyposmia, well, again, we've talked about it, I think you've talked about anosmia and hyposmia, but, you know, you're talking about probably your sense of smell; right?
A. Correct.
Q. Okay. Now, it goes on to say, "She's seen a couple ENTs," and, you know, and it goes on after that.
And so the point I'm trying to make is this was

the first -- this is the first time she mentioned anything to you about a problem with her ability to smell; right?

A. I mean, I think that's right, but, you know, to answer that question so succinctly, I'd have to review my note. I think that's right.

Q. Okay. To the best --

A. I'm sorry to be -- to the best of my knowledge and recollection at this moment in time, that's correct.

Q. Okay. And so -- and you -- and so -- and by the time that this note appears, you know, in May of 2013, she'd already seen some doctors at Charleston ENT about --

A. Correct.

Q. -- with that chief complaint; correct?

A. Correct.

Q. And you hadn't referred her to those doctors at Charleston ENT?

A. Not to my recollection.

Q. Okay. If you would then, I think Exhibit 2 that you have there, or maybe 3, but you have the records from Charleston ENT. I want to ask you to look at those.

A. Got it.

Q. All right. Now, can you turn to -- there's a note there that's dated April 4th of 2013. You might have to flip a few pages in your stack to get to that, because I'm not sure --

A. So it's a doctor's note that I'm looking for.

Q. Correct.

A. I got it. I got it. I got it.

Q. You got it?

A. Uh-huh.

Q. Okay. And I think on the second page you'll see that it is the note of Dr. Mark Ghegan?

A. Okay.

Q. Do you see that?

A. Yes.

Q. Okay. Well, are you aware of any earlier visit or earlier, you know, any time where there's any record that the plaintiff went to a doctor complaining of a problem with smell prior to April the 4th of 2014?

A. I'm certainly not aware of that, but I don't --

Q. So as far as you know, this is the first time she saw a doctor complaining of this -- of a smell issue?

A. In order to give an -- like, you know, an answer that question is worthy of, I'd have to go

through these documents and go through the dates and stuff. You know, I don't have the timeline of her interaction with Charleston ENT.

Q. Okay. Well, you know what? Let me --

A. I'm not aware at this time -- you know, I can't -- from all these hundreds of pages -- like I said, I'm not aware of an earlier date.

Q. So unless there's a record somewhere that says that otherwise, you know, because my point is, I certainly don't want us to get off track with --

A. If this is the earliest Charleston -- I'm not worried she's seen anybody besides Charleston ENT. I'm not aware of a note before this.

Q. Yeah. And if there is one, the note will be -- the note will be there, you know, and it could be pointed to?

A. Yeah, yeah.

Q. But barring something that you're not aware of, but, you know, this is the first time she saw a doctor complaining of a smell problem; isn't that right?

A. I mean, now I'm going back on that note and I can read under Dr. Ghegan's history of present illness, it says: "She has noticed that for the past six months but feels it was present for the last couple of years."

So, yeah, it sounds like this is certainly the first time Dr. Ghegan's seen her.

Q. Yeah. And so --

A. Or anybody at Charleston ENT. So now I guess we're on the same page. This seems like the first time she's seen.

Q. And, again, this note was -- we just talked a moment ago about your note about a visit from May of 2013, which, well, is after the note we're talking about now --

A. Correct.

Q. -- that we've now, sort of, moved back in time, if you will. But the point is, this is before she'd even, at least according to that note, before she'd mentioned a problem with smell to you?

A. Correct.

Q. Okay. All right. Now, the -- I want you to just -- you know, the first, I guess, paragraph, it reads: "I had the pleasure of seeing Rosemary Connelly in the clinic today. She's a 57-year-old who presents with a chief complaint of decreased sense of smell and taste."

It continues on about history of present illness. "She states she has noticed it for the past

six months but feels like it may have been present for the past couple of years."

Now, what I wanted to ask you is, the six months prior to April the 4th of 2013, I mean, we're just using -- well, exactly six months, I guess, would be what? October the 4th of 2012?

A. Okay.

Q. Is that right?

A. Yeah, the math works.

Q. So the way -- what that would indicate is, at this visit, her first visit, what appears to be her first visit to Charleston ENT, she's indicating that she first -- at least the doctor's record indicates she noticed it -- she's noticed it for the past six months, meaning the six months prior to April 4th, 2013; right?

A. Correct.

Q. And that -- just, you know, understanding we're approximating, but that's about the beginning of October of 2012?

A. Correct.

Q. And that would be, you know, a year and a month, you know, or so more after you had performed the surgery on her in August of 2011; right?

A. Roughly.

Q. Now, if you'll keep flipping forward, I want you to go to another note for me. It's going to be a note also from Charleston ENT, and it's from April the 26th of 2013.

A. I have it.

Q. Again, this is -- thank you. Again, this is another note from the Charleston ENT office, but a different doctor. If you'll turn to page -- the second page of that note, I think you'll see that it's Dr. Oma, O-m-a. Oma Hester is the name of the doctor?

A. Yes.

Q. Now, and also, even though this is clear from the dates, but this is about a month before she saw you in, I think May, on May 28th or so of 2013, when she mentioned a problem with smell to you; isn't that right?

A. Yes.

Q. Now, again, it starts off with the first paragraph: "I had the pleasure of meeting Rosemary Connelly in the clinic today with a chief complaint of smell and taste dysfunction."

If you continue on down, about midway through the history of present illness, do you see where it reads, "Eight months ago, she began to notice that she did not have a good sense of smell or taste"?

Are you able to see that sentence, Doctor? I don't mean to be going too fast.

A. So, I mean, "She denies any URI or closed head injuries in association with this sense of anosmia and dysgeusia eight months ago."

Q. Okay. Well, let me make sure. And for our record, I want to --

A. I apologize. I'm trying to be clear, but this is a lengthy note with a lot of words, and I don't know if I've ever read the whole thing. So I'm just, like, trying to be really careful that I'm accurate.

Q. Yeah, sure. I'll need to, for our record, object to the nonresponsive testimony in that answer. Again, that's just a legal matter.

But let me -- what I want to do now, Doctor, is I just want to direct you to the beginning of a particular sentence that's included in the history of present illness on this April 26, 2013, note.

A. Which sentence?

Q. The sentence is -- it begins, I would say, just about midway down that first paragraph of history of present illness, and it begins, "Eight months ago, she began to notice."

Are you with me?

A. "Eight months ago, she began to notice that she did not have a good sense of taste and smell."

Q. That's right. And so --

A. Okay.

Q. And now we've -- both make sure that we're on the same -- we've seen that.

I want you to turn to the next page, which is the last page of the -- of this particular note, and under the recommendations portion, it says: "The identification of the taste and smell disturbance was only eight months ago, which certainly leaves the question of the possibility of some return of function."

Did you see where I read that?

A. Yes.

Q. So in those two places, the point that I wanted to draw your attention to is, is the idea of, you know, she had a recognition -- she's indicating that her first recognition of the problem with respect to smell and taste was eight months prior to the time of that visit, which was April 26th of 2013. And just doing a little bit of math, I mean, can we agree that that gets us back to approximately August 26th of 2012?

A. Okay. Yes.

Q. And that's about a year after your surgery

of -- in August of 2011; right?

A. Approximately. You know, if you need to pin me down to these dates, I do need a timeline, like, you know --

Q. It's fine to approximate. I'm just saying about -- it's about a year; right?

A. Yeah. Yes.

Q. I mean, surgery was August 24th of '11, and eight months -- listen, the math is -- nobody likes it, but I'm trying to take you through to show the timing, you know, just the -- relative to when these records are indicating an awareness of -- of the condition for the first time.

A. Correct.

Q. Now, if we keep flipping forward for me, just this will be the last one on this, where it indicates Ms. Connelly -- excuse me. This is from June 26th of 2014. If you'll keep flipping through that stack of Charleston ENT records.

A. I've got the April note. You want me to go to a June 2013 note?

Q. 2014. June 26, 2014.

A. A good -- is it a good bit in here, or --

Q. It may be near the end of the stack of those

Charleston ENT. Well, hopefully, you'll get to it soon.

A. Okay. June 26, 2014, you said? Dr. Dozier? Did you stay June 26? This note?

Q. Yes, but I think --

A. Oh, that's a CAT scan.

Q. Yeah, I want the note.

A. Okay. So I have RMC Production 165, which is a CAT scan from the date you're asking about, June 26, 2014. In this pile -- and the clip is off of this, I don't know -- the next one I have is 169, and that's a note from January 2015, and the note before it is something else.

Q. Are you able to find one that's got the Bates label calling -- identifying it as RMC Production 160?

A. 160?

Q. That's what I'm looking at. And, I'm sorry, there's probably a better way to get you to it.

Okay. Are you there?

A. Got it.

Q. Thank you.

A. Yes, sir.

Q. Well, thank you for getting there. This is a note, I think it's just a one-pager that is from June 26, 2014, another Charleston ENT doctor. And do

you see at the bottom where this is Dr. Thomas Dozier?

A. Yes.

Q. And I'm going to the very top of this, well, of this note, where it begins: "I saw Rosemary Connelly back in follow-up today regarding chief complaint of decreased smell and taste."

A. Okay.

Q. Now, it appears -- well, it appears this is the next time she saw a doctor with Charleston ENT; is that right?

A. Okay. Yes.

Q. And if you go down a little, I don't know, about a fifth of the way down that paragraph, a little ways in there's a sentence that says: "Her main complaint now is the decrease of smell and taste."

Do you see that?

A. Yes.

Q. Then it continues: "This has been going on for two years."

Do you see that?

A. I see that.

Q. And so, again, if you do the math now, two years taken away from June 26, 2014, that gets you to June 26, 2012, doesn't it?

A. Correct.

Q. Which is -- well, in this case, the accident in this case happened June 6th of 2011. Then surgery happened August 24, 2011. So, you know, you're -- two years prior to June 26, 2014, is about a little more than a year after the accident and, you know, I guess a month or two less than a year after the surgery?

A. Sounds generally correct.

Q. Okay. Now, the point of me going through all this stuff is to get back to this testimony about you -- this -- the taking about a year for the -- you know, for the settling down after the surgery, you know, of the nose. You're not saying that it takes -- it would -- well, do you -- well, those records from Charleston ENT, I mean, when you look at them, do they indicate to you that what those doctors at Charleston ENT are reporting, three different doctors have reported it, and there's different times that are given, whether it's six months, eight months, a year, or two years, rather, but essentially they're saying she didn't notice this condition until, you know, sometime -- if you talk to Dr. Ghegan, for instance, it would say she didn't notice it until approximately October of 2012, Dr. Hester's note would be didn't notice it until approximately

August of 2012, and Dozier's note would be didn't notice it until June of 2012.

But generally there's this period where it's not noticed that is, well, following the surgical procedure that was done in two thousand -- in August 2011. There's this time where there's no noticing of a -- of the smell and taste problem, isn't that what they say?

A. Yeah, it seems in accord with that.

Q. Okay. Now, you're -- and then I'm getting back to this idea of settling down after the surgery. You are not saying that you would expect it to take a year to recognize a problem, your ability to smell would be compromised by a surgery so that you wouldn't know, but you wouldn't know it for, you know, a year, give or take?

A. When a surgeon performs a rhino -- I'm going to have to -- you're going to object that I'm not answering the form of the question or whatever, but I just have to say it this way.

Any surgeon who does, sort of, any operation, any facial operation, rhinoplasty, it's widely practiced, widely accepted, that it takes a year to fully recover from a facelift, a rhinoplasty, et cetera.

And I say that to virtually all my patients, and virtually all plastic surgeons say that to virtually all their patients.

Now, I've never -- I've done a thousand nasal procedures and, like, never had a case of anosmia. So when we are explaining to the patient that it takes a year, we don't say it takes a year for the smell to come back. I mean, her -- her anosmia, I've already concluded that it didn't come from the surgery, but what we're referring to is soft tissue swelling, return of sensation, normal mobility. That's what we talk about taking a year. Lumps and bumps, irregularities, little minor imperfections, or maybe potentially developing infection, all that takes a year until it's considered essentially stable enough where you have to make a decision as far as whether to proceed.

I mean, we got to -- we got to wait a normal waiting period of about six weeks to decide whether we have to do a reduction of the nasal fracture. You wait a year after rhinoplasty to see whether revision is necessary.

I didn't discuss or consider her sense of smell until she brought it to my attention, so that the one-year waiting period all pertains to the rhinoplasty

and fracture reduction outcome.

Q. Okay. And let me, for the record, make that objection about the responsiveness and the -- and that testimony. Again, that's just a legal point that I need to note on the record.

A. I understand.

Q. But what I'm asking you is, we talked about what those records from Charleston ENT say about when she first noticed it, and let's just pick the -- you know, again, I'll even pick the middle number, between -- we went through the math exercise, and it came up with two years before Dozier's and eight months before Hester's and six months before Ghegan's and all that, but, you know, the middle number of those, I guess, would put you into August of 2012. Again, just we're talking for the sake of choosing some sort of approximation.

If you're looking at -- there's -- it's not -- if -- if there's -- well, those are saying -- I mean, we're on the same page. They're saying that she doesn't -- she's not aware, she doesn't know that she's lost her sense -- had a problem with her sense of smell or taste until, you know, about a year after the surgery from the fall?

MR. GRUENLOH: Objection. Calls for speculation.

A. I apologize.

MR. GRUENLOH: My objection is you're asking the doctor to testify what those doctors meant by their note, and so my objection is that it calls for speculation, just for the record.

MR. HINES: You know, I'll withdraw that question. That's fine.

BY MR. HINES:

Q. Doctor, would you expect someone who lost their sense of smell by virtue of a traumatic event that occurred on June the 6th of 2011 and then, as Ms. Connelly did in this case, had surgery, would you expect a person like that to have had this traumatic loss of smell on June 6, 2011, and then to have -- let me make sure I'm making this question -- let me start this again.

A. I think I liked your -- keep going. I think I liked your question.

Q. Well, it's probably so jumbled. I guess what I'm saying is --

A. You're doing good.

Q. -- here I'm asking you this, well, by way of

hypothetical.

I don't mean to cover my microphone, but I'm trying to line up the dates, rather.

In the event that there was a traumatic injury that caused a loss of smell on June 6th of 2011, and, you know, a surgical -- a surgical procedure, the same surgical procedure you performed on August 24, 2011, would you expect the person, would you expect a person not to know that they had lost or had any damage to their sense of smell? Would you expect them not to know that until August of 2012?

MR. GRUENLOH: Objection. Calls for speculation. An incomplete hypothetical.

A. I honestly think that's plausible and really not that shocking, and I'll tell you why. Because, you know, if a person lost a sense of sight or sense of hearing, it would immediately become knowledgeable, but if a person had a substantial loss of smell, I can imagine a scenario how it would occur like that.

I -- might as well object to outside of the realm of the question or whatever, but I was -- this is a neurological injury. Okay? The loss -- her loss of smell, it's not a mechanical problem. It's an injury to the olfactory nerve. It's a neurological injury.

And I'm a surgeon. I work with my hands every day. I operate every day. And I was playing hockey. I got thrown onto the boards. I had an 80 percent compression of my cord. Got knocked out. But I didn't realize that I had a spinal cord injury. And I continued to work. I was having a lot of pain, and the pain was what was bothering me, and I was getting massages and I was having lidocaine injections, but I never saw a neurosurgeon.

I need to finish this. Okay? And -- because -- and I would talk to neurosurgeons. They would say, "Any weakness?"

And I would say, "No."

Now, I'm a pretty strong guy still, and I used to be really strong, lift a lot of weights. It took me several months before I finally went to see a spine surgeon. He asked if I had any weakness. I said no. He tested my weakness, and when he tested my left hand, it was strong, and when he tested my right hand, he pushed it right down, and I was stunned. I was continuing to play hockey. I was continuing to play. It took me three months to recognize that I had about a 70 percent weakness of wrist flexion, and I'm a surgeon that operates with my hands.

And it's fact. Get the -- subpoena the medical records. And so a person can have a neurological injury. Now, in her case, she was -- she could -- she has substantial hyposmia. Okay? She could smell 12 out of the 40. She can't smell 28 out of the 40 or something like that. So she still has -- you know, if you -- if a skunk went in front of her, perhaps she would have some perception, but she's -- she's lost her sense of smell to the majority of items that Dr. Dozier tested.

And so I really don't, honestly, in my heart, have an issue with it taking her some time to come to terms with it. You know, when we have a cold and we have tremendous nasal stuffiness, we experience either anosmia or substantial hyposmia. We might notice that food tastes a little funny, but our chief complaint is our headache, our nasal obstruction, and the fact that our sense of smell is profoundly reduced to us is not really forefront in our mind.

And after a rhinoplasty you have a lot of extranasal swelling. We talked a lot about extranasal swelling, but there's also intranasal swelling. And so if we did a smell test on a bunch of my rhinoplasty patients a month after their rhinoplasty, they would

probably have diminished smell.

Q. Doctor --

A. And so that the time frame of this just doesn't, doesn't call me into question the fact that she has anosmia now, and I can't come up with any other plausible explanation. It wasn't my surgery. It's not a sinus infection. I can't, in my mind, envision any other -- in all honesty -- envision any other possible cause of the anosmia that Dr. Dozier documented, and I believe Dr. Dozier's statement.

Q. Okay. And, Doctor, I do need to make an objection to that question for the -- for record purposes to the extent it's nonresponsive and, well, not relevant. And, you know, anyways, that's just for the legal wrangling that we may need to do later.

A. I understand.

MR. GRUENLOH: Not to be disruptive, I obviously disagree with that. I think that he's attempting to answer the question the best of his ability, and we'll just take that up before the judge. Excuse me.

Q. I guess, you did say extranasal swelling and then also intranasal swelling?

A. Yes.

Q. What's the difference between those two things?

A. You know, the framework, like, the tent poles of a nose, is primarily the bone and the cartilage, and there's layers and layers of soft tissue on the outside, there's a layer of soft tissue on the inside. After a nose job, when you look in the mirror, you see your nose is full. But we're not used to looking up our nose. We're not used to looking at certain obscure areas of our body. We're not -- we don't have a concept of what the inside of our nose looks like.

And so I have to explain this to patients after I do any kind of nose procedure. Whether it's a cancer or anything, they always complain of some stuffiness. If I do a skin cancer on the outside, they're always stuffy on the inside for a while, and I reassure them that that can take months to resolve. Older folks, who maybe their cardiopulmonary efficiency is not as good. If you're a young buck and you're in good shape, you run, you have a lot of cardiopulmonary reserve, whereas if you're an older individual and you have atrial fibrillation and your lung capacity is diminished, those people are really -- if I do a nose cancer on the outside, I don't even go on the inside of the septum or the turbinates or anything, if I just do a little skin

cancer on the outside of the nose, remove the skin around, those people will complain of nasal obstruction for several months, increased snoring and stuff like that, and then that gradually -- that -- I reassure them that it resolves, that I didn't violate their intranasal volume.

Q. Okay. Okay. Just -- is extranasal swelling something that -- I mean, does one or the other of those, intranasal versus extranasal, would one be more likely than the other to have an issue with the ability to smell?

A. Yes. Intranasal.

Q. So when we're talking about smelling -- so I guess the point I want to make is, when we're talking about swelling and also talking about smelling, that the type of swelling that is most important with respect to the sense of smell is intranasal swelling?

A. That's correct. I agree.

Q. And so some of the swelling you've talked about in Ms. Connelly's case, for instance, the massive -- you know, the fairly massive swelling that was noted, was that intranasal or extranasal swelling that would be --

A. Both.

Q. Okay. Both. And that was back all the way to

June of 2011; right?

A. Correct.

Q. Let me ask you to grab your deposition, if you would. I want to go to page -- to page 81, line 20. And are you there now with me, Doctor?

A. Yes.

Q. If you'll begin -- well, I don't know. Please, just if you'll read for me the question and -- if you'll bear with me, it's a long answer, but I think, if you'd go all the way, there's actually a series of questions and answers I need to get you to read for me all the way until page 84, line 7, please.

A. Okay. So you want me to read from page 81, line 20; right?

Q. Yes, sir.

A. To where?

Q. To page 84. And I apologize for the discussion, well, it comprised a few pages here, but all the way to page 84, line 7. This is --

A. Read it aloud, or silently?

Q. Read it aloud, please, and read it into the record.

A. Okay.

MR. GRUENLOH: Before he does that, I'm just

going to make an objection to reading four pages of testimony when I'm not exactly sure that there's a question or that you're doing this for the purpose of impeachment. So my objection for the record.

A. Okay. So this is a question --

MR. HINES: And I'll make the point I'm doing this for the purposes of impeachment on the point we've been discussing about the -- well, about the timing. That's all I'll say on that.

BY MR. HINES:

Q. If you would, Doctor, just read page 81, line 20. Begin there, and all the way --

A. Keep going?

Q. All the way. Keep on going, if you would, all the way to page 84, line.

A. Okay. Question. Just for my purposes, this is a question. Which one of you guys is asking this question?

Q. This was --

A. This is your question?

Q. -- plaintiff's counsel's question to you. It wasn't my question.

A. Okay.

Question: "If someone can't smell, can't inhale in their nose, through their nose, because there is swelling, congestedness, is that -- does that make sense that they wouldn't be able to notice whether or not they had lost their sense of smell if they can't breathe in?"

"Mr. Hines: Object to the form."

"The witness: You know, you know, oh boy, oh boy, that's, like, a clever question. That's, like, freaking clever. But, to be honest with you --

"Mr. Gruenloh: I mean, doesn't it stand to reason that if you can't inhale, you can't smell?"

"Mr. Hines: Object to form."

"The witness: What do we call those? Here again, I'm going to just do this honest. Okay. Like, if someone made a living where those Somalia guys or whatever, Somalia or whatever, so if someone has a --"

Somalia? I didn't say Somalia.

Q. Is it possible that you meant sommelier, like someone who -- who is --

A. Oh, am I mis -- I don't know how sommelier is pronounced.

Q. I can promise you that my wine knowledge is --

is next to nothing, but just in context, if you keep on reading --

A. Okay.

"So if someone was a sommelier or a guy who picks cocoa beans for Nestle's or whatever, where his sense of smell was, like, his thing, I could kind of see how because, I've had people who are Broadway singers worry about nose jobs changing their voice, you know, like a gourmet, you know, relying on their voice or their sense of smell, that messing with their digestive tract might impact that."

And I bet I didn't say digestive tract.

"But from all my time doing nose jobs, I have tons of women fret about how their nose looks at three months and then be happy at 12, because a lot of the exterior swelling goes down. Because I've never had somebody come in and say, 'I really' -- but there is, darn right, you're right that there is some intranasal swelling, because if I do a skin cancer on patients on the outside, I don't violate the inside nosing."

I mean, I know I didn't exactly say that.

"But if I do a big flap on the outside in these

older people whose septum was gotten even more crooked and their heart-lung deficiency is diminished, they'll complain of more snoring and stuff like that. So there is that phenomenon. But I have never had somebody -- so I do have patients come in and say that "swelling on the outside of the nose bothers me because of the way it looks," but I have never had somebody come in three months and say, 'I'm really worried because my smell is bad and I've had this.'

I've never had to say to somebody, 'Man, your sense of smell is down.'

And that's because of intranasal swelling, and it will go away in a year. You know, I don't see that as a clinically common occurrence, that intranasal swelling."

"Mr. Gruenloh: If she had swelling for -- as a result of the surgery as a result of just regular congestion, would you agree with me that if she can't inhale through her nose, she can't smell?"

"Object to form."

"Like, I have a hard time, because if you can't -- to me, if you can't inhale through your nose, that means there's a clothespin on your nose,

and, yeah, you can't smell."

Q. Doctor, thank you for bearing with me with -- with reading that.

Well, to try to connect that to what we were just talking about explicitly, I mean, that was a discussion that you had during your deposition with plaintiff's counsel; right?

A. Correct.

Q. And, I mean, you were -- did that not indicate that you had a hard time with the idea that intranasal swelling -- we talked about intranasal swelling being the type of swelling related to smelling -- that that being an issue, you know, all the way up to, you know, a year after surgery preventing somebody from being able to smell?

A. Can you rephrase that question concisely?

Q. Well, maybe like this: Didn't you have a problem at the time of the deposition in this case back in May with the idea of of someone not being able to know they had -- they'd lost or had, you know, an injury to their sense of smell and taste so long after the -- the event that they were saying caused it?

A. At that -- yes, but at that time, the last thing I would want to do is to mislead anything or speak

anything that would lead to an unjust outcome in a proceeding such as this. I mean, that is the last thing. That's something that I -- you know what I mean? This is a -- this is important to me. You know, I pray and say, "God, let me speak the truth and let me just speak clearly so that, you know, that justice can be rendered in this case."

And, you know, but -- and at that time I wasn't -- that wasn't what I was -- I wasn't in a -- I didn't come into that deposition anticipating that I was going to have to say did the -- that I was going to be asked to be, like, asking -- asked those type questions, am I going to be asked did this cause her anosmia and stuff like that. I just thought it was going to be about the nose job.

So I hadn't really put enough thought into it, you know, to -- to render a firm conclusion. There's times when you -- when you need a little bit of time for reflection and stuff, and what's happened is that this case is four years out, I had kind of forgotten about it, and since that time I've had time to, you know, think over -- think over the case. I've had a chance to look at Dr. Dozier's notes.

The discussion that I had with the plaintiff's

attorney before this meeting when he related to me the story of Rosemary not appreciating an objectionable smell in her refrigerator, I'm not a lie detector, but I don't see the plaintiff -- and I don't know the plaintiff that well, or her daughter. I've done surgery on both of them. It's kind of an intimate thing to do surgery on people. I don't picture either of them as liars. I actually don't. And -- and, I mean, her daughter doesn't have a dog in this fight, and if -- and if they relate in their testimony -- I haven't read their depositions, I hope I never have to, because I don't have time, any more time to spend on this -- but if they relate a story of, you know, her not noticing the smell, and with my history of not noticing my weakness and stuff like that, I really have become more confident and more convinced as -- in reviewing these cases, in discussing this situation for hours and hours, I have become more convinced that I couldn't come up with -- that she has anosmia, based on Dr. Dozier's report, and I cannot come up with any reasonable, plausible explanation for her having anosmia other than this injury. I just can't come up with any kind of realistic scenario. Not sinus infection. Not this instrument. Not her surgery.

As a man, and as a surgeon, and as an otolaryngologist, and as a facial plastic surgeon, I would be hard-pressed to come up with any other plausible explanation as for Dr. Dozier's findings other than this injury. Would it be easier to -- if two months later she had said, "Oh, by the way, I -- my taste is diminished and I didn't smell my husband's flatus, and is there something wrong," that I probably would have looked in there for nasal swelling and had her smell some coffee, and if there was a vague response, I would have said, "Well, let's check it again in four months.

And then after that, I might have considered either getting a CT myself or sending her to Charleston ENT. You know, with this -- with this whole question about whether it's causal, would it be easier to resolve and more convincing and might have become convinced earlier on in the process? Yeah, but -- but I honestly -- you know, no one's gotten to me. No one's bribed me. I'm like this -- it's my -- it's my honest -- it's my honest belief.

And I'm pretty -- in a pretty good position to know. I don't -- I don't have -- in spite of all -- all the objections, I really -- I really feel comfortable

saying that -- and I know it's not what you want to hear, but -- but I don't have -- I don't have a dog in this fight, you know, and I'm willing to stay here, like, as long as it takes and answer any -- any questions you've got honestly, but I honestly believe that she conked her head.

After her last -- like I said, I wasn't coming in there prepared to testify, like, as an expert on anosmia and stuff, but after I did that, I've done some research. I've, you know, looked to say, hey, is there some article that's come out in the last six months or something that -- you know, but in my research on anosmia, it can come from lesser trauma than this. It can come in the absence of a fracture.

And she clearly sustained a frontal rapid deceleration of sufficient intensity. No one could -- no expert could doubt that she did sustain a frontal deceleration of sufficient magnitude to cut her olfactory filaments, and I can't come up with any other explanation for it. I just -- I just -- your questions are legitimate.

Q. That's one -- I guess, maybe to try to get briefly on one thing that you -- that you mentioned just there, which was, I mean, you would agree, in terms of

trying to -- to figure out the relationship, if any, between the fall in June of -- June 6th of 2011 and the smell and taste issues that Ms. Connelly has raised in this lawsuit, you know -- well, the timing issue about her -- when she sought treatment and what the records indicate about no other condition, it makes things -- it makes it hard.

A. I agree with that. I agree with that. I mean, it would be -- we probably wouldn't be here if three months later it had happened like that, but that's not the way it happened. And -- and -- but after -- after hearing Dr. Dozier's -- after reading Dr. Dozier's report and after hearing that Mary and her daughter testified under oath about the refrigerator incident, if -- if that representation that the plaintiff's attorney gave me in regard to that is anywhere near close to what I -- what I feel like I heard, then I have a high level of comfort that there's really no other, like, plausible explanation for her having the anosmia that Dr. Dozier documented.

Q. And what you mean by that is you're not aware of another plausible explanation; right?

A. I'm not aware of it, and I can't even conceive of, like, another.

Q. For instance, if -- this case, plaintiff's -- the plaintiff's lawyer also sent you the deposition transcript of Dr. Rodney Schlosser from MUSC; right?

A. Correct.

Q. But you're not sure about any plausible explanations -- excuse me -- about any explanations that he may have given in that deposition that were other than the fall?

A. Well, I mean, you know, it could be idiopathic. What are the possible -- like, if I was retaking my boards and they said what are all the possible causes of anosmia, you know, I could say idiopathic, intracranial tumor, intranasal tumor, trauma, medication, multiple sclerosis, a rhinoplasty where the doctor didn't have a guard on his osteotome and he was an evil doctor who wanted to hurt somebody and plugged the CSF leak with chewing gum.

I mean, you know -- you know, there's a -- there's a lot of other -- there's other possible causes, but I don't -- I don't -- I don't -- realistically see under the -- in the totality of all this information how one of those other things could have caused it.

Q. Have you seen --

A. I mean, it's kind of like a murder thing where

somebody's shot and there's a guy with a gun and there was nobody else in the whole house.

I mean, if I didn't -- if you didn't see him pull -- you know, drug abuse, cocaine. I mean, I don't -- you know, why don't -- you know, contaminated cocaine or something, you know, that would -- I mean, all those -- the likelihood of any of those other scenarios, with the timing of this, even though it's a year, would be -- it would be more comforting to me and I would have, you know, come to this, like, this level of confidence in my opinion, I would have come to it more quickly if I did not have those totality.

You know, does it help me believe it that she's trying to get some money out of this deal? No. Does it help me to believe it that it took a year? No. Does it -- you know -- do you know what I'm saying? I consider the totality of all those -- all those things in my opinion, but I just can't come up with -- I wish she never fell, you know.

Q. Certainly, but you -- I guess, just to try and wrap it up, and, again, I appreciate your time. But as far as -- for instance, it seemed like you indicated just now that at the time you gave your deposition in this case back in May, you know, well, there were a

number of things that -- you've testified about them, I think, just now, but you weren't in, really, a position in May when you gave your deposition to -- well, to speak with, you know, with -- with confidence about --

A. I'm in a much better position now than I was back then.

Q. And you've talked about the things that you've done since then that in your -- in your view has allowed you to --

A. I've had time to reflect. I've had time to -- yeah, you know.

Q. Okay. I mean, but just to make sure that I understand this, in terms of your experience with anosmia, you know, the loss of smell, as that being one of your patient's chief complaints, I mean, in fairness, that's not something that you've -- you've dealt with a lot in your practice? I mean, isn't that what your testimony is?

A. In my private practice, I've not dealt with anosmia. That's absolutely true.

Q. And when you were talking about -- at one point about, I think, maybe coffee or, you know, you mentioned -- you were talking about if one of your employees had come to you, somebody who worked with you,

and was complaining about a smell issue, about the things you might do to, sort of, look into it. Does that -- that comes from back in your days -- I don't know if the word is, you know, residency or what, but, you know, that was --

A. Right.

Q. -- some -- maybe a couple decades ago in terms of the way that anosmia might have been tested for at that time; is that right?

A. That's true. However, the essence of the test -- you know, the sophistication and the extent of the test has changed somewhat, but the essence of the test hasn't changed. I mean, it's not that long ago. It's not like there's been a lot of research papers published on anosmia compared to, you know, the changes in breast cancer and the changes in sinus surgery and all these other things. There's been a lot of monumental shifts in my field of plastic surgery. The injectables and neural modulators. There's been a lot of changes, but there hasn't really been a lot of changes in the, you know, field of traumatic anosmia or anosmia of other causes.

In therapy and diagnosis, there hasn't been a lot of changes. There's a more widely accepted test.

But, you know, in terms of the field of anosmia and hyposmia, yeah there's a more comprehensive, more standardized test now, but really not that long ago in terms of the development of the field. If you went to the Medical University, the chairman of otolaryngology, head and neck surgery, ENT, at Medical University of South Carolina, they would have done essentially the same tests but with a fewer number of variables, and it would have been the same.

And another thing that made me feel more comfortable with my thing is that when -- you know, I try to stay out of depositions. I try to stay out of litigation and stuff, and I always try to separate it. I don't try to ever get into whether the dog was on a chain that bit the little girl. I try to -- I try to stay as far away from that and just focus on the patient and try to answer what -- you know, confine my involvement to what I know.

But when -- when -- in reading some of my notes and cursorily reading the Charleston ENT notes, I mean, I don't know at what point I became aware that there was possible litigation or litigation in this, in this whole thing, when I would see her and stuff like that. If a patient would disclose or not disclose it to me, I don't

even get into that. I just try to do my job as their doctor the best I can, as honestly as I can, and I try to document it somewhat accurately, but I don't try to ever, like, sway it in my patient's favor or get something. I don't pass any judgments in what I do, and neither does Charleston ENT.

But -- but of all these doctors that have seen her and examined her, none of them have ever, like, kind of indicated that there was some malingering. And I occasionally do see patients where I clearly can, you know, conclude or have a strong feeling that they're malingering. And I've never got that sense, and I don't get that sense in any of my notes that I read, when I contemporaneously wrote them, and I don't get that sense in any of the notes from Charleston ENT. And that's part of -- that's part of my -- you know, I know Dr. Dozier. He's a -- he's an honest physician who would not --

Q. Okay.

A. Honest man.

Q. But you would agree that, you know, under the facts of this case or the information that's available in this case that it's possible for there to be an honest disagreement as to -- as to any relationship

between the fall in June of 2011 and -- and the smell and taste condition that the plaintiff has raised in the case?

A. Boy, I mean, the only way -- under any circumstances and facts and timing of stuff, it would be a difficult thing to prove. I mean, I guess the only way to do it would be to have one doctor do a smell test on the person on Day 1, and on Day 2 slam their head into a wall, and then on Day 3, you know, or 4, or one week, or one month, or, you know, six months later, three months later do a smell test, compare them, and then probably get an MRI with contrast to show whether there was signs of inflammation or microhemorrhage in the area.

Do you see what I mean? To try to prove this, you know, unequivocally that there was a contemporaneous relationship. And I think that's probably rarely -- that's never available. You know, that's not the real world. That's not the real world.

Q. And, also, in this particular case, in terms of what we've talked about, we've talked about timing, we've talked about things, you know, that -- well, there are reasons where, you know, reasonable honest minds can --

A. Might have a genuinely sincere question, and I'll grant you that. Yeah. Yeah. But -- yeah, but -- and so -- and so I guess what you have to do is just have everybody express. And like I said, I don't -- I don't have a dog in this fight, you know. I hate litigation. I hate injuries.

MR. HINES: I understand, Dr. Funcik. Thank you for your time. I don't have any more questions right now.

THE VIDEOGRAPHER: Five minutes left.

REDIRECT EXAMINATION

BY MR. GRUENLOH:

Q. I'll be very brief. You have your deposition in front of you, Doctor?

A. Yes.

Q. All right. I just want to ask -- I just want to follow up on this point that Mr. Hines has made that there's been some great change in your testimony today as opposed to your testimony from when you were giving your deposition.

And I'd like you first to turn to page 66 of your deposition. Do you have that in front of you?

MR. GRUENLOH: And, I mean, some of these answers go on for pages, and to save time, I'm not

going to go through the whole thing. Russ, if you want to go through and come back through, that's -- that's fine.

Q. But what I'm going to direct you to, Doctor, is page 66, line 3, of your deposition, the sentence that reads, "And I believe," and if you could read along with me.

"And I believe, I mean, I can say with -- like, I'm very comfortable saying that she banged her head forward, and there's nothing else in this, not her surgery, or any surgery I have done, or anything else, that could, like, remotely -- I really don't personally feel any doubt that if she has anosmia, that it came from this injury. I really don't doubt. Like, there's no reason to doubt that."

Have I read that correctly?

A. Yes.

Q. Was that your opinion on that date?

A. Yes.

Q. Is that your opinion today?

A. Yes.

Q. All right. I'm going to turn to page 89 of your deposition. All right. Looking at page 89, line 6, again, the answer that spans the course of three

pages, but if you look at line 6 to line 9.

"But if she has hyposmia, I can't conceive of anything else that could have possibly caused it, other than the frontal trauma, enough to break a nose."

Have I read that correctly?

A. Yes.

Q. Was that your opinion on that date?

A. Yes.

Q. Is it your opinion today?

A. Yes.

Q. All right. I'm going to turn -- ask you to turn to page 99 of your deposition.

My question to you. All right. So -- excuse me. This is at line 17. Page 99.

"So where we leave things with you, essentially, is that you're unaware of any other possible causes of the anosmia other than the fall; correct?"

And your answer was? Can you read that into the record?

A. "I'm very comfortable saying that."

Q. Okay. And then, finally, at page 122 -- excuse me -- 121 of your deposition, towards the bottom, if

you'd look up at page -- line 14.

"You said before you walked in here, you mentioned to somebody that you were giving a deposition about somebody who had a lost sense of smell because they fell; right?"

Your answer: "Right."

Question: "Is that what you believe?"

An objection by Mr. Hines.

"Is that what happened before I came in here?"

"Mr. Gruenloh: No."

"That Rosemary Connelly lost her sense of smell because she smell? Because she fell. Excuse me."

And your answer was what?

A. Yes.

Q. All right. Was that your opinion on that date?

A. Yes.

Q. Is it the same opinion you have today?

A. Yes.

MR. GRUENLOH: All right. I don't have any further questions.

THE WITNESS: I just feel more comfortable with it now after. We've spent more time on this deposition than I spent doing her rhinoplasty.

MR. HINES: Mike, I do want to do just a little bit of recross on that -- on that point.

THE VIDEOGRAPHER: We've only got two minutes left, so you want me to take this -- change it out?

MR. HINES: You know, I think I can do it in two minutes.

You know what? That's fine. That's probably hopeless. Go ahead and change out.

THE VIDEOGRAPHER: This is the end of Tape No. 3 in the videotaped deposition of Dr. Thomas Funcik. The time is 8:57 p.m. We are off the record.

(Recess from 8:57 p.m. until 9:03 p.m.)

THE VIDEOGRAPHER: We are back on the record. The time is 9:03 p.m. This is the beginning of Tape No. 4 in the videotaped deposition of Dr. Thomas Funcik.

RECROSS-EXAMINATION

BY MR. HINES:

Q. Dr. Funcik, very briefly, to address what was just asked about by plaintiff's counsel, you went through a number of different pages in your deposition, and if you would, please, turn with me to page 73 of your deposition.

And I'll read this, and I just want

to -- I just -- I want to read this so that it's -- the point that you and I were discussing, I think, is also addressed here and under -- underscored here. Highlighted here.

At page 73, line 24.

"I believe that that's, yeah, correctly stated in terms of those dates. The accident was, you know, it was in June of 2011. The surgical procedure in August of '11. And then if you -- based on the note that I've showed you there from Charleston ENT, it would seem to indicate it was -- this issue of smell and taste was noticed in August of 2012, approximately a year after the surgery.

The point of me making that or pointing that out is to say, Doctor, does that give you -- does that give you pause in -- in offering an opinion about the relationship the fall and the smell and taste issue?"

And the answer, beginning on line 13 is:

"Yes. Yeah, I mean, now, that's a limited number. I didn't ask her about the history or the smell or did you have, you know -- yeah, it doesn't. To me, it doesn't really add up."

And that ends on line -- the part that I've --

you know, it goes on and on, and that's one of the things about these, some of the answers, but I'm stopping there on line -- at that point on line -- page 74, line 17, to make the point.

What you and I were discussing was -- again, the timing issue was something that -- that is -- well, it's a troublesome aspect of -- of trying to understand any relationship between the fall in June of 2011 and the smell and taste issues that Ms. Connelly has raised in this case?

A. Yeah, you asked me if it gave me pause, and I answered honestly that at that time it did give me pause, but the scenario of the discovery with the refrigerator, my reflection on my own case where I didn't realize that I had a neurological injury, you know, of a substantial loss of strength, even though I work with my hands as a surgeon, it no longer gives me pause. You know, it no longer gives me pause.

Q. Okay. And for those reasons that you just -- that's your reasoning on that, but -- but even if it no longer gives you pause, I mean, you would agree, in fairness, that -- that, well, that it's a troublesome aspect of trying to -- to feel -- of trying to make the connection and to evaluate any connection

between the -- the fall and the smell and taste issue that Ms. Connelly's raised in this case?

A. Yes, because, like I said, there's not -- there's -- nobody's had 50 cases of traumatic anosmia where it's become an issue and where it's been so focal, other than just a visit with the patient. You know, if a patient fell down their own stairs and there was no litigation and they showed up a year later, like, that's a -- this is very hypothetical, but if a -- if a person just came to me, I went back into general ENT, and a person came to me and said, "Hey, I fell down my stairs and nine months ago all of a sudden I open up the refrigerator and I didn't notice anything, but my daughter said it smelled bad, how could you live with that in your refrigerator, Mom," and, you know, so I got out some coffee beans and she didn't smell it, I got out some lemon and she didn't smell it. In the scenario if there was no litigation, nothing at stake, then I wouldn't say, "Are you kidding? For nine months you didn't notice, you know, that you didn't -- that your smell was gone or diminished," or something?

I wouldn't really -- I wouldn't really think that person was, you know, crazy or slack. I mean, I would certainly think that -- I might notice it a little

sooner, but -- but I really don't know. You know, I mean, and smell is a thing that you adapt to. I mean, when you walk into someone's house and they have pets or dogs or something like that, smell is a pretty -- of all the senses, it's pretty subjective and hard to quantitate.

MR. HINES: Thank you, Doctor.

REDIRECT EXAMINATION

BY MR. GRUENLOH:

Q. I just have one last question. You -- you talked earlier about -- and don't let me misquote you but, you said, you know, this is kind of like a murder thing where someone got shot and there's only one person with the gun. And I want to make sure that I understand.

In that analogy that you gave, the person that got shot was Rosemary Connelly; right, and the only one with a gun, were you referring to the trauma?

A. Yes.

MR. GRUENLOH: All right. I don't have anything further. Thanks.

MR. HINES: I'm finished. Thank you.

THE VIDEOGRAPHER: This is the end of Tape No. 4. It concludes the videotaped deposition of

Dr. Thomas Funcik. The time is 9:09 p.m. We are off the record.

(Whereupon, the deposition concluded at 9:09 p.m.)

CERTIFICATE

I, the undersigned, Elaine L. Grove-DeFreitas, RPR, Notary Public, in and for the State of South Carolina, do hereby certify that the foregoing deposition of Thomas Funcik, MD. was taken on the 19th day of August 2015.

That the within deponent was sworn to tell the truth, and that the foregoing is an accurate transcription of the testimony taken under oath.

That all exhibits entered herein are attached hereto and made a part of this deposition.

I further certify that I am neither counsel nor solicitor to any of the parties in said suit, nor interested in the event of the cause.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this 21st day of August 2015.

Elaine L. Grove-DeFreitas, RPR
Notary Public for South Carolina
My Commission Expires: 6-25-2020

STATE OF SOUTH CAROLINA — IN THE COURT OF COMMON PLEAS

COUNTY OF CHARLESTON

- - -

ROSEMARY CONNELLY, Plaintiff, : CIVIL ACTION NO. 2013-CP-10-3251

vs.

WINSOR CUSTOM HOMES, LLC., DANIEL ISLAND COMPANY, INC. CLARKE DESIGN GROUP, LLC, KAREN A. NELSON & JOHN W. EDELEN, Defendants,

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VIDEOTAPED DEPOSITION OF MARK D. GHEGAN, M.D.

DATE TAKEN: FRIDAY, AUGUST 21, 2015
TIME BEGAN: 1:18 P.M.
TIME ENDED: 3:03 P.M.
LOCATION: YOUNG, CLEMENT, RIVERS, LLP
25 CALHOUN STREET, SUITE 400
CHARLESTON, SOUTH CAROLINA 29401

REPORTED BY: DEIRDRE J. WEYER, RPR

APPEARANCES:

GRUENLOH LAW FIRM
BY: Wm. MICHAEL GRUENLOH, ESQUIRE
192 East Bay Street, Suite 202
Charleston, South Carolina 29401
843.577.0027
mike@gruenlohlaw.com
Representing the Plaintiff

YOUNG, CLEMENTS, RIVERS, LLP
BY: RUSSELL G. HINES, ESQUIRE
STEPHEN L. BROWN, ESQUIRE
25 Calhoun Street, Suite 400
Charleston, South Carolina 29401
843.720.5488
rhines@ycrlaw.com
sbrown@ycrlaw.com
Representing the Defendant

I N D E X

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E X H I B I T S

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(All exhibits were retained by counsel.)

(Deposition Exhibit Numbers 2, 3, and 4 were marked for identification.)

THE VIDEOGRAPHER: We are now on the record. My name is Len Harris. I'm the videographer for Golkow Technologies. Today's date is August 21st, 2015, and the time is approximately 1:18 p.m. This video deposition is being held in Charleston, South Carolina, in the matter of Rosemary Connelly versus Winsor Custom Homes, LLC, in the Court of Common Pleas, State of South Carolina, County of Charleston, Case No. 2013-CP-10-3251. The deponent is Dr. Mark Ghegan.

Counsel, would you please identify yourselves for the record?

MR. HINES: Rus Hines for the Defendant, Winsor Custom Homes.

MR. GRUENLOH: Mike Gruenloh for the Plaintiff, Rosemary Connelly.

THE VIDEOGRAPHER: The court reporter is Deirdre Weyer. Would the court reporter please swear in the witness?

- - -

MARK D. GHEGAN, M.D.,

after having been first duly sworn, was

examined and testified as follows:

- - -

MR. GRUENLOH: I just want to start by saying thanks for your hospitality today, Rus and Steven, for hosting this deposition here and for agreeing to take Dr. Ghegan so that we don't have to mess with the schedule next week. Thank you very much for that.

MR. HINES: You're certainly welcome.

- - -

DIRECT EXAMINATION

- - -

BY MR. GRUENLOH:

Q Good afternoon, Dr. Ghegan. How are you?

A Good. Good.

Q Can you please tell the jury your name and what you do for a living?

A Mark Ghegan. I'm an otolaryngologist, ear, nose, and throat surgeon with Charleston Ear, Nose, and Throat.

Q And how many offices does Charleston ENT, Ear, Nose, and Throat, have in the Lowcountry?

A Ten, I think.

Q Where is your office that you do most of

your work at?

A Primarily in -- we have two offices in Mt. Pleasant, so I'm primarily in Mount Pleasant.

Q How long has Charleston Ear, Nose, and Throat been treating patients here in the Lowcountry for problems with their noses, their ears, and their throats?

A Under the name Charleston ENT, I think over 20 years. Some of the founding partners are longer than that.

Q How long have you been treating patients here in the Lowcountry for ENT issues?

A Over 10 years. Part of that was with residency at MUSC and then six years in private practice -- seven years in private practice.

Q All right. You've led me into it perfectly. I was going to ask the jury to tell us a little -- for you to tell us a little bit about your education, training, and experience. So could you sort of take us through where you went to medical school all the way through your training up to the point that you began working at Charleston ENT?

A Sure. I did medical school at Medical College of Georgia in Augusta, Georgia, and did

residency in otolaryngology, head and neck surgery, at MUSC, which is a five-year residency. The first year is mostly general surgery and then four years of ENT. Did private practice in Atlanta for one year and then have been back in Charleston since 2009.

Q Great. And how did you do in medical school?

A I did well.

Q Don't be bashful, Doctor. Were you at the top of your class?

A I was. I finished No. 1 in my class.

Q All right. Let me ask you with respect to your clinical experience, is part of -- is part of what you do as an ENT doctor to examine people's noses for the purpose of determining whether or not they have smell disorders?

A It is.

Q All right. How long have you been doing that?

A Since starting residency.

Q I don't want to go into it right now but I want to ask you, Are you familiar with the mechanics of how a blow to the head can cause what we call anosmia, or loss of sense of smell?

A Yes.

Q I skipped this, but are you board certified in anything?

A Board certified in otolaryngology, head and neck surgery.

Q What does it mean to be board certified in those issues?

A It means you've completed the residency, which is a five-year residency, and then you've taken oral and written certifications.

Q Okay. You mentioned that you were familiar with the mechanics of how someone can get or suffer a loss of sense of smell as a result of a blow to the head. Can you tell us generally how you've come to that knowledge?

A Through a combination of medical school, residency, and then just, you know, experience and being in private practice ENT.

Q Is it within the scope of what you do at your practice to diagnose disturbances of a person's sense of smell, or anosmia?

A Yes, it is.

Q Is that one of the reasons that Rosemary Connelly came to see you at Charleston ENT?

A I believe so, yes.

Q Are you aware of anything that you saw Rosemary for at Charleston ENT, you personally, other than trying to figure out what was going on with her sense of smell?

A Not that I'm familiar with.

Q And just to be clear, I've not hired you in this case as an expert or anything like that, correct?

A Correct.

Q Do you understand that you are essentially here today as Rosemary's treating physician?

A Correct.

Q Now, I just want to go through a couple of the things that you've looked at in the course of going through the records and so forth related to Rosemary. Have you had a chance to skim through or read the deposition of Dr. Schlosser?

A I have skimmed through it.

Q All right. Have you had an opportunity to look through the medical records from Rosemary Connelly's visit to Nason Medical, records shortly after she fell?

A Again, yes, I've glanced -- I've skimmed

through it.

Q And have you had an opportunity to look through -- well, let me ask you first: Have you kept records regarding your treatment of Rosemary Connelly?

A Just what's in our system.

Q Let me pass across to you what has been previously marked as Exhibit Number 2, and just tell the jury if you recognize those records.

A Yeah, this looks like our -- our kind of new patient history and review of systems that the patient and the nurses fill out and then a copy of my note, April 4th, 2013, as well as some notes from some of my partners that she has seen in the past as well as copies of CT scan reports from our office.

Q Very good. So those are essentially your records -- or Charleston ENT's records regarding the treatment of Rosemary Connelly?

A Correct.

Q Did you, in fact, reach a medical diagnosis of Rosemary Connelly's complaints regarding smell when you saw her?

A I did.

Q All right. If you would, I'm just going

to ask you to turn to -- let's see. It's about the fourth page in. It bears the Bates stamp on the bottom, RMC79.

A Okay.

Q And can you tell us under "impression" what your impression of her was?

A Number 1, anosmia, and, No. 2, turbinate hypertrophy.

Q And have you based upon with your education, experience, and examination of Rosemary Connelly reached an opinion to a reasonable degree of medical certainty as to the cause of her anosmia?

A I have.

Q All right. We'll get to that in a bit. I want to go through some other things.

MR. GRUENLOH: And at this point, we would offer Dr. Ghegan as an expert on the medicine of ENT and on the treatment, diagnosis, and cause of Rosemary Connelly's loss of sense of smell and disturbance with her sense of taste.

MR. HINES: Just to help make the editing process perhaps easier with the video that we're on -- I was thinking we would go off the record.

Just let me ask something real quick of Steve.

(A discussion was held off the record.)

MR. HINES: When we're doing something via video for use at trial, I mean, it's always -- it's for use at trial and, obviously, or -- it isn't an evidence deposition or whatever, but it's a deposition.

So the point is I want to do the best I can to sort of not make anything needlessly difficult or more difficult. I mean, I'd like to preserve an objection to that on our record. I don't really intend to go -- and by the way, that's not an objection to him, Dr. Ghegan's credentials as an ENT. The point I'm talking about is whether or not a reliable opinion on causation can be given under the circumstances.

And I think that's a legal issue. I mean, after thinking a little bit more about it, I'm pretty comfortable that even an evidence deposition is nonetheless a deposition. The rules as to objections and preservation of those are the same as they always would be.

So, I mean, maybe that's much adieu about something I could have said more simply. The bottom

line is, you know, I'd just like to preserve an objection on that. I'll probably end up withdrawing the objection on that. I just want to preserve it unless there's -- unless that causes you -- something we need to discuss now, I'm happy just to continue on with your examination and let it be --

MR. GRUENLOH: Yeah, it does not, and your objection's preserved.

MR. HINES: Thank you.

BY MR. GRUENLOH:

Q Okay. Let's take a look at your records, Dr. Ghegan. And the first question I have for you is when did Rosemary Connelly first come to see you, according to your records?

A April 4th, 2013.

Q And what was her chief complaint when she presented to you?

A Chief complaint of decreased smell -- sense of smell and taste.

Q All right. Let's -- it says "history of present illness." And before we get to the history that you have listed there of her present illness, down below it's got a paragraph that says, "Please see the patient history and review of symptoms form

for the patient's past medical history, prior hospitalizations, and so on."

Do you see where I'm reading from?

A Yes, I do.

Q Do you take a history of your patients before they come in to see you?

A So we have the patients fill out a form that's a pre -- preprinted form that goes through general ear, nose, and throat problems. And then the nurses typically meet with the patient and go through to kind of hone in what the main reason they're there for and take some notes, and then I go in and take my own history based on, to some degree, of what they've already written and they've presented to us.

Q Great. Why is that important?

A Wanted to get some of the patient's own thoughts of why they're there to try and hone down to make the visit more focused and more specific so that we can try and help people with the specified problem.

Q Let me ask you what may seem to be a silly or an obvious question. Is it important to you as a doctor to talk to the patients that you're going to diagnosis?

A Sure.

Q Let's take a look at what's been Bates stamped as RMC76, and it's a couple of pages earlier. Is that the information -- the patient information form that you were referring to a moment ago?

A It is.

Q All right. Take a look on there -- first, does that appear to be Miss Connelly's patient information form?

A It does.

Q Where it says "for clinic use only," can you tell me, does -- do you have any idea, is that your nurse's handwriting? Rosemary Connelly's handwriting?

A Again, I'm not sure who the initials are there; but that looks like one of our medical assistants or nurses that do the intake. And then the top, upper left name and all the circles typically are filled out -- looks to be filled out by the patient. There are some that are double circled and that's probably where the medical assistant has circled on top of certain things, it looks like.

Q Got it. For our purposes right now, the box that says "for clinic use only" and it appears to

have a signature of a nurse down there, would that have been filled out by a nurse?

A Correct.

Q Okay. And, again, what does your nurse indicate that Rosemary Connelly's chief complaint was on that date?

A Smell and taste.

Q And do you see underneath that where it has a box for characteristics?

A Yes.

Q What is indicated there?

A No smell, limited taste.

Q Let me ask you, Would that have been a result of sort of a question-and-answer session between the nurse and Mrs. Connelly, or how does that work?

A It would have been from them talking, exactly.

Q Under the next box down, it says "duration," or how long. What's your interpretation of what information you're trying to get at there?

A Just how long. Like what it says, how long it's been going on when they first noticed it.

Q And what did your nurse indicate that it

appears Miss Connelly said to her?

A June 2011.

Q And does it indicate "broken nose"?

A Yes.

Q Okay. So at least as far as your interpretation of this, does it appear that Mrs. Connelly advised your nurse that her issues with her smell and taste had been going on or that she believed that they had persisted since June of 2011?

A That's correct.

Q Okay. Let's take a look at your record, the one that we were on a moment ago that starts with Bates stamp RMC78. And under "history of present illness," can you read for us the first two sentences of your record?

A Sure. She states that she noticed it for the past six months but feels like it may have been present for the past couple of years. She states that she broke her nose and had a concussion from a fairly significant fall about two years ago.

Q All right. Is that essentially what Miss Connelly said to you?

A It is.

Q All right. So let's break that down. Did

you understand on that date that she had broken her nose?

A Correct.

Q Did you understand that she had a concussion?

A Correct.

Q And did you understand that she had a fairly significant fall about two years ago?

A Correct.

Q All right. If we could, let's go off the record for just a moment. We've got a board and I'd like you to walk the jury through a couple of things on that.

A Okay.

Q All right.

THE VIDEOGRAPHER: The time is 1:33 p.m. We are off the record.

(A discussion was held off the record.)

THE VIDEOGRAPHER: We are back on the record. The time is 1:34 p.m.

BY MR. GRUENLOH:

Q All right, Doctor, we have up here a demonstrative board. And let me just ask you, Is this board fairly -- a fairly accurate depiction of

the anatomy as it relates to the brain, the cribriform plate, and the olfactory nerves?

A It is.

Q All right. Do you believe that this will assist you in explaining how a blow to the head can cause a loss of sense of smell?

A Sure.

Q All right. You mentioned earlier that you were familiar through your training and experience with the mechanics of how a blow to the head can cause what we call anosmia, or the loss of sense of smell. Can you just sort of take us through that and explain to us how that can happen?

A Sure. I think the diagram kind of summarizes it all; but, basically, the brain is free-floating in cerebral spinal fluid. So it's a fluid -- in a fluid membrane and then surrounded by the skull and the olfactory nerves, or the nerves that help control smelling, penetrate the skull base or the roof of the -- above the sinuses in tiny, little microscopic chambers and then go into the nose. The molecules then are able to get the smelling nerves and send the signal up to the brain.

And so with blunt trauma or trauma to the

head, just like with any concussion with the brain floating around, if there's an abrupt force or abrupt stop, the brain can keep moving forward, basically hit either against the front of the skull, which if these nerves are in through little channels, can cause severing of these nerve fibers.

Q Let me ask you, How fragile are the nerve fibers?

A I mean, I don't know how to basically quantify it; but, I mean, they're microscopic, small nerves. I mean, that would be something you wouldn't be able to see, you know, with the naked eye. You would have to see it under magnification.

Q Understood. Thank you very much for that.

MR. GRUENLOH: We have marked --

THE VIDEOGRAPHER: Do you want me to go off the record for me to remove --

MR. GRUENLOH: We can leave it up for the time being. Thank you.

BY MR. GRUENLOH:

Q We have marked Exhibit No. 3, and I'll show this to you. Have you seen this photo of Miss Connelly before?

A I have.

Q All right. Do you understand that the abrasions on her head are essentially the points of impact where she hit the sidewalk?

A That is my understanding, yes.

Q Okay. If you would, can you sort of -- well, let's go back to your record because I just want to ask you about a couple of more things.

I think we already noted from your record that you were aware that she had a broken nose from this fall, right?

A Um-hum.

Q And you were aware that she had a concussion from this fall, correct?

A Correct.

MR. HINES: Just for the sake of time, I want to just throw it out there and say I'm trying to sort of go with the idea of some leeway because I know the Doctor's got somewhere to be and we're in a deposition format.

So, you know, the objection, you know, in terms of leading, that kind of stuff, my intention is to be lenient and, you know, my position is that when it comes time to make any objections or arguing in front of the judge, that they can be done then. You

know, I'll pipe back down --

MR. GRUENLOH: Yeah, and here's my thought: If you have -- like we dealt with in Dr. Funcik's deposition, if you have an issue that, you know, is going to go across many different questions, I think that it's appropriate for you to identify that; but what I'm not willing to do is say that all objections are preserved to every one of my questions.

So I really do appreciate, you know, that you're giving me that leeway. And for the record, the stuff that I just asked him we had already gone through, which is why I just did it that way in such a leading manner; but I'm going to try my best not to do it. Sometimes it's my nature. But I would just caution you that if you have an objection, please do just make it on the record.

MR. HINES: Sure. And, well -- I guess what I have to say to that is I'm happy for us to, you know -- I understand -- what I believe the rules allow me to do is what I'll do, you know.

MR. GRUENLOH: Sure.

MR. HINES: I'm not trying to be difficult about it; in fact, the opposite, you know. I think

there are certain objections that the rules would require me to make at this time and some they wouldn't. But if I -- if -- you know, if there's anything that -- I'm just going to leave it there. We don't have a judge here to talk to us --

MR. GRUENLOH: Sure.

MR. HINES: -- and that's --

MR. GRUENLOH: I'll do my best on new materials not to do that.

MR. HINES: Thanks.

BY MR. GRUENLOH:

Q Okay. We were talking about the things that you knew on April the 4th, 2013. And if we look at your record, the second sentence sort of sets those out. Can you just give us again a summary of those things that you're aware of on that date?

A That she broke her nose and had a concussion from a fall that she had had two years prior.

Q Okay. Now, understanding the points of impact and the injuries that are depicted on Exhibit No. 3, could you sort of apply the mechanics of what you've just discussed as it relates to the demonstrative behind you to how that may have

occurred to Miss Connelly?

A Sure. I mean, the points of contact based on what it looks like on the photograph would be in this area here and in the nose (indicating). These are the nasal bones here where she had a fracture by the report. And so it's right in the area where, you know, just in front of where these olfactory nerves are coming through the skull base in the cribriform plate.

Q Can -- do you know, can anosmia occur from a traumatic event without the person actually even being struck; for example, in a whiplash or a shell shock type situation?

A Yeah. I mean, there were traumatic injury from car accidents and stuff where there's not actual, you know, physical evidence of physical abrasion or fracture or that kind of thing.

Q Do you have to have a nondisplaced -- excuse me -- a displaced or a comminuted fracture in order to have anosmia?

A Not in my opinion, no.

Q Do you have to have a fracture to the skull in order to have anosmia from a blow to the head?

A Not in my opinion, no.

Q All right. So going back to your record, did you also do a physical examination of Miss Connelly when you saw her on April the 4th, 2013?

A I did.

Q Can you tell the jury essentially what you did and why it's important to do that?

A So, I mean, in any new patients, we do what we consider kind of a complete head and neck exam. So, you know, looking at the general appearance and then looking in the ears, nose, throat, doing a basic kind of function of nerve function, palpating the neck for any kind of masses or anything like that.

The way that we look in the ears is with an otoscope. The throat, depending on how good a look we get, is with a light. And then we use something called a nasal speculum typically to look in the front of the nose which let us look in the front of the nose for the septum, the turbinates, and those kind of things.

Q If you turn to -- I'm sorry, same page. Under your physical examination, do you see where it

says "nose," the third one down?

A Yes.

Q Can you essentially tell us what the significance -- what you found and if there's any significance to that?

A Basically, didn't see any major septum deviation which may be a cause of blockage. The turbinates didn't stick out and some of the other ones it looked like maybe they'd been big from time to time and there was no evidence of infection or major inflammation on exam.

Q Did you do any imaging or have done any imaging of Miss Connelly on that date?

A On that date, she had a CT scan of her sinuses.

Q Why did you do that?

A To see if there's any additional inflammation or sites of obstruction in the nose that might be obstructing kind of molecules from getting up the smelling nerves and therefore affecting her sense of smell.

Q What did you find?

A The CT scan was basically pretty clear. There's no evidence of inflammation or masses or

growths or polyps or sinusitis that would be the cause of obstruction.

Q Did -- you do note that there's moderate to severe inferior turbinate hypertrophy. Do you see what that indication is?

A I do.

Q Can you tell us what turbinate hypertrophy is?

A So the turbinates, you can kind of see them on the exam -- on this diagram here. They're structures basically on the lateral side part of the nose that are comprised of a thin bone surrounded by mucosal lining of the nose and they help humidify the nose. They help -- kind of swell and shrink if you get a cold. Or if you get around allergies and your nose gets more stopped up, they're typically the primary thing that are swelling and shrinking inside the nose.

Q Based upon your education and experience, can you tell us whether or not hypertrophic turbinates can cause permanent anosmia?

A It can cause episodes of anosmia, but I would not think it would cause permanent anosmia.

Q Is there anything that you've seen in

these records or your examination of Miss Connelly to suggest to you that her turbinates are the cause of her disturbance with her sense of smell?

A There's not.

Q I want to go back. With respect to your history, one thing I wanted to ask you about -- and it's at the end of the first paragraph again back on RMC78. She indicates that she does not feel like she has much trouble with allergies. Why was it important for you to find out what's going on with her allergies?

A Well, allergies would be a pretty common cause of swelling of the turbinates, swelling of the linings, polyps, which are a major cause of anosmia and, you know, obstructions inside the nose. So, again, they play a big role in swelling and inflammation inside the nose.

Q Was there anything that you saw either in your examination of Rosemary Connelly or in the imaging that you did that suggested that her disturbance with her sense of smell was caused by some allergic reaction?

A No, there's not.

Q You mentioned that when you looked at the

CT scan that you did, the images of Miss Connelly's sinuses, that they did not indicate any acute -- I don't want to put words in your mouth.

What did you find on the CT as it relates to whether or not she had any issues with sinusitis?

A So the scan -- there's a couple different kind of levels. I mean, the scan could be completely blocked up where the sinuses are completely filled with inflammation and/or infection. And that's seen by basically the areas of the scan are grayed out.

And then there can be a more mild form where you see kind of the lining of the sinuses, they're swollen and inflamed, which tends to go more along with allergies and things like that. And then there's relatively, basically, a clear scan where you're seeing no inflammation, no -- the lining of the sinuses is all normal. You really don't even see it on the scan. And that's what her scan looked like.

As far as the sinuses went, there was no evidence of blockage either mild or moderate or severe on the scan.

Q Was there anything that you saw in your examination or in your records and imaging of

Miss Connelly that indicated that some sinus infection was the cause of her disturbance of sense of smell?

A Nothing that I saw on that day, no.

Q All right. Let's go back to your record as it relates to your recommendation. That's on RMC79.

All right. The second paragraph there of your recommendation has some information in terms of a discussion that you had with Rosemary Connelly. Can you read that into the record for us?

A The whole paragraph?

Q The second sentence is what I'm interested in now.

A Okay.

Q If you feel like it's better to read in the full paragraph, you're certainly welcome to do that.

A Second sentence just says, "We discussed that I think most likely her decreased sense of smell and subsequent decreased taste are a result of the trauma a couple years ago."

Q All right. Is that essentially what you told Miss Connelly when she came to see you?

A It is.

Q All right. Did you reach that determination on that date after doing a physical examination, taking a history, and speaking with Miss Connelly?

A It is those in combination with the CT scan.

Q All right. I want to come back to that opinion and that finding; but before we do that, I want to take a look for just a moment if we could at Dr. Dozier's note. And it's sort of towards the back and it's Bates stamped RMC Production 169.

A Okay.

Q And just for the record, who is Dr. Dozier?

A He's one of my partners at Charleston ENT.

Q Did he also see Miss Connelly?

A He did.

Q All right. Is Dr. Dozier qualified to diagnose one of his patients with anosmia?

A He is.

Q All right. And is Dr. Dozier to you knowledge qualified to determine the cause of one of his patient's anosmia?

A He is.

Q All right. Let me ask you, sir, because you indicated earlier that your impression after your examination of Miss Connelly was anosmia and then here again on this record, which was, looks like, done on January 16th, 2015, the assessment is again anosmia. Do you see where I'm reading from towards the bottom?

A I do.

Q All right. Can you tell me what Dr. Dozier did to confirm your clinical impression of anosmia?

MR. HINES: Objection. Are you trying to make arguments now?

MR. GRUENLOH: Well, yeah. What's your objection so if there's an issue with the question, I mean, I need to know how to deal with it.

MR. HINES: Well, the objection's you're asking one doctor to testify about what another doctor did, I mean, as far as -- it seems outside of the records or, you know, where is the information coming from as to what. What would be the source of information as to what the other doctor did beyond a -- it's a, you know --

MR. GRUENLOH: Let me see if I can fix it. I will just say that my argument will be -- and maybe it's irrelevant what my argument is because I'll go back and see if I can lay a little bit more foundation. But the doctors are in the same practice, they've both see her, and he's already testified that he's reviewed this record.

So I think that there's more than ample foundation for him to answer the question, but let me see if I can ask it in a little bit better way.

BY MR. GRUENLOH:

Q Doctor, the record that's in front of you, RMC Production 169, have you had an opportunity to review that before today?

A I have.

Q Was it important for you to understand that -- or whether a patient that you diagnosed clinically with anosmia, whether or not that diagnosis was, in fact, confirmed with some smell testing?

A Yes.

Q All right. And do you know whether or not Miss Connelly's -- well, your diagnosis of anosmia as it relates to Miss Connelly was, in fact, confirmed

with a smell test?

A It was. Dr. Dozier performed one on January 2015.

Q All right. And are you familiar with the smell test that Dr. Dozier performed on her?

A I am.

Q And are you familiar with the result of that test?

A I am.

Q All right. Can you tell the jury, first of all, what test was performed on Miss Connelly on that date?

A It's called the University of Pennsylvania Smell Identification Test.

Q And for lack of a better word, is that kind of the state-of-the-art for smell tests?

A It's pretty rudimentary. I don't know if I'd call it state-of-the-art; but it's kind of the standard, really only test -- objective test that's out there that has kind of objective data associated with it.

Q All right. And do you know, does that test -- I want to ask you whether it was designed specifically for this. But does that test do

anything to account for or to try and weed out people who might be faking it?

A It does.

Q Tell the jury how the test attempts to determine that.

A So the test is 40, I believe, questions and they're basically like the old scratch-and-sniff smelling things. You have a multiple-choice answer of four choices for each smell and you scratch them and you smell it and you basically put down your choice of 1 to 4 which of those smells it is and then it's graded by the physician to determine level or degree of anosmia and -- depending on the number that they get right.

And so I don't remember the exact breakdown; but, basically, there's a slight decreased, more decreased, and no sense of smell. And then there's a malingering, which means the patient's trying to fake the test. And typically, just by laws of probability, it's 1 in 4 that someone should get about 10 of them right even if they're just randomly guessing on them.

And so if a patient only gets -- basically gets none of them right, then they must be smelling

it and purposely picking the wrong answer. And for her, she got 13 of 40, which is in the range not malingering. From a probability standpoint, if she's just guessing on every one, then she should get about that number right. But it's consistent with anosmia.

Q And let me just make sure I've got this straight. What does 13 out the 40 mean on that SIT 40 test?

A So it's consistent with anosmia.

Q All right. Did that essentially confirm your earlier diagnosis of anosmia?

A It did.

MR. HINES: Objection.

BY MR. GRUENLOH:

Q Based upon your review of your own practice's records and your review of the records of your patient, Rosemary Connelly, has the diagnosis of anosmia been confirmed?

A It has, in my opinion.

Q Let me ask you, Doctor, based upon your examination of Miss Connelly, your review of her records, and your experience and education on these subjects, do you have an opinion to a reasonable degree of medical certainty as to what the cause of

her anosmia is?

A I do.

Q What is that opinion?

MR. HINES: Objection.

MR. GRUENLOH: You may answer.

THE WITNESS: That the anosmia is a result of the trauma on -- in June of 2011.

BY MR. GRUENLOH:

Q Do you have an opinion to a reasonable degree of medical certainty as to whether or not Rosemary Connelly's anosmia is permanent?

A I do.

Q And what is that opinion?

MR. HINES: Objection.

MR. GRUENLOH: You may answer it.

THE WITNESS: I believe that it is permanent.

BY MR. GRUENLOH:

Q Okay. We've talked a lot today about her anosmia, meaning her sense of smell. What I want to ask you about now is the diminished taste that she has reported with. And let's do it this way: Can you -- think -- I think it's -- I think we all sort of have some understanding of how taste and smell are

connected, but can you sort of tell us to what extent they are connected?

A I mean, most people feel like the majority of taste is smell related, that there are four and, some people argue, five basic senses of taste -- salt, sweet, bitter, sour -- and that those kind of lay a foundation for it; but a lot of what people discern as their taste has a lot to do with the aroma and the smell of food.

The easiest way to describe it that everyone can usually relate to is if anyone's ever had a bad cold, usually food tastes pretty bland; you can't smell real well; you don't really have a whole lot of sense of taste. Tend to go hand in hand.

Q Do you have an opinion to a reasonable degree of medical certainty what the cause is of Rosemary Connelly's complaints of a diminished sense of taste?

A I do.

Q And what is that opinion?

MR. HINES: Objection.

THE WITNESS: Her anosmia.

BY MR. GRUENLOH:

Q All right. Her anosmia? Her loss of

sense of smell?

A Correct.

Q And do you have an opinion to a reasonable degree of medical certainty whether or not that disturbance with her sense of taste is permanent?

A I do.

MR. HINES: Objection.

BY MR. GRUENLOH:

Q What is that opinion?

A That it's related to her anosmia.

Q And does that mean that it's permanent or does that mean that it may come back?

A Permanent.

Q Okay. Do you bill for your services?

A We do.

Q All right. And I think we covered this, but aside from paying you and a couple of your partners some time ago for an hour of your time, have I paid you to testify here? Have I paid you for any of your opinions here today?

A No.

Q All right. Take a look at the back of your records. And we've got about four or five pages back there, and let me identify them by Bates number.

They are -- okay. So at the top, it says, Charleston ENT Associates 402680, 2 of 4. Do you see that?

A Um-hum.

Q And then 3 of 4 and then 4 of 4. Do you see that?

A I do.

Q All right. Do those appear to be your billing records for the treatment of Miss Connelly?

A They do.

Q All right. And we've marked as Exhibit No. 4 --

MR. GRUENLOH: I'm looking for the marked copy. Ah, here it is.

BY MR. GRUENLOH:

Q Let me put that in front of you. And you can see I've drawn your attention to Charleston ENT Associates and it has a number of bills listed there. Do those appear to be the bills for the service of seeing Miss Connelly?

A They do.

Q All right. And what is the amount listed as the total there?

A 2,720.

Q For a situation as serious as a

neurological injury, some may think that $2,720 is not a whole lot of money. And what I want to ask you, sir, Is there any treatment? Is there anything that you can really do to help bring back somebody's smell --

MR. HINES: Objection.

BY MR. GRUENLOH:

Q -- once they have suffered a traumatic loss of sense of smell?

MR. HINES: Just for the record -- I guess I believe it would be preserved based upon the rules anyway, but I need to object to it being leading and argumentative and it's a pretty compound question. There's a lot packed in that question I need to object to.

BY MR. GRUENLOH:

Q Is there any treatment for a traumatic anosmia?

A There's not.

Q Those are all the questions I have for you, Doctor.

MR. GRUENLOH: I would move into evidence Exhibit No. 4. We had previously moved into evidence Exhibit No. 2 and 3. And I believe you indicated to

me, Rus, that Exhibits 1 and 2 you have no objections to at this point; is that right?

MR. HINES: Yeah, I believe that's right. But just -- I want to make sure I remember, because these are the Charleston ENT records, correct?

MR. GRUENLOH: Yes, and they are -- my representation -- you can take my representation to you that they are the mirror image of what we used --

MR. HINES: Up to, from the --

MR. GRUENLOH: Right.

MR. HINES: Absolutely.

MR. GRUENLOH: Which is why I marked them as 2 today.

MR. HINES: That's why I wanted to make sure that we were talking about the same numbers. But, yes, that's all. And what was marked as 1 from the other depo isn't here today, right?

MR. GRUENLOH: That's correct.

MR. HINES: Gotcha.

MR. GRUENLOH: So any objections to any of that?

MR. HINES: To those documents, no.

MR. GRUENLOH: All right. Very good.

- - -

CROSS EXAMINATION

- - -

BY MR. HINES:

Q Okay. Doctor, Dr. Ghegan --

A Yep.

Q -- we met, gosh, before -- even before -- I guess before today when we made an attempt to take your deposition and ended up having a court reporter issue as far as not having one to be there to take the testimony. I appreciated your time and also the Plaintiff's counsel time just sitting around and talking about things, you know, just discuss this matter. And, you know, having met you just now a moment ago and again, on the record, I'm Rus Hines --

(Cell phone rings.)

MR. HINES: Let's go off the record, please.

THE VIDEOGRAPHER: Time is 2:02 p.m. We are off the record.

(There was a pause in the proceedings.)

THE VIDEOGRAPHER: We are back on the record. The time is 2:02 p.m.

BY MR. HINES:

Q Thank you, Doctor. I apologize for that.

A No problem.

Q My better half must need me for something. I'll have to get back to her in a moment. But just for the sake of an introduction on the record again, Rus Hines representing the Defendant in this case, Winsor Custom Homes.

And I want to begin by making sure I understand what it is that you are using to base opinions on in this case. What by that I mean is I want to know what documents you have seen, you know, what records reviewed, and what your interaction has been with Miss Connelly in particular.

Now, I think Exhibit 2 is right there in front of you, isn't it?

A Um-hum.

Q Thank you. If you look through Exhibit 2, because as I understand it, that contains all of the Charleston ENT's records on this patient?

A Correct.

Q So it's the entirety of, you know, any treatment she's sought at the whole office, whether it's with you or another doctor?

A Correct.

Q Okay. Now, let's see, can we -- so if we count up, is it visit by visit? We're looking at an early April of 2013 was the very first visit. In fact, since we have it in front of us, let's just do it just to get the date. April the 4th of 2013, that would be the first time that she was treated at your office?

A Correct.

Q And so prior -- that was the first time you'd ever seen Miss Connelly?

A Correct.

Q Now, I want to ask based upon the other records, did you ever see her on any other -- at any other time?

A I did not.

Q And have you spoken with her at any other time since that day?

A I have not.

Q And how long was the visit on that day?

A I don't know off the top of my head. Probably with the CT scan and all, 30 minutes maybe. Something like that.

Q Is that -- how long?

A I mean, not face to face with me; but I

probably spent -- I can just say on average I usually spend 10 minutes, 15 minutes with someone and then review the scan. I'm not sure how the timing of the scan was. I don't know.

Q Gotcha. I want to make this -- I think you were described earlier as a treating physician of Miss Connelly --

A Um-hum. Correct.

Q -- correct?

And just in case there's any confusion about this, just maybe because of the word "treating," it might cause somebody to think it's an ongoing course of treatment that you have had with Miss Connelly and I want to make sure that I'm correct in understanding that's not what we're talking about?

A Correct.

Q In fact, so far as the treatment that you provided to Miss Connelly occurred on April the 4th of 2013?

A Correct.

Q And that's it?

A That's it, correct.

Q And as far as you speaking with

Miss Connelly in person, you've got, you know, the amount of time that you just mentioned in that setting of that one visit?

A Correct.

Q Now, and looking at -- let's start then on this April the 4th, 2013, note. Let's just go ahead and do that.

A Um-hum.

Q You were asked earlier about when someone comes in and gives a history and you were asked -- looked at it and if you'll -- you put the note in front of you that says April 4th, 2013. It says RMC78 on the bottom. You've got it right there?

A Yep.

Q And that history says -- she states she has noticed it for the past six months but feels like it may have been present for past couple years?

A Correct.

Q And then that would be the history that you took after speaking with this patient?

A Correct.

Q Now, I mean, doesn't that say that -- that the -- well, the first time she noticed an issue with smell and taste was six months prior to that visit?

A First time that she became aware of it, correct, but then that she thinks that it may have been present for longer.

Q And there was some discussion about that earlier about thinking that it may be present for longer?

A Right.

Q And, you know what? Let's quickly mention that. Would you flip to that? It's RMC76 and it's specifically on that left side of the page where it says "duration," then it says "June 2010, broken nose"?

A 2011, yep.

Q Excuse me. "June 2011" -- thank you -- "broken nose"?

A Yep.

Q What is meant by -- well, -- well, you were interested in knowing when the patient noticed the issue of smell and taste, right?

A I mean, how long it's been going on, sure.

Q But also -- and I want to make sure I get this clear. Your testimony, obviously, is that it was caused by an incident back in June of 2011?

A Um-hum.

Q But don't these records say that, you know, whether or not it was caused by an incident in June of 2011, it was not noticed -- that issue of smell and taste was not noticed by Miss Connelly until six months before she came to see you in April of 2013?

A Correct, that's when I guess she first started having -- becoming aware of it, exactly.

Q So nothing about this record at all says she had an awareness of this condition before -- six months before April of 2013?

A I think the fact that she thinks that it may have been going on for several years says that she had some degree of awareness of it; otherwise, it wouldn't -- if it was just six months, I don't think I would have written that she had an awareness of it for the past couple years.

Q But it doesn't seem to be -- that what's you wrote, Doctor, is that she noticed it six months ago and thinks perhaps it started at some point in time --

A Well, she must have had some awareness of something going on years ago or she wouldn't have said that to me.

Q Well, how about this: She says that she noticed the condition. Gosh, now that I notice it, you know what? That's what it must have been.

Isn't that what that's saying? That's not saying --

A That's the same thing. I mean, if someone's aware of something for a couple of years, then they've been aware of it for a couple of years. I guess I don't understand what you're asking. If she had said it was just six months, she would have said six months, not -- she wouldn't have said six months is when it's really become bothersome to me but I feel like it's been there for a while.

I mean, I think that's -- if I ask someone about their sinus problem or their ear problem and they say it's been bothering me for years but it's really been really bad for the past week or two, that makes a difference. Instead of them saying, I've never, ever had any trouble with it but just a week ago it started hurting for the first time ever, I think there's a difference between those two.

Q Now, when -- your record, though, doesn't say that -- well, I guess are you saying that there's a difference between noticing something and being

aware of something?

A I think it's semantic to some degree, yes.

Q And I want to just make sure that I'm understanding what it says, because it says that -- I tell you what, let's -- let me -- I might come back to that at another point, and let me ask this -- or another point.

Your history here indicates something about a concussion?

A Um-hum.

Q You did not diagnose her with a concussion on that day, right?

A No.

Q That -- what that is, is that she has told you that at this time in the past back in June of 2011 she had a concussion, right?

A Correct.

Q And that she broke her nose?

A Correct.

Q Have you -- you didn't diagnose her with a broken nose just like you didn't diagnose her with a concussion, right?

A Correct.

Q So your information on that has been

provided to you from the patient herself?

A Yep.

Q Do you know what doctor -- actually, your record says that Dr. Funcik is the doctor that did the nasal bone repair?

A Correct. She had mentioned it to me.

Q Did you have Dr. Funcik's records in front of you?

A At that time, I didn't have any records from him or anything. Since, I think I've seen them at some point going through some of the stuff.

Q I mean, that's what I want is what all you've had to go through as far as --

A Recently, you mean, or before the visit -- at the time of the visit?

Q Well, at the time of the visit, you didn't have these records?

A At the time of the visit, I didn't have any records, right.

Q But now I want to know what you had at any time?

A Okay.

Q I mean, in the -- for instance, what --

A I don't know that I've seen any of

Dr. Funcik's actual records. I don't believe I have.

Q And Dr. Funcik, his -- why is it that you did -- is it not -- your testimony earlier was that it was important to get a history from a patient, was it not?

A Um-hum.

Q And in this case, the patient had indicated to you that she had an injury for which she treated with Dr. Funcik, that the injury that y'all were discussing about the smell and taste complaint that, you know, had happened back in June of 2011?

A Correct.

Q Is it -- I mean, is it important to you to have Dr. Funcik's records for review?

A At that time at that visit, you mean?

Q (No audible response).

A Not really, no.

Q But now I'm talking about -- because we're talking to a jury now --

A Yeah.

Q -- on camera now and, obviously, have opinions to offer and they affect legal obligations of people or have the potential to.

And is it -- I mean, I guess what I'm

getting at is would Dr. Funcik's records be pertinent, would that be important to understand the relationship between the fall that he treated and the condition that's now an issue in this lawsuit?

A Not necessarily. I don't think it would change anything for me.

Q No matter what's in 'em?

A I mean, I guess maybe if there's something in there, yeah, then I guess it's possible something could change, but not from anything that I'm aware of, no.

Q But as far as what you're aware of though, you're not aware at all of what's in Dr. Funcik's records, are you?

A No, I'm not.

Q So you don't know what's in them?

A Correct.

Q But you're still offering to a reasonable degree of medical certainty the opinion that the fall, the fact that Dr. Funcik treated it, caused the smell and taste issues that are at issue in this lawsuit?

A Correct.

Q Did the smell testing -- you testified

earlier that it was important for your diagnosis of anosmia back on April the 4th of 2013, it was important for that diagnosis to be confirmed with smell testing, didn't you?

A No, I don't think I said that. I think I said it's a way of diagnosing. I don't know that I said it's an important way. I typically don't get them unless someone keeps coming back and wants to know a degree of it.

Q You know, the testimony before, I'm sure, will speak for itself; but maybe let me try to see if I can clear up any confusion.

I thought the testimony or what was asked you of was, Was it important to you to have your diagnosis in April of 2013 confirmed by smell testing? Was that something that's important?

A Yeah, I think it -- I think it -- yeah, I think it's important. I mean, if I was getting someone -- again, because now it's a legal matter and everything else. But if someone just came to me where there's a basic sense of smell being lost, then there's not a routine test that I get.

Q And I guess on that point, you did not do any smell testing on Miss Connelly on that April 4th,

2013, visit, did you?

A Not that I'm aware of, no.

Q Are you aware of any smell testing being done on Miss Connelly before the smell testing that was talked about? I think it's the document RMC169.

A I'm not aware.

Q And so the first smell testing that you're aware of that was done on Miss Connelly was January 16th of 2015, this year?

A Correct.

Q Looking through these records -- and I want to get -- just to put them in front of me so I can get the date right. I was trying to get into this a little bit earlier and I just want to run through it now quickly for a timeline standpoint.

A Okay.

Q We've talked about your visit with doctor -- excuse me -- with Miss Connelly, the Plaintiff. That was April the 4th of 2013, correct?

A Um-hum.

Q The next time that she saw a doctor at your practice was April the 26th of 2013, right?

A Correct.

Q So not even in the same month you saw her

and then Dr. Hester saw her?

A Correct.

Q Now, is the next time that she was seen by any doctor in your practice -- if you'll keep flipping, I think that -- was it June of 2014?

A Sure.

Q Would you just confirm that I got that date right?

A June of 2014, yep.

Q So it's been, well, over a year since those two visits in April of 2013?

A Correct.

Q And then the next and final visit to your practice would have been January -- was it January 16th of 2015?

A January... Yes, January 16th, 2015.

Q And that was the one we talked about the smell testing?

A Correct.

Q Okay. I wanted to ask you if -- I really feel like I need to make sure I understand this point. Would you please turn to the document called RMC81? It is the second page of the second note from -- excuse me -- from the second visit to

Charleston ENT, the one with Dr. Hester.

A Okay.

Q Do you see down in the -- in the -- on page 81 -- excuse me -- the final paragraph under "recommendations" and where the sentence begins, "The identification of the taste and smell disturbance was only eight months ago"?

A Correct. Yes.

Q So in addition to -- that's not you. That's another doctor in your practice who is indicating here -- well, and if it's in the -- if it's in the recommendations -- let me start with this. It's in the recommendations of this note that the doctor seems to think it's a clinically significant history?

A Correct.

Q And when the doctor -- and, again, this is not you, but this is another doctor, Dr. Hester, is saying there that this patient came to see our practice complaining of smell and taste problems, right?

A Um-hum.

Q And as far as when the Plaintiff first would have had a complaint of smell and taste

problems, meaning, I've identified my complaint, not, you know -- that was -- in the case of this note, it was eight months prior to the April 26th of 2013, right?

A Um-hum.

Q So if we did some just quick ball park math, that gets you about the end August 2012?

A Okay.

Q I mean, isn't that -- what you wrote -- it was six months in your note and it was eight months here. Putting aside, you know, the six versus eight, you're not saying anything different than Dr. Hester is saying about when -- about identification of the complaint of smell and taste, right?

A Correct.

Q Thank you for letting me go through that because I know -- well, I just didn't want to be -- we talked about -- you mentioned semantics, and I don't want to -- well, to get caught up in semantics. I just wanted to try to clear that up about the awareness or notice and stuff that we talked about.

MR. GRUENLOH: Objection. Move to strike.

BY MR. HINES:

Q Were you ever provided with an article for review from the Indian Journal of Psychological Medicine?

A Was I provided with an article?

Q (No audible response).

A I think -- I don't think I've read -- I think he gave me something with an article, yeah. I don't think I had a chance to read it.

Q So that article, was it -- you're here today offering the opinions that you're offering to the jury in this trial and, you know, it wasn't significant to you to even read that article?

A I didn't actually have time to do it, yeah.

Q That article was given to you by Plaintiff's counsel?

A Um-hum.

Q And it's an article? It's not a medical record or something specific to this patient?

A Correct.

Q And this article, I -- any -- well -- it certainly would play no role in any treatment that you were giving, you know, because, in fact -- well, you hadn't been treating. You were not treating her

at the time that this article was given to you?

A Correct.

Q Would you consider it to be unusual for someone who had -- let me ask you this: If someone suffers a traumatic loss of smell, does that happen at the time of the trauma?

A Typically, you would expect it to, yeah.

Q And it's -- that's a shearing injury?

A Um-hum.

Q And that's essentially -- that's when it happens?

A Um-hum.

Q And your opinion in this case is that it happened on June the 6th of 2011?

A Um-hum.

Q So if that opinion is correct, that means from June 6th of 2011 on there was this loss of smell and taste for Miss Connelly?

A Um-hum. Correct.

Q Is it -- does it give you any trouble in offering that opinion, I mean, you going to what we've talked about, about the lapse in time between that event and actually identifying that complaint?

A Not really. I think a lot of people hope

and feel like it's swelling and inflammation and it's going to get better with time and, you know, if they let time pass, it'll get better and they can just go ahead.

I just saw someone three weeks ago with the almost exact same thing. He was in a bike accident. Flipped over, hit his head, hasn't been able to smell for nine months and he was just coming to see me for the first time saying the same thing. I think he read something on the Internet, supposed to give it a year to see how it does. Give it some time. All the inflammation will go down and the sense of smell and taste and stuff will come back.

So I think that's a -- I don't think that's unreasonable for somebody to try and give it some time to see if it will get better on its own.

Q Well, the person you're speaking of now, you're saying that that person had an accident nine months ago?

A Um-hum.

Q And then came to see you for the first time, you know, nine months later?

A Correct.

Q And at that time, they said, Doc, for the

last nine months I haven't been able to smell. What's going on?

A Correct.

Q That's not what Miss Connelly said. She said, Doc, I'm coming to see you in April of 2013. I haven't been able to smell for six months and I had this accident a year -- 14 months before that.

MR. GRUENLOH: Objection. Misstates the facts.

BY MR. HINES:

Q Well, Doctor, let me ask you, Does that -- I mean, isn't that -- you know, I think you know what I'm getting at?

A Right.

Q Isn't there a difference between --

A Not necessarily. I mean, now, since then, I've looked at her records. And she says that she had the accident; she had trauma; she had surgery. And so I think her probably impression was that eventually it would come back when all of the swelling and all of the inflammation went down.

And I think that's a reasonable -- a fair number of people feel that way, that they feel like once swelling and inflammation and everything heals,

that eventually it's going to get back to normal. I can't say why it took her a while to come back. I can't -- I can't speak for her.

Q Are you saying that she noticed that she had a loss of taste and smell at the time of the accident and continuing on?

A That's my understanding, yes.

Q But doesn't the note from -- your note, the one we just looked at with Dr. Hester -- and I can get you another one from Dr. Dozier's. You're welcome to look at it.

It also indicates that -- says she was in an accident three years ago. She's -- this has been a problem for her, smell and taste, for two years?

A I mean, it says that she feels like on the duration that she told the nurse that she thinks it happened at that time.

Q I'm talking about isn't there a difference between "I think the problem that I" -- isn't what she -- what all these records are saying is that I come to -- let's just start with -- just use you because you're the first doctor she saw there.

Doctor, it's April the 4th of 2013. I'm having a problem with my -- with my -- my sense of

smell and my sense of taste. I've lost my sense of smell and I've lost my sense of taste. And you say, Okay, let's talk about that.

When was it that you -- you know, when did this become a problem for you; meaning, when did you notice you couldn't smell and had a problem with tasting? She said, Six months ago. Huh. And then say, But, you know, when I think about it, I was in this accident that happened, you know, 14 months ago and I had to have a surgery and, you know, it's -- you know, I bet that's where it started.

But this person is not -- is saying I didn't -- the person is putting together, giving you some history to try to identify what the person may believe was the event that started it; but these records don't -- you know, isn't there a difference between an event that may have caused it and actually noticing the problem?

MR. GRUENLOH: Objection, compound question. Objection, misstates facts in evidence. And, objection, asked and answered.

THE WITNESS: Do I still answer?

MR. HINES: Sure, you may.

THE WITNESS: I guess -- I mean, at the

time, I don't know I'm going to be getting, you know, any questions answered too. I don't know that if she -- if I had rephrased a question to her at the time and say, Well, how was your sense of smell a year after the accident? Could you smell at all? If she had said, No, I couldn't smell then either but I thought it would get better, I mean -- again, I can't go back and answer those questions for her.

So I think the records are as good as the records are. I don't know that -- again, she's saying that in parts of her records that it goes back to the time of the accident. So all I have is kind of what she's -- what she said.

Q But what she's not saying is that her identification of the complaint -- the complaint is loss of taste and smell --

A Right.

Q -- right?

And you would agree that she did not have that complaint, according to your record?

A But we don't have a record that says nine months before I saw her that she came in and told someone that she could smell real well either. I mean, we just don't have all the information there.

Q Well, Doctor, as far as not having all the information, this is a case where the Plaintiff, you know -- this is not about picking on anybody, okay? I mean, this is a case where the Plaintiff wants some money, and not a small amount of money. And the reason is because the Plaintiff says the people I represent caused her to lose her smell and taste.

But didn't you just tell me that we don't have all the information, I mean, but at the same time you're going to say to a jury, yeah, these guys did it. I mean --

A I think all there is asking my opinion of whether I think it's related to the accident or not. I'm not saying anything about money or anything else. All I'm saying is it's my opinion that the trauma is a common cause of loss of sense of smell and I think that's the cause here. Okay. But you're saying that -- understanding that you're doing that to a reasonable -- you know, you're telling that --

A I think my understanding is just more likely than not that I think that that's the cause of it.

Q But aren't you saying that's more likely than not based only on one visit and only on the

records that you have even though there's a lot of time out there between the fall and when you're offering the opinion and things that you may well not have?

A I agree.

Q And so even with all that information, at least the potential for it, you would agree that there's potentially significant information that would -- that could be material to your opinion that you just don't have?

A Correct.

MR. HINES: I think this would be a good time for a break and Steve and I are going to step out and chat, Doctor --

THE WITNESS: Okay.

MR. HINES: -- just to finish that up.

THE VIDEOGRAPHER: I'm going to go ahead and change this out. You only have 3 minutes remaining.

This is the end of Tape No. 1 of the videotaped deposition of Dr. Mark Ghegan. The time is 2:30 p.m.

(A break was taken from 2:30 p.m. to 2:44 p.m.)

THE VIDEOGRAPHER: We are back on the record. The time is 2:44 p.m. This is the beginning of Tape No. 2 in the videotaped deposition of Dr. Mark Ghegan.

BY MR. HINES:

Q Dr. Ghegan, when Miss Connelly came to see you on April the 4th of 2013, she didn't say anything to you about any legal claim that she was pursuing or intending to pursue?

A Not that I remember, no. Not that I recall.

Q Would it have been significant to you if someone came to you and said, you know -- well, said that to you, indicated there was a legal issue?

A I don't think it would change anything I do, no.

Q But I thought you indicated that if someone -- if there's a legal issue, then that smell testing is something that's looked to?

A I think if you're trying to look for an objective measure to the degree of sense of smell, then I think it offers that, offers an objective measure.

Q There was some question earlier about, you

know, the word "malingering" and I think that -- is there some -- that smell test, I think sometimes I'll see it called UPSIT, just SIT, the smell identification test and the SIT 40. It has some, you might call, safeguards in the test to hope to lessen the chance that someone could do that?

A Correct.

Q And what are those safeguards?

A Basically like I described earlier. I mean, it's mainly probability. So it's a multiple choice thing. There's four choices for each question and the thought is if someone gets zero of them right, then the laws of probability they would have gotten some percentage of them correct even just with randomly guessing, whereas they would have had to purposely mark the wrong answer if they were malinger-- or if they could actually smell it.

Q For that -- for those safeguards to be effective, wouldn't you agree that it would be important for the person who was being tested not to know about the safeguards in advance?

A Correct. Correct.

Q So did the -- I guess the effectiveness of those safeguards can be totally undermined if a

person was to know in advance what they were?

A Correct. Correct.

Q Your testimony is -- I mean, this is -- as far as your opinion is concerned and the opinion that in the issue as to the relationship, if any, between the fall that Miss Connelly had back in June of 2011 and a problem with her senses of smell and taste, you are certainly -- you would agree that reasonable minds could differ -- and I'm talking about experts, people that are, you know, in the field, could look at records and have a different opinion than what you've expressed?

A Sure. Sure.

Q And again -- well, it's fair to say that your opinion is -- well, you only have the information that you have been given, right?

A Correct.

Q That's all you're basing the opinion on?

A Correct.

Q So, for instance, you talked earlier about allergies and how there are allergies -- well, I think you mentioned that allergies were not something that was the cause -- you know, a particular concern for you in terms of being a -- something causing this

loss of smell --

A No, they can. If they're severe enough, they could cause. I would expect it to come and go. I mean, if anyone's ever had allergies, it's worse at times, better at times, comes and goes. So I wouldn't expect it to be never smelling. I mean, I would think it would be something that would come and go. I mean, you get around certain things. If it was severe enough to cause trouble in loss of smell, I would expect to see some changes on the CT scan to indicate the severity of it.

Q If you saw that, then you'd think, hey, that could be another -- that could be something that's causing this issue?

A Correct.

Q Have you read Dr. Dozier's note from Miss Connelly's visit from June of 2014?

A I have at one point, yes.

Q Would you mind reading it now? Just read it to yourself, if you will.

A From the June 2014?

Q Yes, sir.

A Okay.

(Witness complies).

Q And, Doctor, once you've finished reading that note just to yourself, just let me know and then I'll ask you something about it.

A Okay.

Q The last part of that note is a -- is under "plan." I'll read this and, if you'll follow along, because I know now you've had an opportunity just then to read that. And so I wanted you to have that opportunity, but I want to read a portion now.

"Plan: I have discussed with patient that I think she may have developed some allergies. I'd like to try her on some"...

A Mupirocin.

Q Thank you.

-- "nasal spray and I'd like to get her set up for an allergy skin test. Based on the results, we will make some recommendations. I am thinking that her turbinate hypertrophy is so severe that she may have a drying of normal nasal secretions leading to the foul odor and that perhaps the mupirocin spray will change the bacterial milieu of her nasal cavity and hopefully alleviate these symptoms."

You see that, obviously?

A Correct.

Q But in this -- in Dr. Dozier's note, obviously, there is this -- well, you would agree that her allergies are something that was of interest to Dr. Dozier?

A Correct.

Q And is that not significant to your opinion?

A I can't speak on behalf of what Dr. Dozier was thinking. I mean, I think he probably -- my guess would be he was looking for some other possible cause in order to try and continue to possibly help her to alleviate her symptoms. I don't know how, to what degree he felt that was the cause or -- I mean, you'd have to ask him specifically.

Q Do you know if she had the testing done that Dr. Dozier referenced there?

A The allergy test?

Q Yes.

A Yes, I do see a record of the allergy test, correct.

Q And what does that testing indicate?

A I would call her having moderate allergies based on the test. She tested positive to a lot of

different things. We usually rate them basically at 3 to a 6 depending on the size of the reaction, and hers were mostly 3s and 4s. She'd have one 6 to grass. Looks like Timothy grass.

Q Is that significant to your --

A It shows that, I mean, that certainly allergies were playing a role in some of her turbinate hypertrophy and probably some of the inflammation that's noted throughout some of the records.

Q And do you think they're playing a role in the smell and taste issue?

A I think that if we could document it that if she had times when she was smelling really well and other times when she was not smelling very well and it kind of would come and go, then I would think it would play a big role in it.

Q And do you know if that is something that she's experienced?

A I'm not aware of any records or anything that's indicated that she's had any return of her smell from time to time.

Q But, again, you're only aware of the records you're aware of?

A Correct. Exactly. Correct.

Q And if you were -- we're here today in an office; but, you know, we're doing that for scheduling to make things easier, particularly understanding and appreciative of your time. But if you were in front of a jury who was going to be asked to decide a legal matter, I mean, you're still comfortable in providing the opinion, understanding, you know, other records of her health care could show that information?

A Correct.

Q Okay. Do you know who Miss Connelly's primary care physician is?

A I don't know off the top -- it may be in here somewhere; but I don't know off the top of my head.

Q Or if she has one?

A I'm not aware.

Q Do you know of any issues that -- do you know of any other accidents that she's had since this fall, any other -- any other trauma that she potentially could have suffered?

A I'm not aware of any.

Q But you would -- but you'd -- as far as

you don't know, you would agree that there's a lot about Miss Connelly's life that you don't know?

A Correct.

Q And there's a lot about Miss Connelly's -- well, there's a lot about Miss Connelly's relevant medical history, or at least potentially relevant history, that you don't know?

A Correct.

Q Can genetics play a role in a loss of smell and taste? Is there anything that -- you know, is that something that can be --

A Not that I've seen in any studies or reports. I'd say it's not out there, but not that I would be so sure.

Q What about neurodegenerative disease?

A Sure. I mean, there's a whole laundry list. I'm sure if you were to look in a textbook there'd be probably 50 things like there are for everything else. There's potential causes, but there's others that are more likely that we tend to see.

Q As far as your tending to see them, I mean, how often are you seeing anosmia, or loss of smell, cases?

A Similar to where it plays a degree and what they come in -- not usually their primary complaint. I'd say as their primary complaint is maybe once a month or maybe every two months, so not real frequently, but as a combination of symptoms, frequently, multiple times for a week. But again, most of it's people with bad sinus and allergy problems and things like that.

Q How many permanent cases of loss of smell, anosmia, from trauma have you seen?

A Probably less than a handful.

Q So it's rare?

A (No audible response.)

Q Is that a "yes"?

A Yes.

Q I'm sorry for that. That's just because of the -- we need to be able to have those answers.

Have you ever been qualified to offer expert opinion in a courtroom before?

A Qualified, or ever give an expert opinion?

Q You know, I appreciate that question. I'm not -- I'm talking has a judge ever said the term "qualified"? Have you ever participated in a legal proceeding before?

A I have not, no.
Q Okay. You're not saying that trauma is the most common cause of loss of smell, are you?
A Not saying it's the most common, but it is a cause of loss of smell.
Q But there are other causes -- a number of other causes, right?
A Correct.
Q I think you just -- you skimmed Dr. Schlosser's deposition, didn't you?
A Very briefly, like, for a minute or so. It's that thick (indicating).
Q But, you know -- well, maybe just suffice it to say that the testimony touches on other causes, other potential causes for a loss of taste and loss of smell?
A Correct.
Q And, you know -- and you're not denying that, you know, there certainly are a number of other causes that are out there?
A No doubt.
Q Thank you, Doctor. That's all I've got.
MR. GRUENLOH: Doctor, I just have a few follow-up questions.

- - -

REDIRECT EXAMINATION

- - -

BY MR. GRUENLOH:

Q First of all, Mr. Hines asked you if there could be pertinent records that might have a bearing upon your opinion. And I think you said, yeah, there could be, and I want to discuss with you whether there is. All right?

First thing he asked you about is whether or not you'd seen Dr. Funcik'S records and y'all were talking about whether or not there was a concussion, that you'd never confirmed the concussion and so forth.

MR. GRUENLOH: And, Rus, I've got this Nason record here. It's RMC15 through RMC17, and I'll just put that in front of you.

BY MR. GRUENLOH:

Q Have you seen the Nason Medical record from when Rosemary Connelly went in to see Nason a few days after she saw Funcik?

A I have.

Q All right. And do you see on the second page of that document that Miss Connelly was

diagnosed with a concussion?

A I do.

Q Are the doctors over at Nason qualified to diagnose somebody with a concussion?

MR. HINES: Object.

BY MR. GRUENLOH:

Q To your knowledge, are the doctors over at Nason able to diagnose somebody with a concussion?

MR. HINES: Object to form -- or objection to the question.

THE WITNESS: To my knowledge, yes.

BY MR. GRUENLOH:

Q All right. When you see a record like that from a -- look at the third page and tell us who signed it.

A Brian Schwartzberg.

Q All right. Is he an M.D.?

A He is.

Q All right. When you see a record like that, is that something that in your practice you're able to and willing to rely upon?

A Yes.

Q All right. And, you know, kinda what started this is we were showing you your record where

it said that Miss Connelly had a broken nose and a concussion. And does that record right there which you reviewed prior to today confirm, in fact, that those things are, in fact, correct?

A It confirms that that was their diagnosis, yes.

Q All right. Now, with respect to allergies, you were asked a number of questions about allergies. First of all, Dr. Dozier did the allergy test, right?

A Correct.

Q All right. With respect to the exact findings of the allergies and any -- his observations, would you defer to him on those subjects?

A I would.

Q All right. You characterized it as moderate allergies; is that correct?

A Correct.

Q Do moderate allergies cause permanent anosmia?

A Typically, not in my case. I mean, not in my opinion. Sorry.

Q All right. You had some --

A I will -- if I can qualify that. Skin testing is a result of allergies on the skin. Doesn't necessarily always correlate to symptoms. So we can have people that have relatively mild to moderate allergies that can have pretty significant sinus disease. You can have people with fairly significant allergy testing that seem to be relatively symptomatic. So they don't always correlate when you want them to.

Q All right. You were asked a number of questions about all the things that you don't know about Rosemary Connelly's life. You don't know what she did when she was 3 years old, do you?

A I don't.

Q All right. But you did get an opportunity to review her testimony, correct?

A I did, yes.

Q All right. And do you recall that you reviewed testimony relating to the timing of her injury, first of all?

A I do.

Q Do you recall that you reviewed testimony regarding to whether she had ever been able to smell anything after the accident?

A I do.

Q Do you recall that you reviewed testimony from Rosemary Connelly that you gave under oath as to whether or not the disruption of her sense of smell from the time of the accident was continuous?

A I do.

Q All right. And did all of those things support your opinion?

A They did.

Q All right. I don't have any further questions.

MR. HINES: One quick second.

THE WITNESS: Yeah.

(There was a pause in the proceedings.)

MR. HINES: Thank you, Doctor. That's all. I appreciate your time.

THE WITNESS: Thank you.

THE VIDEOGRAPHER: This is the end of Tape No. 2 and concludes the deposition of Dr. Mark Ghegan. The time is 3:03 p.m.

- - -

(Witness excused.)

- - -

(Deposition was concluded at 3:03 p.m.)

CERTIFICATE OF REPORTER

I, Deirdre J. Weyer, Registered Professional Reporter and Notary Public for the State of South Carolina at Large, do hereby certify:

That the foregoing deposition was taken before me on the date and at the time and location stated on page 1 of this transcript; that the deponent was duly sworn to testify to the truth, the whole truth and nothing but the truth; that the testimony of the deponent and all objections made at the time of the examination were recorded stenographically by me and were thereafter transcribed; that the foregoing deposition as typed is a true, accurate and complete record of the testimony of the deponent and of all objections made at the time of the examination to the best of my ability.

I further certify that I am neither related to nor counsel for any party to the cause pending or interested in the events thereof. Witness my hand, I have hereunto affixed my official seal this 21st day of August 2015, at Moncks Corner, Berkeley County, South Carolina.

_____

Deirdre J. Weyer
Registered Professional Reporter
Notary Public
State of South Carolina at Large
My Commission expires:
May 15, 2023

PATIENT NOTE

NAME: **Rosemary Connelly**
DATE: **06/06/11**

Rosemary fell while jogging today. There was no loss of consciousness or other injury. She struck her right nose, the nasal tip, cheeks, etc. She denies other injury. She has abrasions at all of these areas and fairly massive swelling of the right nasal dorsum. She had epistaxis.

Examination is as stated above. There is no septal hematoma, no active bleeding in the nose. She has very impressive soft tissue swelling. She permitted reasonable pressure on palpation, and the bony pyramid is essentially stable. However, due to the massive subperiosteal swelling, it is impossible to perfectly ascertain the appearance of the position of the nasal pyramid.

I want to re-evaluate her in one week. It is unlikely, but possible, that she may need open reduction of a nasal fracture. I asked her to avoid any coagulants, avoid heavy nose-blowing and use Afrin or oral decongestants for her nasal obstruction. Wound care for her abrasions was covered in detail.

Thomas Funcik, M.D.

TF/ppi

COASTAL FACIAL PLASTIC SURGERY, P.A.
HISTORICAL DATA SHEET

Name Connelly, Rosemary Date of birth 7.1.55 Today's Date 6/14/2011
Address: Home REDACTED Telephone# REDACTED
Work _____ Telephone _____
May we contact you by phone? yes
Marital status: S (M) D Sep Occupation retired Ages of children 19 & 20
How where you referred to us? (Check all that apply and fill in name of doctor or person)

- ✓ Friend Carol Little
- ___ Patient
- ___ Doctor
- ___ Dentist
- ___ Nurse
- [redacted]
- ___ Yellow pages
- ___ Magagize
- ___ Newspaper
- ___ Other Media
- ___ Hospital referral service
- ___ Other

Which procedure(s) are you interested in?

___ Rhinoplasty(nose)	___ Chin	___ Collagen
___ Eyelids	___ Chemical peel	___ Fat transfer
___ Face or neck lift	___ Dermabrasion	___ Hair transplant
___ Forehead lift	___ Parisian Peel	___ Removal of cyst or mole, skin cancer ,etc.
___ Ears	___ Botox	___ Scar revision
		___ other

Have you consulted another doctor in regards to this type of procedure(s)? Yes (No)
If so, whom? _____
Have you had any previous cosmetic surgery? (Yes) No
If yes, please state what type of procedure and when performed eyes, lipo
Who performed the surgery? funcik Were you satisfied with results? (Yes) No
If no, why? _____

Medical History

When was your last physical examination? 2010
Who is your family doctor? Dr. Judy Schliff (Doctor's CARE)
Who is your internist? _____
Who is you OB/GYN? _____

No Yes List allergies to any medications: sulfa
(No) Yes Have you had any reaction to Local or any other anesthersia?
Explain _____
No (Yes) Are taking any over the counter or prescription medications? List them:
20 mg. PROTAC
~~No~~ Yes Do you take vitamins regularly? _____
(No) Yes Are you pregnant at present or trying to conceive? When was your last menstrual period? _____
~~No~~ Yes Have you ever taken acutane?
No (Yes) Do you take aspirin, Advil, Motrin, or any other medicines that may affect clotting or bleeding?
~~No~~ Yes Have you ever had herpes, fever blisters, or cold sores? Circle those which apply
~~No~~ (Yes) Have you ever had surgery or injuries to or around the face, neck or eyes?
If so, when 6/6/2011 Describe injury fell on nose
No Yes Do you have a history of bleeding or excessive bruising?

Have you or any member of your immediate family been affected by any of the following conditions? Please identify who by relationship.

- ___ Heart trouble
- ___ High blood pressure
- ___ Diabetes
- ___ Bleeding
- ___ Poor healing
- ___ Psychiatric or nerve problems

Continued on back

__Thyroid condition _____ __Excessive scarring _____
__Arthritis _____ __Tuberculosis _____
__Excessive bruising _____ __Other _____

Have you every had any of the following surgeries: (give date)

__Sinus surgery _____ __Skin surgery _____
✓__Tonsillectomy 1960's __Dental surgery _____
__Adenoidectomy __Breast surgery _____
__Chest or lung __ __Thyroid surgery _____
__Bladder surgery __Abdominal surgery(ie, gallbladder, intestinal) _____
__Fracture repair __Orthopedic surgery including back _____
__Hernia repair __Other (no matter how remote, minor or unrelated)

__Reproductive system including D&C, removal of ovary, hysterectomy, of (C-section) 1990, 1992
Number of pregnancies 2 Number of Deliveries 2
Were there any complications to any of the above mentioned procedures? NO

(No)	Yes	Do you have hay fever, asthma, or allergies?
No	Yes	Do you have chest pains with stress or exertion?
No	Yes	Do you have stomach trouble or ulcers?
No	Yes	Have you ever had liver, gall bladder trouble, or yellow jaundice? (Circle which)
No	Yes	Do you have skin irritations, rashes or sensitivity to adhesive tape?
No	Yes	Do you have headaches or dizzy spells?
No	Yes	Has any part of your body been paralyzed?
No	Yes	Do you ever have convulsion or seizure?
No	Yes	Have you ever had loss of vision?
No	(Yes)	Do you have dry or teary eyes?
No	Yes	Do you suffer with blurred vision?
No	Yes	Are you being treated for glaucoma?
No	(Yes)	Where you ever treated for anemia?
No	Yes	Have you every been treated for a venereal disease?
No	Yes	Have you ever taken hormones or thyroid medication?
No	Yes	Do you smoke more than 10 cigarettes per day?
No	Yes	Do you drink more than 3 cups of coffee per day?
No	Yes	Do you usually take two or more alcoholic beverages per day?
No	Yes	Do you often get depressed? not often
No	Yes	Have you ever had a nervous breakdown or panic attack?
No	Yes	Have you ever received medical attention for a nervous condition?
No	Yes	Are you fearful of doctors or dentist?
No	Yes	Do you have any medical problems that have not been covered?
No	Yes	Are there any private medical conditions such as drug use, HIV infection, etc. That you would like to discuss with me privately?
No	(Yes)	Do you give consent and authorize the recommended diagnostic, medical, surgical, anesthetic and other diagnostic services that the clinic deems beneficial while you are under their care?

Signature: Rosemary Connelly Date: 6/14/2011

p:\historicaldata.wpd
updated 10/02

PATIENT NOTE

NAME: **Rosemary Connelly**
DATE: **06/ /11**

Rosemary comes back for re-evaluation. She is to keep more ointment on her abrasions.

With respect to her nasal fracture, it seems to be progressing nicely. There is no septal hematoma. As expected, there is some tenderness and swelling in the right paranasal area.

Our suspicion that there is a non-displaced or minimally displaced nasal fracture has been confirmed. In the meantime, Rosemary went to Nason Medical Clinic and had an extensive workup with CT, x-ray, etc. I read the x-ray report that confirmed a nasal fracture. There was no further description as far as displacement, extent, location, etc. I attempted to view the imaging on a disk, but it was not compatible with my computer, so I was unable to review this.

We discussed her options. She has the option of letting it heal conservatively *vs.* a reduction of the nasal fracture. Either way, she is likely to have some deformity in the area. If she were my wife, because it is minimally displaced, I would allow it to just simply heal for about six weeks and then perform some b.i.d. digital massage to try to make it as smooth as possible.

If corrective surgery is necessary, it would be advisable to wait a full year before performing any further surgery such as rasping, open reduction, etc.

I want to check her again in one month.

Thomas Funcik, M.D.

TF/ppi

MEDICAL RECORDS RELEASE REQUEST

I hereby authorize and instruct NASON MEDICAL
to release to Dr. Thomas Funcik, at the above address, all information in my medical record. This is to include all office notes, diagnostic tests, surgical reports, and correspondence.

Your timely cooperation is greatly appreciated.

Lauren Capuza
WITNESS

Rosemary Connelly
SIGNATURE PATIENT/GUARDIAN

ROSEMARY CONNELLY
PRINT PATIENT NAME

6/14/11
DATE

NEED COPY OF CT REPORT (WRITTEN)

NASON MEDICAL CENTER right there.

EMERGENCY – URGENT CARE – DIAGNOSTIC IMAGING

Date:	06/14/11
Send to:	DR FUNCIK
Phone:	
Fax number:	843-884-6992
From:	Nason Medical Center Business Office Medical Records Tonya Herriott
Office fax:	(843) 552-4121
Phone Number:	(843) 552-4240

	URGENT		REPLY ASAP		PLEASE COMMENT		PLEASE REVIEW		FOR YOUR INFORMATION

TOTAL PAGES, INCLUDING COVER: 8

Comments:

RE: ROSEMARY CONNELLY
DOB: REDACTED

Per your request, please see attached medical records for the above patient.

Have a Great Day!

Sincerely,
Tonya Herriott
Medical Records Representative

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1101 Bowman Road • Mt. Pleasant, SC 29464
phone: 843•284•4911 fax: 843•284•4910 Website: http://www.nasonmedical.com

NASON MEDICAL CENTER right there.
EMERGENCY - URGENT CARE - IMAGING
1101 BOWMAN ROAD • MT. PLEASANT, SC 29464
843.388.3500

PATIENT: Rosemary Connelly
DATE OF BIRTH: REDACTED
DATE: 06/10/2011 10:55 AM
VISIT TYPE: Urgent Care

Chief Complaints/ Concerns

Head injury Pt sts that she has a severe headache/facial pain accompanied with dizziness and nausea following trauma Monday morning. She sts that she tripped on some construction debris while jogging on the sidewalk causing her to fall facedown onto the pavement leaving her with multiple abrasions to her face and right knee. She was initially seen by her plastic surgeon however no imaging was performed of her facial bones or right knee. Onset was 5 Day(s) ago. Severity moderate-severe. Location: head/face/ Where: street/sidewalk. Context: fall. Pertinent positives include nausea, laceration. Pertinent negatives include loss of feeling in arms, loss of feeling in legs, neck pain, double vision, chest pain, vomiting, rash/abcess, abdominal pain, recent illness, tingling.

Right Knee Pain Upon questioning of her right knee abrasion, pt sts that she is experiencing some dull, achy right knee pain increased when walking/standing. She denies any point tenderness. Onset was 5 Day(s) ago. Severity moderate-severe. Patient was injured on the right knee. Pertinent positives include nausea. Pertinent negatives include loss of feeling, trouble breathing, double vision, vomiting.

Past Medical/Surgical History

Medical Condition
depression

Current Medications

Brand Name	Dose	Sig Codes	Start Date	Stop Date
Prozac				

Family History

Family Mbr	Condition
Family h/o	Cancer

Social History

Not a Smoker
Not an Alcohol Drinker

Allergies

Allergen/Ingredien	Brand
Sulfamethoxazole	Bactrim
Trimethoprim	Bactrim

Patient's last Tetanus was given more than 5 years ago.

Review of Systems

Respiratory: No SOB or cough.
Cardiovascular: No chest pain or palpitations.
Vascular: Negative for claudication.
Gastrointestinal: No vomiting, diarrhea or constipation.
Neuro/Psychiatric: No dizziness, no emotional disturbances.

Vital Signs

Date	Time	Temp F	Pulse	Resp Rate	Bp Systolic	Bp Diastolic	Pulse Ox	Weight Kg

06/10/2011	11:08 AM	97.30	65	18	122	87	99

Vitals done by Chris Carlton

Physical exam
General/Constitutional: Well nourished well developed.
Head / Face: Normalocephalic.
Eyes: No exopthalmus, papillary reaction is normal and EOM intact.
Ears: Hearing grossly intact, tympanic membranes normal.
Nose / Throat: No nasal deformity. Mucous membranes normal. Tongue and throat appear normal.No mucosal lesions.
Neck / Thyroid: Supple, without adenopathy or enlarged thyroid.
Lymphatic: No palpable cervical, supraclavicular or axillary adenopathy.
Respiratory: Normal to inspection. Lungs clear to percussion and auscultation.
Cardiovascular: Regular rhythm. No murmurs, gallops or rubs.
Integumentary: Multiple abrasions to forehead, nose, shoulder, and right knee
Musculoskeletal: Moderate swelling to bridge of nose with slight assymmetry to the right, no signs of septal hematoma. Focallized tenderness over right patella. Slight bilateral paracervical tenderes.
Extremities: Extremities appear normal. No edema or cyanosis.
Neurological: Alert and oriented.
Psychiatric: No unusual anxiety or evidence of depression.

Scribe was Seth Price

OrdDate	OrdTime	Description	Dose	Route	Units	PSB	PSA	GivenBy
06/10/2011	11:10 AM	Tetanus, Diphtheria Toxoid Adult pt tolerated meds well/ no adverse reaction	.5 Ml	IM	1			Chris Anderson

Assessment/ Plan
Pain in joint, right knee
Right knee contusion
Headache
Fracture, right nasal bone
Concussion
Pt instructed to f/u with her PCP, Dr. Funcik, next week as scheduled.

The discharge Instruction for Contusions was given to the patient.
The discharge instruction for Facial Fracture was given to the patient.

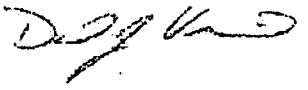
Prescribed Medications:

Brand Name	Dose	Sig Codes	Start Date	Qty	Units
Baclofen	10 Mg		06/10/2011	5	

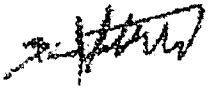
Sample Medications:
BiPap

Diagnostic Studies

Ordered	Order	Timeframe	Appt.	Scheduled	Interpretation
06/10/2011	CT Scan - Cervical spine, w/o contrast				spasm, loss of lordosis
06/10/2011	CT Scan - Head/brain, w/o contrast				neg
06/10/2011	X-ray knee(s) w/ sunrise, 4 views, R				neg
06/10/2011	CT Scan - Facial bones, w/o contrast				Rt nasal bone fx, mild chronic sinusitis.



Daniel Venancio PA



Brian J. Schwartzberg MD
I saw and discussed patient with PA, reviewed chart, and agree with findings and plan.

NASON MEDICAL CENTER right there.
1101 Bowman Road
Mount Pleasant, South Carolina 29464
(843) 284-4928 Office
(843) 284-4910 Fax

Professionally Interpreted by:
Carolina Radiology Associates, LLC

NAME: CONNELLY, ROSEMARY **DATE OF EXAM: 06/10/2011**
DOB: REDACTED **PATIENT ID:** REDACTED
PHYSICIAN:
SCHWARTZBERG/VENANCIO

EXAM: CT of the cervical spine.

HISTORY: Pain in the neck.

TECHNIQUE: Axial images from the base of the skull down to the thoracic inlet were done and we did obtain both coronal and sagittal reconstruction images.

FINDINGS: There is a loss of lordosis usually seen in the cervical area and this could be due to muscle spasm. Hypertrophic bone and narrowing of the facet joints on the left side at C3-C4 and C4-C5 is seen and there are moderate degenerative changes at C5-C6. No acute abnormalities are noted. There are no fractures seen.

IMPRESSION:

1. Moderate facet arthropathy on the left at C3-C4 and C4-C5.

2. Moderate degenerative disc disease at C5-C6.

Images were interpreted at CRA office.

Billie Ed Shelley Jr, M.D.
Electronic Signature

DD: 06/10/2011
DT: 06/10/2011

smj

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Mount Pleasant, South Carolina 29464
(843) 284-4928 Office
(843) 284-4910 Fax

Professionally Interpreted by:
Carolina Radiology Associates, LLC

NAME: CONNELLY, ROSEMARY **DATE OF EXAM: 06/10/2011**
DOB: REDACTED **PATIENT ID:** REDACTED
PHYSICIAN:
SCHWARTZBERG/VENANCIO

EXAM: Maxillofacial CT.

IMPRESSION: Nausea and vomiting status post trauma, facial pain.

TECHNIQUE: 1 mm thick axial imaging obtained through the maxillofacial bones. Coronal reconstructed images were performed and reviewed.

FINDINGS: Partially imaged mastoidal air cells are clear. The temporomandibular joints are normally aligned and there is no evidence of mandibular fracture. There is mild mucoperiosteal thickening in bilateral maxillary air cells without gas-fluid level. The bilateral osteomeatal complexes are patent. There is minimal involvement of left posterior ethmoidal air cells. Right nasal bone fracture is present. No other maxillofacial bone fracture is seen. There is no evidence of intraorbital hematoma.

IMPRESSION:

1. Nasal bone fracture.

2. Minimal chronic paranasal sinusitis.

Images were interpreted at CRA office.

John J. Daly Jr, M.D.
Electronic Signature

DD: 06/10/2011
DT: 06/10/2011

smj

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Mount Pleasant, South Carolina 29464
(843) 284-4928 Office
(843) 284-4910 Fax

Professionally Interpreted by:
Carolina Radiology Associates, LLC

NAME: CONNELLY, ROSEMARY **DATE OF EXAM: 06/10/2011**
DOB: REDACTED **PATIENT ID:** REDACTED
PHYSICIAN:
SCHWARTZBERG/VENANCIO

EXAM: Right knee.

HISTORY: Pain.

FINDINGS: AP, oblique, and lateral views of the right knee show no evidence of a fracture. Bones demonstrate a normal alignment. There is a sunrise view of the patella and this shows no abnormalities.

IMPRESSION:

1. Unremarkable right knee.

Images were interpreted at CRA office.

Billie Ed Shelley Jr, M.D.
Electronic Signature

DD: 06/10/2011
DT: 06/10/2011
ks

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Mount Pleasant, South Carolina 29464
(843) 284-4928 Office
(843) 284-4910 Fax

Professionally Interpreted by:
Carolina Radiology Associates, LLC

NAME: CONNELLY, ROSEMARY **DATE OF EXAM: 06/10/2011**
DOB: REDACTED **PATIENT ID:** REDACTED
PHYSICIAN:
SCHWARTZBER/VENANCIO

EXAM: CT of the head.

HISTORY: Severe headache, nausea, vomiting, neck pain.

TECHNIQUE: Axial images were done through the head without intravenous contrast.

FINDINGS: No extraaxial fluid collections are seen.

Ventricles show a normal size and configuration. No extraaxial fluid collections can be seen. No osseous abnormalities are seen.

IMPRESSION:

1. Unremarkable, unenhanced CT of the head.

Images were interpreted at CRA office.

Billie Ed Shelley Jr, M.D.
Electronic Signature

DD: 06/10/2011
DT: 06/10/2011
ks

PATIENT INFORMATION

Patient Full Name: Rosemary (First) (M.I.) Connelly (Last) Today's Date: 7/12/2011

Street Address: REDACTED City: Sullivans Island

State: SC Zip Code: 29482 Home Phone: 843 REDACTED

Work Phone: _____ Cell Phone or Pager: REDACTED

Which Number can we call regarding and appointment? Home Work (Cell/Pager)

E-mail Address: REDACTED @yahoo.com

YES_____I want updated e-mails NO_____I do not want any e-mails

Social Security Number: REDACTED Birthdate: REDACTED

Sex: Fe Marital Status: married Age: 56 ?!!

Employer: N/A Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: Bill Connelly Phone Number(s): REDACTED

How did you hear about us? Paul Hansley

[redacted]

PATIENT NOTE

NAME: **Rosemary Connelly**
DATE: **07/12/11**

Just over a month ago, Rosemary suffered a nasal fracture in a fall. At that time, I indicated that I wanted to follow her closely. In the intervening period, she had a CT scan which confirmed the presence of a nasal fracture. From the first time I saw her, we felt that it would be possible that she may need open reduction of the nasal fracture.

She returns today reporting that she notices swelling and prominence on the right side where the fracture occurred, along with some intermittent nasal bleeding and some nasal obstruction on the right side.

Examination reveals this to be consistent with a previous history of trauma. She has some soft tissue and subperiosteal swelling as well as some palpable bony deformities of the upper dorsum.

ASSESSMENT AND RECOMMENDATION

At her convenience, I would recommend proceeding with open reduction of nasal fracture. This involves IV sedation, office operating room and making a controlled incision in the nasal bones, mobilizing the entire bony nasal pyramid and then casting the bone for a period of one week. This procedure may take up to a year to completely settle down.

Although I have not performed an open reduction nasal fracture where the nasal crookedness was not improved, there is no such thing as a perfect outcome. There will always be some palpable bony irregularities. There is also the possibility that even though the bones are set properly, she may need to have a minor revision which would involve either injection of some filler material such as Restylane or some rasping of any residual bony prominences.

Unfortunately, no intervention can be carried out until one year after the corrective surgery.

Thomas Funcik, M.D.

cc: Ms. Rosemary Connelly

TF/ppi

PATIENT NOTE

NAME: **Rosemary Connelly**
DATE: **08/09/11**

Rosemary comes in for her pre-operative visit. She fractured her nose a short time ago. In addition to reducing the fracture, she wants to have some refinements. We plan to take the hump down, narrow her tip and elevate the nasal tip.

Rosemary and I spent well over an hour together discussing the risks, alternatives, benefits and limitations of the procedure. She understands from her daughter's rhinoplasty that no nose is perfect either before or after surgery. There will always be some irregularities. Her recovery likely will be dramatically more prolonged than her daughter's because of the history of antecedent trauma, her relatively thicker skin and the more significant reduction. She may need an additional revisional surgery at substantial additional cost and also may need things such as massage, cortisone injection, Restylane injection, again all at additional cost.

The risk of septal perforation, bleeding, DVT, PE, MI, the need to delay any revision for an entire year, etc., were all explained. The need for absolute compliance with all of our instructions was stressed.

Thomas Funcik, M.D.

TF/ppi

COASTAL FACIAL PLASTIC SURGERY, P.A.
DIAGNOSTIC SUMMARY

Patient Rosemary Connelly
Allergies & Drug Sensitivities Sulfa

SIGNIFICANT SURGICAL PROCEDURES OR CONDITIONS

DATE	SURGICAL PROCEDURE
[redacted]	[redacted]
8/24/11	NASAL FRACTURE, EXTERNAL NASAL DEFORMITY, NASAL OBSTRUCTION SECONDARY TO NASAL SEPTAL DEVIATION AND BILATERAL INFERIOR TURBNATE HYPERTROPHY.

ONSET	CONDITION
[redacted]	[redacted]
8/24/11	OPEN REDUCTION OF NASAL FRACTURE, FUNCTIONAL SEPTOPLASTY, BILATERAL INFEROR TURBINOPLASTY OPEN RHINOPLASTY.

OTHER

diagsum.wpd

OPERATIVE REPORT

NAME: **Rosemary Connelly**

DATE: **August 24, 2011**

PRE-OPERATIVE DIAGNOSIS: **Nasal fracture, external nasal deformity, nasal obstruction secondary to nasal septal deviation and bilateral inferior turbinate hypertrophy**

POST-OPERATIVE DIAGNOSIS: **Same**

SURGEON: **Thomas Funcik, M.D.**

PROCEDURE: **Open reduction of nasal fracture, functional septoplasty, bilateral inferior turbinoplasty, open rhinoplasty**

ANESTHESIA: **Local with IV sedation.**

DESCRIPTION OF PROCEDURE:

The patient was positioned on the operating table in a supine position. After establishing IV access and appropriate monitors, deep IV sedation was achieved. The nose was anesthetized with 2% lidocaine with 1:100,000 epinephrine, as well as 4% cocaine. After allowing adequate time for hemostasis, the face was prepped and draped in the usual sterile fashion.

The procedure was begun by performing a left hemitransfixion incision. A completely intact mucoperichondrial and mucoperiosteal flap was elevated. The obstructing portions of the bony and cartilagenous septums were excised, being careful to preserve a generous dorsal and caudal structure tip support. The hemitransfixion was closed with 5-0 chromic, and the septomucosal leaves were quilted with 4-0 plain gut.

Bilateral inferior turbinoplasty was then performed. The turbinates were first infractured then outfractured with a Sayer elevator. The anterior inferior aspect of the turbinate was then cross clamped for hemostasis and then excised. The newly exposed free border was cauterized.

The nose was then opened by connecting bilateral marginal incisions to a mid columellar inverted V incision. The skin/soft tissue envelope was elevated up to the rhinion in the supraperichondrial and subperiosteal planes. The nasal dorsum was taken down by using a glabellar rasp, a tungsten carbide dorsal rasp, as well as an 11-blade scalpel for the cartilagenous portion of the dorsum. Once the dorsal height was felt to have been taken down aesthetically and uniformly, the nasal tip was addressed. Tip rotation and refinement was achieved by vertical dome excision in a strategic location to optimize tip symmetry. The domes were reanastamosed with 5-0 prolene, carefully preserving intact underlying nasal mucosa. A columellar strut

consisting of the patient's quadrilateral cartilage was secured with 4-0 chromic. A septocolumellar suture was placed in a figure-8 fashion using 5-0 prolene. A shield shaped tip graft was meticulously carved and secured with 5-0 prolene. Lateral osteotomies were performed through pyriform aperture incisions. Surgicell was placed in the pyriform aperture incisions. The nose was irrigated, suctioned, carefully inspected and palpated, and an aesthetic result was felt to have been achieved.

The patient's intranasal and columellar incisions were closed with 6-0 fast-absorbing gut. Surgicell was placed in the nasal vestibule. A standard nasal dressing consisting of Mastisol, Micropore tape and an Aquaplast cast was applied. Surgicell coated in Bacitracin was placed bilaterally for stability due to the significant reduction and delicacy of her soft tissues. A nasal drip pad was applied.

The patient was awakened and ambulated to recovery in stable condition. Detailed post-operative verbal and written wound care instructions were provided to the patient and her caretaker. They have my home, office and cell phone numbers to help with any questions or concerns.

Thomas Funcik, M.D.

TF/ppi

INFORMED CONSENT FOR AESTHETIC AND RECONSTRUCTIVE SURGERY

PATIENT: Rosemary Connelly

DATE: _____

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

1. I voluntarily request Thomas Funcik, M.D., the staff of the Coastal Facial Plastic Surgery Center, and such associates, technical assistants, and other health care providers as they deem necessary, to carry out the following surgery:
Rhinoplasty & Open reduction Nasal Fracture

2. I understand that Thomas Funcik, M.D., may discover other or different conditions which require additional or different procedures than those planned. I authorize him, and such associates, technical assistants, and other health care providers to perform such other procedures which are advisable in their professional judgement.

3. I understand that no warranty or guarantee has been made to me as to result or cure.

4. I understand that external incisions may leave scars that are visible. The location of these incisions have been described to me. I realize that occasionally, scars may have to be revised because of unsatisfactory appearance.

5. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical procedures planned for me. I realize that common to surgical procedure is the potential for infection, blood clots in the veins and lungs, hemorrhage, poor healing, skin loss, nerve damage, painful or unattractive scarring, impairment of organs such as eye or lip function.

6. I also realize that the following additional risks and hazards may occur in connection with the following procedures:
Dermabrasion or Chemical Peel: Pigment changes in the skin.
Nasal Surgery: Deformity of skin, bone or cartilage, perforation of the nasal septum, breathing obstruction, recurrence or worsening of the condition may occur. Additional surgery may be required for correction.

7. THIS PARAGRAPH PERTAINS TO SMOKERS: Smokers are recognized to have a significantly higher risk of postoperative wound healing problems as well as operative and postoperative bleeding. Patients should discontinue smoking for four weeks before and after surgery. Although it helps to stop smoking for several weeks before and after the surgery, this does not eliminate the increased risk resulting from long term smoking.

8. I understand that anesthesia involves additional risks and hazards but I request the use of anesthetics for the relief and protection from pain during the planned and additional (if indicated) procedures. I consent to the administration of anesthesia to be applied by or under the direction and supervision of Dr. Funcik or such anesthetists or anesthesiologists as they shall select and to the use of such anesthetics as they may deem advisable, with the exception of:
None
(name of particular anesthetic)
I realize the anesthesia may have to be changed possibly without explanation to me.

9. I have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of nontreatment, the procedures to be used, and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent.

10. ( )IF INITIALED, I have been told that a medical grade synthetic implant may be used in the above mentioned operation and have been advised of the risks as well as alternative methods of treatment. I understand that on occasion, implants are rejected by the body.
( )IF INITIALED, I have been informed that the above operation may require transplantation of _____ from other areas of my body or from other persons.
Sulfa allergy

11. I certify that Thomas Funcik, M.D. has discussed the operation with me to my satisfaction, this form has been fully explained to me, that I have read it or had it read to me, that the blank spaces have been filled in, and that I understand its content.

12. I certify that I have read the consultation information and filled out the patient registration and medical history form fully and correctly to the best of my knowledge, and that the information I have supplied is complete and correct.

13. I agree to follow the instructions given to me by Thomas Funcik, M.D. and his staff to the best of my ability before, during, and after the above mentioned surgical procedure, and will notify Thomas Funcik, M.D. of any problems following my surgery.

14. I hereby give permission to Dr. Thomas Funcik or any assistant he may designate to take photographs for diagnostic purposes and to enhance the medical record; I agree that these photographs will remain his property. I further authorize him to use such photographs for teaching purposes or to illustrate scientific papers, books, or lectures, if in his professional judgement, medical research, education, or science will be benefitted by their use.

15. This consent will remain in effect until revoked by me in writing.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING.

Signed: Rosemary Connelly Date: 8/9/21 Time: 11 am/pm
(patient or legal guardian)

Witness: _____ Date: _____ Time _____ am/pm
informed.wpd

Chart# _____

PREOPERATIVE RECORD

Name Connelly Rose Mary Age 56 Wt 145 Date 8/24/11

Arrival Time 830 NPO Status Midnight

Person Picking Up Patient Mary Relationship Mary/daughter

Pt. Staying At Home With Mary Ph# _____

Present Meds: Keflex Last Dose/Time 8pm Date 8/23/11

ASA d/c 10 BP 122/74 Pulse 72 Time 845a

Pre-Op Meds.: Valium ____ mg. Dramamine ____ mg. Given @ ____

WBC ✓ RBC ✓ HGB ✓ HCT ✓ K ✓ UA ✓

PT ✓ PTT ✓ Platelets ✓ EKG ✓ Chest Film

Pregenancy Test Hx Last Menstral Period _____

SURGICAL CHECK LIST

Allergies	Sulfa
History/Physical	✓
Consent Signed	✓
Lab work in chart	✓
Opthamology report	✓
Contact lens removed	✓
Voided Pre-Op	✓
BP, Pulse taken Pre-Op	✓
~~Id band~~ in place	✓
Permit checked with scheduled surgery	✓
Pictures checked	✓
Called Pre-op	✓
Consult Note Read	✓

OPERATIVE RECORD

PERSONNEL

Oper. Rm. _____

Surgeon T. Trucis

Assistant Gail

Anesthes. L. Cuth

Type Anes. MAC

Pre-Operative Diagnosis: Rhinoplasty

Post-Operative Diagnosis: Turbs & S. Ectomy

Operation Performed: _____

SPECIMENS & IMPLANTS

Pathology ~~X~~

Other _____

Implant _____

Manufacturer _____

Lot _____ Batch _____

TIMES

Injection Time 915

Starting Time 930

Ending Time 1300

Anes. Start 830

Anes. End 1315

Count: Corr. ✓ Incorr ___

Needles 8

Blades 3

Wound Class (I) II III

RECOVERY RECORD

EVALUATION - SCORE			1330	1345	1400	1415	1430	1445
PULSE	Strong	2						
	Weak	1	✓	✓	✓	✓	✓	✓
	Regular	2						
	Irregular	1	✓	✓	✓	✓	✓	✓
COLOR	Pink	2						
	Pale, mottled	1	✓	✓	✓	✓	✓	✓
	Cyanotic	0						
VENTILATION	Exchanging well	2						
	Diminished	1	✓	✓	✓	✓	✓	✓
AIRWAY	Clear	2						
	Obstructed	1	✓	✓	✓	✓	✓	✓
CONSCIOUSNESS	Fully awake	2						
	Arousable	1	✓	✓	✓	✓	✓	✓
	Unresponsive	0						
MOVEMENT	Purposeful	2						
	Involuntary	1	✓	✓	✓	✓	✓	✓
	Not moving	0						

DISCHARGE

Time 1450 DCG BP

DCG. To: Mary

Rx: Lortab

Instruction Book given Explained

Surgical Site/DCG. Yes

Return Visit 1 wk

Additional Information

A+O x 4 Ambulated

C Care tolerated

fluids & N+V

Pt voided x 2

BP 134/78 P 78 Resp 14

Post op explained to

pt + daughter w/ Q+A

pt IV d/c'd LT hand

pt d/c'd via wheelchair

in care of family

Bp 151/98 @ 145 pm

Bp 134/76 @ discharge

INFORMED CONSENT FOR ANESTHESIA SER... 3

☐ MONITORED ANESTHESIA CARE (WITH SEDATION)	
EXPECTED RESULT	REDUCED ANXIETY AND PAIN, PARTIAL OR TOTAL AMNESIA RELATING TO SURGICAL PROCEDURE.
TECHNIQUE	DRUGS INJECTED INTO THE BLOODSTREAM, BREATHED INTO THE LUNGS, OR BY OTHER ROUTES, PRODUCING A SEMI-CONSCIOUS STATE.
RISKS	AN UNCONSCIOUS STATE, DEPRESSED BREATHING, INJURY TO BLOOD VESSELS.

☐ I UNDERSTAND THAT THE TYPE OF ANESTHESIA SERVICE CHECKED WILL BE USED FOR MY PROCEDURE.

☐ IT HAS BEEN EXPLAINED TO ME THAT THERE IS A POSSIBILITY THAT THE ANESTHESIA TECHNIQUE INDICATED MAY NOT SUCCEED. IN THIS EVENT, I AUTHORIZE THE PROVIDER OF ANESTHESIA TO USE OTHER APPROPRIATE TECHNIQUES, INCLUDING, BUT NOT LIMITED TO, GENERAL ANESTHESIA.

☐ UNEXPECTED SEVERE COMPLICATIONS WITH ANESTHESIA CAN OCCUR AND INCLUDE, BUT ARE NOT LIMITED TO, INFECTION, BLEEDING, DRUG REACTIONS, BLOOD CLOTS, LOSS OF SENSATION, LOSS OF LIMB FUNCTION, PARALYSIS, STROKE, BRAIN DAMAGE, HEART ATTACK OR DEATH.

☐ I HAVE NOT HAD ANYTHING TO EAT OR DRINK SINCE: _____.

Rosemary Connelly
PATIENT OR AUTHORIZED REPRESENTATIVE

Aug 24 - 2011
DATE

Witness
WITNESS

8/24-2011
DATE

ANESTHESIA RECORD

Surgeon: French

Procedure: L knee replacement

Anesthetist MD [illegible] CRNA Pre-Med Ancef 1gm, Reglan 10mg, Decadron 10mg

- ☒ Patient Identified
- ☒ Chart Reviewed
- ☒ Pre-Anesthesia Evaluation Done
- ☒ Machine & Monitoring checked
- ☒ Alarms Functioning

Labs

Monitors: ☒ EKG ☒ BP ☒ OXIMETER ☒ O_2% ☒ TEMP ☐ P.N.S ☐ VERBAL

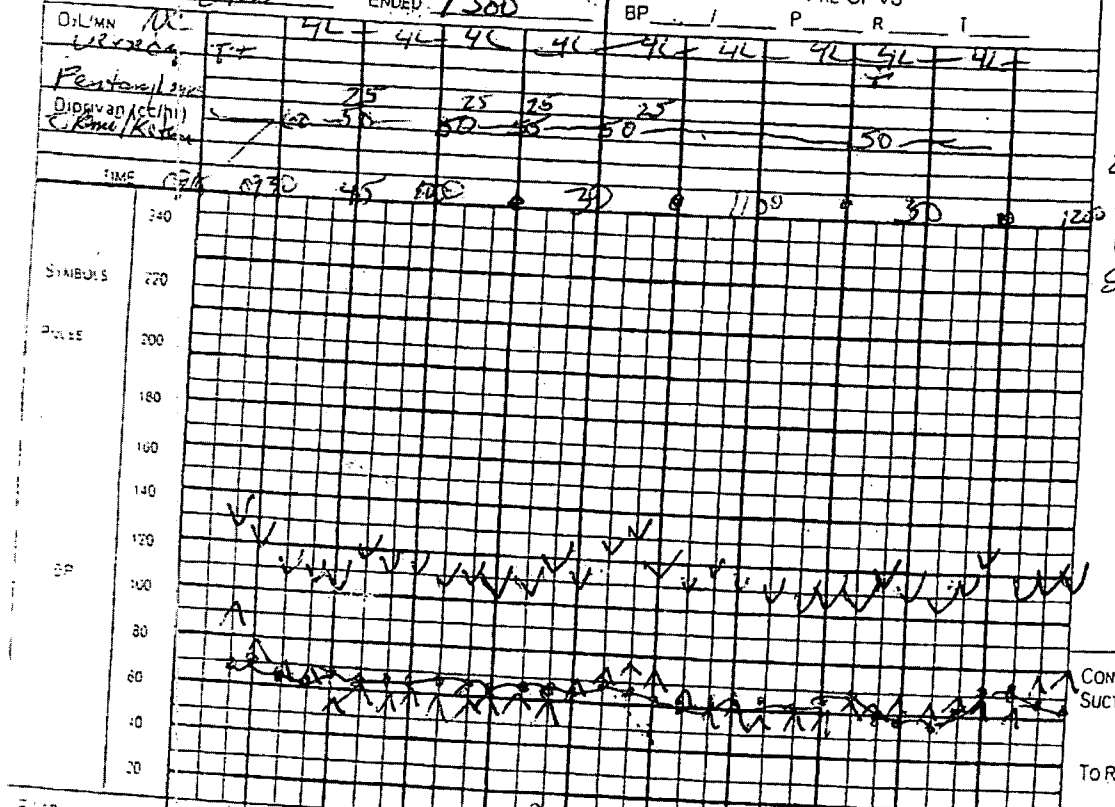
ANES BEGAN 0830 ENDED

SURG BEGAN 0930 ENDED 1300

PRE-OP VS BP ___/___ P___ R___ T___

REMARKS

0830 IV TSA
Chart reviewed
questions answered
20gauge IV to
Left hand.
0930 IV sedated &
Spontaneous resp.
Intubated.



CONDITION AT CLOSE:
SUCTION/EXTUBATION IN OR ☐
IN RR ☐
TO RR AT ___ A.M. P.M.
VITAL SIGNS STABLE ☐
ACTIVE REFLEXES ☐

													FLUID	AMOUNT START	AMOUNT GIVEN
RESP	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV	SV			
ENC	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	LR	1000	500
	97	98	97	98	96	95	98	98	97	96	98				
$ETCO_2$	/														
BP															
BLOOD LOST															

ANESTHESIA TECHNIQUES

GENERAL
INDUCTION IV ☐ MASK ☐
MAINTENANCE MASK ☐ OPA ☐ OETT ☐ SIZE ___ NETT ☐ SIZE ___

REGIONAL
SPINAL ☐
EPIDURAL ☐
R.B.B.B. ☐
M.A.C. ☒
OTHER ___

EYE CARE ☐
ELBOW PADS ☒
HEAD CUSHION ☒
WARMING BLANKET ☒

TOTALS
ESTIMATED BLOOD LOSS ___
URINE OUTPUT ___
TOURNIQUET N/A
PATIENT POSITION Supine

Connelly, Rosemary
PATIENT NAME

CHART #

8/24/2010
DATE

ANESTHESIA RECORD

Surgeon: Lunac

Procedure:

Anesthetist MD Kitten CRNA Pre-Med

- ☒ Patient Identified
- ☒ Chart Reviewed
- ☒ Pre-Anesthesia Evaluation Done
- ☒ Machine & Monitoring-checked
- ☒ Alarms Functioning

Labs

Monitors

EKG	☒	OXIMETER	
BPC	☒	O_2%	
STETH	☒	TEMP	
$EtCO_2$	☐	P.N.S.	
VERBAL	☐		

ANES BEGAN _____ ENDED _____

SURG BEGAN _____ ENDED _____

PRE-OP VS BP ____/____ P____ R____ T____

REMARKS

1315 VSS pt awake & alert ambulated to RR c assistance IV intact d/c'd Voided.

O2L/MN 4L 4L 4L 4L

Ancef 1g

Diprivan (cc/hr) 50 25

Zofran 4

TIME 1250 30 4 1300 30

SYMBOLS

PULSE

BP

V

Λ

240 220 200 180 160 140 120 100 80 60 40 20

RESP	SV	SV	SV	SV	SV
EKG	SR	SR	SR	SR	SR
O_2 SAT	98	98	96	96	97
Et. CO_2	+	+	+	+	+
IVF	LR				
BLOOD LOST					

CONDITION AT CLOSE

SUCTION/EXTUBATION IN OR ☐

IN RR ☐

TO RR AT _____ A.M. / P.M.

VITAL SIGNS STABLE ☐

ACTIVE REFLEXES ☐

FLUID	AMOUNT START	AMOUNT GIVEN

TOTALS

ESTIMATED BLOOD LOSS _____

URINE OUTPUT _____

TOURNIQUET _____ N/A

PATIENT POSITION _____

ANESTHESIA TECHNIQUES

GENERAL

INDUCTION I.V. ☐ MASK ☐

MAINTENANCE MASK ☐ OPA ☐ OETT ☐ SIZE _____ NETT ☐ SIZE _____

REGIONAL

SPINAL ☐

EPIDURAL ☐

R.B.B.B. ☐

M.A.C. ☐

OTHER _____

EYE CARE ☐

ELBOW PADS ☐

HEAD CUSHION ☐

WARMING BLANKET ☐

Connelly, Rosemary

PATIENT NAME

CHART #

8/24/2000

DATE

NAME	AGE	SEX	WEIGHT	HEIGHT
Connelly, Rosemary	56	Fe	145	5'6"

PROPOSED PROCEDURE	CURRENT MEDICATIONS
Rhinoplasty, Bernicle	Prozac
PREVIOUS ANESTHESIA / OPERATIONS	**ALLERGIES**
Bleph. Lipo, C Section	Sulfa
FAMILY HISTORY OF ANESTHESIA COMPLICATIONS	
NAC	
AIRWAY / TEETH / HEAD & NECK	
Class I	

SYSTEM	WNL	COMMENTS
RESPIRATORY	(✓)	TOBACCO USE ☐ YES ☐ NO ____ PACKS/DAY ____ YEARS
CARDIOVASCULAR	(✓)	
HEPATO/GASTROINTESTINAL	(✓)	
NEURO/MUSCULOSKELETAL	(✓)	
RENAL/ENDOCRINE	(✓)	
OTHER		

PHYSICAL STATUS (CIRCLE) (1) 2 3 4 5 E

PLANNED ANESTHESIA/SPECIAL MONITORS

* MAC WITH I.V. SEDATION
EXPLAINED AND ACCEPTED BY PATIENT *

SIGNATURE [signature] DATE 8/24/2011 TIME 1330

POST ANESTHESIA NOTE VSS P & A A+O x3 Denies Anesthetic Complication

SIGNATURE [signature] DATE 8/24/11 TIME 1355

Consult

COASTAL FACIAL PLASTIC SURGERY

NAME: Rosemary Connelly

Patient #: _____ Weight: 145 Age: 56 Sex: F Family Doctor: Susan Jones

Temp: _____ Pulse: _____ Resp.: _____ BP ____/____

Ht: 5'6

SURGICAL PROCEDURE ① Rhinoplasty + Open reduction Nasal Fx ② B-Ectomy Nose

Present Meds.: Prozac

Allergies: Sulfa (Hives)

HISTORY: CHIEF COMPLAINT: _____

Past Medical History (If yes, explain below)

Y N	Herpes Simplex	Y N	Diabetes	Y N	Contact Lens
Y N	Neurologic Disease	Y N	Bleeding	Y N	ETOH
Y N	Heart Disease	Y N	Ulcer	Y N	Cough
Y N	Liver Disease	Y N	Asthma	Y N	Smoke
Y N	Lung Disease	Y N	Glaucoma	Y N	[illegible] Pneumonia
Y N	Kidney Disease	Y N	Blood Pressure	Y N	Other: _____
Y N	MVP	Y N	Heart Murmur		

Explanation: · Eyelids '05 here · C-Section · Lipo 08 here

Family History: Diabetes, Hypertension, Bleeding, Anesthesia Problems

PHYSICAL EXAMINATION:

H.E.E.N.T. nl

HEART nl LUNGS nl

NECK nl NEURO nl

TRUNK nl ABD nl

ABNORMAL FINDINGS ϕ

Patient Condition acceptable for IV SEDATION or GENERAL ANESTHETIC (circle one)

IMPRESSION: Acceptable group

PLAN: O.R.

DATE: 8/9/11 SIGNED _____, M.D.

LAB WORK ORDERED: DATE ORDERED _____

____CBC	____Chest X-ray	____St. Eliz.	____PT	____U/A
____EKG	____Doctor's Clin. Lab	____PTT	____Serum K+	
____BUN/Creat.	____Serum Pregnancy	____Opth. Eval.	____Platelets	____Other

This history and physical as been performed with regard to this surgical procedure and is not meant to be a all inclusive evaluation of the patient.

H&P WPD

CONFIRMATION OF SURGICAL ARRANGEMENTS FOR Rosemary Connelly

PROPOSED SURGICAL PROCEDURE(S) Rhinoplasty & Open reduc Nasal Fx

YOU ARE TO HAVE SURGERY ON August AT 24th Wednesday

PLEASE ARRIVE AT 8:30 am

The following pre-operative instructions are given for your benefit. **It is necessary that you follow these instructions closely in order to ensure that you derive the best possible result from your surgery.** If for some reason you are unable to follow the instructions, please call our office as soon as possible. Feel free to call us with any questions you may have regarding these instructions for your upcoming surgery.

1) You may be required to have lab work done prior to your operation. Please have the lab work done on or before NONE.

2) You will be given a prescription for an antibiotic Keflex 500mg 2x day. Begin taking this the day before surgery 8.23.11. You will take 2 tablets this day. **Do not take these the morning of surgery.** You will resume this medication the day after surgery ad continue until all tablets are taken.

Additional prescriptions: NONE

PLEASE BRING ALL MEDICATION WITH YOU THE DAY OF SURGERY.

3) **Arnica Montana 30X (anti-bruising medication):** Dissolve **3 Pellets** under the tongue **three times a day**. Begin two days before surgery and continue up to two weeks after surgery, depending on the amount of bruising present. **You may take it the morning of surgery.** Do not eat, drink or brush your teeth for thirty minutes before or after taking. Water is okay.

4) **DO NOT TAKE ASPIRIN** (acetylsalicylic acid) products that contain aspirin (Bufferin, Anacin, Empirin, Stanback, Excedrin, Fiorinal, etc.) **or products that contain IBUPROFEN** (Advil, Nuprin, Mediprin, Motrin, etc.) for at least **ten days prior** to or after surgery. **Only Tylenol may be used.** Medication for arthritis or back pain may need to be discontinued prior to surgery. Any medication taken within a two week period of surgery, including over-the-counter products, must be approved by Dr. Funcik or his nurse.

5) **DO NOT TAKE VITAMIN C** or **VITAMIN E** for at least **ten days** prior to surgery.

6) Patients receiving medication for hypertension or cardiac ailments should take their medication with a small amount of water the morning of surgery.

7) Wash your Hair & Face thoroughly the night before surgery with D Soap. Patients who are to have hair transplant or facelift surgery should wash t hair the morning of surgery as well. Men should shave closely the day of sur particularly in the upper lip area. Gentlemen with moustaches do not need to re

the moustache unless instructed by Dr. Funcik. **Do not apply anything on your** ~~Hair or face~~ **after it is washed.**

8) **DO NOT EAT OR DRINK ANYTHING AFTER MIDNIGHT THE NIGHT BEFORE SURGERY.** This includes chewing gum, Lifesavers, breath mints, hard candy, etc. Arnica Montana should be taken the night before and morning of surgery.

9) No alcoholic beverages for at least 48 hours prior to surgery.

10) On the day of surgery, remove all makeup, nail polish, false eyelashes, wigs, hair pieces and jewelry. Please wear a shirt that buttons up the front and pants that are elastic-waisted, such as jogging pants. Ladies, do not wear pantyhose. You may wear shoes that do not have high heels. Our suggestion is a pair of tennis shoes and warm pair of socks or a pair of footies.

11) Patients must arrange for someone to drive them to the office the morning of surgery and pick them up that afternoon. It is imperative that you not be alone the night of your surgery. We will be unable to proceed with surgery if these arrangements are not made.

12) You may want to bring a scarf, hat, sunglasses or other articles to cover your dressings when leaving the office if you are concerned regarding confidentiality.

13) You should not have a permanent or hair coloring within ten days prior to surgery and for six weeks following surgery. Females who wear their hair short and are having a facelift procedure should not have their hair cut within four weeks before or after surgery.

14) Avoid the use of tanning beds, sun lamps and overexposure to the sun for at least one week prior to surgery.

15) Please contact us immediately for instructions if you develop a cold, sore throat, fever blisters, or any skin eruptions. None of these would prevent surgery from being carried out, but we may wish to give you some additional instructions.

16) Please notify us immediately if you should need to postpone your surgery so that we may fill the vacancy in our surgery schedule and reschedule your surgery. Please call (843) 884-3277 or 693-0355.

17) Patients who smoke should discontinue smoking one month prior to and following surgery.

I understand and agree to the above.

Signed Rosemary Connelly Date Aug 9th, 2011

Signed _____ Date _____

TF/ppi

Coastal Facial Plastic Surgery
1280 Johnnie Dodds Blvd., Suite 101
Mount Pleasant, SC 29464
(843) 884-3277

Name: Rosemary Connelly

Please purchase the following items:

- [x] Dial Soap (pre-op use)
- [ ] Neutrogena Shampoo (post-op use)
- [ ] Johnson's Baby Shampoo (post0op use)
- [x] Q-Tips
- [x] Peroxide
- [x] Vaseline
- [x] Extra-Strength Tylenol
- [ ] Eucerin Cream - **Plain only** (no Plus)
- [x] Afrin Nasal Spray and Saline Nasal Spray
- [ ] Refresh P.M. Ointment
- [ ] Refresh Plus (no preservatives)
- [x] Arnica Montana - **30x** (available at health food stores)
- [x] Clear Liquids - 7-Up, Ginger Ale, Sprite
- [x] Soft foods (i.e., mashed potatoes, pudding, Jello)
- [ ] Frozen garden peas and baggies
- [x] Pain medications will be provided day of surgery
- [ ] Garments
- [ ] _____
- [ ] _____

TF/ppi

[redacted]

6/6/11 Debrided

6/13/11 ..

7/12/11 ..

8/9/11 Prego

~~8/24/11~~ Open NSR,

8/31/11 Bandage/dressing
Suture DC'd - d/c'd Swallow
as expected - Care explained,
Q's answered NJN

9/8/11 Pregnancy swallow as expected

9/20/11 D/c'd swallow test
No problems. Cleared. NJN

11/17/11 Great progress
Begin surgical wound

7/31/13 Instated

8/19/13 HCS ⊕ Nne

Kendig → supervisor

Parsons helping

COASTAL FACIAL PLASTIC SURGERY
CONSULTATION AND PROGRESS NOTES

Date 11/23/11 Patient's Name Rosemary Connelly Age 56 M___ F ✓

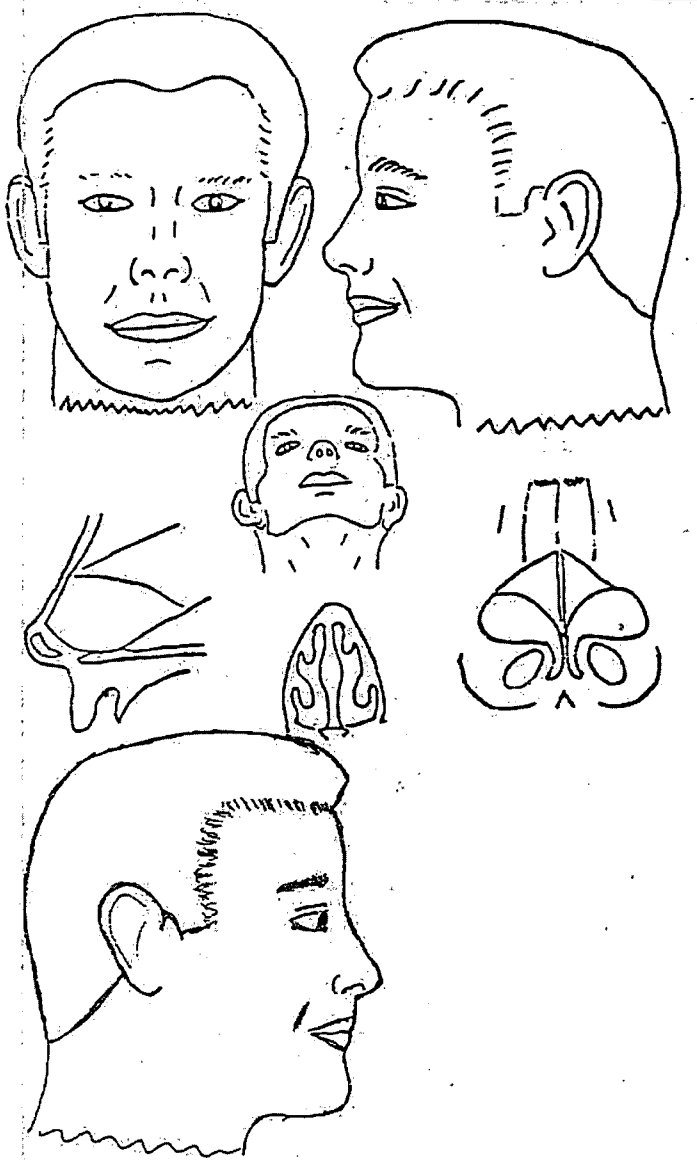
HX & C.C.

Consult Information,
AAFPRS Brochure Reviewed____

Procedure(s), Alt., Risks, Limitations Discussed____

List of risks sheet given____ signed____

Video Imaging____ Limitations Explained____
Predetermination Letter Dictated____
Photos____



DATE	PROGRESS NOTE
12/6/11	D → 6FC Unmasked facial milia
2/22/12	R → NL Hick.
7/17/12	Used rest of Rest.
11/26/12	D → C ?

PATIENT NOTE

NAME: **Rosemary Connelly**
DATE: **05/28/13**

Rosemary came in today for Dysport and Restylane. She mentioned that she has had hyposmia since her injury. When I saw her, it was a couple of days after her injury, and she denied loss of consciousness. She has seen a couple of ENTs to document this. They did an examination of the upper cribriform plate area with vasoconstriction to rule out sinus tumor, etc. They suggested possibly an MRI if it persists or worsens to rule out a tumor in this area.

Using an artificial skull as a teaching aid, I explained to Rosemary the anatomy of the cribriform plate and explained how a frontal injury may sometimes result in some disruption in some of the branches of the olfactory nerve.

Thomas Funcik, M.D.

TF/ppi

PATIENT NOTE

NAME: **Rosemary Connelly**
DATE: **07/31/13**

Rosemary had a reduction of nasal fracture and an open rhinoplasty in August 2011. It has been nearly two years.

She comes in today with three concerns:

1) Persistent fullness in the supratip.
2) Persistent anosmia.
3) Persistent nasal obstruction.

We spent a good bit of time discussing all three of these concerns. Rosemary and I were observing the supratip fullness since not only preoperatively, but since her early post-operative stage. She was patient and faithful with digital massage.

On palpation, it is clear that the reduction in the height of the bony dorsum is straight, symmetrical and adequate. Nonetheless, she does, indeed, have considerable thickness of the skin in the area. We compared the thickness of her supratip skin to the skin of my nose, Kristen's nose and Maureen's nose, and Rosemary's was the thickest.

Unfortunately, compounding this is the fact that she has some other factors going on. One is that she has what appears to be possibly a minute epidermal inclusion cyst of the left nasal supratip. This was apparently injected by Dr. Germain with, I suspect, cortisone, yet it persisted.

In addition, she has some rosacea (which goes hand in hand with thicker skin), as well as some sort of an apparently inflammatory eruption on the right side.

With respect to her anosmia, she has been worked up by an ENT colleague (I believe Dr. Ghegan) and was told that this is essentially uncorrectable.

With respect to her nasal obstruction, her septum is straight, but she does potentially have a bit of turbinate hypertrophy.

ASSESSMENT AND RECOMMENDATIONS

First things first. We are going to get a copy of Dr. Germain's note to see if we can determine and confirm if it was, indeed, cortisone that was injected on the left. Since cortisone was not successful, she may require excision of the area on the left which

could leave a small depressed scar. We are going to put her on a topical anti-rosacea regimen, starting with Prosacea over-the-counter. Then we will probably fairly soon perform one or two cortisone injections. Down the road, she may benefit from dermabrasion.

Unfortunately, the skin tends to thicken with age. I showed her a picture of myself in my 20s that revealed I had relatively thin skin on the dorsum, but due to my rosacea, the skin has thickened considerably. We could be siblings!

I want to see her again in a couple of weeks to perhaps perform a cortisone injection. She understands that cortisone is not magic, it takes time to work, and it may create some subtle waviness. Nonetheless, it is a powerful agent in some cases.

Thomas Funcik, M.D.

Enclosure (copy of pre-operative note)

cc: Ms. Rosemary Connelly
REDACTED

TF/ppi

Rosemary Connelly
REDACTED

THOMAS FUNCIK MD
FACIAL PLASTIC SURGERY

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: ROSEMARY CONNELLY REDACTED
Patient's Address: REDACTED
City: SULLIVAN'S ISLAND State: SC Zip Code: REDACTED
Social Security Number: REDACTED

The undersigned hereby authorizes Coastal Facial Plastic Surgery
Thomas Funcik, M.D
2671 Brickside Lane, Mount Pleasant, SC 29466
Phone: (843) 884-3277 Fax: (843) 884-6992

o to release X to obtain

The type of information to be disclosed is as follows:
- o Physicians progress notes/ visit notes
- o Photographs /slides
- o Pre and post op surgery records
- o Consents of treatment
- o Path reports
- o History forms
- o Entire record

X DIAG. X SCRIPT X PROCEDURE DONE > REGARDING BUMP ON L SIDE NOSE

Date of Service(s): _____

I authorize the disclosure of this information via (check preferred method)
- o Mail
- X Fax
- o Both

Please release to / obtain from:

Medical Facility / Physician: GERMAIN DERMATOLOGY
Address: 612 SEACOAST PARKWAY MT PLEASANT SC 294464
Phone: (843) 881-4440 Fax: (843) 881-8440

I understand that I have a right to cancel this authorization at any time. I understand that if I cancel this authorization I must do so in writing. I understand that the cancellation will not apply to information which has already been released in response to this authorization as stated in the Notice of Privacy Practice. Unless otherwise cancelled this authorization will expire/end 90 days from this date. I also understand that, unless I specify otherwise, this release form may authorize release of information related to physical illness, mental illness, and communicable diseases, including but not limited to HIV, AIDS, and/or AIDS-related information. I also understand that faxed and/or photocopies of this release are permissible.

Rosemary Connelly — 7/31/13
Signature of Patient or Legal Guardian — Date

Relationship to patient, if signed by Legal Guardian — Date

[illegible] — 7/31/13
Signature of Witness — Date

Rosemary I. Connelly (23184, REDACTED
57 yr. Female)

Date of Service: 5/. J13 - Germain Dermatology

DERMATOLOGY VISIT NOTE

Patient History:

- History Updated Today? Yes

I have reviewed and updated any changes in the patient's history today.

Past Medical History:

- Past Medical History

- Arthritis / Joint Pain
- Depression / History of Depression

Past Medical Skin History:

- Patient Past Medical Skin History

- Acne
- Keloid(s)/Scars/Healing Problems
- Rosacea

Family History:

- Cancer
- Daughter had Psoriasis

Surgical History:

- Past Surgeries/Hospitalizations

- 2 c-sections

Dermatology Allergies:

- Are You Allergic To Any Of The Following?

- Local anesthetic (lidocaine)? no
- Adhesive tape/bandaids? no
- Latex? no

Social History:

- Social History

Patient denies alcohol use, denies using illegal drugs and denies STD history.

- Smoking History

Denies tobacco use.

Female Patients Only:

- Female Patient Questions

- Are you pregnant? no
- Are you trying to become pregnant? no
- Are you nursing? no

- Female Patient Contraception

- Contraception Type 1: post-menopausal

ROS:

- Allergic/Immunologic: (+) allergies to medications
- Integumentary (skin): (+) cysts , (+) new or changing lesions , (+) rosacea

Skin Cancer / Atypical Nevi Hx:

- No History of Skin Cancer/Atypical Nevi

CC/ HPI:

- Visit Concern(s)

Lesion/ Spot/ Mole/ Growth
Skin Issues

Rosemary I. Connelly (231
57 yr. Female REDACTED

Date of Service: [illegible] /2013 - Germain Dermatology

The pt requested a full skin today

Lesion/Spot/Mole/Growth:

Duration: 8 months
Location: nose
Severity: Changing and Worsening
Timing: waxes and wanes
Signs/ Symptoms: changing size, nontender, not going away and raised
Type Lesion: bump

Skin Issues:
Signs/ Symptoms: bumps
Duration: extended duration
Severity: worsening
Previous Treatments: Laser
Modifying Factors: nothing (+) and nothing (-)
Location: under eyes

[redacted]

General Exam:

- 57 year old female patient appears well developed, well nourished, in no apparent distress and appears stated age.

Examinations below found to be normal (except as noted on exam)
-Head (incl. face)
-Back (incl. spine)
-Chest (incl. breasts/axillae)
-Genitalia, groin, buttocks
-Abdomen
-Left upper extremity
-Right upper extremity
-Left lower extremity
-Right lower extremity
-Neck
-Skin

- Hair Exam shows hair growth and distribution normal.
- Lips, Teeth, Gums Exam shows no obvious abnormalities.
- Eccrine and Apocrine Exam shows no evidence hyperhidrosis, chromhidrosis, or bromhidrosis.
- Ophthalmologic exam shows eyelids and conjunctiva clear.

Skin Exam/ A&P:

- Exam/ Assessment & Plan (SmartStamps Table)
Problem 1 - Xerosis on examined areas
Description: Mild scale c/w xerosis.
Assessment: Xerosis

Problem 2 - Seborrheic Keratosis on examined areas
Description: A 'stuck on' appearing, brown scaly flat papule.
Assessment: Seborrheic Keratosis

Problem 3 - Photodermatitis on examined areas
Description: Changes consistent with photodermatitis noted.

Assessment: Photodermatitis

Problem 4 - Benign Nevi on examined areas
Description: Multiple clinically benign nevi.
Assessment: Benign Nevi

Problem 5 - Cyst on L side of nose
Description: A subcutaneous mass.
Assessment: Cyst, Inflammed
Plan: Intralesional injection today Notes: Pt to begin Doryx 150 mg QD.

Problem 6 - Rosacea on face
Description: Erythema and telangiectasias.
Assessment: Rosacea

Problem 7 - Lesion on right lower eyelid; left lower eyelid
Description: Flesh-colored papules.
Assessment: Syringoma(s)
Notes: Continue Magic Eyes.

Problem 8 - Milia on right malar crescent
Description: Discrete white papule(s).
Assessment: Milium
Notes: Continue Rejuvination Pads 2.5x.

Problem 9 - Idiopathic Guttate Hypomelanosis on legs
Description: Scattered depigmented macules.
Assessment: Idiopathic Guttate Hypomelanosis

Intralesional Injection Procedure Details:

Problem 5 - Cyst on L side of nose
Description: A subcutaneous mass.
Assessment: Cyst, Inflammed
Plan: Intralesional injection today Notes: Pt to begin Doryx 150 mg QD.

Treatment options were discussed with the patient prior to the procedure. All risks and complications were reviewed. Intralesional injection performed today. A total of 0.08 cc of Kenalog-Acetonide at a concentration of 2.0 mg/cc was used. Patient tolerated the procedure well.
Exact number of lesions injected: 1

A total of 0.08 cc
of Kenalog-Acetonide

Exact number of lesions injected: 1

Rosemary I. Connelly (2311
57 yr. Female, DOB REDACTED

Date of Service: 5, 2013 - Germain Dermatology

at a concentration of 2.0 mg/cc

Patient Counseling:

- Counseling Topics Particular Disease and Return if no better
- Return if no better Patient was instructed to return or call the office, if the lesion changes, worsens or fails to improve.
- Particular Disease The diagnosis, prognosis and treatment alternatives for cyst, rosacea, millium, & syringomas were discussed with patient. All questions were answered and treatment will be modified at next visit after re-evaluation. Side effects of medications reviewed.Literature was given Rebate card(s) were given today

Patient Instructions:

The pt was given the following verbally and in writing at today's visit: Doxycycline Side Effects

Patient Photos:

Final Comments:

- Final Comments for today's visit: I have discussed the findings of today's evaluation with the patient. The discussion included a complete verbal explanation of any changes in the examination results, diagnosis, treatment options, and current treatment plan. A schedule for future care needs was explained. Pt verbalizes understanding of these instructions. If any questions should arise after returning home I have encouraged the patient to feel free to call the office. Pt advised of the importance of doing self skin exams every month. Pt voiced understanding. Pt instructed to use soapless cleanser, luke warm water, no wash cloth, and to apply moisturizer within 3 minutes after bathing. Pt also advised to avoid fragrant products and irritating substances. Pt was counseled on skin cancer prevention. Things discussed included good sun sense, wearing a hat with a large brim, using sun protective clothing, staying out of the sun between 10:00 A.M and 3:00 P.M., using sunscreen with appropriate SPF and in sufficient quantities, and the importance of doing self skin exams every month. Pt was advised to RTC if any changes in moles is noted or if any new growths occur. Pt voiced understanding. Pt was reassured concerning benign appearance of all moles/lesions (other than any atypical appearing noted above), however, pt instructed to follow-up if any changes occur. Pt. verbalized an understanding and agrees with treatment plan. Skin cancer education given.
- Labs/Path Results: No lab/path results reviewed.
- Medical Follow Up: Patient was instructed to follow-up in 1 month for follow-up appointment with Louisa G. Floyd, PA-C for cyst re-evaluation.
- Medical Assistant Name: None
- Dr. Germain Assistance in Patient Care: Dr. Germain assisted with the counseling, examination and treatment of this patient today.
- Final Comment Notes: none
- Signature

Louisa Floyd, PA

Louisa Floyd, PA

<More Info>

Providers
- Germain , Marguerite A

Secondary Providers
- Floyd, Louisa G

Prescriptions Given
- Doryx 150 mg tablet,delayed release - 30 (2 refills) - 1 tablet by mouth DAILY Take 1 PO QD with food

Rosemary I. Connelly (231
57 yr. Female, DOB REDACTED

Date of Service: 5, , 2013 - Germain Dermatology

Medications

- Prozac

Allergies

- Codeine - Date Entered: 5/7/2013 4:00:33 PM
- Codeine - Date Entered: 5/7/2013 4:56:09 PM
- SULFA (SULFONAMIDE ANTIBIOTICS)
- Sulfa (Sulfonamides) - Date Entered: 5/7/2013 4:56:09 PM

Coastal Facial Plastic Surgery

COASTAL FACIAL PLASTIC SURGERY
Nurse Notes

Name: Rosemary Connelly Date: 8/19/13

Chart: [redacted] DOB: [redacted] Physician: Funck

1445 Pt order for cortisone injection and shave of left nasal tip
Pt ate lunch, no blood thinners
allergies to Sulfa - no c/o
1% Lidocaine c Epi 1:100,000 .1 cc injected by K Funck
.8cc Cortisone injected by K Funck
~~and Kenalog injected~~ (not given)
Monopolar ESU used setting at 13 / coag 14
pad to R thigh
pre clean, dry, intact
post clean, dry, intact
Pt tolerated well
Verbal and written instructions given and pt
verbalized understanding

RL Tyson RN

INFORMED CONSENT FOR AESTHETIC AND RECONSTRUCTIVE SURGERY

PATIENT: Rosemary Connelly

DATE: 8/19/13

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

1. I voluntarily request Thomas Funcik, M.D., the staff of the Coastal Facial Plastic Surgery Center, and such associates, technical assistants, and other health care providers as they deem necessary, to carry out the following surgery:

   Mini ENT, left nasal tip and columella injection

2. I understand that Thomas Funcik, M.D., may discover other or different conditions which require additional or different procedures than those planned. I authorize him, and such associates, technical assistants, and other health care providers to perform such other procedures which are advisable in their professional judgement.

3. I understand that no warranty or guarantee has been made to me as to result or cure.

4. I understand that external incisions may leave scars that are visible. The location of these incisions have been described to me. I realize that occasionally, scars may have to be revised because of unsatisfactory appearance.

5. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical procedures planned for me. I realize that common to surgical procedure is the potential for infection, blood clots in the veins and lungs, hemorrhage, poor healing, skin loss, nerve damage, painful or unattractive scarring, impairment of organs such as eye or lip function.

6. I also realize that the following additional risks and hazards may occur in connection with the following procedures:
   Dermabrasion or Chemical Peel: Pigment changes in the skin.
   Nasal Surgery: Deformity of skin, bone or cartilage, perforation of the nasal septum, breathing obstruction, recurrence or worsening of the condition may occur. Additional surgery may be required for correction.

7. THIS PARAGRAPH PERTAINS TO SMOKERS: Smokers are recognized to have a significantly higher risk of postoperative wound healing problems as well as operative and postoperative bleeding. Patients should discontinue smoking for four weeks before and after surgery. Although it helps to stop smoking for several weeks before and after the surgery, this does not eliminate the increased risk resulting from long term smoking.

8. I understand that anesthesia involves additional risks and hazards but I request the use of anesthetics for the relief and protection from pain during the planned and additional (if indicated) procedures. I consent to the administration of anesthesia to be applied by or under the direction and supervision of Dr. Funcik or such anesthetists or anesthesiologists as they shall select and to the use of such anesthetics as they may deem advisable, with the exception of:

   None
   (name of particular anesthetic)

   I realize the anesthesia may have to be changed possibly without explanation to me.

9. I have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of nontreatment, the procedures to be used, and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent.

10. ( )IF INITIALED, I have been told that a medical grade synthetic implant may be used in the above mentioned operation and have been advised of the risks as well as alternative methods of treatment. I understand that on occasion, implants are rejected by the body.
    ( )IF INITIALED, I have been informed that the above operation may require transplantation of _____ from other areas of my body or from other persons.

11. I certify that Thomas Funcik, M.D. has discussed the operation with me to my satisfaction, this form has been fully explained to me, that I have read it or had it read to me, that the blank spaces have been filled in, and that I understand its content.

12. I certify that I have read the consultation information and filled out the patient registration and medical history form fully and correctly to the best of my knowledge, and that the information I have supplied is complete and correct.

13. I agree to follow the instructions given to me by Thomas Funcik, M.D. and his staff to the best of my ability before, during, and after the above mentioned surgical procedure, and will notify Thomas Funcik, M.D. of any problems following my surgery.

14. I hereby give permission to Dr. Thomas Funcik or any assistant he may designate to take photographs for diagnostic purposes and to enhance the medical record. I agree that these photographs will remain his property. I further authorize him to use such photographs for teaching purposes or to illustrate scientific papers, books, or lectures, if in his professional judgement, medical research, education, or science will be benefitted by their use.

15. This consent will remain in effect until revoked by me in writing.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING.

Signed: Rosemary Connelly (patient or legal guardian) Date: 8/19 Time: ____ am/pm

Witness: Nicole Brown Date: 8/19/13 Time: 2:40 am/pm

informed.wpd

TELEPHONE COMMUNICATION RECORD

PATIENT NAME ROSEMARY CONNELLY
CHART #
TELEPHONE #
TIME 9:56

date/initials	
[redacted]	
8/14/13	CM to pt to call
8/16/13	Dpah & pt discussed Dr Frank's 7/31/13
	letter note - rec Cortisone injections ② pt is
	taking Prozac for Rosacea ③ stop nasal tip
	exfoliating rec nasal dermabrasion in future
	She will also undertake Lag and F/U - 8/19 2:30
	for Cortisone injection. Pt's note & pt ④ note sent to pt
	per the French sergeant K Jefferies

tele.wpd

COASTAL FACIAL PLASTIC SURGERY, P.A.
DIAGNOSTIC SUMMARY

Patient ROSEMARY CONNELLY
Allergies & Drug Sensitivities SULFA

SIGNIFICANT SURGICAL PROCEDURES OR CONDITIONS

DATE	SURGICAL PROCEDURE
8/19/13	HORIZONTAL EXCISIONAL BIOPSY OF AFOREMENTIONED LESION

ONSET	CONDITION
8/19/13	LESION LEFT SIDE OF NOSE

OTHER

diagsum.wpd

HORIZONTAL EXCISIONAL BIOPSY

NAME:	**Rosemary Connelly**
DATE:	**August 19. 2013**
PRE-OPERATIVE DIAGNOSIS:	**Lesion left side of nose**
POST-OPERATIVE DIAGNOSIS:	**Same**
PROCEDURE:	**Horizontal excisional biopsy of aforementioned lesion.**
SURGEON:	**Thomas Funcik, M.D.**
ANESTHESIA:	**Local**

DESCRIPTION OF PROCEDURE:

The biopsy site was confirmed by the patient and corroborated with pre-operative photography and reference to the chart. 1% Lidocaine with 1:100,000 epinephrine buffered with sodium bicarbonate was injected into the site. After allowing adequate time for hemostasis, the area was prepped and draped in the usual sterile fashion. A 15-blade scalpel was used to horizontally excise the lesion, being careful to provide an adequate amount of deep dermis for later re-epithialization. Hemostasis was obtained with unipolar electrocautery.

Detailed verbal post-operative and wound care instructions were provided. The patient has our office and pager number to call with any questions or concerns.

Thomas Funcik, M.D.

TF/ppi

PATIENT NOTE

NAME: Rosemary Connelly
DATE: June 5, 2014

Rosemary returns today for evaluation of her nose. She suffered a nasal fracture in approximately June of 2011 and underwent open reduction of nasal fracture and rhinoplasty in August of the same year. Although she is improved overall, she continues to have some functional and cosmetic concerns. She explained that there is some litigation regarding the injury, but I have no reason to delve into any of those specifics except as they bear on her medical status or to answer Rosemary's questions.

As far as the appearance is concerned, we both would like to have some more refinement of the nasal tip. It is narrower and more symmetrical than before her rhinoplsty, yet not as narrow as a perfectly proportioned nose. This bulbosity is multifactorial- her natural cartilage anatomy, congenital skin thickness, exacerbated skin thickness from rosacea, post-surgical scar tissue, etc. We have done some limited resurfacing and cortisone injection as well as a small excision. We are also treating it medically with sunscreen and Prosacea. For now, she is content. Down the road we may consider dermabrasion which would most likely considerably improve the situation. All of these concerns seem to be not directly related to her injury.

From a functional standpoint, she continues to complain of variously of anosmia, hyposmia and dysosmia and some nasal obstruction. According to Rosemary, she was recently evaluated by Dr. Pullano, who noted some intranasal edema, diagnosed a possible infection and prescribed an oral antibiotic. On examination today, the septum and turbinates are not markedly abnormal or deviated, but I did detect some pale edema in the upper nasal cavity even after vasoconstriction with Afrin.

Dysomias can be difficult to diagnose and treat. Rosemary indicated she was evaluated for this concern at Charleston ENT. As a former ENT, I have confidence in their assessment but do not have their records. If her symptoms persist, I recommended she be reevaluated for this concern, perhaps performing a CT or other imaging given the longstanding duration of the concern. Mary asked me whether the smell concerns could be related to the surgery or the injury. I told her I felt very confident that they were not secondary to our surgical procedure. The olfactory nerve fibers are not in significant jeopardy during rhinoplasty or reduction of uncomplicated nasal fractures. I have never had a case of anosmia in almost thirty years of performing nasal surgery. Anosmia can occur, however, when the olfactory nerve fibers are severed or injured as a result of a blow to the front of the head.

Again, a competent ENT re-evaluation is in order from a medical and perhaps legal standpoint.

Thomas Funcik, M.D.

Thomas Funcik, M.D.
2671 Brickside Lane
Mt. Pleasant, SC 294667180
(843)884-3277

Patient: Rosemary Connelly
REDACTED

Chart #: 00045480
Case #: 9378

[redacted]

Date	Description	Procedure	Modify	Dx 1	Dx 2	Dx 3	Dx 4	Units	Charge
11/26/2012	Dysport	DYSPORT		873.5	873.5	959.0		1	297.00
11/26/2012	Discount	DISCOUNT						1	-5.00
11/26/2012	Visa/Mastercard Payment	VISA/MCA						1	-292.00

Provider Information
Provider Name: COASTAL FACIAL
License: 15088
Commercial PIN:
SSN or EIN: REDACTED

Total Charges: $297.00

[redacted]

Patient Signature: _____ Date: _____

Thomas Funcik, M.D.
2671 Brickside Lane
Mt. Pleasant, SC 294667180
(843)884-3277

3/14/2013

Patient: Rosemary Connelly
REDACTED

Chart #: 00045480
Case #: 9378

[redacted]

Date	Description	Procedure	Modify	Dx 1	Dx 2	Dx 3	Dx 4	Units	Charge
6/6/2011	Established Comprehensive	99215		873.5	873.3	959.0		1	[illegible]
6/6/2011	Emergency work In	99058		873.5	873.3	959.0		1	[illegible]
6/14/2011	Post-op	99024		873.5	873.3	959.0		1	[illegible]
[redacted]									
12/6/2011	Established Comprehensive	99215		706.9	709.0	706.2	782.2	1	[illegible]
12/6/2011	Exc. trnk,arm,leg .6-1.0 cm	11401		706.9	709.0	706.2	782.2	1	[illegible]
12/6/2011	Exc. trnk,arm,leg 1.1-2.0 cm	11402		706.9	709.0	706.2	782.2	1	[illegible]
12/6/2011	Exc. Lesion 2.1 To 3.0	11403		706.9	709.0	706.2	782.2	1	[illegible]
12/6/2011	Ex.face,ear,el,nose,lip .6-1.0	11441		706.9	709.0	706.2	782.2	1	[illegible]
12/6/2011	Ex.face,ear,el,nose,lip .6-1.0	11441	51	706.9	709.0	706.2	782.2	1	[illegible]
12/6/2011	Photos/Reports/Copy of Records	99080		706.9	709.0	706.2	782.2	1	[illegible]
12/6/2011	Medical Supplies	99070		706.9	709.0	706.2	782.2	1	[illegible]
12/6/2011	Procedure Tray	A4550	59	706.9	709.0	706.2	782.2	1	[illegible]
[redacted]									
1/19/2012	Visa/Mastercard Payment	VISA MCA						1	[illegible]
2/22/2012	Restylane	RESTYLAN		873.5	873.3	959.0		1	[illegible]
2/22/2012	Check	CK						1	[illegible]
7/17/2012	Dysport	DYSPORT		873.5	873.3	959.0		2	[illegible]
7/17/2012	Restylane Reinjection	RESTYR11		873.5	873.3	959.0		1	[illegible]
7/17/2012	Discount	DISCOUNT						1	[illegible]
7/17/2012	Visa/Mastercard Payment	VISA MCA						1	[illegible]

Provider Information

Provider Name: COASTAL FACIAL
License: 15088
Commercial PIN:
SSN or EIN: REDACTED

Total Charges: $ 28[illegible].70

[redacted]

[redacted]

Patient Signature: _____ Date: _____

Coastal Facial Plastic Surgery
Thomas Funcik, M.D.

Thursday, September 22, 2011

Re: Rosemary Connelly
DOB REDACTED

List of services performed on Wednesday, August 24, 2011

PROCEDURE	FEE
Open Reduction of Nasal Fracture	$ 2,846.00
Functional Turbinectomy	$ 1,485.00
Rhinoplasty	$ 4,495.00
Private Surgical Suite & Anesthesia Service & Supplies	$ 1,800.00
TOTAL	**$ 10,626.00**

Mrs. Connelly paid $6295.00 for the Rhinoplasty, Private Surgical Suite and Anesthesia Service and Supplies on July 12, 2011.

Thomas Funcik, MD

COASTAL FACIAL PLASTIC SURGERY

Thomas Funcik, M.D.

SURGICAL FEE QUOTE

Name [redacted] Date 6/11/11

Surgical Procedure	Surgical Fee
1) Open Reduction Nasal Fx	$ 2846.00 *
2) Rhinoplasty	$ 4.495.00 *
3)	$
4)	$
5)	$
6)	$
Other Fees (implants, overnight fee)	$
Private Surgical Suite and Anesthesia Service and Supplies	$ 1800.00 *
Subtotal	$
$1,800.00 Deposit (Paid when surgery date is selected and booked)	$ 1800.00 PAID 6/28 VISA
Balance Due (Paid at pre-op appointment in full)	$ 7,341.00

*(1) need 1 month Rev pre-op (2) 6 wk Sx

Fees quoted above do not include pre-testing fees (labs, EKG, x-ray, etc.). Fees for biopsy testing may b billed by outside laboratories. In the rare event of complications, additional fees may be incurred and will be the patient's responsibility.

A $1,800.00 deposit is required at the time all cosmetic surgery is scheduled. The balance of all surgical fees and anesthesia fees are due three weeks prior to surgery at the pre-op appointment.

Once you have been scheduled for surgery, we request that you make every effort to avoid canceling or re-scheduling. However, should it become necessary for you to cancel or re-schedule, the $1,800.00 deposit is refundable up until two weeks before surgery. After that, the deposit is non-refundable unless the cancellation is due to severe illness or a death in the family.

[redacted]

I understand and agree to the above.

Signed _____ Date

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COASTAL FACIAL PLASTIC SURGERY

Thomas Funcik, M.D.

SURGICAL FEE QUOTE

Name: RoseMary Connolly Date 6/14/11

Surgical Procedure	Surgical Fee
1) Open Reduction Nasal Fracture	$ 2846.00 *
2) Rhinoplasty	$ 4,495.00 *
3)	$
4)	$
5)	$
6)	$
Other Fees (implants, overnight fee)	$
Private Surgical Suite and Anesthesia Service and Supplies	$ 1800.00 *
Subtotal	$
$ 1,800.00 Deposit (Paid when surgery date is selected and booked)	$
Balance Due (Paid at pre-op appointment in full)	$

*(1) need 1 Month Rev Pre-op (2) 6 wk SX

Fees quoted above do not include pre-testing fees (labs, EKG, x-ray, etc.). Fees for biopsy testing may be billed by outside laboratories. In the rare event of complications, additional fees may be incurred and will become the patient's responsibility.

A $1,800.00 deposit is required at the time all cosmetic surgery is scheduled. The balance of all surgical fees and anesthesia fees are due three weeks prior to surgery at the pre-op appointment.

Once you have been scheduled for surgery, we request that you make every effort to avoid canceling or re-scheduling. However, should it become necessary for you to cancel or re-schedule, the $1,800.00 deposit is refundable up until two weeks before surgery. After that, the deposit is non-refundable unless the cancelation is due to severe illness or a death in the family.

I understand and agree to the above.

Signed: _____ Date

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06/13/11 1427105964 [redacted]

PATIENT INFORMATION

PHYSICIAN NUMBER OR EIN	DATE OF SERVICE MO	DA	YR	PROCEDURE CODE	MOD	MOD	MOD	MOD
[redacted]	06	06	11	99215				
	06	06	11	99458				

[redacted]

0
538
635

[redacted]

[redacted]

0043303

010316
0002 of 0002

ROA 1172

COSTAL FACIAL PLASTIC SURGERY

RELAY

Transaction Set # 1 FACIAL PLASTIC, COASTAL.

Patient Name

7892 CONNELLY, ROSEMARY $251.60

Rendering Provider:
Referring Provider:
Facility Name: COASTAL FACIAL PLASTIC SURGERY
Diagnosis Codes: 87352,87330,9590

		Proc Cd	PoS	Un	Dx Cds	Amount
06/06/2011	06/06/2011	HC:99215	11::1	1	1:2:3	$151.60
06/06/2011	06/06/2011	HC:99058	11::1	1	1:2:3	$100.00

Transaction Set # 2 FACIAL PLASTIC, COASTAL $3205.90

Patient Name

7895 [redacted] $2443.40

Rendering Provider:
Referring Provider:
Facility Name: COASTAL FACIAL PLASTIC SURGERY
Diagnosis Codes: 7069,70900,2382

		Proc Cd	PoS	Un	Dx Cds	Amount
06/02/2011	06/02/2011	HC:99215	11::1	1	1:2:3	$151.60
06/02/2011	06/02/2011	HC:11100	11::1	1	1:2:3	$107.40
06/02/2011	06/02/2011	HC:11100:59	11::1	1	1:2:3	$107.40
06/02/2011	06/02/2011	HC:11100:59	11::1	1	1:2:3	$107.40
06/02/2011	06/02/2011	HC:11100:59	11::1	1	1:2:3	$107.40
06/02/2011	06/02/2011	HC:11100:59	11::1	1	1:2:3	$107.40
06/02/2011	06/02/2011	HC:11100:59	11::1	1	1:2:3	$107.40
06/02/2011	06/02/2011	HC:11100:59	11::1	1	1:2:3	$107.40
06/02/2011	06/02/2011	HC:11312	11::1	1	1:2:3	$195.00
06/02/2011	06/02/2011	HC:99080:25	11::1	1	1:2:3	$25.00
06/02/2011	06/02/2011	HC:99070	11::1	1	1:2:3	$100.00
06/02/2011	06/02/2011	HC:A4550	11::1	1	1:2:3	$50.00
06/02/2011	06/02/2011	HC:11312:59	11::1	1	1:2:3	$195.00
06/02/2011	06/02/2011	HC:11312:59	11::1	1	1:2:3	$195.00
06/02/2011	06/02/2011	HC:11312:59	11::1	1	1:2:3	$195.00
06/02/2011	06/02/2011	HC:11312:59	11::1	1	1:2:3	$195.00
06/02/2011	06/02/2011	HC:11312:59	11::1	1	1:2:3	$195.00
06/02/2011	06/02/2011	HC:11312:59	11::1	1	1:2:3	$195.00

ROSEMARY CONN[illegible]Y

Thomas Funcik, M.D.
Coastal Facial Plastic Surgery
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6/16/11

Work Injury

FELL RUNNING THINKS SHE BROKE NOSE

SERVICE	CPT	FEE
NEW PATIENT		
COMPREHENSIVE	99205	$217.75
EXTENDED	99204	$173.20
DETAILED	99203	$111.40
EXPANDED	99202	$79.80
FOCUSED	99201	$60.00
ESTABLISHED		
COMPREHENSIVE	99215	151.00
EXTENDED	99214	$117.75
EXPANDED	99213	$74.60
FOCUSED	99212	$45.00
BRIEF FOLLOW UP	99211	$30.00
POST-OP	99024	$0.00
OFFICE CONSULTATION MEDICARE DOES NOT PAY		
EXTENDED	99246	$172.81
DETAILED	99243	$124.00
EXPANDED	99242	$87.00
FOCUSED	99241	$60.00
INCISION AND DRAINAGE		
I&D ABSCESS	10060	$119.30
I&D COMPLICATED OR MULTIPLE	10061	325.00
BIOPSY	11100	$107.40
REMOVAL OF SKIN TAGS		
MULTIPLE AREAS; UP TO AND INCLUDING 15 LESIONS	11200	87.50
EACH ADDITION 10 LESIONS	11201	25.00
SHAVING OF EPIDERMAL OR DERMAL LESIONS		
TRUNK, ARM, LEGS LESION DIAMETER 0.6 TO 1 CCM	11301	97.00
TRUNK, ARM, LEGS LESION DIAMETER 1.1 TO 2.0CM	11302	116.00
TRUNK, ARM, LEGS LESION DIAMETER OVER 2 CM	11303	135.75
SCALP, NECK, HANDS, FEET LESION DIAMETER 1.1 TO 2.0CM	11307	116.00
SCALP, NECK, HANDS, FEET LESION DIAMETER OVER 2.0 CM	11308	131.50
FACE, EARS, EYES, NOSE, LIPS, LESION DIAMETER 1.1 TO 2.0 CM	11312	129.25
FACE, EARS, EYES, NOSE, LIPS LESION DIAMETER OVER 2CM	11313	781.25

PROCEDURES	CPT	FEE
EXCISION -BENIGN LESIONS		
TRUNK, ARM, LEGS LESION DIAMETER 0.6 TO 1.0 CM	11401	$149.00
TRUNK, ARM, LEGS LESION DIAMETER 1.1 TO 2 CCM	11402	$169.00
TRUNK, ARM, LEGS LESION DIAMETER	11403	300.00
TRUNK, ARM, LEGS LESION DIAMETER 3.1 - 4.0 CM	11404	325.00
TRUNK, ARM, LEGS LESION DIAMETER OVER 4.0 CM	11406	529.00
SCALP, NECK, HANDS, FEET LESION DIAMETER 0.6-1.0 CM	11421	$169.50
SCALP, NECK, HANDS, FEET LESION DIAMETER 1.1-2.0 CM	11422	$176.50
SCALP, NECK, HANDS, FEET LESION DIAMETER 2.1-3.0 CM	11423	$209.30
SCALP, NECK, HANDS, FEET LESION DIAMETER 3.1 -4.0 CM	11424	330.00
SCALP, NECK, HANDS, FEET LESION DIAMETER OVER 4.0 CM	11426	675.00
FACE, EARS, EYES, NOSE, LIPS LESION DIAMETER 0.6-1.0 CM	11441	$730.00
FACE, EARS, EYES, NOSE, LIPS LESION DIAMETER 1.1 TO 2.0 CM	11442	$339.00
FACE, EARS, EYES, NOSE, LIPS LESION DIAMETER 2.1-3.0 CM	11443	$415.00
FACE, EARS, EYES, NOSE, LIPS LESION DIAMETER 3.1 - 4.0 CM	11444	350.00
FACE, EARS, EYES, NOSE, LIPS LESION DIAMETER OVER 4.0 CM	11446	560.00
EXCISION -MALIGNANT LESION		
TRUNK, ARM, LEGS LESION DIAMETER 1.1 TO 2 CCM	11602	750.00
TRUNK, ARM, LEGS LESION DIAMETER 2.1-3.0 CM	11603	300.00
TRUNK, ARM, LEGS LESION DIAMETER 3.1-4.0 CM	11604	360.00
TRUNK, ARM, LEGS LESION DIAMETER OVER 4.0 CM	11606	$400.00
SCALP, NECK, HANDS, FEET LESION DIAMETER 1.1-2.0 CM	11622	285.00
SCALP, NECK, HANDS, FEET LESION DIAMETER 2.1-3.0 CM	11623	325.00
SCALP, NECK, HANDS, FEET LESION DIAMETER 3.1-4.0 CM	11624	$75.00
SCALP, NECK, HANDS, FEET LESION DIAMETER OVER 4.0 CM	11626	600.00
FACE, EARS, EYES, NOSE, LIPS LESION DIAMETER 1.1-2.0 CM	11642	$450.00
FACE, EARS, EYES, NOSE, LIPS LESION DIAMETER 2.1-3.0 CM	11643	$507.00
FACE, EARS, EYES, NOSE, LIPS LESION DIAMETER 3.1-4.0 CM	11644	$380.00
FACE, EARS EYES, NOSE, LIPS LESION DIAMETER OVER 4.0CM	11646	
REPAIR COMPLEX		
SCALP, ARM, OR LEG COMPLEX REPAIR 1.1-2.5 CM	13120	$300.00
SCALP, ARM, OR LEG COMPLEX REPAIR 2.6-7.5 CM	13121	$526.00
FH, CHEEKS, CHIN, MOUTH, NECK COMPLEX REPAIR 1.1-2.5 CM	13131	$450.00
FH, CHEEKS, MOUTH, NECK COMPLEX REPAIR 1.1-2.0 2.6-7.5 CM	13132	$775.00

PROCEDURES	CPT	FEE
EYELIDS, NOSE, EARS, LIPS TO 1.0 CM or LESS	13150	$425.00
EYELIDS, NOSE, EARS, LIPS TO 1.1 CM TO 2.0 CM	13151	$600.00
EYELIDS, NOSE, EARS, LIPS TO 2.6 CM TO 7.5 CM	13152	$818.00
TISSUE TRANSFERS		
SCALP ARMS AND LEGS 10.0 SQ CM OR LESS	14020	1000.00
SCALP ARMS AND LEGS 10.1 to 30cm	14021	1500.00
FOREHEAD, CHEEKS, CHIN, MOUTH NECK HAND FEET 10 SQ CM OR LESS	14040	1350.00
FOREHEAD, CHEEKS, CHIN, MOUTH NECK HAND FEET 10.1 Sq Cm To 30.0 Sq	14041	$1750.00
EYELIDS,NOSE EARS AND LIPS 10SQ CM OR LESS	14060	$1400.00
EYELIDS,NOSE EARS AND LIPS 10.1 TO 30.0 SQ CM	14061	$2500.00
TISSUE TRANSFER FOR MORE THAN 30 SQ Cm	14300	$2570.00
MUSCLE FLAPS		
FOREHEAD FLAP WITH PRESERVATION OF VASCULAR PEDICLE	15731	2700.00
MUSCLE, MYOCUTANEOUS, OR FASCIOCUTANEOUS FLAP, HEAD AND NECK	15732	$2500.00
KENALOG / CORTIZONE INJECTIONS		
KENALOG	J3301	$225.00
KENALOG INTRALESION INJECTION	11900	$100.00
ROCEPHIN SHOT		
OTHER		
CARTILAGE GRAFT (EAR)	21235	$1060
REPAIR LIP, FULL THICKNESS, VERMILION ONLY	40650	$500.00
PHOTOS/SPECIAL REPORTS	99080	$25.00
USE OF OPERATING ROOM	99070	$100.00
PROCEDURE TRAY	A4550	$50.00
FACIAL PLASTIC SURGERY		
FACIAL CONSULTATION	99244	$85.00
SEPTOPLASTY	30520	$3570.00
TURBINECTOMY	30130	$1455.00
OPEN TREATMENT OF NX & SEPTAL FX	21335	$2646.00
CLOSED TREATMENT OF NX & SEPTAL FX	21337	$1600.00
ORAL COMMISSUREPLASTY		$1200.00
LIPOSUCTION, NECK / FACELIFT	15839	$4815.00
BLEPHAROPLASTY UPPER	15822	$1490.00
BLEPHAROPLASTY - LOWER	15820	$1500.00

PROCEDURES	CPT	FEE
OTOPLASTY	69300	$2265.00
TELANGIECTASIA	17106	$500.00
RHINOPLASTY		$899.00
FILLERS		
BOTOX	64612	$297.00
DYSPORT		$297.00
SCULPTRA		$1000.00
RESTYLANE		$500.00
JUVEDERM		$350.00
RE-INJECTION		$85.00
RADIESSE		$650.00
PERLANE		$750.00

Abrasion to face
forehead + knee

PROCEDURES

TODAY'S CHARGE	
PAID CASH, CHECK, MC, VISA	
BALANCE	

Bill Insurance Please

DIAGNOSIS (ICD 9 CM)	CPT	FEE
SKIN LESION	709.9	
PIGMENTED SKIN LESION, TATTOO		
HYPERPIGMENTATION	709.0	
EPIDERMAL INC. CYST	706.2	
NEOPLASM, BENIGN		
CANCER LIP, EYELID	173.1	
MALIGNANT LIP	7720	
MALIGNANT SKIN	1732	
CHIN, FOREHEAD, NOSE		
EYEBROW CREEK	173.3	
NECK OR SCALP	1727	
MALIGNANT TRUNK	173.5	
MALIGNANT UPPER LIMB	1736	
MALIGNANT LEG	173.7	
BENIGN LIP	216.0	
BENIGN EARLOBE	216.1	
BENIGN LESION EYELID	216.1	
EAR	216.2	
CHIN, EYEBROW, FOREHEAD	216.3	
NOSE CREEK	216.3	
NECK OR SCALP	216.4	
BENIGN, UPPER LIMB	216.5	
BENIGN TRUNK	216.5	
BENIGN LOWER LIMB	216.7	

DIAGNOSIS (ICD 9 CM)	CPT
LIPOMA(S)	214.9
FACE	214.0
TURBINATE HYPERTROPHY	478.0
CYSTIC ACNE	706.1
EPIDERMAL INC. CYST	706.2
MUCUS RETENTION CYST	527.2
MASS, SKIN, SOFT TISSUE	782.2
BENIGN NEOPLASM OF SKIN	216.9
PIGMENTED NEVUS OF THE FACE	216.2
TELANGIECTASIA	448.1
SEPTAL PERFORATION	478.1
CANCER, FACE	173.9
MEDICAL RECORD DEPARTMENT, BA	733.2
KELOID SKIN	701.4
ACQUIRED NOSE DEFOR	738.0
TELANGIECTASIA	448.1
NEEDLES FACE	959.3
POTENTIC KERATOSIS	702.11
History of Malignant neoplasm Nose	V10.22
History of Malignant neoplasm Skin	V10.83
History of personal Respiratory Sy	V13.09

Kosha acy

Thomas Funcik, M.D.

Coastal Facial Plastic Surgery

www.greatface.com

[illegible] Johnnie Dodds Blvd.
Suite [illegible]
Mt. Pleasant, SC [illegible]
843-654-3277 (or 843-[illegible])

SERVICE	CPT	FEE
NEW PATIENT		
PRE-EXCISE	99205	$217.75
EXCISED	99204	$171.50
ALED	99203	$141.40
ANDED	99202	$79.80
USED	99201	$60.00
ESTABLISHED		
ABNED-SHAVE	99214	$97.75
EXCISED	99213	$151.75
WELLED	99212	$74.60
OSED	99211	$45.00
E-FO LOW UP	99024	$25.00
IT-CR	99070	$7.00
OFFICE CONSULTATIONS		
ENDED	99244	$177.0
ALED	99243	$134.00
ANDED	99242	$92.00
USED	99241	$60.00
DISCISION AND DRAINAGE		
ASSESSED	10060	$116.00
COMPLICATED OR MULTIPLE	10061	$220.00
RD	11100	$27.40
REMOVAL OF SKIN TAGS		
IPLE AREAS, UP TO 4 ANS USING 15 BOMOIN	11200	$7.00
EACH ADDITIONAL 10 LESIONS	11201	$5.00
MAYING OF EXTERNAL OR DERMAL LESIONS		
RAUMA, LEGS LESION DIAMETER 0.5 TO 1.0CM	11901	$7.00
RAUMA, ARMS LEGS LESION DIAMETER 1.1 TO 2.0CM	11902	$15.00
RAUMA, ARM, LEGS LESION DIAMETER OVER 2.0CM	11903	$23.75
OF NECK, HANDS, FEET, ION DIAMETER 1.1 TO 2.0CM	11602	$10.00
CALP, NECK, HANDS, FEET ION DIAMETER OVER 2.0 CM	11603	$31.00
E, EARS, EYES, NOSE, LIPS, ON DIAMETER 1.1 TO 2.0 CM	11612	$39.25
S, EARS, EYES, NOSE, LIPS, ON DIAMETER OVER 2.0CM	11613	$51.75

SERVICE	CPT	FEE	PROCEDURES	CPT	FEE
			EXCISION - BENIGN LESIONS		
			TRUNK, ARM, LEGS LESION DIAMETER 0.5 TO 1.0 CM	11400	$149.00
			TRUNK, ARM, LEGS LESION DIAMETER 1.1 TO 2.0CM	11401	$183.00
			TRUNK, ARM, LEGS LESION DIAMETER	11402	$90.00
			TRUNK, ARMS, LEGS LESION DIAMETER 3.1 - 4.0 CM	11404	$226.00
			TRUNK, ARM, LEGS LESION DIAMETER OVER 4.0 CM	11406	$25.00
			SCALP, NECK, HANDS, FEET LESION DIAMETER 0.6-1.0 CM	11421	$159.50
			SCALP, NECK, HANDS, FEET LESION DIAMETER 1.1-2.0 CM	11422	$176.00
			SCALP, NECK, HANDS, FEET LESION DIAMETER 2.1 TO 3.0 CM	11423	$203.30
			SCALP, NECK, HANDS, FEET LESION DIAMETER 3.1 - 4.0 CM	11424	$227.00
			SCALP, NECK, HANDS, FEET LESION DIAMETER OVER 4.0 CM	11426	$75.00
			FACE, EARS, EYES, NOSE, LIPS LESION DIAMETER 0.6-1.0 CM	11441	$250.00
			FACE, EARS, EYES, NOSE, LIPS LESION DIAMETER 1.1 TO 2.0 CM	11442	$336.00
			FACE, EARS, EYES, NOSE, LIPS LESION DIAMETER 2.1-3.0 CM	11443	$415.00
			FACE, EARS, EYES, NOSE, LIPS LESION DIAMETER 3.1 - 4.0 CM	11444	$50.00
			FACE, EARS, EYES, NOSE, LIPS LESION DIAMETER OVER 4.0 CM	11446	$60.00
			EXCISION - MALIGNANT LESION		
			TRUNK, ARM, LEGS LESION DIAMETER 0.5 TO 1.0CM	11600	$50.00
			TRUNK, ARM, LEGS LESION DIAMETER 1.1-2.0 CM	11601	$00.00
			TRUNK, ARM, LEGS LESION DIAMETER 2.1-3.0 CM	11602	$00.00
			TRUNK, ARM, LEGS LESION DIAMETER 3.1-4.0 CM	11604	$50.00
			TRUNK, ARM, LEGS LESION DIAMETER OVER 4.0 CM	11606	$400.00
			SCALP, NECK, HANDS, FEET LESION DIAMETER 1.1-2.0 CM	11622	$85.00
			SCALP, NECK, HANDS, FEET LESION DIAMETER 2.1-3.0 CM	11623	$25.00
			SCALP, NECK, HANDS, FEET LESION DIAMETER 3.1-4.0 CM	11624	$75.00
			SCALP, NECK, HANDS, FEET LESION DIAMETER OVER 4.0 CM	11626	$00.00
			FACE, EARS, EYES, NOSE, LIPS LESION DIAMETER 1.1-2.0 CM	11642	$490.00
			FACE, EARS, EYES, NOSE, LIPS LESION DIAMETER 2.1-3.0 CM	11643	$527.00
			FACE, EARS, EYES, NOSE, LIPS LESION DIAMETER 3.1-4.0 CM	11644	$00.00
			FACE, EARS, EYES, NOSE, LIPS LESION DIAMETER OVER 4.0CM	11646	
			REPAIR COMPLEX		
			SCALP, ARM OR LEG COMPLEX REPAIR 1.1-2.5 CM	13120	$350.00
			SCALP, ARM OR LEG COMPLEX REPAIR 2.6-7.5 CM	13121	$528.00
			FH, CHEEKS, CHIN, MOUTH, NECK COMPLEX REPAIR 1.1-2.5 CM	13132	$420.00
			FH, CHEEKS, MOUTH, NECK COMPLEX REPAIR 1.1-2.5 7.6 CM	13132	$775.00

PROCEDURES	CPT	FEE
EYELIDS, NOSE, EARS, LIPS TO 1.0 CM OR LESS	13150	$420.00
EYELIDS, NOSE, EARS, LIPS TO 1.1 CM TO 2.5 CM	13151	$600.00
EYELIDS, NOSE, EARS, LIPS TO 2.6 CM TO 7.5 CM	13152	$816.00
TISSUE TRANSFERS		
SCALP ARMS AND LEGS 10.0 SQ CM OR LESS	14020	1000.00
SCALP, ARMS AND LEGS 10.1 to 30cm	14021	1500.00
FOREHEAD, CHEEKS, CHIN, MOUTH, NECK HAND FEET 10 SQ CM OR LESS	14040	1350.00
FOREHEAD, CHEEKS, CHIN, MOUTH, NECK HAND FEET 10.1 Sq Cm To 30.0 Sq	14041	$1750.00
EYELIDS, NOSE EARS AND LIPS 10.0 CM OR LESS	14060	$1400.00
EYELIDS, NOSE EARS AND LIPS 10.1 TO 30.0 SQ CM	14061	$2500.00
TISSUE TRANSFER FOR MORE THAN 30.0 Sq Cm	14300	$2970.00
MUSCLE FLAPS		
FOREHEAD FLAP WITH PRESERVATION OF VASCULAR PEDICLE	15731	2200.00
MUSCLE, MYOCUTANEOUS, OR FASCIOCUTANEOUS FLAP, HEAD AND NECK	15732	$2500.00
KENALOG / CORTIZONE INJECTIONS		
KENALOG	J3301	$225.00
KENALOG INTRALESION INJECTION	11900	$100.00
ROCEPHIN SHOT		
OTHER		
CARTILAGE GRAFT (EAR)	21235	$1060
REPAIR UP, FULL THICKNESS, VERMILION ONLY	40650	$800.00
PHOTOS/SPECIAL REPORTS	99080	$25.00
USE OF OPERATING ROOM	99070	$100.00
PROCEDURE TRAY	99070	$50.00
FACIAL PLASTIC SURGERY		
FACIAL CONSULTATION	99244	$65.00
SEPTOPLASTY	30520	$3570.00
TURBINECTOMY	30130	$1465.00
OPEN TREATMENT OF NA & SEPTAL FX	21335	$2640.00
CLOSED TREATMENT OF NA & SEPTAL FX	21337	$1500.00
ORAL COMMISSUREPLASTY		$1200.00
LIPOSUCTION, NECK / FACELIFT	15838	$4815.00
BLEPHAROPLASTY, UPPER	15823	$1500.00
BLEPHAROPLASTY, LOWER	15820	$2010.00

PROCEDURES		
[illegible]	[illegible]	
[illegible]	[illegible]	
[illegible]	[illegible]	

08/24/09 1427105964 CHECK NUMBER [redacted]

PATIENT INFORMATION

PHYSICIAN NUMBER OR EIN	[redacted]	DATE OF SERVICE MO	DA	YR	PROCEDURE CODE	MOD	MOD	MOD	MOD	DAYS/UNITS
[redacted]										
1427105964		081309			99244	25	51	59		
1427105964		081309			99080		25			
1427105964		081309			11402					
1427105964		081309			11422					
1427105964		081309			99070					
1427105964		081309			46550					
[redacted]										
1427105964		070109			99243	25	51	59		
1427105964		070109			99080					
1427105964		070109			11443					
1427105964		070109			13132	51				
1427105964		070109			99070					
1427105964		070109			46550					
[redacted]										
1427105964		081109			99241					

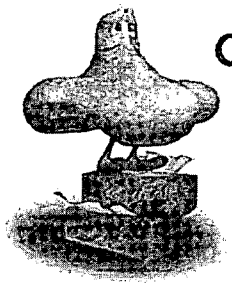
[redacted]

273656 002260
0002 of 0002

[redacted]

ROA 1176

Willy Schwenzfeier, MD
Edward McNellis, RPh, MD
Eugene Brown, RPh, MD
Shaun Scott, MD
Edward Behrens, MD, PhD
Matthew Scarlett, MD
Michael Noone, MD
Thomas Dozier, MD
Mark Ghegan, MD



Charleston ent
Ear, Nose & Throat

Craig Kilgore
Executive Director
Jennifer Donahue
Director of Medical Operations
Dawn Gay Truslow
Co-Administrator, Surgery Center of Charleston
Melody Still
Co-Administrator, Surgery Center of Charleston

Charleston Ear, Nose, and Throat Associates
Surgery Center of Charleston

May 20, 2013

Gruenloh Law Firm
Patrick Aulton Chisom, Esq.
9 Broad Street
Charleston, SC 29401

RE: Patient: Rosemary Connelly
DOB: REDACTED
Our Account #: REDACTED

Dear Sir/Madam:

Enclosed are the medical records you requested from our office. Please return this letter and a check in the amount of $20.00 payable to Charleston ENT Associates. Our tax ID number is REDACTED

If you have any questions or feel that there is missing or incomplete documents, please feel free to give me a call.

Sincerely,

LaDawna McIntyre-Smiley

LaDawna McIntyre-Smiley

Charleston ENT Associates
Medical Information Form

Patient's Legal Name: Rosemary Connell Age: 57 Weight: 138 Height: 5'6 Today's Date: 4/4/2013
Gender: Male / (Female) Insurance: BCBS Texas Referred by: _____ Primary MD: Drs. Cape

What is your occupation: retired

Why are we seeing you today: problems sense of smell/taste

What medication(s) have you taken for this issue: none

Testing/labs completed for this issue. Please include location and approximate date of testing/labs: _____

FOR CLINIC USE ONLY:

Chief complaint: smell + taste

Location: _____

Characteristics: (color, size, feeling) ø smell, limited taste

Severity: (scale of 1-10) _____

Duration: (how long) June 2011 exposed

Timing: (how often) has broken nose

Context: (situation assoc w/ symptoms i.e. after swimming, flying, morning, night, after eating, etc.)

Modifying factors: (What has pt done to make symptoms better or worse?) Ointment in nose helps

Assoc. S/S: (Secondary signs/symptoms) sinus swelling

Family hx of symptoms: _____

Other: _____

Nurse: _____

Patients: Please complete each section completely

EAR	Hearing Loss	N	Y	Right Left Both	
	Ringing of the ears	N	Y	Right Left Both	
	Loud noise exposure	N	Y		
	Family history of hearing loss	N	Y		
	Do you use a hearing aid	N	Y	Right Left Both	
	Ear pain	N	Y	Right Left Both	
	History of ear infections	N	Y		
	Ear drainage	N	Y	Right Left Both	
	Ear surgery	N	Y		
	Dizziness	N	Y		
NOSE	History of sinus infections	N	Y	How many per year? _____	
	Sinus pain/pressure	N	Y	Right Left Both	
	Postnasal drip	N	Y		
	Runny nose	N	Y	Right Left Both	
	Lack of ability to smell	N	Y		
	Nasal stuffiness	N	Y	Right Left Both	
	Headaches	N	Y		
	Nosebleeds	N	Y		
	Nasal surgery	N	Y		
	Do you see an allergist	N	Y	If yes, who? _____	
	Allergy testing / shots	N	Y	When? _____ Where? _____	
THROAT	Sore Throat	N	Y		
	History of tonsillitis	N	Y	How many times per year? _____	
	History of strep throat	N	Y	How many times per year? _____	
	Tonsillectomy	N	Y		
	Hoarseness or voice change	N	Y		
	Reflux/heartburn symptoms	N	Y		
	Frequent coughing	N	Y	How long? _____	
	Frequent clearing of throat	N	Y	How long? _____	
	Difficulty swallowing	N	Y		
SLEEP	Do you snore?	N	Y		
	Have you stopped breathing during your sleep?	N	Y		
	Daytime tiredness	N	Y		
	Previous sleep study	N	Y	Where? _____ When? _____	
	Recent weight gain	N	Y		
	Do you use breathing devices to sleep (CPAP)	N	Y		
OTHER	Do you currently smoke or use tobacco products?	N	Y	# packs per day? _____ for how long: _____	
	Are you a previous tobacco user?	N	Y	When did you quit? _____	
	Does anyone in your household smoke?	N	Y		
	Do you consume alcohol?	N	Y	How many beverages a week? _____	
	Family history of cancer	N	Y	mother / father	
	Any masses/lumps in your neck	N	Y		
	Mouth/gum sores or problems with dentures	N	Y		
	If your child is being seen, is he/she in daycare	N	Y		
	Do you have pets in your house?	N	Y		
	Are immunizations current	N	Y	_____	
	Do you have family or friends that are patients of ours?	N	Y	Which doctor? _____ What is your relationship with our patient? _____	

Rev 06/18/12

TDP 4/26/13

Charleston ENT Associates
Health History Form

Patient Legal Name: Rosemary Connelly Nick Name: _____ Date of Birth: REDACTED Gender M / F Today's Date: 4/4/2013
Emergency Contact: _____ Emergency Contact's Numbers - Cell #: REDACTED Home #: _____ Work #: _____
Pharmacy of choice: Bilo Sweetgrass Location: _____

Previous surgery:	Date	Location	Complications
nasal	3/2011	Dr. Funcik	I now have trouble smelling
T+A	1960's		

Drug Allergies:	Reaction:
1. Sulfa	hives
2. Codeine	Vomiting
3.	
4.	

Food Allergies:	Reaction:
1. none	
2.	

Latex Allergy (N) Y Reaction: _____

Current Rx & OTC medications, aspirin, herbs & vitamins:
1. [redacted] Vitamins
Reason: _____
2. _____
Reason: _____
3. _____
Reason: _____
4. _____
Reason: _____
5. _____
Reason: _____

To be completed by clinic staff

Planned surgery: _____
_____
Date: _____
Doctor: _____

Current Weight: _____ Height: _____
Age: _____ BMI: _____ BMI%: _____

LMP: _____ Pregnant: N Y

Date of last EKG: _____
EKG performed at: _____

Date of last blood work: _____
Blood work done at: _____

Were you premature? _____
How many weeks? _____

History of problems with anesthesia: N Y
Explain: _____
History of problems with malignant hyperthermia: N Y
Explain: _____

Medicare ONLY: Does the patient have advance directive:
N Y
If no, offer them a copy.
If yes, ask the patient to provide a copy for SCC.

Date medical history reviewed: _____
Signature of reviewer: _____

Patients: Please circle N for No or Y for Yes.
Please answer every question individually and completely. Thank you.

Chronic bronchitis	(N)	Y	
Shortness of breath	(N)	Y	
Emphysema	(N)	Y	
Cough/cold	(N)	Y	How often: _____
Asthma/wheezing	(N)	Y	
Smoker (current or former?)	(N)	Y	How much: _____ How often: _____
Tuberculosis	(N)	Y	When: _____
Heart surgery	(N)	Y	When: _____
Chest Pain	(N)	Y	How often: _____
Heart Attack	(N)	Y	When: _____
Heart Failure	(N)	Y	
Irregular Heartbeat	(N)	Y	Explain: _____
Other heart disease	(N)	Y	Explain: _____
Angioplasty	(N)	Y	When: _____
Circulation problems	(N)	Y	Explain: _____
High Blood Pressure	(N)	Y	
Bleeding Problem/Anemia	N	(Y)	What kind: Thalassemia
Sickle Cell Disease	(N)	Y	Disease or Trait: _____
Abnormal weight loss	(N)	Y	How much: _____ Time frame: _____
Stomach/intestinal issues	(N)	Y	What kind: _____
Reflux	(N)	Y	
Diabetes	(N)	Y	Type I or Type II Insulin: N Y
Liver disease	(N)	Y	Explain: _____
Thyroid disease	(N)	Y	Type: _____
Hepatitis	(N)	Y	Type A Type B Type C
HIV/AIDS	(N)	Y	
Kidney Disease	(N)	Y	Explain: _____
Fever	(N)	Y	Explain: _____
Arthritis	(N)	Y	Rheumatoid/osteoarthritis/ _____
Fibromyalgia	(N)	Y	
Joint/muscle disease	(N)	Y	Type: _____
History of Seizures	(N)	Y	When: _____
Stroke	(N)	Y	When/Effect: _____
Frequent Headache	(N)	Y	
Anxiety/Depression	(N)	Y	
Bipolar	(N)	Y	
Schizophrenia	(N)	Y	
Cancer	(N)	Y	Type/When: _____
Radiation/Chemotherapy	(N)	Y	
Sleep Apnea	(N)	Y	Study done at: _____ When: _____
Special Needs Child	(N)	Y	Explain: _____
Mobility Accommodations:	(N)	Y	Wheelchair/other: _____
Other:	N	Y	Explain: _____

Nurse: _____ Date: 4.4.13

Rev 06/18/12

Charleston ENT Associates, L.L.C.
EAR-NOSE-THROAT- HEAD AND NECK SURGERY
PLASTIC AND RECONSTRUCTIVE SURGERY
180 Wingo Way, Suite 103. Mt. Pleasant, SC 29464
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Anna Maria Kammeyer, PA-C
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Natalie M. Bickley, AuD, CCC-A
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Melissa A. Franklin, M.A., CCC-A
Kati Hinrichsen, AuD., CCC-A
Vanhphenh (Penny) S. Leong, M.S., CCC-A
Brittany C. Milligan, AuD., CCC-A
Karen M. Moore, AuD., CCC-A, F-AAA
Emily C. Pastore, AuD., CCC-A

April 4, 2013

Patient: **Rosemary Connelly**
DOB: REDACTED
Chart#:

I had the pleasure of seeing **ROSEMARY CONNELLY** in the clinic today. She is a 57-year-old who presents with chief complaint of decreased sense of smell and taste.

History of Present Illness: She states she has noticed it for the past six months but feels like it may have been present for the past couple of years. She states that she broke her nose and had a concussion from a fairly significant fall about two years ago. She did have repair of the nasal bone fracture with Dr. Funcik. She feels like that may have been when her symptoms of decreased smell started. She states she uses a little spearmint oil under her nose which seems to help with mild nasal congestion that she has had. She does not feel like she has much trouble with allergies.

Please see the Patient History and Review of Systems form for the patient's past medical history, prior hospitalizations and surgeries, family history, social history, review of systems, and current medications. This form is reviewed in detail with the patient.

Physical Examination:

General:	The patient is pleasant and cooperative with examination.
Ears:	Ear canals are clear bilaterally. Tympanic membranes are translucent and mobile.
Nose:	There is a mild septal deviation and mild inferior turbinate hypertrophy, but without active inflammation or evidence of acute purulent drainage. Mucosa is pink and moist.
Throat:	Oral cavity/oropharyngeal exam reveals no mucosal lesions or masses. Uvula is midline. Palate is symmetric.
Neck:	Neck is supple. There are no palpable masses or lesions.
Lymphatics:	There is no evidence of cervical adenopathy.
Psychiatric:	The patient is alert and oriented.
Head:	Head is normocephalic, atraumatic with symmetric facial movements. Inspection of the skin reveals no suspicious lesions, masses, or scars.
Neurologic:	Cranial nerves are grossly intact.
Eyes:	Extraocular movements are intact. Pupils are equal, round and reactive to light and

accommodation.

Radiograph:
CT scan of the sinuses is obtained given her decreased sense of smell to look for a conductive component. The septum is relatively midline. There is moderate to severe inferior turbinate hypertrophy but the paranasal sinuses, including the ethmoids, are clear.

Impression:
1. Anosmia.
2. Turbinate hypertrophy.

Recommendations:
I have given her a sample of nasal steroid spray to see if that will help with the turbinate hypertrophy and help her nasal airway. We discussed that I think most likely her decreased sense of smell, and subsequent decreased taste, are result of the trauma a couple of years ago. We also discussed that it could be a viral etiology as well. We discussed the likelihood off fully recovering is low since it has been a while since her symptoms began. She will let us know if the symptoms get worse and we can discuss the possibility of additional imaging studies such as an MRI scan to rule out an intracranial process, but she would like to hold off on that for now.

Mark D. Ghegan, M.D.
MDG/kls

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Karen M. Moore, AuD., CCC-A, F-AAA
Emily C. Pastore, AuD., CCC-A

April 26, 2013

Patient: **Rosemary Connelly**
DOB: REDACTED
Chart#:

I had the pleasure of meeting **ROSEMARY CONNELLY** in the clinic today, with a chief complaint of smell and taste dysfunction.

History of Present Illness:
The patient presents, today, for a second opinion regarding decreased smell and taste. She relates this primarily to a fall she had on 06/03/2011. She was jogging around a construction site in the Daniel Island area and tripped on some type of debris. She ended up fracturing her nose and had bloody nasal discharge, but no loss of consciousness. She saw a plastic surgeon that day and, 4 months later, underwent repair of her nasal fracture. Eight months ago, she began to notice that she did not have a good sense of taste or smell. She says she can sense a little bit of salty taste and some sweet taste, but otherwise, she does not feel like she has any taste. Everything seems to be bland. She denies any URI or other closed-head injuries in association with this sense of anosmia and dysgeusia 8 months ago. She denies any prior similar episodes. She was recently seen and evaluated by Dr. Ghegan and had a CT scan of her sinuses done. This showed evidence of turbinate hypertrophy, but clear paranasal sinuses. I did review this imaging, today, as well.

Please see the Patient History and Review of Systems form for the patient's past medical history, prior hospitalizations and surgeries, family history, social history, review of systems, and current medications. This form was reviewed in detail with the patient.

Physical Examination:
General: The patient is pleasant and cooperative with examination.
Ears: Ear canals are clear bilaterally. Tympanic membranes are translucent and mobile.
Nose: There is a mild septal deviation, with mild inferior turbinate hypertrophy. No purulence or polyposis is noted. Mucosa is generally pink and moist. See procedure note below.

Throat:	Oral cavity and oropharynx exams reveal no mucosal lesions or masses. Uvula is midline. Palate is symmetric.
Neck:	Neck is supple. There are no palpable masses or lesions.
Lymphatics:	There is no evidence of cervical adenopathy.
Psychiatric:	The patient is alert and oriented.
Head:	Head is normocephalic and atraumatic. Inspection of the skin reveals no suspicious lesions, masses, or scars.
Neurologic:	Cranial nerves II-XII are grossly intact.
Eyes:	Extraocular movements are intact, without nystagmus. Pupils are equal, round, and reactive to light.

Procedure:
Diagnostic endoscopy was performed today, after topical anesthesia and decongestion, with a zero-degree endoscope. This revealed some persistent congestion of the mucosa throughout the nasal passage, but nothing that appeared to be significantly obstructing superiorly, and no polyps or purulence was noted.

Impression:
1. Anosmia.
2. Dysgeusia.
3. Turbinate hypertrophy.

Recommendations:
The patient would like to proceed with an MRI, which was discussed previously. I think that is appropriate. We will go ahead and get that scheduled and will contact her with the results. The identification of the taste and smell disturbance was only 8 months ago, which certainly leaves the question of the possibility of some return of function. If, however, the onset of this was actually related to the trauma, then, at this point, I would not expect a recovery. We will contact her with the results of the MRI as noted.

T. Oma Hester, M.D., F.A.C.S.
TOH/kns

Charleston ent
Ear, Nose & Throat
THE SURGERY CENTER OF CHARLESTON

CHARLESTON ENT ASSOCIATES, L.L.C./RADIOLOGY
180 Wingo Way, Suite 103, Mt. Pleasant, SC 29464
Phone (843) 216-8774 Fax (843) 216-8779

Name: Rosemary Connelly
Date: 04/04/2013
MR#: 182959
DOB: REDACTED
Physician: Mark D. Ghegan, M.D.

CT SCAN

Examination: CT scan of the paranasal sinuses without contrast

Clinical Indication: Anosmia

Technique: The Xoran MiniCAT was used with the Standard Cone Beam Volume protocol. The patient was seated and positioned upright. Axial Volume CT data was acquired. Multiplanar reconstruction was performed on a viewing workstation to obtain sagittal and coronal images.

Quality of Study: No motion or streak artifact present. Patient positioning is appropriate for scan type. All anatomic structures of the paranasal sinuses were included in the exam.

Comparison: None

Nasomaxillary Complex:
1. The nasal septum is midline.
2. There is moderate to severe inferior turbinate hypertrophy.
3. The middle turbinates appear normal without evidence of concha bullosa.
4. The ostiomeatal complexes are well visualized with no evidence of obstruction or inflammation.
5. The maxillary sinuses are well pneumatized with no evidence of acute or chronic mucosal inflammatory disease.

Frontoethmoidal Complex:
1. The frontal sinuses are well pneumatized with no evidence of acute or chronic mucosal inflammatory disease.
2. The ethmoid sinuses are well pneumatized with no evidence of acute or chronic mucosal inflammatory disease.

Sphenoid Sinuses:
The sphenoid sinuses are well pneumatized with no evidence of acute or chronic mucosal inflammatory disease.

Middle Ears:
The visualized mastoid air cells and middle ear spaces are clear.

Recommendations for Follow up: No incidental findings to be followed up at this time.

Impression:

1. Moderate to severe inferior turbinate hypertrophy.
2. Clear paranasal sinuses.

Mark D. Ghegan, M.D./sen
DD: 04/05/2013 DT:04/09/2013

5

Charleston ent
Ear, Nose & Throat
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Name: Rosemary Connelly
Date: 04/04/2013
MR#: 182959
DOB: REDACTED
Physician: Mark D. Ghegan, M.D.

CT SCAN

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Comparison: None

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Middle Ears:
The visualized mastoid air cells and middle ear spaces are clear.

Recommendations for Follow up: No incidental findings to be followed up at this time.

Impression:

1. Moderate to severe inferior turbinate hypertrophy.
2. Clear paranasal sinuses.

Mark D. Ghegan, M.D./sen
DD: 04/05/2013 DT:04/09/2013

Charleston ent
Ear, Nose & Throat

Patient: Rosemary H. Connelly
DOB: REDACTED
Chart#:

06/26/2014 I saw **ROSEMARY CONNELLY** back in followup today regarding chief complaint of decreased smell and taste. **HISTORY OF PRESENT ILLNESS:** She states that about three years ago, she was running on Daniel Island, tripped on some construction debris, fell, and hit her shoulder and face. She suffered a nasal fracture and several months later underwent a rhinoplasty to correct it. Her main complaint now is the decrease of smell and taste. This has been going on for two years. She has seen Dr. Ghegan and Dr. Hester in our practice for evaluation. She states she can smell very strong smells such as ammonia and occasional curry will give her some stimulation of a taste sensation, but in general she has significant difficulties smelling, and this has been present for quite some time. She has been having nasal congestion, facial pressure, dental pain, and a foul odor in her nose. She has been treated with two rounds of oral antibiotics recently. She does not use any allergy medications and has not generally felt like she had significant allergies. Review of the ENT and allergy systems is otherwise negative. **EXAM:** ***General:*** The patient is pleasant and cooperative with examination. ***Ears:*** Ear canals are clear bilaterally. Tympanic membranes are translucent and mobile. ***Nose:*** See nasal endoscopy below. ***Throat:*** Oral cavity exam reveals no mucosal lesions or masses. ***Neck:*** Neck is supple. There are no palpable masses or lesions. No thyromegaly detected. ***Lymphatics:*** There is no evidence of cervical adenopathy. ***Head:*** Head is normocephalic, atraumatic, with symmetrical facial movements. **PROCEDURE:** The nose is decongested and anesthetized and a flexible nasal endoscopy is performed. There is mucosal edema and hyperemia but no active mucopurulence. There are no mucosal masses or crusting on the right side to explain the foul odor. **RADIOGRAPHS:** A CT scan of the sinuses is performed which shows clear paranasal sinuses with no evidence of intranasal masses or obvious skull base fractures. She does have significant inferior turbinate hypertrophy on the scan. **ASSESSMENT:** (1) Anosmia and dysgeusia. (2) No evidence of sinusitis on CT scan. (3) Nasal obstruction, facial pressure, and dental pain. **PLAN:** I have discussed with the patient that I think she may have developed some allergies. I would like to try her on some Mupirocin nasal spray, and I would like to get her set up for an allergy skin test. Based on the results, we will make some recommendations. I am thinking that her turbinate hypertrophy is so severe that she may have drying of normal nasal secretions leading to the foul odor and that perhaps the Mupirocin spray will change the bacterial milieu of her nasal cavity and hopefully alleviate these symptoms.

TS Dozier

Thomas S. Dozier, M.D.
TSD/krc

cc: Thomas Funcik, M.D.
Jennifer Pullano, M.D.

History and Physical

Patient Information: CONNELLY, ROSEMARY
Chart # 182959 DOB REDACT Age 56 Years Gender F
Referring Physician: THOMAS DOZIER Today's Date 6/26/2014
Instructions: MA – ask patient, "Do you currently or have you ever had..."

History of Breathing or Lung Issues	■ N	□ Y
History of Sleep Apnea	■ N	□ Y
History of Fever	■ N	□ Y
History of Cardiac or Heart Issues:	■ N	□ Y
History of High Blood Pressure	□ N	■ Y
Other:	■ N	□ Y
History of Blood Disorders:	■ N	□ Y
History of Infectious Diseases such as Hepatitis or HIV:	■ N	□ Y
History of Cancer	■ N	□ Y
History of Thyroid, Kidney or Diabetes:	■ N	□ Y
History of Digestion/Liver Disorders:	■ N	□ Y
History of Bone and Joint Issues:	■ N	□ Y
Nervous System Issues/Stroke:	■ N	□ Y
History of Mental Illness:	■ N	□ Y
Personal/Family History of Problems W/Anesthesia	■ N	□ Y
History of Smoking:	■ N	□ Y
Other:		
Special Needs Child	■ N	□ Y
Mobility Accommodations	■ N	□ Y
Premature	■ N	□ Y
Other:	■ N	□ Y

Date of last EKG N/A Where: none
Date of last blood work 6/17/2014 Where: Dr. Palano

Pregnant ■ N □ Y
Last menstrual period: N/A

History Completed By:
Printed Name: Christen Bee Date: 6/26/2014 2:06 PM Christen Bee, MA

Charleston ent

Referral Form

Date: 7/8/2014

Patient Name: CONNELLY, ROSEMARY Birth REDACTED Phone: (843) REDACTED

Diagnosis: 477 ICD9:

Procedure: Allergy Test Multi-Prick w/ IDT

DOCTOR / PA SIGNATURE: TS Dozier

Thomas Dozier, MD

REFERRAL TO:

Physician / Facility: Allergy Dept. of Charleston ENT

Address: 2295 Henry Tecklenburg Blvd, Charleston, SC 29414

Telephone (843) 766-7103 Fax: (843) 763-3834 Auth. No.:

☐ STAT: ☐ URGENT: ☐ ROUTINE:

Comments: pt scheduled for 7/16/14

APPOINTMENT:

PLEASE NOTIFY OUR OFFICE IF YOUR APPOINTMENT IS NOT SCHEDULED IN A TIMELY MANNER ☐ Initials

Patient Will Self Schedule:

Date: Time

Patient Instructions:

Date: 7/8/2014 Time Initials: hld

IMPORTANT

Mail or Fax Results to:

DOZIER, THOMAS

298 Midland Parkway, Summerville, SC 29485

Phone: (843) 766-7103

Fax: (843) 725-4012

MQT: standard test panel Date: 7/31/2014 COMPLETE

Connelly, Rosemary
Allergy ID: 20456
Local Chart #: 182959
Age: 59 (07/01/1955)
Therapy Started: -/-/---

Asthmatic: No
Pets In Home: Yes
Treatment:
Last Off Vis: 6/26/2014
EPI Exp: -/-/---

Patient Notes
Dx: 477.0
Pt tested positive for 19 antigens.

By: Taylor, Myra
At: Charleston ENT
Doctor: Thomas Dozier

Controls: Histamine #3 dilution (+) 7 Glycerin #2 dilution (-) 5

	Prick	#5 ID	#2 ID	Endpoint
Box Elder	2 mm	-	5 mm	-
American Elm	0 mm	-	5 mm	-
Hickory	0 mm	-	7 mm	3
White Ash	0 mm	-	7 mm	3
Sycamore	0 mm	-	7 mm	3
Cottonwood	0 mm	-	8 mm	-
Mountain Cedar	0 mm	-	7 mm	3
White Oak	0 mm	-	5 mm	-
Birch	0 mm	-	5 mm	-
Mulberry	4 mm	5 mm	-	4
Timothy	9 mm	-	-	6
Bermuda	2 mm	-	5 mm	-
Johnson	4 mm	5 mm	-	4
D Farinae	4 mm	5 mm	-	4
D Pteronyssinus	0 mm	-	5 mm	-
Dog	0 mm	-	5 mm	-
Alternaria	5 mm	5 mm	-	4
Aspergillus	0 mm	-	7 mm	3
Bipolaris	0 mm	-	5 mm	-
Penicillium	0 mm	-	5 mm	-
Mucor	4 mm	5 mm	-	4
Rhizopus	4 mm	5 mm	-	4
Candida	4 mm	5 mm	-	4
Cockroach	4 mm	5 mm	-	4
Lambs Quarters	0 mm	-	5 mm	-
Ragweed Mix	7 mm	5 mm	-	4
Sheep Sorrel	0 mm	-	7 mm	3
Cocklebur	0 mm	-	5 mm	-
English Plantain	4 mm	5 mm	-	4
Wormwood	0 mm	-	5 mm	-
Pigweed	0 mm	-	7 mm	3
Cat	4 mm	5 mm	-	4
Total Sticks:	32	11	20	Total: 63

Notes
Pt c/o constant congestion which started after she broke her nose 3 years ago. She has tried peppermint oil with no relief. EC and IT were discussed. She will f/u with Dr Dozier on 7/30 to review AT and discuss a treatment plan. MRT

RMC Production 163

Charleston ent

Referral Form

Date: 6/26/2014

Patient Name: CONNELLY, ROSEMARY Birth date: REDACTED Phone: REDACTED

Diagnosis: Facial pain, Anosmia ICD9:

Procedure: CT Sinus w/out contrast

DOCTOR / PA SIGNATURE: TS Dozier

Thomas Dozier, MD

REFERRAL TO:

Physician / Facility: CT SV

Address: 298 Midland Pkwy, Summerville, SC 29485

Telephone: (843) 873-8733 Fax: Auth. No.:

☐ STAT: ☐ URGENT: ☐ ROUTINE:

Comments: In office

APPOINTMENT:

PLEASE NOTIFY OUR OFFICE IF YOUR APPOINTMENT IS NOT SCHEDULED IN A TIMELY MANNER ☐ Initials

Patient Will Self Schedule:

Date: 6/26/2014 Time

Patient Instructions:

Date: 6/26/2014 Time Initials: jwa

IMPORTANT

Mail or Fax Results to:

DOZIER, THOMAS

298 Midland Parkway, Summerville, SC 29485

Phone: (843) 766-7103

Fax: (843) 725-4012

RMC Production 164

CHARLESTON ENT ASSOCIATES, L.L.C./RADIOLOGY
298 Midland Parkway, Summerville, SC 29485
Phone: (843) 873-8733 Fax: (843) 873-8732

Name: Rosemary Connelly
Date: 06/26/2014
MR#: 182959
DOB: REDACTED
Physician: Thomas S. Dozier, M.D.

CT SCAN

Examination: CT scan of the paranasal sinuses without contrast

Clinical Indication: Recent sinusitis, with foul-smelling nasal discharge.

Technique: The Xoran MiniCAT was used with the Standard Cone Beam Volume protocol. The patient was seated and positioned upright. Axial Volume CT data was acquired. Multiplanar reconstruction was performed on a viewing workstation to obtain sagittal and coronal images.

Quality of Study: No motion or streak artifact present. Patient positioning is appropriate for scan type. All anatomic structures of the paranasal sinuses were included in the exam.

Comparison: None.

Nasomaxillary Complex:
1. The nasal septum is generally midline.
2. The inferior turbinates are severely hypertrophic bilaterally.
3. The middle turbinates appear normal without evidence of concha bullosa.
4. The ostiomeatal complexes are well visualized with no evidence of obstruction or inflammation.
5. The maxillary sinuses are well pneumatized with no evidence of acute or chronic mucosal inflammatory disease.

Frontoethmoidal Complex:
1. The frontal sinuses are well pneumatized with no evidence of acute or chronic mucosal inflammatory disease.
2. The ethmoid sinuses are well pneumatized with no evidence of acute or chronic mucosal inflammatory disease.

Sphenoid Sinuses:
The sphenoid sinuses are well pneumatized with no evidence of acute or chronic mucosal inflammatory disease.

Recommendations for Follow up: No incidental findings to be followed up at this time.

Impression:
Clear paranasal sinuses.

TS Dozier

Thomas S. Dozier, M.D./slc
DD: 06/26/2014 DT: 06/27/2014

Charleston ent

Phone (843)766-7103 Fax (843)763-3834

rick C. Angelos, M.D.
ward G. Behrens, M.D., Ph.D.
gene G. Brown, III, R.Ph., M.D.
omas S. Dozier, M.D.
ark D. Ghegan, M.D.
Orin Hester, M.D., F.A.C.S.
ward L. McNellis, R.Ph., M.D.
onald J. McVicar, D.O., F.A.C.S.
ichael C. Noone, M.D.
atthew D. Scarlett, M.D.
. Willy Schwenzfeier, M.D., F.A.C.S.
mm N. Scott, M.D.
ik R. Swanson, M.D.

Lorraine E. Booze, PA-C
S. Blair Brewer, PA-C
Roxanne F. Hall, PA-C
Anna Maria Kammeyer, PA-C
Natalie M. Bickley, AuD, CCC-A
Salley B. Davidson, M. AuD., CCC-A
Melissa A. Franklin, M.A., CCC-A
Kati Hinrichsen, AuD., CCC-A
Kari D. Horne, AuD., CCC-A
Vanhphenh (Penny) S. Leong, M.S., CCC-A
Carlos P. Minaya, AuD.
Karen M. Moore, AuD., CCC-A, F-AAA
Sarah Thomas, AuD., CCC-A

'ATIENT: **losemary Connelly**
IOB: REDACTED
:HART#:
IOS: **1/16/2015**

I saw **ROSEMARY CONNELLY** back in follow-up regarding chief complaint of anosmia. **HISTORY OF PRESENT ILLNESS:** She comes in today to take the University of Pennsylvania Smell Identification test. Review of the ENT and allergy systems is otherwise negative. **EXAM:** ***General:*** The patient is pleasant and cooperative with examination. ***Ears:*** Ear canals are clear bilaterally. Tympanic membranes are translucent and mobile. ***Nose:*** Nose shows congestion on anterior rhinoscopy. ***Throat:*** Oral cavity exam reveals no mucosal lesions or masses. ***Neck:*** Neck is supple. There are no palpable masses or lesions. No thyromegaly detected. ***Lymphatics:*** There is no evidence of cervical adenopathy. ***Head:*** Head is normocephalic, atraumatic, with symmetrical facial movements. **SPECIAL TESTING:** A smell identification test was performed. It was scored according to the answer key provided, and she got 13 out of 40 test items correct, which is consistent with anosmia, but no suspicious for malingering. **ASSESSMENT:** Anosmia. **PLAN:** I discussed with Ms. Connelly in detail the results of her test. I suspect, at this point being several years out from the injury, this is unlikely to improve. She will follow up on an as-needed basis.

TSDozier

Thomas Dozier, MD
TSD/sc

cc: Thomas Funcik, M.D.
Jennifer Pullano, D.O.

CHARLESTON ENT ASSOCIATES LLC
2295 HENRY TECKLENBURG

CHARLESTON, SC 29414-7801
843 763 5342

[CQFMAIN] Inquiry
Date 01/13/2015
Time 10:06a
User NLH001
Page 1

Patient Name: ROSEMARY H CONNELLY
Patient #: 182959
DOB: REDACTED
Death Date: 00/00/0000
Age: 59 Sex: F
SSN: REDACTED

Date Registered: 04/03/2013

Resp Party: ROSEMARY H CONNELLY
Bill To #:

Dr #: 16 THOMAS S DOZIER
RDr #: 16 THOMAS S DOZIER
[redacted]
Bill Cycle: 1 A F
Credit Status: 0

Patient E-mail:
Responsible Party E-mail:

Balances

0 - 30:	.00
31 - 60:	.00
61 - 90:	.00
91 - 120:	.00
121 - 150:	.00
151+ :	.00
Total Balance:	.00
- Pending:	.00
= Patient Balance:	.00
Budget Due:	.00
Non-budget Due:	.00
Total Due:	.00
Budget Balance:	.00
Budget Payment:	.00

Billing History: 09/03/2014 08/06/2014
06/05/2013 00/00/0000

Responsible Party Address:
REDACTED
REDACTED REDACTED
H/Ph #:
W/Ph #: 000-0000
M/Ph #: 000-0000

Patient Address:
REDACTED
REDACTE REDACTED
W/Ph #: 000-0000
M/Ph #: 000-0000

Last Transactions:
Charge: 08/04/2014 .00
Personal: 09/09/2014 199.51
[redacted]

Location: 4 CHARLESTON ENT
Diagnosis: 477.0 RHINITIS, ALLER

[redacted]

Debit mode details

Patient#/Name: REDACT ROSEMARY H CONNELLY

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
04/09/2013	1313261U	399/JG001	17 M GHEGAN	5 CHARLESTO	.00	.00

[redacted]

Patient#/Name: 182959 ROSEMARY H CONNELLY

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
04/10/2013	1317233U	560/DMP001	17 M GHEGAN	5 CHARLESTO	146.00	146.00

[redacted]

[redacted]

Patient#/Name: 182959 ROSEMARY H CONNELLY

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
04/10/2013	1317231U	439/JG001	717 M GHEGAN	5 CHARLESTO	553.00	553.00

[redacted]

Patient#/Name: 182959 ROSEMARY H CONNELLY

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
04/30/2013	1325104U	565/PMF001	21 T HESTER	5 CHARLESTO	542.00	542.00

[redacted]

Post Date	Debit#	Batch#/User	Dr# Name	Total
06/10/2013	100028711611U	456/	17 M GHEGAN	20.00

[redacted]

Patient#/Name: 182959 ROSEMARY H CONNELLY

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
06/30/2014	1586771U	439/JG001	716 T DOZIER	4 CHARLESTO	553.00	553.00

[redacted]

CHARLESTON ENT ASSOCIATES LLC
2295 HENRY TECKLENBURG

CHARLESTON, SC 29414-7801
843 763 5342

[CQFMAIN] Inquiry
Date 01/13/2015
Time 10:06a
User NLH001
Page 3

Patient#/Name: 182959 ROSEMARY H CONNELLY

Post Date	Debit#	Batch#/User	Dr#	Name	Loc#	Name	Orig Pend	Total
07/14/2014	1584079U	280/STG001	16	T DOZIER	4	CHARLESTO	353.00	353.00

[redacted]

Patient#/Name: 182959 ROSEMARY H CONNELLY

Post Date	Debit#	Batch#/User	Dr#	Name	Loc#	Name	Orig Pend	Total
07/23/2014	1601657U	539/JG001	17	M GHEGAN	5	CHARLESTO	553.00	553.00

[redacted]

Patient#/Name: 182959 ROSEMARY H CONNELLY

Post Date	Debit#	Batch#/User	Dr#	Name	Loc#	Name	Orig Pend	Total
08/04/2014	1600079U	399/JG001	16	T DOZIER	4	CHARLESTO	.00	.00

[redacted]

****

Provider	Date	Procedure	Notes	Amount	Subtotal	Total
Nason Medical Center	6/10/11	Office/outpatient visit		$ 206 00		
		X-ray Exam Knee		$ 77 00		
		Ct scan, cervical spine, w/o contrast		$ 785 00		
		Ct Scan, Head/Brain, w/o contrast		$ 575 00		
		Ct Scan, maxiflofacial, w/o costrast		$ 710 00		
					$ 2,353 00	
Carolina Radiology						
Assocaites, LLC	6/10/11	Radex KNE Compl		$62 00		
	6/10/11	CT Head/BRN C-Matrl		$248 00		
	6/10/11	CT CRV SPI C-MATRL		$289 00		
	6/20/11	CT MAXLFCL		$289 00		
					$888 00	
Theobold Family Chiro	6/15/11	Spine entire a/p LAT		$ 65 00		
		Typ Prob Roc		$ 15 00		
		Paraspinal Images		$ 30 00		
		Spnl Adjstmt 3-4 area		$ 35 00		
	6/17/11	Spnl Adjstmt 3-4 area		$ 35 00		
	6/22/11	Spnl Adjstmt 3-4 area		$ 35 00		
	6/27/11	Spnl Adjstmt 3-4 area		$ 35 00		
	7/1/11	Spnl Adjstmt 3-4 area		$ 35 00		
	7/12/11	Spnl Adjstmt 3-4 area		$ 35 00		
	7/15/11	Spnl Adjstmt 3-4 area		$ 35 00		
	7/19/11	Spnl Adjstmt 3-4 area		$ 35 00		
	7/22/11	Spnl Adjstmt 3-4 area		$ 35 00		
	7/29/11	Spnl Adjstmt 3-4 area		$ 35 00		
	8/2/11	Spnl Adjstmt 3-4 area		$ 35 00		
	8/9/11	Spnl Adjstmt 3-4 area		$ 35 00		
	8/17/11	Spinal adjustment(s)		$ 25 00		
	6/17/13	Spnl Adjstmt 3-4 area		$ 35 00		
	6/19/13	Spnl Adjstmt 3-4 area		$ 35 00		
	6/25/13	Spnl Adjstmt 3-4 area		$ 35 00		
	6/27/13	Spnl Adjstmt 3-4 area		$ 35 00		
	7/25/13	Spnl Adjstmt 3-4 area		$ 35 00		
	7/31/13	Spnl Adjstmt 3-4 area		$ 35 00		
	8/2/13	Spnl Adjstmt 3-4 area		$ 35 00		
	8/6/13	Spnl Adjstmt 3-4 area		$ 35 00		
	9/25/13	Spnl Adjstmt 3-4 area		$ 35 00		
	10/2/13	Spnl Adjstmt 3-4 area		$ 35 00		
	9/25/13	Spnl Adjstmt 3-4 area		$ 35 00		
	11/8/13	Spnl Adjstmt 3-4 area		$ 35 00		
	11/15/13	Spnl Adjstmt 3-4 area		$ 35 00		
	11/21/13	Spnl Adjstmt 3-4 area		$ 35 00		
	1/31/14	Spnl Adjstmt 3-4 area		$ 35 00		
					$ 1,080 00	
Charleston ENT Associates	4/10/13	Dr Ghegan - 1317233U		$146 00		
	4/10/13	CT Scan		$553 00		
	4/30/13	Dr Hester - 1325104U		$542 00		
	6/10/13	Dr Ghegan - 10002871611U		$20 00		
	6/30/14	CT Scan		$553 00		
	7/14/14	Dr Dozier - 1584079U		$353 00		
	7/23/14	CT Scan		$553 00		
					$2,720 00	
Thomas Funcik	6/6/11	Estabilish Comprehensive		$151 60		
		Emergency work in		$100 00		
	12/6/11	Established Comprehensive		$151 60		
		Exc trnk, arm, leg 6 - 1 0 cm		$149 00		
		Exc trnk, arm, leg 1 1 - 2 0 cm		$165 00		
		Exc Lesion 2 1 to 3 0		$190 50		
		Ex face, ear, el, nose, lip 6 - 1 0		$250 00		
		Ex face, ear, el nose, lip 6 - 1 0		$250 00		
		Medical Supplies		$100 00		
		Procedure Tray		$50 00		
Coastal Fiacial Plastic Surgery	8/24/11	Open Reduction of Nasal Fracture		$2,846 00		
		Prvate Surgical Suite & Anesthesia Service & Supplies		$1,800 00		
					$6,203 70	
						$ 13,244.70

NASON MEDICAL CENTER right there.
EMERGENCY - URGENT CARE - IMAGING
1101 BOWMAN ROAD • MT. PLEASANT, SC 29464
843.284.4911

IF PAYING BY CREDIT CARD, FILL OUT BELOW		
CHECK CARD USING FOR PAYMENT ☐ AMERICAN EXPRE ☐ DISCOVER ☐ MASTERCAR ☐ VISA		
CARD NUMBER	CVV	AMOUNT
SIGNATURE		EXP. DATE

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NBR
08/22/13	$0.00	REDACTED

SHOW AMOUNT PAID HERE $

ADDRESSEE:

Rosemary Connelly
REDACTED
USA

☐ Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

REMIT TO:

Nason Medical Center, LLC
PO Box 51629

Summerville, SC 29485-1629

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

DATE	PATIENT NAME	PROVIDER	SERVICE	DESCRIPTION OF SERVICE	AMOUNT
06/10/11	Rosemary Connelly	Schwartzberg, Brian	99204	Office/outpatient visit, new, mod complex	$206.00
06/10/11	Rosemary Connelly	Schwartzberg, Brian	90703	TETANUS VACCINE IM	$42.00
06/10/11	Rosemary Connelly	Schwartzberg, Brian	90471	IMMUNIZATION ADMIN	$26.00
06/10/11	Rosemary Connelly	Schwartzberg, Brian	73564	X-RAY EXAM KNEE 4 OR MORE COMPLETE	$77.00
06/10/11	Rosemary Connelly	Schwartzberg, Brian	72125	CT scan, cervical spine, w/o contrast	$785.00
06/10/11	Rosemary Connelly	Schwartzberg, Brian	70450	CT scan, head/brain, w/o contrast	$576.00
06/10/11	Rosemary Connelly	Schwartzberg, Brian	70486	CT scan, maxillofacial, w/o contrast	$710.00
06/10/11				Cash Payment - Thank You	-$35.00
06/13/11				Applied Encounter Credit - PMT	-$35.00
[redacted]					
07/07/11				Check Payment - Thank You	-$42.00
07/07/11				Check Payment - Thank You	-$26.00
07/07/11				Check Payment - Thank You	-$88.30
07/07/11				Check Payment - Thank You	-$44.60
07/07/11				Check Payment - Thank You	-$88.20
07/07/11				Check Payment - Thank You	-$28.20
[redacted]					

ACCOUNT NBR	CHARGES
54618	$2,421.00

MESSAGE:
For Billing Questions or to make a Quick and Easy Payment by phone, Please Call (843) 552-4240
Thank you for your prompt payment.

PLEASE PAY THIS AMOUNT »»»» $0.00

** PAYMENT DUE UPON RECEIPT * THANK YOU **

ENCOUNTER INVOICE

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NASON MEDICAL CENTER right there.
EMERGENCY - URGENT CARE - IMAGING
1101 BOWMAN ROAD • MT. PLEASANT, SC 29464
843.284.4911

IF PAYING BY CREDIT CARD, FILL OUT BELOW		
CHECK CARD USING FOR PAYMENT ☐ AMERICAN EXPRE ☐ DISCOVER ☐ MASTERCAR ☐ VISA		
CARD NUMBER	CVV	AMOUNT
SIGNATURE		EXP. DATE

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NBR
08/22/13	$0.00	REDACTED

SHOW AMOUNT PAID HERE $

ADDRESSEE:

Rosemary Connelly
REDACTED
USA

REMIT TO:

Nason Medical Center, LLC
PO Box 51629

Summerville, SC 29485-1629

☐ Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

DATE	PATIENT NAME	PROVIDER	SERVICE	DESCRIPTION OF SERVICE	AMOUNT
07/07/11				Move Line Item Credit	$8.40
07/07/11				Move Line Item Credit	$8.40

ACCOUNT NBR	CHARGES
54618	$2,421.00

MESSAGE:
For Billing Questions or to make a Quick and Easy Payment by phone, Please Call (843) 552-4240
Thank you for your prompt payment.

PLEASE PAY THIS AMOUNT »»»» $0.00

** PAYMENT DUE UPON RECEIPT * THANK YOU **

ENCOUNTER INVOICE

Printed by tbonneville (200) on 8/22/2013 3:06:16 PM

ROA 1200

CAROLINA RADIOLOGY ASSOCIATES, LLC
P O BOX 51030
MYRTLE BEACH SC 29579
(800)841-4236

Patient:
Acct #: 384672
CONNELLY, ROSEMARY
REDACTED

Responsible party:
CONNELLY, ROSEMARY
REDACTED

Srvc. Date	CPT	Proc. Description	Charge	Balance	Physician
06/10/2011	73564	RADEX KNE COMPL 4/MORE V	$62.00	$0.00	SHELLEY JR, BILLIE ED
[redacted]					
06/10/2011	70450	CT HEAD/BRN C-MATRL	$248.00	$0.00	SHELLEY JR, BILLIE ED
[redacted]					
06/10/2011	70486	CT MAXLFCL AREA C-MATRL	$289.00	$0.00	DALY, JR, JOHN J
[redacted]					
06/10/2011	72125	CT CRV SPI C-MATRL	$289.00	$0.00	SHELLEY JR, BILLIE ED
[redacted]					

TOTAL BALANCE: $0.00

This report has been Reproduced from the Original
Reproduced Tuesday, March, 26, 2013 11:28:05 AM (EMULATE)

Theobald Family Chiropractic
900 Johnnie Dodds Blvd.
Mt. Pleasant SC 29464
(843)849-3730

09/26/11

Patient: Rosemary Connelly
REDACTED
Account Number: REDACTE
Case #: D

739.1 CERVICAL SPINE
723.4 Symptom - Radiculitis
739.2 Thoracic T1-T12
724.1 Symptom - Pain Thoracic Region

[redacted]

Date	Description	Procedure	Modify	Dx	Units	Charge
06/15/11	Spine Entire A/P LAT	72010		1,2,3,4	1	65.00
06/15/11	Typ. Prob. Foc.	99201		1,2,3,4	1	15.00
06/15/11	Paraspinal Imaging	93740-25		1,2,3,4	1	30.00
06/15/11	Spnl Adjstmt 3-4 Areas	98941		1,2,3,4	1	35.00
06/17/11	Spnl Adjstmt 3-4 Areas	98941		1,2,3,4	1	35.00
06/22/11	Spnl Adjstmt 3-4 Areas	98941		1,2,3,4	1	35.00
06/24/11	Spnl Adjstmt 3-4 Areas	98941		1,2,3,4	1	35.00
06/27/11	Spnl Adjstmt 3-4 Areas	98941		1,2,3,4	1	35.00
07/01/11	Spnl Adjstmt 3-4 Areas	98941		1,2,3,4	1	35.00
07/12/11	Spnl Adjstmt 3-4 Areas	98941		1,2,3,4	1	35.00
07/15/11	Spnl Adjstmt 3-4 Areas	98941		1,2,3,4	1	35.00
07/19/11	Spnl Adjstmt 3-4 Areas	98941		1,2,3,4	1	35.00
07/22/11	Spnl Adjstmt 3-4 Areas	98941		1,2,3,4	1	35.00
07/29/11	Spnl Adjstmt 3-4 Areas	98941		1,2,3,4	1	35.00
08/02/11	Spnl Adjstmt 3-4 Areas	98941		1,2,3,4	1	35.00
08/09/11	Spnl Adjstmt 3-4 Areas	98941		1,2,3,4	1	35.00
08/17/11	Spinal Adjustment(S)	98941		1,2,3,4	1	25.00

Provider Information
Name: David Theobald
License: 2191
SSN or EIN: REDACTED

Total Charges:	590.00
Total Payments:	590.00
Total Balance Due:	0.00

[redacted]

Patient Signature: _____ Date: _____

Theobald Family Chiropractic
900 Johnnie Dodds Blvd.
Mt. Pleasant SC 29464
(843)849-3730

02/17/14

Patient: [redacted]

Account Number: [redacted]
Case #: [redacted]

739.1 CERVICAL SPINE
723.4 Symptom - Radiculitis
739.2 Thoracic T1-T12
724.1 Symptom - Pain Thoracic Region

[redacted]

Date	Description	Procedure	Modify	Dx	Units	Charge
06/17/13	Spnl Adjstmt 3-4 Areas	98941		1,2,3,4	1	35.00
06/19/13	Spnl Adjstmt 3-4 Areas	98941		1,2,3,4	1	35.00
06/25/13	Spnl Adjstmt 3-4 Areas	98941		1,2,3,4	1	35.00
06/27/13	Spnl Adjstmt 3-4 Areas	98941		1,2,3,4	1	35.00
07/25/13	Spnl Adjstmt 3-4 Areas	98941		1,2,3,4	1	35.00
07/31/13	Spnl Adjstmt 3-4 Areas	98941		1,2,3,4	1	35.00
08/02/13	Spnl Adjstmt 3-4 Areas	98941		1,2,3,4	1	35.00
08/06/13	Spnl Adjstmt 3-4 Areas	98941		1,2,3,4	1	35.00
09/25/13	Spnl Adjstmt 3-4 Areas	98941		1,2,3,4	1	35.00
10/02/13	Spnl Adjstmt 3-4 Areas	98941		1,2,3,4	1	35.00
11/08/13	Spnl Adjstmt 3-4 Areas	98941		1,2,3,4	1	35.00
11/15/13	Spnl Adjstmt 3-4 Areas	98941		1,2,3,4	1	35.00
11/21/13	Spnl Adjstmt 3-4 Areas	98941		1,2,3,4	1	35.00
01/31/14	Spnl Adjstmt 3-4 Areas	98941		1,2,3,4	1	35.00

Provider Information
Name: David Theobald
License: 2191
SSN or EIN: [redacted]

Total Charges:	490.00
Total Payments:	490.00
Total Balance Due:	0.00

[redacted]

Patient Signature: _____ Date: _____

CHARLESTON ENT ASSOCIATES LLC
2295 HENRY TECKLENBURG

CHARLESTON, SC 29414-7801
843 763 5342

[CQFMAIN] Inquiry
Date 01/13/2015
Time 10:06a
User NLH001
Page 1

Patient Name: ROSEMARY H CONNELLY
Patient #: 182959
DOB: REDACTED
Death Date: 00/00/0000
Age: 59 Sex: F
SSN: REDACTED

Date Registered: 04/03/2013

Resp Party: ROSEMARY H CONNELLY
Bill To #: REDACTED

Dr #: 16 THOMAS S DOZIER
RDr #: 16 THOMAS S DOZIER

[redacted]

Bill Cycle: 1 A F
Credit Status: 0

Patient E-mail:
Responsible Party E-mail:

Balances

0 - 30:	.00
31 - 60:	.00
61 - 90:	.00
91 - 120:	.00
121 - 150:	.00
151+ :	.00
Total Balance:	.00
- Pending:	.00
= Patient Balance:	.00
Budget Due:	.00
Non-budget Due:	.00
Total Due:	.00
Budget Balance:	.00
Budget Payment:	.00

Billing History: 09/03/2014 08/06/2014
06/05/2013 00/00/0000

Responsible Party Address:
REDACTED
REDACTED
H/Ph #
W/Ph #
M/Ph #: 000-0000

Patient Address:
REDACTED
M/Ph #: 000-0000
W/Ph #: 000-0000

Last Transactions:
Charge: 08/04/2014 .00
Personal: 09/09/2014 199.51

[redacted]

Location: 4 CHARLESTON ENT
Diagnosis: 477.0 RHINITIS, ALLER

[redacted]

****
Debit mode details
****

Patient#/Name: [redacted] ROSEMARY H CONNELLY

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
04/09/2013	1313261U	399/JG001	17 M GHEGAN	5 CHARLESTO	.00	.00

[redacted]

Patient#/Name: 182959 ROSEMARY H CONNELLY

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
04/10/2013	1317233U	560/DMP001	17 M GHEGAN	5 CHARLESTO	146.00	146.00

[redacted]

[redacted]

Patient#/Name: 182959 ROSEMARY H CONNELLY

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
04/10/2013	1317231U	439/JG001	717 M GHEGAN	5 CHARLESTO	553.00	553.00

[redacted]

Patient#/Name: 182959 ROSEMARY H CONNELLY

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
04/30/2013	1325104U	565/PMF001	21 T HESTER	5 CHARLESTO	542.00	542.00

[redacted]

Post Date	Debit#	Batch#/User	Dr# Name	Total
06/10/2013	100028716111U	456/	17 M GHEGAN	20.00

[redacted]

Patient#/Name: 182959 ROSEMARY H CONNELLY

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
06/30/2014	1586771U	439/JG001	716 T DOZIER	4 CHARLESTO	553.00	553.00

[redacted]

CHARLESTON ENT ASSOCIATES LLC
2295 HENRY TECKLENBURG

CHARLESTON, SC 29414-7801
843 763 5342

[CQFMAIN] Inquiry
Date 01/13/2015
Time 10:06a
User NLH001
Page 3

Patient#/Name: 182959 ROSEMARY H CONNELLY

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
07/14/2014	1584079U	280/STG001	16 T DOZIER	4 CHARLESTO	353.00	353.00
[redacted]						

Patient#/Name: 182959 ROSEMARY H CONNELLY

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
07/23/2014	1601657U	539/JG001	17 M GHEGAN	5 CHARLESTO	553.00	553.00
[redacted]						

Patient#/Name: 182959 ROSEMARY H CONNELLY

Post Date	Debit#	Batch#/User	Dr# Name	Loc# Name	Orig Pend	Total
08/04/2014	1600079U	399/JG001	16 T DOZIER	4 CHARLESTO	.00	.00
[redacted]						

****

Thomas Funcik, M.D.
2671 Brickside Lane
Mt. Pleasant, SC 294667180
(843)884-3277

3/14/2013

Patient: Rosemary Connelly
REDACTED
Chart #:
Case #: 9378

[redacted]

Date	Description	Procedure	Modify	Dx 1	Dx 2	Dx 3	Dx 4	Units	Charge
6/6/2011	Established Comprehensive	99215		873.5	873.3	959.0		1	151.60
6/6/2011	Emergency work In	99058		873.5	873.3	959.0		1	100.00
6/14/2011	Post-op	99024		873.5	873.3	959.0		1	0.00
[redacted]									
12/6/2011	Established Comprehensive	99215		706.9	709.0	706.2	782.2	1	151.60
12/6/2011	Exc. trnk,arm,leg .6-1.0 cm	11401		706.9	709.0	706.2	782.2	1	149.00
12/6/2011	Exc. trnk,arm,leg 1.1-2.0 cm	11402		706.9	709.0	706.2	782.2	1	165.00
12/6/2011	Exc. Lesion 2.1 To 3.0	11403		706.9	709.0	706.2	782.2	1	190.50
12/6/2011	Ex.face,ear,el,nose,lip .6-1.0	11441		706.9	709.0	706.2	782.2	1	250.00
12/6/2011	Ex.face,ear,el,nose,lip .6-1.0	11441	51	706.9	709.0	706.2	782.2	1	250.00
12/6/2011	Photos/Reports/Copy of Records	99080		706.9	709.0	706.2	782.2	1	25.00
12/6/2011	Medical Supplies	99070		706.9	709.0	706.2	782.2	1	100.00
12/6/2011	Procedure Tray	A4550	59	706.9	709.0	706.2	782.2	1	50.00
[redacted]									
1/19/2012	Visa/Mastercard Payment	VISA/MCA						1	-66.55
2/22/2012	Restylane	RESTYLAN		873.5	873.3	959.0		1	590.00
2/22/2012	Check	CK						1	-590.00
7/17/2012	Dysport	DYSPORT		873.5	873.3	959.0		2	594.00
7/17/2012	Restylane Reinjection	RESTYREI		873.5	873.3	959.0		1	65.00
7/17/2012	Discount	DISCOUNT						1	-100.00
7/17/2012	Visa/Mastercard Payment	VISA/MCA						1	-559.00

Provider Information

Provider Name: COASTAL FACIAL
License: 15088
Commercial PIN:
SSN or EIN: REDACTED

Total Charges: $ 2831.70

[redacted]

[redacted]

Patient Signature: _____ Date: _____

Thomas Funcik, M.D.
2671 Brickside Lane
Mt. Pleasant, SC 294667180
(843)884-3277

3/14/2013

Patient: Rosemary Connelly
REDACTED
Chart #:
Case #: 9378

[redacted]

Date	Description	Procedure	Modify	Dx 1	Dx 2	Dx 3	Dx 4	Units	Charge
11/26/2012	Dysport	DYSPORT		873.5	873.3	959.0		1	297.00
11/26/2012	Discount	DISCOUNT						1	-75.00
11/26/2012	Visa/Mastercard Payment	VISA/MCA						1	-222.00

Provider Information
Provider Name: COASTAL FACIAL
License: 15088
Commercial PIN:
SSN or EIN: REDACTED

Total Charges: $ 297.00

[redacted]

[redacted]

Patient Signature: _____ Date: _____

Coastal Facial Plastic Surgery
Thomas Funcik, M.D.

Thursday, September 22, 2011

Re: Rosemary Connelly
DOB: REDACTED

List of services performed on Wednesday, August 24, 2011

PROCEDURE	FEE
Open Reduction of Nasal Fracture	$ 2,846.00
Functional Turbinectomy	$ 1,485.00
Rhinoplasty	$ 4,495.00
Private Surgical Suite & Anesthesia Service & Supplies	$ 1,800.00
TOTAL	**$ 10,626.00**

Mrs. Connelly paid $6295.00 for the Rhinoplasty, Private Surgical Suite and Anesthesia Service and Supplies on July 12, 2011.

Thomas Funcik, MD

1280 Johnnie Dodds Blvd., Suite 101 • Mt. Pleasant, SC • 29464 • 843.884.3277 • www.greatface.com

City of Charleston
PERMIT

Issued to WINSOR CUSTOM HOMES

No. BRII-00089 LOCATION REDACTED

NATURE OF WORK NEW SINGLE-FAMILY CONSTRUCTION

☒ RESIDENTIAL ☐ COMMERCIAL

☒ NEW CONSTRUCTION ☐ ADDITION ☐ RENOVATION ☐ UP FIT

ISSUED BY _____ BUILDING OFFICIAL DATE 1/8/14

REQ. FLOOD ZONE/ELEV AE 14' CERTIFICATE REQUIRED ☒ YES ☐ NO

INSPECTIONS BLDG. NO. BRII-00089

Foundation App. Date & Initial Dis. App. Initial

Use App. Date & Initial Dis. App. Initial

Const. Elevation Cert. App. Date & Initial Dis. App. Initial

Sheathing App. Date & Initial Dis. App. Initial

Plbg. & Piping App. Date & Initial Dis. App. Initial

Insulation App. Date & Initial Dis. App. Initial

Final Electrical Cert. App. Date & Initial Dis. App. Initial

Final App. Date & Initial Dis. App. Initial

Sprinkler App. Date & Initial Dis. App. Initial

FIRE (Applies to all Commercial Buildings) App. Date & Initial Dis. App. Initial

Final App. Date & Initial Dis. App. Initial

TEMPORARY POWER POLE

ADDRESS: REDACTED

ELECTRICAL PERMIT # _____

BUILDING PERMIT # _____

INSPECTIONS:

App: _____ Dis. App.

REDACTED

ELE-00684

REDACTED

ELE-00636

REDACTED

MECHANICAL PERMIT

REDACTED

ADDRESS _____

MECHANICAL PERMIT # _____

BUILDING PERMIT # BRII-00089

INSPECTIONS:

Slab App. Dis. App.

Rough 9/9/14 App. 9-11-13 Dis. App.

Final App. Dis. App.

FIRE PERMIT DECAL

SPECIAL INSPECTIONS

CONCRETE ☐ GEO TECH ☐

WELDING ☐ BOLTING ☐

FIRE PROOFING ☐

ENGINEERING DECAL

THIS CARD MUST BE DISPLAYED AT THE CONSTRUCTION SITE AND MUST BE PROTECTED FROM THE WEATHER UNTIL JOB IS COMPLETED.

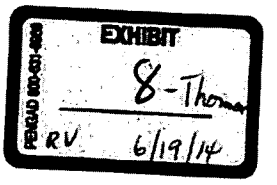
CONTRACTOR/OWNER IS RESPONSIBLE FOR REMOVAL OF ALL CONSTRUCTION DEBRIS.

EXHIBIT 3-Thomas

FRV 6/19/14

2013-0494 0153

Daniel Island
ARCHITECTURAL
REVIEW BOARD



CONSTRUCTION GUIDELINES

General Rules
The following rules apply to all employees of Daniel Island contractors and service personnel while on Daniel Island premises. Infractions of any of these rules may result in penalties of the complete construction deposit(s) being withheld.

1. The construction traffic will be allowed Monday through Friday, from 7:00 am until 6:00 pm and 7:00 am until 7:00 pm during daylight savings time. Construction traffic is permitted on Saturdays from 8:30 am to 4:30 pm. All construction related activities are prohibited on Sundays* and major holidays. *After Hours and Sunday work permits may be requested for an additional fee for inside quiet work only.
2. Contractors are required to keep their job sites as neat and clean as possible. Trash and discarded materials must be removed weekly. There will be no stockpiling or dumping on adjacent lots or on streets. Construction materials are to be neatly piled on site; debris and rubbish are to be contained and periodically removed; tall, unsightly weeds are to be routinely cut back, streets adjoining a construction site are to be frequently swept clean of dirt and construction trash. Fines will be deducted from the Construction Deposit for messy job sites.
3. Install erosion control measures (silt fencing) to the perimeter of the property.
4. Builders are required to place a dumpster on site during construction. Should a builder be working on two adjacent homes, one dumpster can service both properties. Builders may use recycling services instead of a dumpster on a job site but the Builder is ultimately responsible for flying debris.
5. All vacant property shall be kept neat and cleared of debris, and shall be well and continuously maintained in its natural condition until construction commences on the property.
6. Contractors will use only the utilities provided on the immediate site on which they are working.
7. Any damage to streets and curbs, drainage inlets, streetlights, street markers, mailboxes, walls, etc. is the responsibility of the owner/builder.
8. There will be no washing of any truck on the streets. Any concrete delivery truck washed out must be on the construction site.
9. Operators of vehicles are required to see that they do not spill any damaging materials while within Daniel Island. If spillage occurs, operators are responsible for cleaning up. Cleanups done by Daniel Island personnel will be charged to the responsible party. Please report any spills as soon as possible to the ARB.
10. If any telephone, cable, TV, electrical, or water lines are cut, it is the builder's responsibility to report such an accident to the community association and appropriate utility within 30 minutes.

130 River Landing Drive, Suite 1-C | Charleston, SC 29492 | (843) 881-6122 | (f) (843) 856-1728

Daniel Island
ARCHITECTURAL
REVIEW BOARD

11. Loud radios or noise will not be allowed within the neighborhoods. This is distracting and discomforting to property owners. Normal radio levels are acceptable. Do not mount speakers on vehicles or outside of homes under construction.
12. No vehicles (trucks, vans, cars, etc.) may be left in the job area overnight. Construction equipment may be left on the site while needed, but must not be kept on the street. Parking should be off streets whenever possible.
13. No contractor personnel will be permitted to bring pets on the property.

The following list represents a schedule of fines for homes during construction. These fines will be collected from the construction deposit.

a.	Littered site/No dumpster	$250.00
b.	Damage to right-of-way	$100.00, plus restoration
c.	Parking or dumpster on adjacent property or major road without designated parking spaces	$100.00 per violation
d.	Building material or equipment on adjacent property	$100.00
e.	No temporary sanitary facilities	$100.00
f.	Nonconforming job sign	$100.00
g.	Damage to natural areas	$1500.00 plus restoration deducted from deposit
h.	Damage to common areas	$1500.00 plus restoration deducted from deposit
i.	Unauthorized plan change (minor)	$250.00
j.	Unauthorized plan change (major)	$1500.00
k.	Unauthorized finishes, ie. (paint, stain, roof material)	$1500.00
l.	Silt fences not installed or maintained properly	$250.00
m.	Clearing site without permit	$1500.00
n.	Fill placed on tree roots	$250.00

130 River Landing Drive, Suite 1-C | Charleston, SC 29492 | (843) 881-6122 | (f) (843) 856-1728

Daniel Island
ARCHITECTURAL
REVIEW BOARD

o.	Working on a Sunday without a permit	$500.00
p.	Working After Hours without a permit	$500.00
q.	Working on a Holiday	$1000.00
r.	Site fill or installation of landscaping without approval	$1500.00
t.	Lot damage to adjacent property	$500.00, plus restoration deducted from deposit
u.	Dirt/Trash in the Street	$100.00
v.	Dumpster overflowing more than 3 business days	$500.00
w.	Unauthorized tree removal	$1500.00, plus mitigation
x.	Failure to maintain lot	$100.00

ARB will assess fines on a case-by-case basis and may pursue legal action if necessary. The amounts of the fines given above are subject of periodic increases at the sole discretion of the ARB.

****Builder shall have 24 hours to remedy violation, unless otherwise noted by the ARB, before fines are doubled.**

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Daniel Island
ARCHITECTURAL
REVIEW BOARD

Daniel Island ARB Inspection Timeline

1. Meet ARB staff on site to review site conditions (silt fencing, tree protection, etc.) prior to commencement of construction
2. Provide ARB with copy of City of Charleston building permit within 10 business days of permit issuance
    a. $500 fine for copy of permit received after 10 business days
3. Within 10 days of City foundation sign-off provide ARB with stamped foundation survey and schedule meeting with ARB staff for foundation inspection
    a. $500 fine for foundation survey not submitted within 10 business days of survey being stamped by a registered land surveyor
4. Within 10 business days of City framing sign-off provide ARB with proof of city approval and contact ARB staff for framing inspection
    a. $500 fine for ARB staff not contacted within 10 business days of city approval
5. Provide ARB with copy of Certificate of Occupancy (CO) within 10 days of issuance
    a. $500 fine if not submitted within 10 business days of CO issuance
6. Request ARB perform final inspection within 90 calendar days of issuance of CO by City of Charleston
    a. If final inspection is not requested within 90 calendar days of issuance of CO, builder's construction deposit will be forfeited

*Site conditions, Foundation and Framing inspections will be required for each home constructed on Daniel Island and may be waived at the ARB's sole and absolute discretion. Final inspections will never be waived.
*If inspections are waived all documentation must still be submitted to the ARB within the times prescribed above

130 River Landing Drive, Suite 1-C | Charleston, SC 29492 | (843) 881-6122 | (f) (843) 856-1728

Building Photographs

See Instructions for Item A6.

Building Street Address (including Apt., Unit, Suite, and/or Bldg. No.) or P.O. Route and Box No.
REDACTED

City CHARLESTON State SC ZIP Code REDA

FRONT VIEW (3/21/11)

REAR VIEW (3/21/11)

Building Photographs

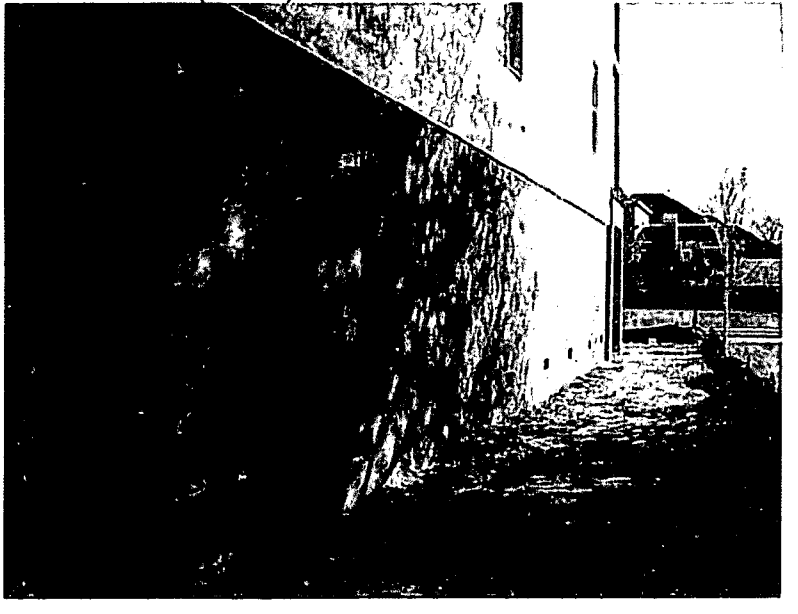
Continuation Page

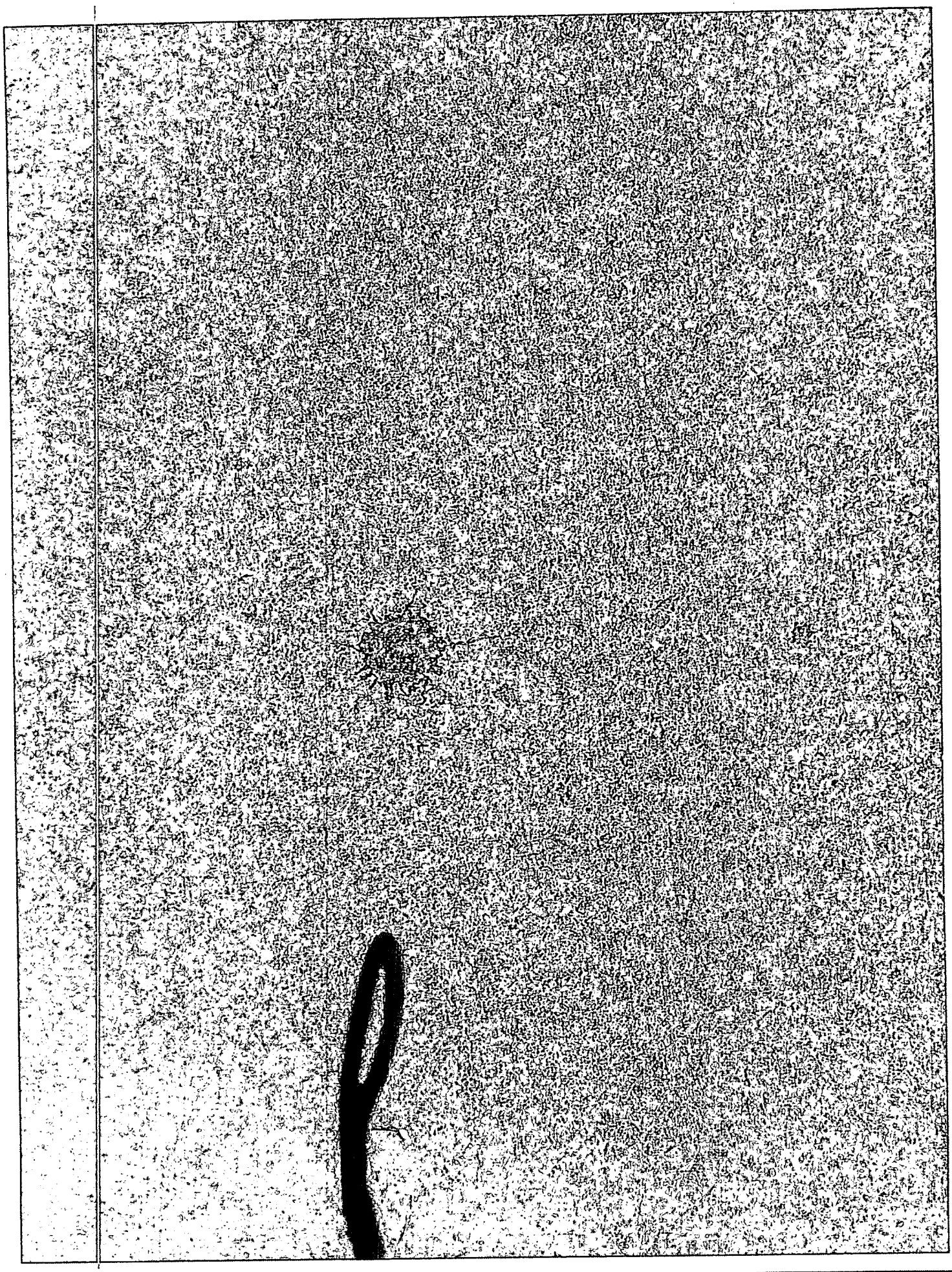
Building Street Address (including Apt., Unit, Suite, and/or Bldg. No.) or P.O. Route and Box No.	For Insurance Company Use:
REDACTED	Policy Number
City CHARLESTON State SC ZIP Code REDACTED	Company NAIC Number

If submitting more photographs than will fit on the preceding page, affix the additional photographs below. Identify all photographs with: date taken; "Front View" and "Rear View"; and, if required, "Right Side View" and "Left Side View."

RIGHT SIDE VIEW (3/21/11)

LEFT SIDE VIEW (3/21/11)





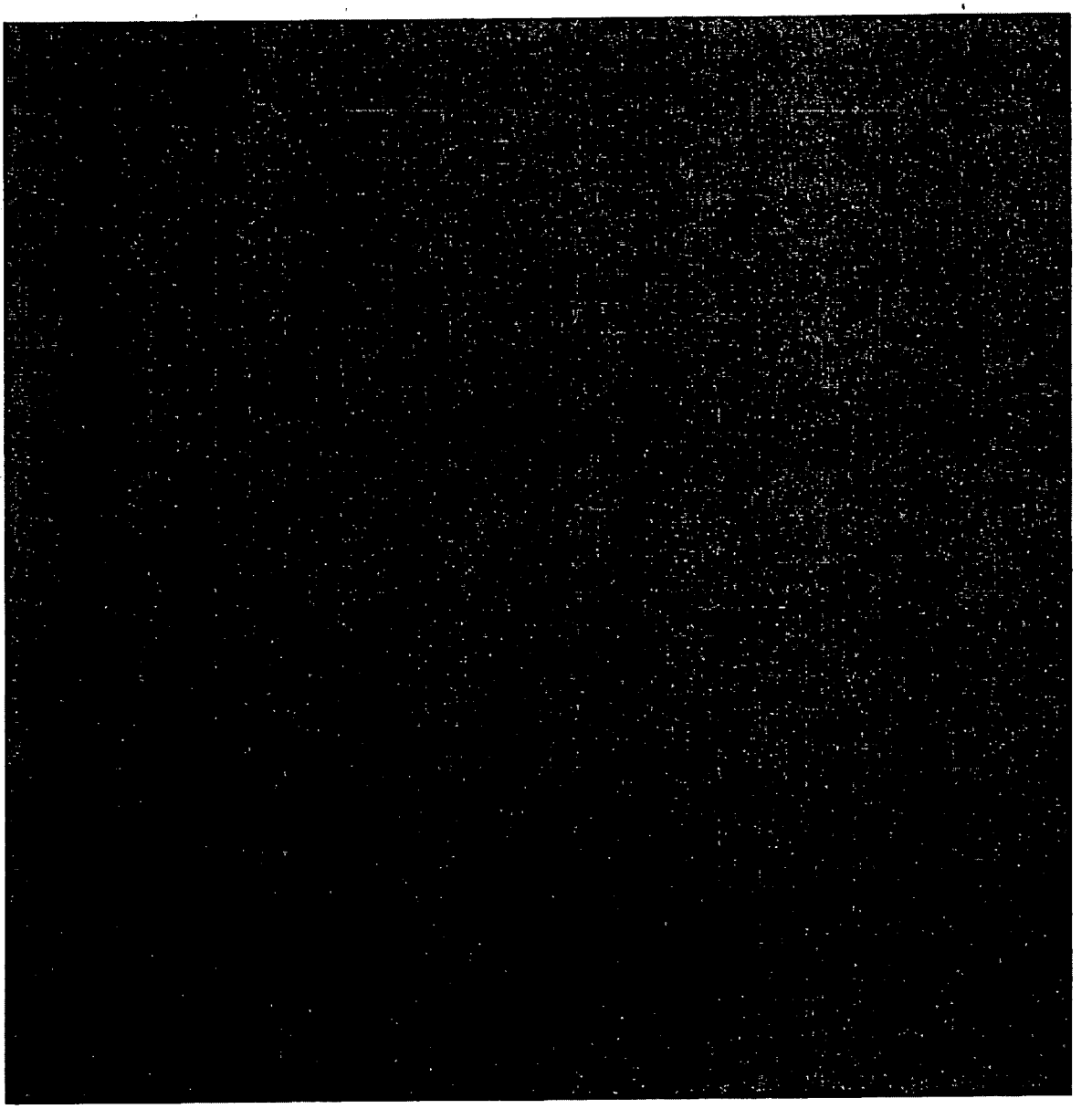
RMC 96

ROA 1218

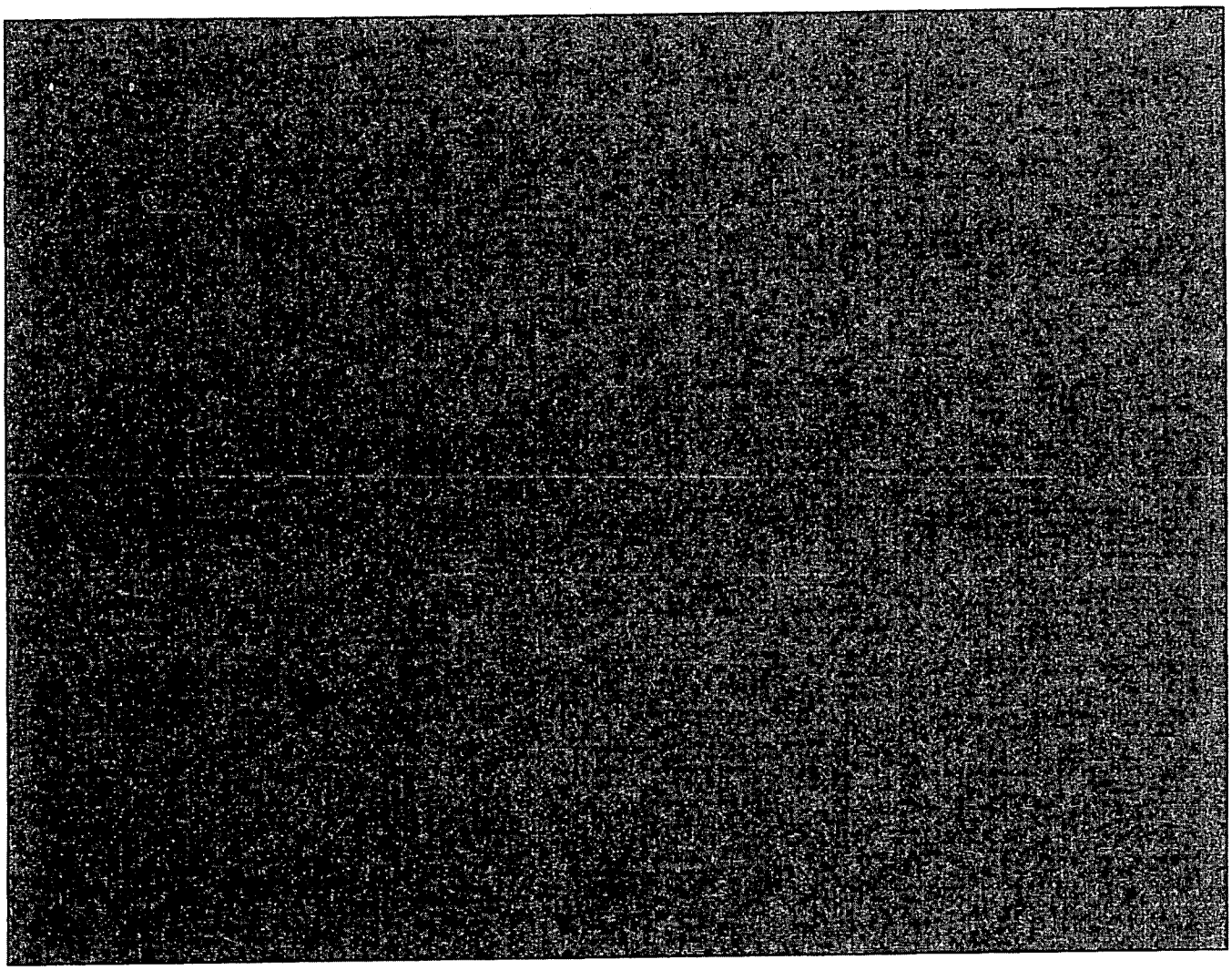
Rosemary Hartkorn Connelly

✓ Friends | ✓ Following | Message

Timeline About Friends 2 Mutual Photos More



ALL-STATE LEGAL®
DEFENDANT'S EXHIBIT
3

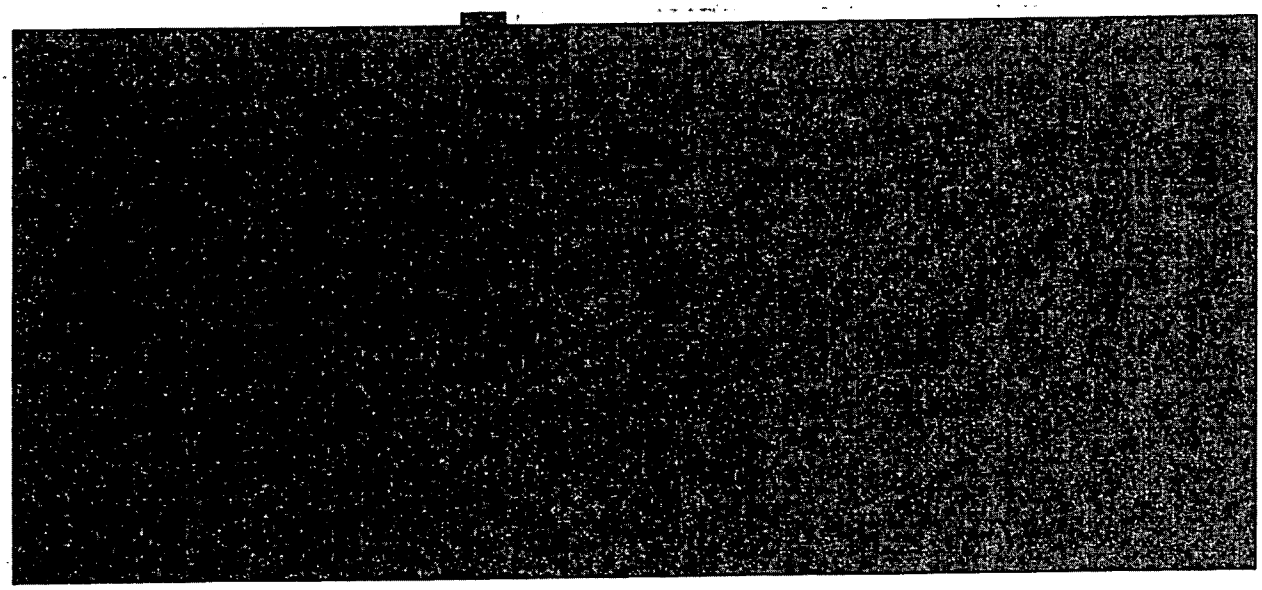


Rosemary Hartkorn Connelly
May 28 ·

Please join us at Daniel Island REDACT for bootcamp benefiting The Magdalene House of Charleston, a recovery home for ladies with addictions! It is only $20. and it is for a great cause! 9-10 this Saturday and a certified trainer!

Like · Comment · Share

6 people like this.



Like · Comment · Share

44 people like this.

[redacted]

Ally Marie was with Rosemary Hartkorn Connelly and 3 others at Sullivan's Island Beach.
May 19 ·

Like · Comment · Share

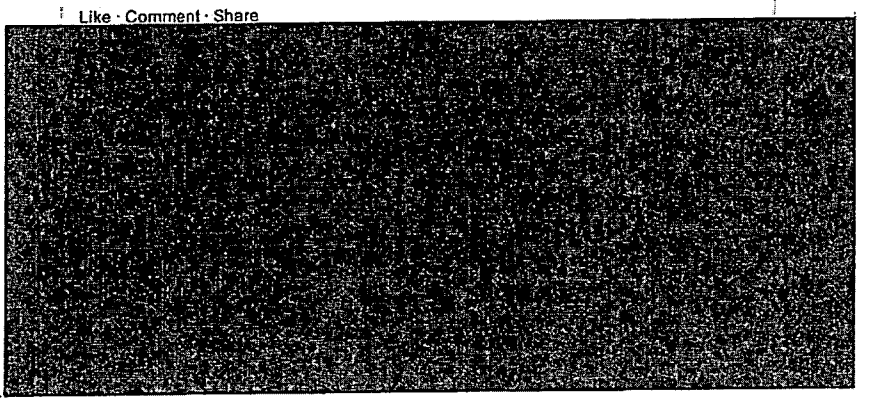
[redacted]

Ally Marie added 3 new photos — with Rosemary Hartkorn Connelly and 4 others at Sullivan's Island Beach.
May 19

Laura Gulledge
May 11 · Edited ·

werk it — with Rosemary Hartkorn Connelly.

Like · Comment · Share



April

[redacted]

Julia Mallard was with Rosemary Hartkorn Connelly and Cecilia Lipman.
December 13, 2013 ·

Like · Comment · Share

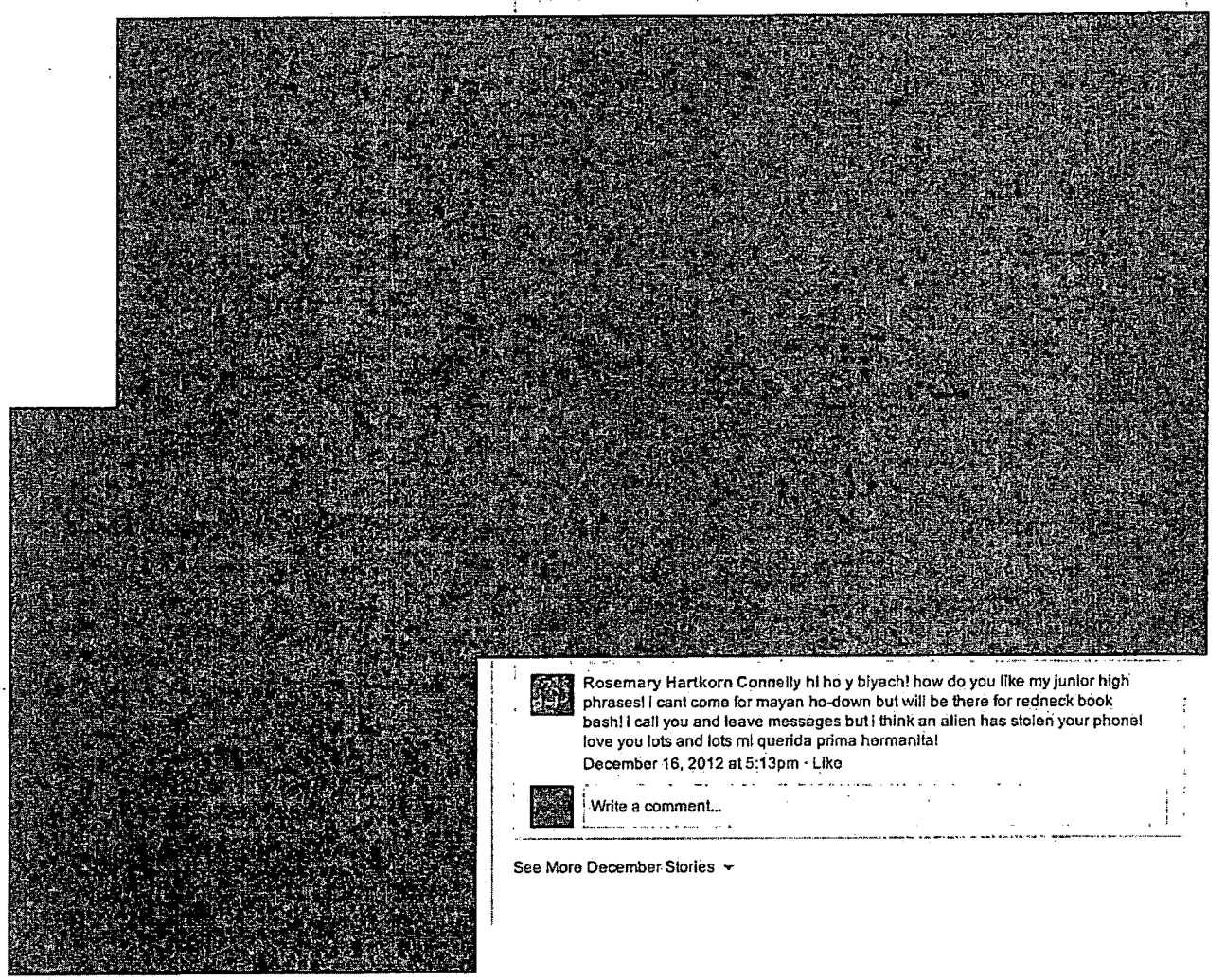
[redacted]

[redacted]

RMC Production 140

ROA 1224

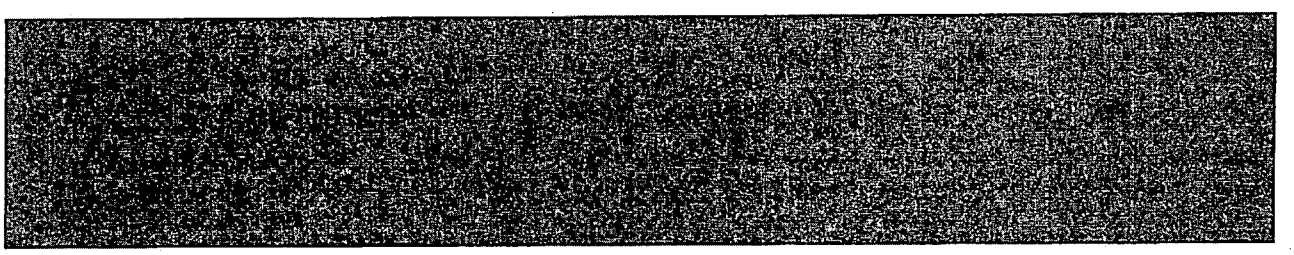
Like · Comment · Share

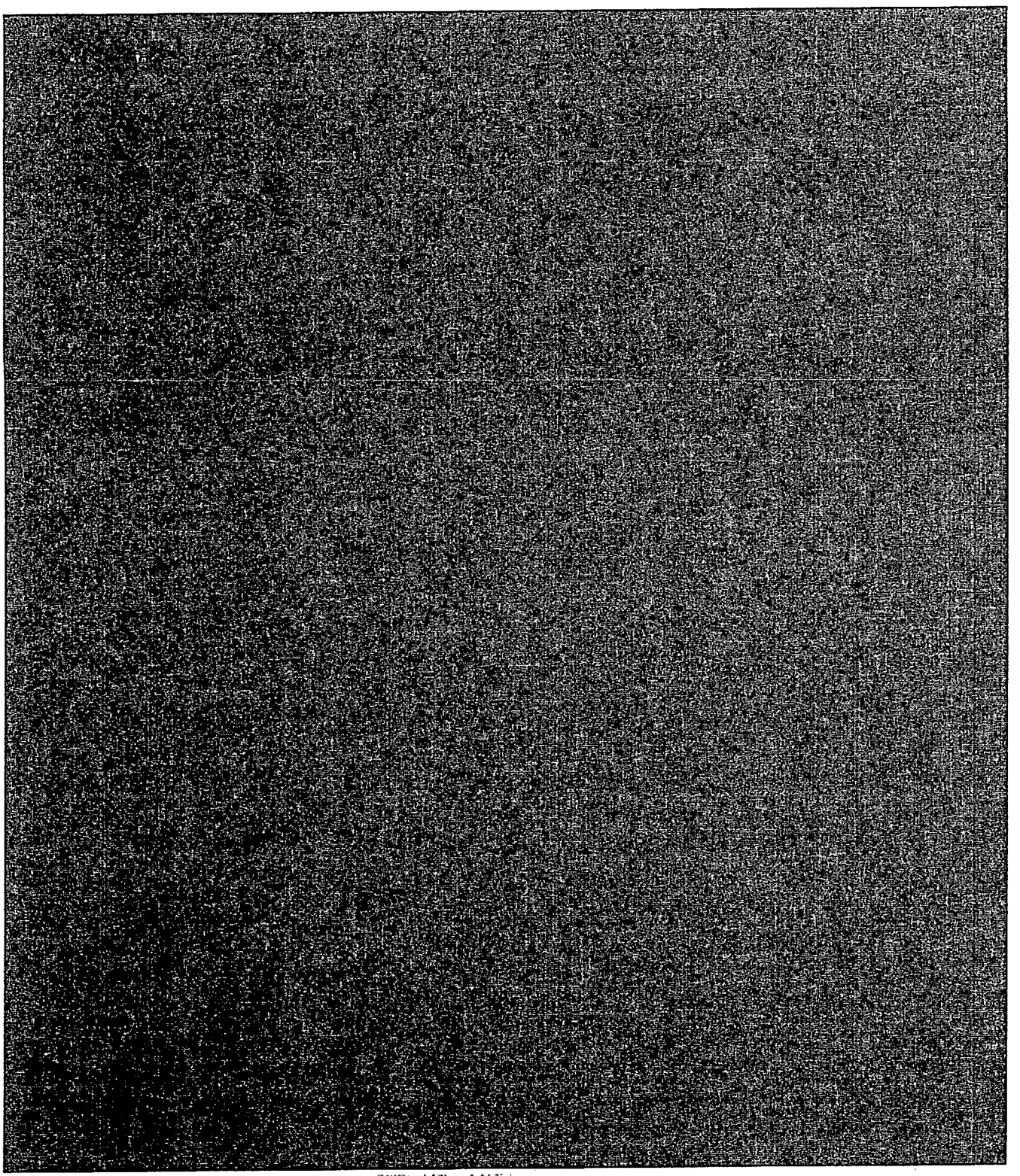


Rosemary Hartkorn Connelly hi ho y biyach! how do you like my junior high phrases! I cant come for mayan ho-down but will be there for redneck book bash! I call you and leave messages but i think an alien has stolen your phone! love you lots and lots mi querida prima hermanita!
December 16, 2012 at 5:13pm · Like

Write a comment...

See More December Stories





Rosemary Hartkorn Connelly Hi I am not sure exactly I will let you know we are at the Mansion in Buckhead--for a seminar for Billy--expenses paid!!! Chrsitina will drive down from CLemson (she is a sophmore) and then we all go to the game SEC on Sat--so that is all I know now but I will give you update LOVE YOU
October 31, 2011 at 7:02pm · Like

Write a comment...

[redacted]

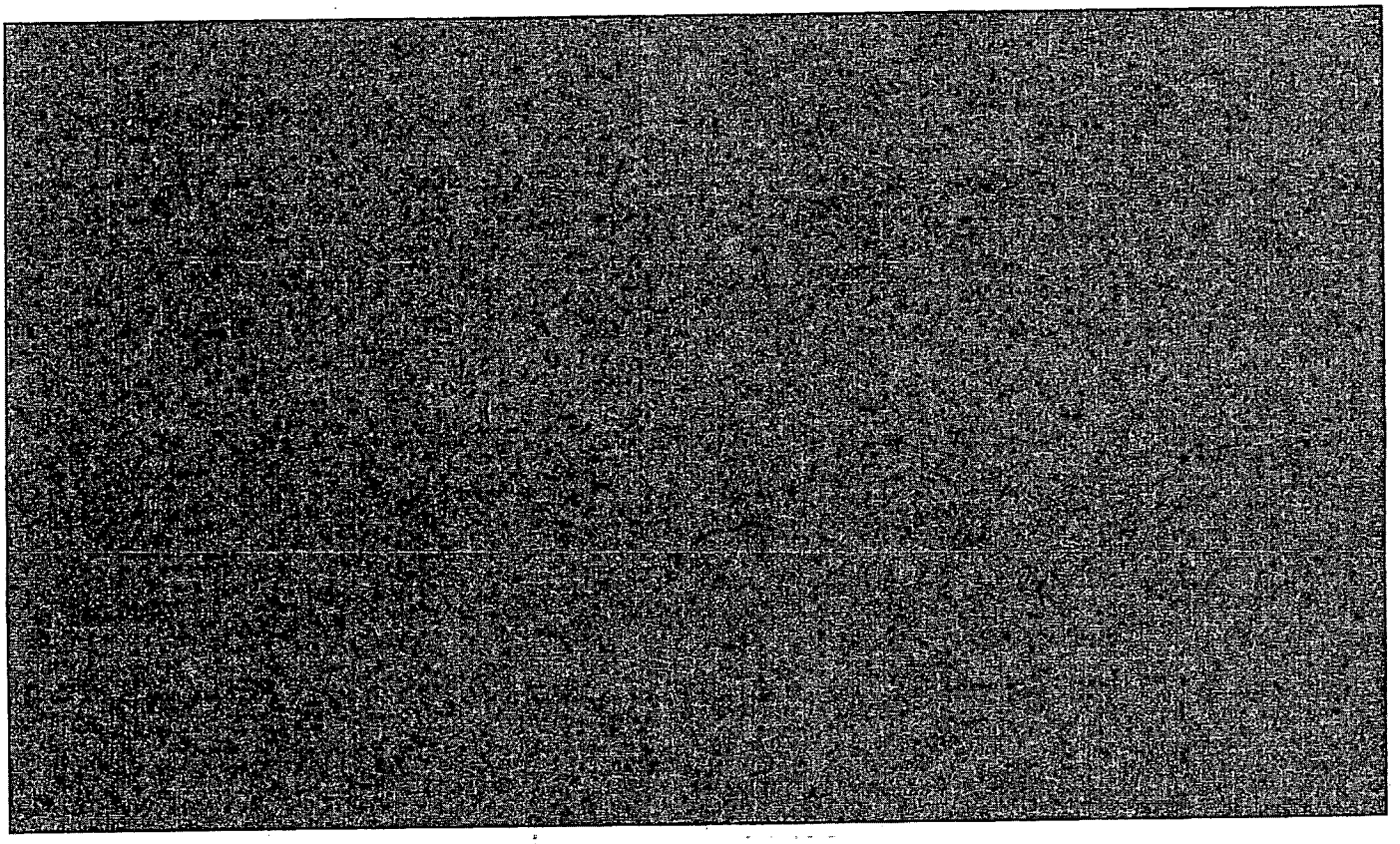
Kay Toraño Rosemary Hartkorn Connelly
September 3, 2011 ·

¿Te acuerdas?

Like · Comment · Share

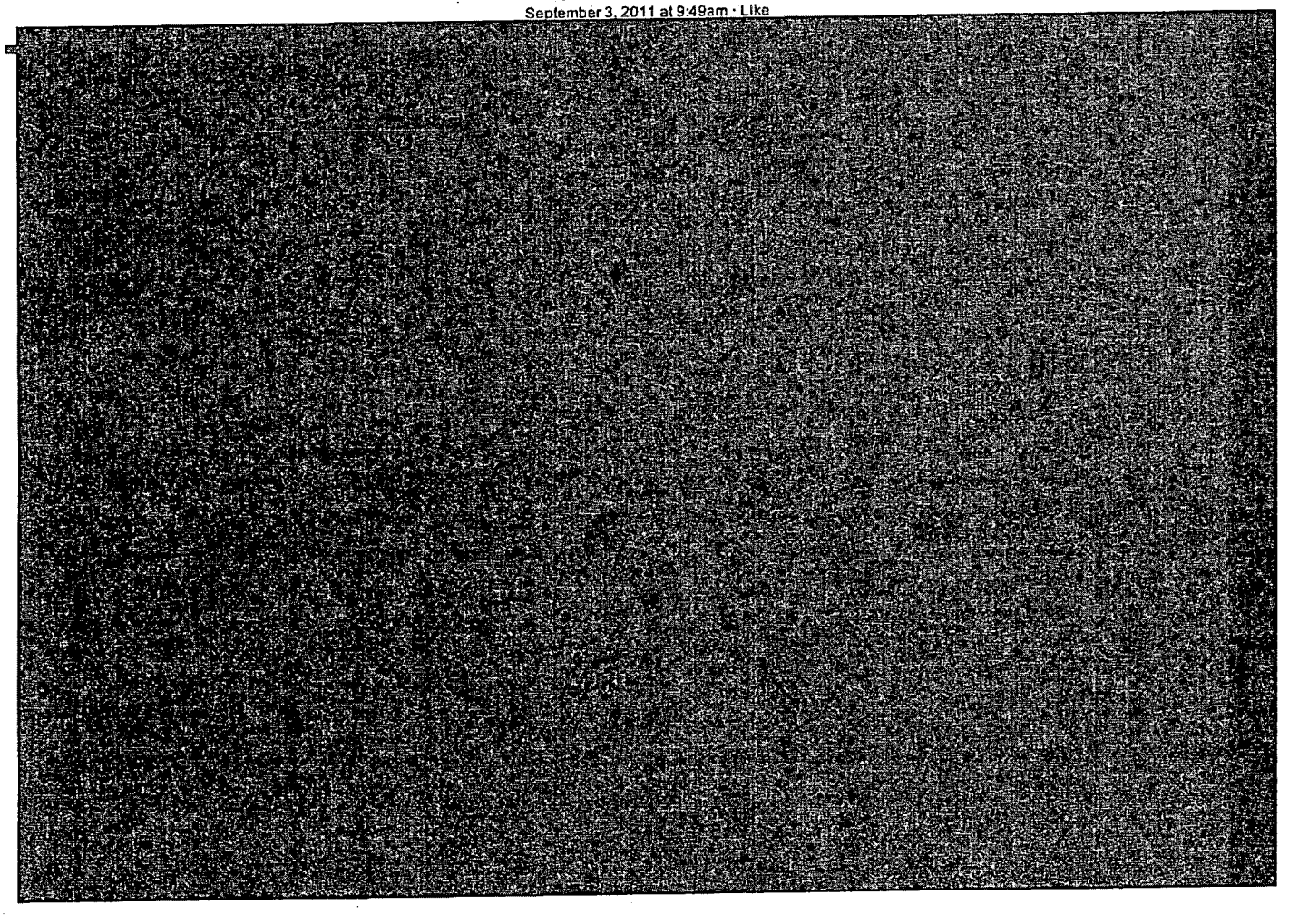
Rosemary Hartkorn Connelly tu las hicieste? yumyum!
September 3, 2011 at 2:51pm · Like

[redacted]



Rosemary Hartkorn Connelly Oh man!!! Como puedo olvidarme de estas memorias! Frank se tumbo en la cama de los nervios y cocinamos tu y yo para la tripulacion que ni me dieron las gracias!!!!!! lo pasamos MUY bien!! te quiero amiga!

September 3, 2011 at 9:49am · Like

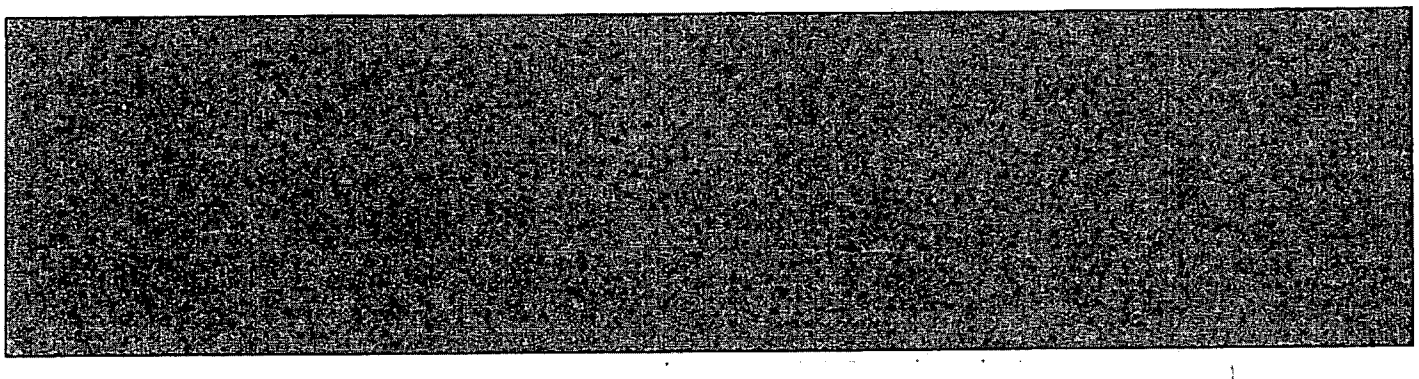


[redacted]

Rosemary Hartkorn Connelly changed her profile picture.
August 9, 2011 ·

Like · Comment · Share

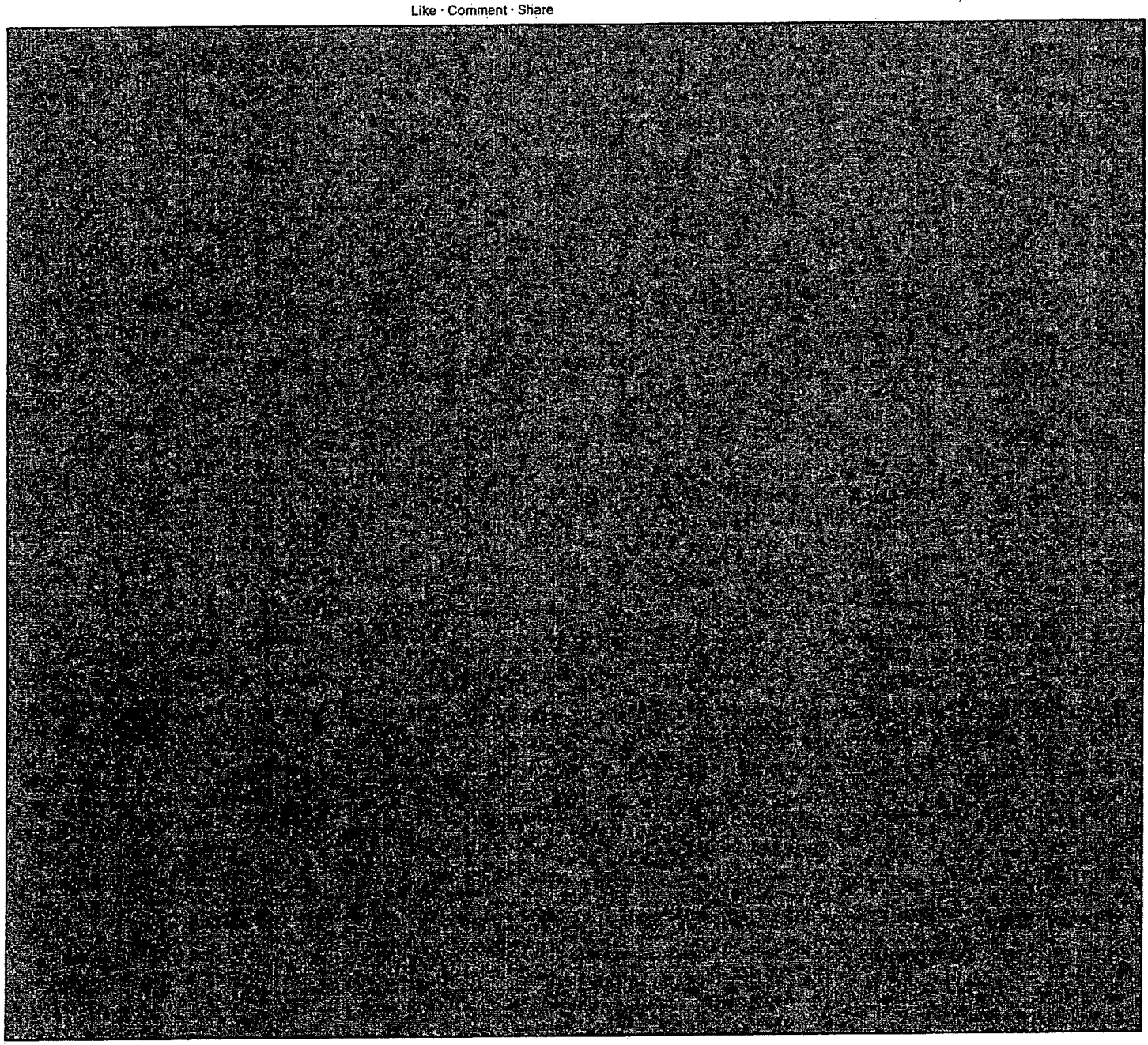
[redacted]



Rosemary Hartkorn Connelly
June 7, 2011 ·

Hi!! an update! running yesterday I fell on the sidewalk and fractured my nose!! Thank goodness I didnt break any teeth-the moral of this story I guess is running is dangerous for our crowd!! No ,not really, as soon as I can I will be back out there. In the meantime I look like I got hit with 10 uglysticks!!!!

Like · Comment · Share



CONNELLY & VOGELZANG LLC

LAW OFFICES IN: CHICAGO, ILLINOIS | CHARLESTON, SOUTH CAROLINA
FIRM LICENSED IN AZ, IL, MO, SC, TX, WI, WV

June 7, 2011

VIA FACSIMILE (843) 856-1874 & EMAIL: winsor@winsorcustomhomes.com
The Office of Winsor South, LLC
Winsor Custom Homes, LLC
234 Seven Farms Dr., Ste. 201-C
Daniel Island, SC 29492

RE: house construction at REDACTED

To whom it may concern,

My client fell on the sidewalk on 6/6/2011 in front of this construction site due to the dangerous conditions which as of this morning still exists. Your company still has dangerous debris on the pedestrian walk. She may have a broken nose. She has multiply cuts and abrasions to her face, arms, and shoulder and is currently under a doctor's care.

Please have your attorney call me at 843 REDACT Should I not hear from you, I will assume you prefer the more formal route of filing a complaint at law. Regardless, please promptly make the pedestrian walk safe from all your construction debris so another person is not injured.

Also, please advise Karen Nelson, John Edelen, Clark Design Group and Daniel Island Reality of my accusation against the owners and agents of this property. I informed Daniel Island Reality this morning of the conditions since this is the only phone number listed on the only construction sign on the property.

Sincerely,

William M. Connelly

William M. Connelly

WMC/lm

SN COURT'S EXHIBIT 3 8-25-15

From: Winsor Custom <winsor@winsorcustomhomes.com>
Sent: Tuesday, June 07, 2011 5:33 PM
To: 'Lark McDonald Killerman'
Subject: RE: REDACTED Construction site

Yeah. Just got this email. Sidewalk is and has been clean, but we don't own the sidewalk. Find it hard to believe someone fell there but I hope they are OK. Will pass on information to owners of property.

From: Lark McDonald Killerman [mailto:LMcDonald@convoglaw.com]
Sent: Tuesday, June 07, 2011 12:11 PM
To: winsor@winsorcustomhomes.com
Cc: Bill Connelly
Subject: REDACTED - Construction site

Attached please find correspondence re: above. Please advise as soon as possible.
William M. Connelly
(Dictated Not Read)

Lark McDonald
Paralegal
Connelly & Vogelzang, LLC
13 Cumberland St.
Chas., SC 29401
(843) 727-0199
(843) 793-3214 (fax)
CONNELLY VOGELZANG LLC

No virus found in this message.
Checked by AVG - www.avg.com
Version: 10.0.1382 / Virus Database: 1511/3686 - Release Date: 06/07/11

From: Bill Connelly <BConnelly@convoglaw.com>
Sent: Wednesday, June 08, 2011 12:48 PM
To: Winsor Custom
Subject: RE: REDACTED

Driveway rock,clear plastic sheets and black plastic sheets. You didn't see that when you cleaned up?

From: Winsor Custom [mailto:winsor@winsorcustomhomes.com]
Sent: Wednesday, June 08, 2011 12:40 PM
To: Bill Connelly
Subject: RE: REDACTED

What construction material?

From: Bill Connelly [mailto:BConnelly@convoglaw.com]
Sent: Wednesday, June 08, 2011 12:33 PM
To: winsor@winsorcustomhomes.com
Cc: Lark McDonald Killerman
Subject: REDACTED

Yes, that is the problem your construction material was all over the public sidewalk or right of way and it appeared that condition was there for awhile. Also no caution sign was present. We have taken photos of the mess. Don't really understand why you believe someone could not fall from all this debris. Please have owners contact me with insurance information or their attorney may contact me. Pleased that you cleaned the debris from sidewalk. Will advise if MD decides if she broke her nose.

No virus found in this message.
Checked by AVG - www.avg.com
Version: 10.0.1382 / Virus Database: 1511/3688 - Release Date: 06/08/11

No virus found in this message.
Checked by AVG - www.avg.com
Version: 10.0.1382 / Virus Database: 1511/3688 - Release Date: 06/08/11

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON	)	CASE NO. 2013-CP-10-3251
ROSEMARY CONNELLY,	)	
Plaintiff,	)	
v.	)	**DEFENDANT'S MOTION FOR DIRECTED VERDICT**
WINSOR CUSTOM HOMES, LLC,	)	**(At the Close of Plaintiff's Evidence)**
Defendant.	)	

Plaintiff's evidence is now closed. Defendant moves for a directed verdict pursuant to Rule 50(a), SCRCP.

This is a premises liability case.

It is not a case about silt fence maintenance. Defendant did not owe Plaintiff a legal duty to maintain a silt fence. It owed Plaintiff a duty not to create a hazardous condition on the sidewalk.

To illustrate this point, suppose on the date of accident the silt fence was totally down on all sides of the property except the side along the sidewalk and Plaintiff jogged by without incident. Perhaps Defendant would have been in breach of a duty owed to the ARB to maintain the silt fence, but Defendant would not have breached any duty to Plaintiff.

Although the general rule is that an abutting landowner does not owe a duty of care with respect to the safety of the sidewalk there is an exception to this rule when the landowner creates an unsafe condition on the sidewalk. *See* Shaw v. City of Charleston, 351 S.C. 32, 567 S.E.2d 530 (2002).

COURT'S EXHIBIT 9 8-27-15

Under a premises liability theory, a contractor, like Defendant, generally equates to an invitor and has the same duties that the property owner would have to invitees. Lane v. Gilbert Constr. Co. Ltd., 383 S.C. 590, 681 S.E.2d 879 (2009).

South Carolina has adopted Restatement (Second) Torts § 343A regarding known or obvious dangers. Callander v. Charleston Doughnut Corp., 305 S.C. 123, 406 S.E.2d (1991).

Section 343A provides as follows:

> (1) A possessor of land is not liable to his invitees for physical harm caused to them by any activity or condition on the land whose danger is known or obvious to them, unless the possessor should anticipate the harm despite such knowledge or obviousness.
>
> (2) In determining whether the possessor should anticipate harm from a known or obvious danger, the fact that the invitee is entitled to make use of public land, or of the facilities of a public utility, is a factor of importance indicating that the harm should be anticipated.

With respect to Subsection (2), comment g explains that, even where it is applicable, "defendants, however, may reasonably assume that members of the public will not be harmed by known or obvious dangers which are not extreme, and which any reasonable person exercising ordinary attention, perception, and intelligence could be expected to avoid. This is true particularly where a reasonable alternative way is open to the visitor, known or obvious to him, and safe."

It cannot reasonably be denied that the hazard at issue, i.e., the downed silt fence, was known and/or obvious to Plaintiff. Indeed, Plaintiff makes much of just how bad the condition of the fence was, with counsel highlighting Plaintiff's Exhibit 8 (RMC 96) in his opening statement as key evidence against Defendant, telling the jury it would hear evidence from Defendant's own 30(b)(6) designee himself agreeing that the photo showed the fence to be 70% down. Both Plaintiff and Ms. Smith (i.e., the only known witness to Plaintiff's fall) thereafter

testified that RMC 96 showed the hazard to be in substantially the same condition as it was prior to the fall.

Plaintiff's counsel's opening also advised the jury that, as Plaintiff and Ms. Smith approached the fence, they saw that it was down, laying so as to partially obstruct the sidewalk and jog over to the left to avoid it. Plaintiff's counsel also told the jury that it was a "windy" day and the fence was made of a "light almost hefty bag material" that, if not secured (as, according to Plaintiff, Winsor obviously failed to do), can get up in to the air and move. Both Plaintiff and Smith thereafter testified that they observed the hazard prior to the fall. Plaintiff herself explained that she knew the fence was supposed to be "taught" and secured to the wooden stakes but that it was not; rather, it was down and encroaching upon the sidewalk, unsecured, and moving on a windy day.

The undisputed testimony is that Plaintiff was not forced to run along the sidewalk and that she and Smith would sometimes run on the street instead of the sidewalk. Based on the undisputed testimony of Plaintiff and Smith, and plainly shown in RMC 96, Plaintiff approached the hazard from an unobstructed vantage point (and, indeed, not even Ms. Smith could have obstructed her view with Plaintiff and Ms. Smith confirming that Plaintiff always runs to the right of Ms. Smith); according to Plaintiff, she runs an approximately 10-minute mile, which would equate to a speed of approximately 6 miles per hour.

Plaintiff agreed that it was important to watch for safety hazards while she was jogging and, indeed, that she observed the hazard and attempted to run around it but was tripped up, not simply because of the hazard posed by the down fence, but because the wind—on a windy day—blew the fence—a fence which she knew to be unsecured, which she knew to be down and being

buffeted by the wind, and which her own counsel described as a "light almost hefty bag material"—into her foot.

Based upon the only and undisputed evidence Plaintiff has presented relevant to this analysis, Plaintiff's claim fails under § 343A as a matter of law.[1] Defendant is therefore entitled to a directed verdict.

Respectfully submitted,

YOUNG CLEMENT RIVERS, LLP

By: _____

Stephen L. Brown
Russell G. Hines
P.O. Box 993
Charleston, SC 29402
(843) 720-5488
SBrown@ycrlaw.com
RHines@ycrlaw.com
Attorneys for Winsor Custom Homes, LLC

Charleston, South Carolina

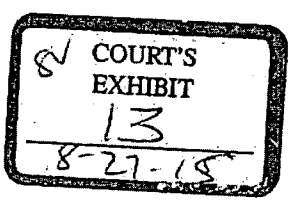
Dated: 8/27/15

[1] Going back to the above point about this being a premises liability case and not a case about silt fence maintenance, ultimately § 343A makes this a distinction without a difference. Section 343A applies to "**any activity** or condition . . . ." (emphasis added). Maintenance of a silk fence, or lack thereof, is an "activity" to which § 343A applies. But still, assuming, *arguendo*, § 343A does not apply, a reasonable jury could not find Plaintiff to be less than 51% at fault for the accident and her claim should be barred by her comparative negligence.

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON	)	CASE NO. 2013-CP-10-3251
ROSEMARY CONNELLY,	)	
	)	
Plaintiff,	)	
	)	
v.	)	
	)	
WINSOR CUSTOM HOMES, LLC; THE DANIEL ISLAND COMPANY, INC.; CLARKE DESIGN GROUP, LLC; KAREN A. NELSON; and JOHN W. EDELEN;	)	**JURY CHARGE NO. 1**
	)	
Defendants.	)	

SIDEWALK

Although the general rule is that an abutting landowner does not owe a duty of care with respect to the safety of the sidewalk there is an exception to this rule when the landowner creates an unsafe condition on the sidewalk. *See* Shaw v. City of Charleston, 351 S.C. 32, 567 S.E.2d 530 (2002).



STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON	)	CASE NO. 2013-CP-10-3251
ROSEMARY CONNELLY,	)	
	)	
Plaintiff,	)	
	)	
v.	)	
	)	
WINSOR CUSTOM HOMES, LLC; THE DANIEL ISLAND COMPANY, INC.; CLARKE DESIGN GROUP, LLC; KAREN A. NELSON; and JOHN W. EDELEN;	)	**JURY CHARGE NO. 2**
	)	
Defendants.	)	

PREMISES LIABILITY THEORY

This is a premises liability case, which is to say, Plaintiff has alleged that Defendant by an activity or condition relating to real property, that is, relating to land; specifically the house under construction at 1376 Smythe Street on Daniel Island. Under a premises liability theory, a contractor, like Defendant, is treated has the same duties that the property owner would have to what the law calls "invitees." In this case, Plaintiff is an invitee. Lane v. Gilbert Constr. Co. Ltd., 383 S.C. 590, 681 S.E.2d 879 (2009).

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	)	IN THE COURT OF COMMON PLEAS NINTH JUDICIAL CIRCUIT CASE NO. 2013-CP-10-3251
ROSEMARY CONNELLY, Plaintiff, v. WINSOR CUSTOM HOMES, LLC; THE DANIEL ISLAND COMPANY, INC.; CLARKE DESIGN GROUP, LLC; KAREN A. NELSON; and JOHN W. EDELEN; Defendants.	)	**JURY CHARGE NO.** 3

KNOWN OR OBVIOUS DANGERS

In a premises liability case, a possessor of land, like Defendant, is not liable to invitees, like Plaintiff for physical harm caused to them by any activity or condition on the land whose danger is known or obvious to them, unless the possessor should anticipate the harm despite such knowledge or obviousness.

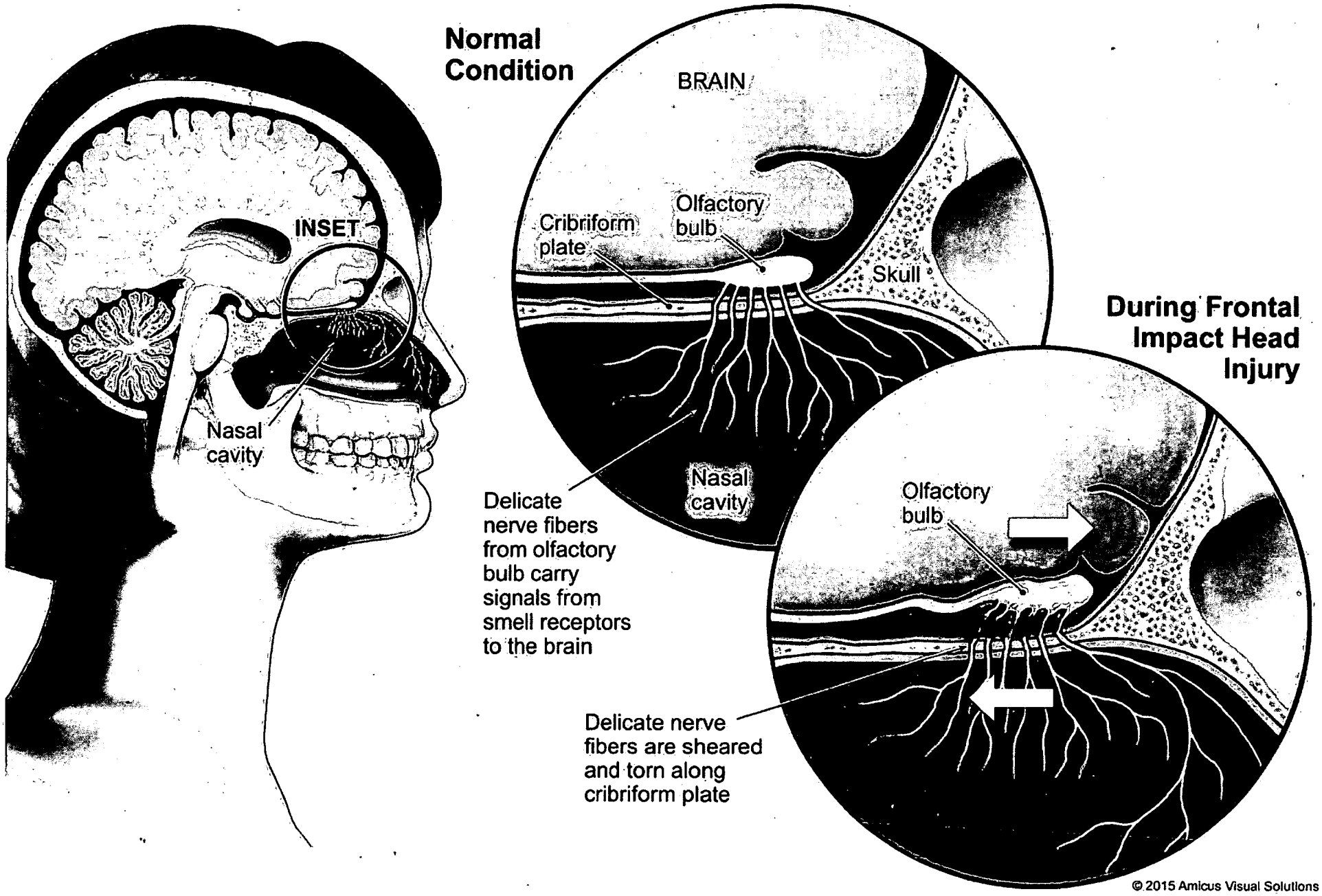
In determining whether the possessor should anticipate harm from a known or obvious danger, the fact that the invitee is entitled to make use of public land, or of the facilities of a public utility, is a factor of importance indicating that the harm should be anticipated.

In this case, Plaintiff was entitled to make use of the public sidewalk; however, even where a Plaintiff is entitled to make use of public land, Defendant may reasonably assume that members of the public will not by harmed by known or obvious dangers which are not extreme,

1082

and which any reasonable person exercising ordinary attention, perception, and intelligence could be expected to avoid. This is particularly true where a reasonable alternative way is open to the visitor, known or obvious to him, and safe. Callander v. Charleston Doughnut Corp., 305 S.C. 123, 406 S.E.2d (1991); Restatement (Second) Torts § 343A

Anosmia - Loss Of Sense Of Smell



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STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON	)	CASE NO. 2013-CP-10-3251
ROSEMARY CONNELLY,	)	
Plaintiff,	)	**DEFENDANT'S POST-TRIAL MOTIONS**
v.	)	**FOR (1) JNOV or (2) NEW TRIAL ABSOLUTE or (3) NEW TRIAL *NISI* REMITTITUR**
WINSOR CUSTOM HOMES, LLC,	)	
Defendant.	)	

FILED
2015 SEP -8 PM 4:36
JULIE J. ARMSTRONG
CLERK OF COURT

TO: THE HONORABLE J.C. NICHOLSON, JR., presiding circuit judge, and Plaintiff ROSEMARY CONNELLY, by and through her attorneys of record, WM. M. GRUENLOH, ESQUIRE, PATRICK AULTON CHISUM, ESQUIRE, and BRIAN R. HOLMES, ESQUIRE, all of GRUENLOH LAW FIRM

COMES NOW Defendant Winsor Custom Homes, LLC ("Defendant"), by and through its undersigned counsel, within ten days after the trial of this action,[1] pursuant to Rules 50 and 59, SCRCP, and any other applicable procedural and/or substantive law, and hereby moves this Honorable Court as follows: (1), as Defendant's primary post-trial motion, for judgment in its favor notwithstanding the jury's verdict ("JNOV"); or (2), as a lesser alternative, for a new trial absolute; or (3), as an even lesser alternative, for a new trial *nisi* remittitur.[2]

[1] On account of the Labor Day holiday on Monday, September 7th, 2015, the tenth day since trial ended on Friday, August 28th, is Tuesday, September 8th. *See* Rule 6(a), SCRCP.

[2] Because, as a practical matter, it would appear the only relief Defendant could obtain at this time, i.e., post-trial, would be in the form of either JNOV or a new trial, whether absolute or *nisi* remittitur, Defendant's post-trial motions are labeled consistent with such relief; however, as indicated below, to the extent applicable, Defendant also moves for alteration, amendment, and/or reconsideration under Rule 59(e). *See* Elam v. S.C. Dep't of Transp., 361 S.C. 9, 21, 602 S.E.2d 772, 778 (2004) ("[I]t is proper to view a Rule 59(e) motion not only as a vehicle to request the trial court 'alter or amend the judgment,' but also as a vehicle to seek 'reconsideration' of issues and arguments.").

BRIEF BACKGROUND AND PROCEDURAL POSTURE

This is a personal-injury case arising out of a trip-and-fall accident on the morning of Monday, June 6, 2011 (the "Subject Accident"). Plaintiff Rosemary Connelly ("Plaintiff") and her friend/exercise partner, Cori Smith ("Smith"), were jogging on the sidewalk past a lot, located at REDACTED Street on Daniel Island (the "Premises"), on which Defendant, a general contractor, was in the process of building a new home. According to Plaintiff, the Subject Accident happened because the silt fence installed at the Premises was in a state of disrepair,[3] detached from its wooden support stakes, and partially obstructing the sidewalk,[4] and even though she saw the obstacle posed by the downed silt fence and attempted to jog around it, the wind blew it into contact with Plaintiff's foot.

Beyond disputing the threshold issue of liability, Defendant also disputes a causal connection between the Subject Accident and Plaintiff's alleged permanent loss of her sense of smell/decreased sense of taste (the "Smell/Taste Problem")—the Smell/Taste Problem is, by far, the most significant damage claimed by Plaintiff in this suit.

The case was set for a date-certain trial during the term of court beginning Monday, August 24th, 2015. On the first day of the term, i.e., the 24th, the jury was selected and the Court addressed legal matters, including hearing, and denying, Defendant's challenge to the testimony

---

[3] Defendant was required by the construction guidelines of the Daniel Island Architectural Review Board ("ARB") to install the silt fence to the perimeter of the Premises. (Plaintiff's Trial Exhibit No. 11 [at page 1 of 4 (General Rule 3) ("Install erosion control measures (silt fencing) to the perimeter of the [Premises].")] (a copy of which is attached hereto as **Exhibit A**); *see also* id. [at page 2 of 4 (stating $250.00 as the scheduled fine for "1. Silt fences not installed or maintained properly")]; *see also* Plaintiff's Trial Exhibit No. 7 [at Bates No. -0302 (depicting the Premises/the silt fence on March 21, 2011)] (a copy of which is attached hereto as **Exhibit B**).)

[4] According to Plaintiff, the photograph identified as RMC 96 accurately depicts the silt fence at the time of the Subject Accident. (Plaintiff's Trial Exhibit No. 8 [at RMC 96] (a copy of which is attached hereto as **Exhibit C**))

of Plaintiff's experts, Drs. Thomas Funcik and Mark Ghegan,[5] as unreliable and not properly considered by the jury with respect to the alleged causal connection between the Subject Accident and the Smell/Taste Problem.

The case was then tried from Tuesday, August 25th, to Friday, August 28th. On the first day of trial, i.e., the 25th, and again on the second, i.e., the 26th, Defendant (unsuccessfully) moved for a mistrial on account of the subject of insurance being raised in the presence of the jury. At the close of Plaintiff's evidence, and again at the close of all evidence, Defendant unsuccessfully moved for a directed verdict.[6] [7] Viewing the case as one about ordinary (non-premises-liability-based) negligence for Defendant's alleged negligent maintenance of the silt fence, the Court granted a directed verdict in Plaintiff's favor (over Defendant's objection, of course) at the close of all evidence, ruling as a matter of law that Defendant owed Plaintiff a duty

[5] The testimony of Drs. Funcik and Ghegan had been taken the week before via video for use at trial. Copies of Dr. Funcik's two depositions (i.e., his video deposition and his earlier deposition that was not videoed) and Dr. Ghegan's deposition were marked as Court's exhibits.

[6] Defendant argued Restatement (Second) Torts § 343A ("Known or Obvious Dangers"), recited and analyzed below, applied to this case and entitled Defendant to judgment as a matter of law. More specifically, Defendant argued that this is a premises liability case, i.e., a case about whether Defendant is liable for an accident arising out of a hazardous condition (in the form of the downed silt fence), for which Defendant was alleged to be responsible, on the sidewalk abutting the Premises, not an ordinary (non-premises-liability-based) negligence case about the particular issue of silt fence maintenance. In other words, premises liability provided the only potentially viable theory of liability available to Plaintiff against Defendant under the circumstances, and even viewing the evidence in the light most favorable to Plaintiff, Defendant was entitled to judgment in its favor as a matter of law under § 343A. Defendant further argued that, even were this case properly viewed as sounding in ordinary (non-premises-liability-based) negligence for Defendant's alleged negligent maintenance of the silt fence, § 343A still applied (because it applies to "harm caused . . . by any activity or condition on the land . . . [,]" which would include maintenance of the silt fence or lack thereof) and Defendant was nonetheless entitled to judgment as a matter of law. Further still, Defendant argued that, even were § 343A not applicable, no reasonable jury could find Plaintiff less than 51% at fault for the Subject Accident, and Defendant was nonetheless entitled to judgment as a matter of law on account of Plaintiff's claim being barred her own comparative negligence.

to maintain the silt fence and had breached that duty, refusing Defendant's proposed jury charges relating to premises liability and § 343A, and sending the case to the jury for a determination of the issues of proximate cause, comparative negligence, and damages with respect to Plaintiff's cause of action for ordinary (non-premises-liability-based) negligence for Defendant's alleged negligent maintenance of the silt fence.

The jury found Plaintiff's damages to be in the amount of $500,000, but also found Plaintiff comparatively negligent, attributing to her 35% of the total fault for the Subject Accident. The Court thereafter announced judgment in favor of Plaintiff, against Defendant, in the amount of $325,000, i.e., $500,000 reduced by 35%, and allowed the parties ten days to make post-trial motions.

Defendant's post-trial motions timely follow.

POST-TRIAL MOTIONS

1. Defendant's Primary Post-Trial Motion: Motion for JNOV

Pursuant to Rule 50(b), and, for that matter, Rule 59(e), Defendant moves for JNOV/judgment as a matter of law, for the reasons set forth below.

Legal Standard

In considering a motion for JNOV, or, for that matter, a motion for a directed verdict, the trial court must determine whether, viewing the evidence and all reasonable inferences in the light most favorable to the non-moving party, a verdict for the opposing party would be reasonably possible. Wright v. Craft, 372 S.C. 1, 18, 640 S.E.2d 486, 496 (Ct. App. 2006); *see*

[7] The Court did grant Defendant a directed verdict on plaintiff's cause of action for negligence per se and also granted a directed verdict in favor of Defendant on Plaintiff's claim for punitive damages.

also id., 640 S.E.2d at 495 ("When reviewing a motion for directed verdict or JNOV, an appellate court must employ the same standard as the trial court.").

(a) **Most respectfully, the Court should grant JNOV in favor of Defendant for this reason: The only potentially viable cause of action Plaintiff had against Defendant was under the law of premises liability based on Defendant's duty to avoid creating a hazardous condition on the sidewalk abutting the Premises; however, with Plaintiff's consent, the only cause of action actually submitted to the jury was under the law of ordinary (non-premises-liability-based) negligence based on Defendant's supposed duty to maintain the silt fence; by consenting to this ordinary (non-premises-liability-based) negligence cause of action being the only cause of action submitted to the jury, Plaintiff effectively dismissed any/all other causes of action; Because Defendant did not owe Plaintiff a duty to maintain the silt fence, Plaintiff's ordinary (non-premises-liability-based) negligence cause of action, i.e., Plaintiff's only remaining cause of action, must fail; therefore, Defendant is entitled to judgment in its favor as a matter of law.**

Most respectfully, the Court erred in denying Defendant a directed verdict and granting Plaintiff a partial directed verdict, because Defendant did not owe Plaintiff an affirmative duty to maintain the silt fence; consequently, a verdict in favor of Plaintiff was not reasonably possible under an ordinary (non-premises-liability based) negligence cause of action for Defendant's alleged negligent maintenance of the silt fence. *See* Huggins v. Citibank, N.A., 355 S.C. 329, 332, 585 S.E.2d 275, 276 (2003) ("An essential element in a cause of action for negligence is the existence of a legal duty of care owed by the defendant to the plaintiff. . . . If there is no duty, the defendant is entitled to judgment as a matter of law.").

"In a negligence action, the court must determine, as a matter of law, whether the defendant owed a duty of care to the plaintiff." Id. "Duty is generally defined as 'the obligation to conform to a particular standard of conduct toward another.'" Id. at 333, 585 S.E.2d at 276 (citing Hubbard v. Taylor, 339 S.C. 582, 529 S.E.2d 549, 552 (2000)). "An affirmative legal duty to act exists only if created by statute, contract, relationship, status, property interest, or some other special circumstance." Carson v. Adgar, 326 S.C. 212, 217, 486 S.E.2d 3, 5 (1997).

"Duty arises from the relationship between the alleged tortfeasor and the injured party. In order for negligence liability to attach, the parties must have a relationship recognized by law as the foundation of a duty of care." Id.; *see also* Ravan v. Greenville Co., 315 S.C. 447, 468, 434 S.E.2d 296, 308 (Ct. App. 1993) ("It is essential to liability for negligence to attach that the parties shall have sustained a relationship recognized by law as the foundation of a duty of care."). "Where this relationship is 'too attenuated,' a duty will not arise." Ravan, 315 S.C. at 467, 434 S.E.2d at 308 (citing S.C. State Ports Auth. v. Booz-Allen & Hamilton, Inc., 289 S.C. 373, 376, 346 S.E.2d 324, 325-26 (1986)); *see also* Huggins, 355 S.C. at 333, 585 S.E.2d at 277 ("The concept of duty in tort liability will not be extended beyond reasonable limits.").

As a builder on Daniel Island, Defendant had to abide by the ARB's Construction Guidelines, which, as noted above, required Defendant to, among other things, "[i]nstall erosion control measures (silt fencing) to the perimeter of the property." (**Exhibit A** [at page 1 of 4 (General Rule 3)].) The ARB was empowered to enforce its guidelines via assessment of fines for violations (with violations having to be remedied within 24 hours, unless otherwise noted by the ARB, before fines doubled) and, if necessary, pursuit of legal action. (Id. [at page 3 of 4].) According to the ARB's schedule of fines, the fine for "[s]ilt fences not installed or maintained properly" was $250. (Id. [at page 2 of 4].)

Defendant owed the ARB, not Plaintiff, a duty to install and maintain the silt fence; this duty, imposed by the ARB's Construction Guidelines, arose solely out of Defendant's relationship to the ARB as a builder on Daniel Island, a relationship to which Plaintiff was a complete stranger.

To illustrate this point, suppose the silt fence was completely down on all sides of the property except the side along the sidewalk, or, for that matter, suppose Defendant had simply

never installed the silt fence, and Plaintiff simply jogged by without incident. Defendant would have been in breach of a duty owed to the ARB, but Defendant would not have breached any duty to Plaintiff—because Defendant did not owe Plaintiff a duty to "maintain the silt fence." Similarly, suppose the silt fence was completely down on the side of the property along the side walk but none of it actually encroached upon the sidewalk, i.e., it was down but lying in yard, and Plaintiff simply jogged by without incident. Here, again, Defendant would have been in breach of a duty owed to the ARB, but Defendant would not have breached any duty to Plaintiff—because, again, Defendant did not owe Plaintiff a duty to "maintain the silt fence."

To further illustrate this point, by way of analogy, consider case law addressing whether violation of a duty imposed by statute creates a private right of action. Even where the statutory law creates an affirmative duty, unless the legislature specifically creates a private cause of action for breach of that duty, a private cause of action "can be implied only if the legislation was enacted for the special benefit of a private party[,]" Doe v. Marion, 373 S.C. 390, 397, 645 S.E.2d 245, 248 (2007). The ARB's construction guidelines were not enacted for the special benefit of Plaintiff—and there can be no reasonable contention to the contrary.

Of course, only the ARB's construction guidelines, not a statute (or regulation authorized by the legislature), are involved in this case. The Court already (correctly) granted Defendant a directed verdict on Plaintiff's cause of action for negligence per se, recognizing that the ARB's construction guidelines are not the same as a statute (or regulation authorized by the legislature) and could not possibly support a claim of negligence per se. But even assuming, *arguendo*, it were theoretically possible for violation of the ARB's construction guidelines to support such a claim (i.e., the guidelines were treated the same as a statute or regulation authorized by the legislature), failure to maintain the silt fence still would not pass the test for determining when a

duty created by statute (or regulation authorized by the legislature) will support an action for negligence, because Plaintiff cannot show that the "essential purpose" of the ARB's silt fence-maintenance requirement "is to protect from the kind of harm the plaintiff has suffered . . . ." Norton v. Opening Break of Aiken, Inc., 313 S.C. 508, 443 S.E.2d 406 (Ct. App. 1994) (citing Whitlaw v. Kroger Co., 306 S.C. 51, 53, 410 S.E.2d 251 (1991)) ("In order to show that the defendant owes him a duty of care arising from a statute, the plaintiff must show two things: (1) that the essential purpose of the statute is to protect from the kind of harm the plaintiff has suffered; and (2) that he is a member of the class of persons the statute is intended to protect."). The essential purpose of the ARB's silt fence-installation/maintenance requirement, which, to be clear, required the silt fence to be installed around the entire perimeter of the Property, not just on the side abutting the sidewalk, was erosion control, not to protect from the kind of harm at issue in this case. (**Exhibit A** (at page 1 of 4 (General Rule 3) (requiring Defendant to "[i]nstall **erosion control measures (silt fencing)** to the perimeter of the property") (emphasis added)].)

None of this is to say Defendant did not owe Plaintiff any duty of care at all with respect to its activities/the conditions on, or abutting, the Premises; it owed Plaintiff a duty, as it would any other member of the public making use of the sidewalk, not to create a hazardous condition on the sidewalk. (*See* Lane v. Gilbert Constr. Co. Ltd., 383 S.C. 590, 681 S.E.2d 879 (2009) (under a premises liability theory, a contractor, generally equates to an invitor and has the same duties that the property owner would have to invitees); Shaw v. City of Charleston, 351 S.C. 32, 567 S.E.2d 530 (2002) (while the general rule is that an abutting landowner does not owe a duty of care with respect to the safety of the sidewalk there is an exception to this rule when the landowner creates an unsafe condition on the sidewalk)). And this duty, which arises under the law of premises liability, not ordinary (non-premises-liability-based) negligence, supported the

only potentially viable theory of liability that **was** available to Plaintiff against Defendant for the Subject Accident.

Defendant uses past tense ("was"), instead of present tense ("is"), because, in fact, Plaintiff no longer has even a potentially viable premises-liability cause of action against Defendant. During argument at trial on the question of whether Defendant was entitled to a directed verdict, Plaintiff's counsel agreed with the Court that Plaintiff's theory of liability against Defendant was a cause of action for ordinary (non-premises-liability-based) negligence for negligent maintenance of the silt fence. Plaintiff then abandoned her prior requests for jury charges related to premises liability (*see* Plaintiff's Proposed Jury Charges (copy attached hereto as **Exhibit D**) [at VI ("Unsafe Condition"), VII ("Notice"), VIII ("Latent Dangers"), and IX ("Sidewalks")]), took no exception to the Court's ordinary (non-premises-liability-based) negligence charge, and, without objection, allowed the case to be submitted to the jury on that basis alone, without any charge on premises liability.

Plaintiff effectively consented to the dismissal of any premises-liability claim against Defendant. *Cf.* TNS Mills, Inc. v. S.C. Dep't of Revenue, 331 S.C. 611, 617, 503 S.E.2d 471, 474 (1998) ("An issue conceded in a lower court may not be argued on appeal."); Bowman v. Bowman, 357 S.C. 146, 591 S.E.2d 654 (Ct. App. 2004) (a party may not "seek and receive a particular result at trial and then challenge it on appeal"). Consequently, since Plaintiff has no other claims, all Defendant must now show—which it has shown above—to be entitled to judgment in its favor as a matter of law is that the only claim Plaintiff elected to submit to the jury, i.e., the ordinary (non-premises-liability-based) negligence cause of action for negligent maintenance of the silt fence maintenance, must fail, because Defendant did not owe Plaintiff a duty of care to maintain the silt fence. In other words, when Plaintiff agreed that this was not a

premises-liability case and that the case should go forward on that ordinary (non-premises-liability-based) negligence theory alone, Plaintiff left herself with but one egg, which she put in the wrong basket.

Most respectfully, because Defendant did not owe Plaintiff a duty to maintain the silt fence, Plaintiff's ordinary (non-premises-liability-based) negligence cause of action, i.e., Plaintiff's only remaining cause of action, must fail; therefore, Defendant is entitled to judgment in its favor as a matter of law.

(b) Most respectfully, the Court should grant JNOV in favor of Defendant for this reason: Even assuming, *arguendo*, Plaintiff still had (or could somehow revive) a premises-liability claim against Defendant, Defendant is nonetheless entitled to judgment as a matter of law on the merits of such a claim under § 343A.

South Carolina has adopted Restatement (Second) Torts § 343A regarding known or obvious dangers. Callander v. Charleston Doughnut Corp., 305 S.C. 123, 126, 406 S.E.2d 361, 362 (1991).

Section 343A provides as follows:

> (1) A possessor of land is not liable to his invitees for physical harm caused to them by any activity or condition on the land whose danger is known or obvious to them, unless the possessor should anticipate the harm despite such knowledge or obviousness.
>
> (2) In determining whether the possessor should anticipate harm from a known or obvious danger, the fact that the invitee is entitled to make use of public land, or of the facilities of a public utility, is a factor of importance indicating that the harm should be anticipated.

With respect to subsection (2), comment g explains that, even where it is applicable, "defendants, however, may reasonably assume that members of the public will not be harmed by known or obvious dangers which are not extreme, and which any reasonable person exercising ordinary attention, perception, and intelligence could be expected to avoid. This is true

particularly where a reasonable alternative way is open to the visitor, known or obvious to him, and safe."

It cannot reasonably be denied that the hazard at issue, i.e., the downed silt fence, was known and/or obvious to Plaintiff.[8] Indeed, even though, as addressed below, Defendant contends the jury could not reasonably have found (and did not reasonably find) Plaintiff to be less than 51% at fault for the Subject Accident, the fact that the jury found Plaintiff 35% at fault plainly reflects that the hazard was known and/or obvious to Plaintiff.

Moreover, during trial, Plaintiff made much of just how bad was the condition of the silt fence; for instance, Plaintiff's counsel highlighted the photograph identified as RMC 96, (**Exhibit C** [at RMC 96]), in his opening statement as key evidence against Defendant, telling the jury it would hear evidence from Defendant agreeing the photo showed the silt fence to be 70% down—even though Plaintiff's position at trial was that 70% was a conservative estimate. Plaintiff's counsel stated, and both Plaintiff and Smith testified, that RMC 96 accurately depicted the condition at the time of the fall.

Plaintiff's counsel also advised the jury that, as Plaintiff approached the fence, she saw it was down, laying so as to partially obstruct the sidewalk, and jogged over to the left to avoid it. Plaintiff's counsel told the jury that it was a "windy" day and the fence was made of a "light

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[8] Comment *b* on subsection (1) provides as follows:

> *b.* The word "known" denotes not only knowledge of the existence of the condition or activity itself, but also appreciation of the danger it involves. Thus the condition or activity must not only be known to exist, but it must also be recognized that it is dangerous, and the probability and gravity of the threatened harm must be appreciated. "Obvious" means that both the condition and the risk are apparent to and would be recognized by a reasonable man, in the position of the visitor, exercising ordinary perception, intelligence, and judgment.

almost hefty bag material" that, if not secured (as, according to Plaintiff, Winsor obviously failed to do), can get up into the air and move. Both Plaintiff and Smith testified they observed the hazard prior to the fall. Plaintiff herself explained she knew the fence was supposed to be "taught" and secured to the wooden stakes but it was not; rather, it was down and encroaching upon the sidewalk, unsecured, and moving on a windy day.

The undisputed testimony is that Plaintiff was not forced to run along the sidewalk and, indeed, that she and Smith would sometimes run on the street instead of the sidewalk. Based on the undisputed testimony of Plaintiff and Smith, and plainly shown in RMC 96, Plaintiff approached the hazard from an unobstructed vantage point on a clear day—Smith, for instance, described it as a "beautiful windy day." Not even Smith could have obstructed Plaintiff's view; both Plaintiff and Smith testified Plaintiff was running ahead of Smith and, also, that Plaintiff always ran to Smith's right. And they were not running particularly fast; according to Plaintiff, she ran an approximately 10-minute mile—equating to a speed of about 6 miles per hour.

Plaintiff agreed it was important to watch for safety hazards while jogging; she testified that, when she jogged, she focused her attention on the terrain ahead; and, again, it was admitted that she observed the hazard and attempted to run around it but was tripped up, not simply because of the hazard posed by the downed silt fence, but because a gust of wind—on a windy day—blew the fence into her foot—a fence that she knew to be unsecured, that she knew to be down and being buffeted by the wind, and that her own counsel described as a "light almost hefty bag material."

Most respectfully, based on the only, and undisputed, evidence Plaintiff presented relevant to this analysis, even assuming, *arguendo*, Plaintiff still had (or could somehow revive)

a premises-liability claim against Defendant, Defendant is nonetheless entitled to judgment as a matter of law on the merits of such a claim under § 343A.

(c) **Most respectfully, the Court should grant JNOV in favor of Defendant for this reason: Even assuming, *arguendo*, Defendant owed Plaintiff an affirmative duty to "maintain the silt fence" that could support an ordinary (non-premises-liability-based) negligence cause of action, such a claim nonetheless fails, and Defendant is nonetheless entitled to judgment as a matter of law, under § 343A, because § 343A applies to "any activity or condition . . . ."**

By its plain language, § 343A applies to "any **activity** or condition . . . ." (emphasis added). Most respectfully, maintenance of the silt fence, or lack thereof, would be an "activity" to which § 343A applies (and, at that, the "condition" of the silt fence as a result of alleged negligent maintenance would fall within § 343A); consequently, even if a duty of care did exist that could theoretically support a cause of action by Plaintiff against Defendant for ordinary (non-premises-liability-based) negligence for alleged negligent maintenance of the silt fence, such a claim nonetheless fails, as a matter of law, under § 343A, for the same reasons set forth 1.(b) above.

(d) **Most respectfully, the Court should grant JNOV in favor of Defendant for this reason: Even assuming, *arguendo*, that § 343A does not apply, Defendant is nonetheless entitled to judgment in its favor as a matter of law, because, under the circumstances, even viewing the evidence and all reasonable inference in the light most favorable to Plaintiff, Plaintiff cannot reasonably be found to bear less than 51% of the fault for the Subject Accident; therefore, she should be completely barred from recovery against Defendant on account of her own comparative negligence.**

Most respectfully, even assuming, *arguendo*, § 343A does not apply, for the same reasons set forth in 1.(b) above, Plaintiff could not reasonably be found to be less than 51% at fault for the Subject Accident (and, indeed, the jury's finding to the contrary was unreasonable); consequently, recovery by Plaintiff against Defendant should be barred by Plaintiff's comparative negligence, with Defendant entitled to judgment as a matter of law. Bass v. Gopal,

Inc., 384 S.C. 238, 247, 680 S.E.2d 917, 921 (Ct. App. 2009) ("If the sole reasonable inference that may be drawn from the evidence is that the plaintiff's negligence exceeded fifty percent, the circuit court may determine judgment as a matter of law in favor of the defendant."); *see, e.g.*, Humphrey v. Day & Zimmerman Inc., 997 F. Supp. 2d 388 (D.S.C. 2014) (finding, as a matter of law, on summary judgment, the plaintiff's negligence greater than the negligence attributable to the defendant and, accordingly, the plaintiff's claims barred under the doctrine of comparative negligence).

2. A Lesser Alternative: Motion for a New Trial Absolute

Pursuant to Rule 59(a), and, for that matter, Rule 59(e), for the reasons set forth below, Defendant moves for a new trial absolute. *See also* Rule 50(b) ("A motion for a new trial may be joined with this motion, or a new trial may be prayed for in the alternative.").

(a) Most respectfully, the Court should grant Defendant a new trial absolute, because the jury's verdict was grossly excessive and/or under the thirteenth juror doctrine.

The jury's finding that Plaintiff suffered damages in the amount of $500,000 was grossly excessive indicating the jury was motivated by some improper influence.[9]

To begin, the subject of insurance was raised in the presence of the jury on a number of occasions during trial. First, Plaintiff mentioned insurance on cross-examination. Defendant immediately moved for a mistrial, and the Court denied the motion. The Court offered Defendant a curative instruction, which Defendant declined on the basis that it was impossible to cure the prejudice to Defendant by Plaintiff's reference to insurance; in other words, the bell could not be un-rung and attempting to cure would only further infect. Next, insurance (albeit

[9] Notably, the total amount of monetary loss Plaintiff presented was $13,244.70. (First Page of Plaintiff's Trial Exhibit No. 4 [summary of medical specials] (a copy of which is

health insurance, specifically) was referenced in the video deposition of Dr. Funcik that was played for the jury. Defendant again moved for a mistrial, which the Court denied. On its own initiative, the Court also gave the jury a curative instruction regarding insurance. Defendant objected to this instruction, again expressing its position that a curative instruction was not possible. Finally, over Defendant's objection (on the same basis as before), the Court included in its charge to the jury an instruction, essentially a curative instruction, about insurance.

Also, a great deal of evidence cuts sharply against such a large damages determination. Again, the Smell/Taste Problem is, by far, the most significant damage claimed by Plaintiff in this suit. The only reasonable inference to be drawn from the evidence is that, while Plaintiff claimed to have had the Smell/Taste Problem ever since the date of the Subject Accident, Plaintiff did not actually notice this loss for at least a year thereafter. Not to mention being inconsistent with the only medical evidence in the record regarding the mechanism of injury in cases of traumatic loss of smell, i.e., a sudden and permanent shearing of the olfactory nerve filaments,[10] the very idea that such a loss was capable of going unnoticed by Plaintiff for a year or more is wholly inconsistent with such a large value being given to it.

In other words, it is simply illogical for Plaintiff to have it both ways; she cannot, on the one hand, attempt to explain away the year-plus lapse in time between the Subject Accident and her noticing the Smell/Taste Problem, but, then, on the other hand, claim tremendous damage on account of the Smell/Taste Problem, i.e., the same problem that she lived with for at least a year

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attached hereto as **Exhibit E**).) Accordingly, the jury found more than $485,000 in nonpecuniary damages.

[10] In this regard, Defendant also notes that Plaintiff's testimony that, per Dr. Funcik, she expected it to take a year after surgery, on August 24, 2011, for her to return to normal, was completely undermined by Dr. Funcik's own testimony; Dr. Funcik testified that he tells all of his patients that have nasal cosmetic surgery that it will take about a year for things to "settle

without realizing it. Compare this with a loss of the senses of sight, hearing, or touch; it is simply inconceivable that a person could lose any of those senses without noticing their absence for any significant period of time. This is not to say that the Smell/Taste Problem is trivial, but the interests of justice require maintaining a reasonable perspective about the Plaintiff's claimed loss, and not just generally, but under Plaintiff's particular circumstances, which involve Plaintiff not even recognizing the loss for a year or more.

The lack of such perspective is well shown by considering Plaintiff's counsel's closing argument about valuing the Smell/Taste Problem in terms of a job Plaintiff would be working every waking hour for the rest of her life. Common sense tells us that Plaintiff is not, in fact, "suffering" from the Smell/Taste Problem every waking hour of her life, because common sense tell us that there a many times—if not, in fact, the vast majority of our waking hours—when a person simply does not notice any particular smell at all—and, of course, not all smells are pleasant. Similarly, common sense tells us that a person does not spend the entirety of their waking hours eating; consequently, a person does not spend the entirety of their waking hours "suffering" from a deficit in their ability to taste.

Moreover, beyond the mere fact that it took Plaintiff at least a year before she even noticed the Smell/Taste Problem, the evidence in this case about Plaintiff's life with the Smell/Taste Problem is inconsistent with the jury's large damages determination. Upon questioning from her own counsel, Plaintiff testified about things she was still capable of enjoying, such as going to the beach and dancing at her daughter's college graduation party. Plaintiff's daughter, Christina Connelly ("Christina"), testified that she has a close relationship with her mother and communicates with her on essentially a daily basis. According to Christina,

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out," or words to that effect, but in saying this he is referring to aesthetics, not to intranasal

Plaintiff is a happy person and still goes out to eat regularly.[11] (In this same vein, please see Plaintiff's facebook account activity that was admitted as Defendant's Trial Exhibit No. 3.) And, while she contradicted (and was impeached with) her deposition testimony on this point (by claiming, at trial, that she had done so only when she believed Plaintiff's condition was not permanent), Smith, Plaintiff's friend, testified that she was even able to playfully tease Plaintiff about the Smell/Taste Problem.

Most respectfully, for the reasons stated herein, and, for that matter, the reasons set forth in 1.(b) above, Defendant requests the Court grant it a new trial absolute on account of the jury's shockingly excessive damages determination and/or grant a new trial absolute by exercising its discretion under the thirteenth juror doctrine. *See* O'Neal v. Bowles, 314 S.C. 525, 527, 431 S.E.2d 555, 556 (1993) ("If the amount of the verdict is grossly inadequate or excessive so as to

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swelling that could impact a person's ability to smell.

[11] Curiously, Christina also referenced her mother having a "decreased" sense of smell, which cuts against Plaintiff's claim that she has not smelled at all the Subject Accident. On this point, Defendant notes that, when Plaintiff first sought medical treatment for the Smell/Taste issue (on April 4, 2013, with Dr. Ghegan at Charleston ENT), although Dr. Ghegan used the word "anosmia" in his impression, Dr. Ghegan's note reflects that Plaintiff "present[ed] with [a] chief complaint of **decreased** sense of smell and taste." (Portion of Plaintiff's Trial Exhibit No. 2 [at pp. 8-79 (emphasis added)] (attached hereto as **Exhibit F**); id. at p. 79 ("We discussed that I think most likely her **decreased** sense of smell, and subsequent decreased taste, are result of the trauma a couple of years ago.") (emphasis added).) Similarly, on Plaintiff's second visit to Charleston ENT, when she saw Dr. Hester on April 26, 2013, although Dr. Hester's impression uses the word "anosmia," Dr. Hester's note indicates the history Plaintiff gave was "regarding **decreased** smell and taste." (**Exhibit F** [at p. 80 (emphasis added)].) This theme is continued in Dr. Funcik's note from May 28, 2013, wherein he reflects Plaintiff "mentioned that she has had **hyposmia** since her injury." (Portion of Plaintiff's Trial Exhibit No. 1 (emphasis added) (attached hereto as **Exhibit G**).) Dr. Funcik testified that "hyposmia" is the medical term for decreased sense of smell; whereas, "anosmia" is the medical term for lost sense of smell. Even the record of Plaintiff's initial visit with Dr. Dozier at Charleston ENT, i.e., her third visit to the practice overall, on June 26, 2014, reflects Dr. Dozier saw Plaintiff "regarding [her] chief complaint of **decreased** smell and taste." (**Exhibit F** [at p. 160] (emphasis added).) It was not until Plaintiff presented for her second visit with Dr. Dozier, on January 16, 2015, about a year and a half after this lawsuit was filed, that Plaintiff's complaint was actually described as "anosmia." (**Exhibit F** [at p. 169].)

be the result of passion, caprice, prejudice, or some other influence outside the evidence, the trial judge must grant a new trial absolute."); Folkens v. Hunt, 300 S.C. 251, 254, 387 S.E.2d 265, 267 (1990) ("The thirteenth juror doctrine is a vehicle by which the trial court may grant a new trial absolute when he finds that the evidence does not justify the verdict. This ruling has also been termed granting a new trial upon the facts.").

(b). Most respectfully, the Court should grant Defendant a new trial absolute via alteration, amendment, and/or reconsideration of its rulings (i) denying Defendant's challenge to Plaintiff's experts' testimony with respect to the alleged causal connection between the Subject Accident and the Smell/Taste Problem; (ii) denying Defendant's motions for a mistrial on account of the subject of insurance being raised in the presence of the jury, to include the Court's curative instruction to the jury and, later, jury charge regarding insurance; (iii) granting Plaintiff a partial directed verdict; and (iv) refusing Defendant's requested jury charges pertaining to premises liability and § 343A.

(i) Regarding denial of Defendant's challenge to Plaintiff's experts' testimony with respect to the alleged causal connection between the Subject Accident and the Smell/Taste Problem

Dr. Funcik never treated Plaintiff for the Smell/Taste Problem; Plaintiff had not even reported the problem to him until May 28, 2013, after she had already seen Charleston ENT on her own the month before. Indeed, Dr. Funcik conceded that he did not see patients complaining of loss of smell as a regular part of his practice and that he "probably would not be the first doctor in Charleston they would see for that concern"[12]—when discussing the possibility of him treating a member of his office staff were they to come to him with such a complaint, he even mentioned that he "would probably sit down and Google it to make sure I wasn't missing anything . . . ." (*See* Dr. Funcik (video deposition from August 19, 2015) at p. 145, lines 4-24.) Dr. Funcik even admitted that, when he was first deposed he had trouble making the timing of the Subject Accident and Plaintiff's recognition of the Smell/Tate Problem add up. At that, he

testified that the reason he felt comfortable offering his opinion on causation in his second (i.e., the video deposition) was because Plaintiff's counsel had related certain information to him about the deposition testimony of Plaintiff's daughter (i.e., Christina) and his own recollection of a certain incident where he experienced some sort of nerve-related—but, to be sure, completely unrelated to Plaintiff's actual medical condition at issue in this case—lessening—not complete loss of, as in the case of Plaintiff's sense of smell—of strength in one of his hands.

Although he did treat Plaintiff for the Smell/Taste Problem, Dr. Ghegan confirmed that his treatment of Plaintiff involved a single office visit on April 4, 2013; the total visit lasted about 30 minutes, with Dr. Ghegan's interaction with Plaintiff being 10-15 minutes. He further testified that, even though he was offering the opinion that the Subject Accident was the cause of the Smell/Taste Problem, he did not have—and, of course, had not reviewed—any of Dr. Funcik's records of Plaintiff for the Subject Accident, and, although he answered, "not necessarily," when asked if his review of those records would be important in understanding the relationship between the Subject Accident the Smell/Taste Problem, he conceded the possibility that review of these records could change his opinion. (Dr. Ghegan at p. 53, line 7 - p. 54, line 23; *see also* p. 66, line 14 – p. 68, line 11 (where Dr. Ghegan agrees there is information potentially material to his opinion that he does not have.)

Most respectfully, the Court erred in denying Defendant's challenge to Plaintiff's experts' testimony with respect to the alleged causal connection between the Subject Accident and the Smell/Taste Problem, because these experts' testimony on this issue could not reasonably be found to be substantively reliable; the Court should alter, amend, and/or reconsider its decision in this regard and grant Defendant a new trial absolute. *See* Watson v. Ford Motor Co.,

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[12] (*See* Dr. Funcik (video deposition from August 19, 2015) at p. 16, lines 22-24.)

389 S.C. 434, 446-47, 699 S.E.2d 169, 175 (2010) ("[E]xpert testimony receives additional scrutiny relative to other evidentiary decisions. Specifically, in executing its gatekeeping duties, the trial court must make three key preliminary findings which are fundamental to Rule 702 before the jury may consider expert testimony. First, the trial court must find that the subject matter is beyond the ordinary knowledge of the jury, thus requiring an expert to explain the matter to the jury. Next, while the expert need not be a specialist in the particular branch of the field, the trial court must find that the proffered expert has indeed acquired the requisite knowledge and skill to qualify as an expert in the particular subject matter. Finally, the trial court must evaluate the substance of the testimony and determine whether it is reliable. Expert testimony is not admissible unless it satisfies all three requirements with respect to subject matter, expert qualifications, and reliability. Thus, only after the trial court has found that expert testimony is necessary to assist the jury in resolving factual questions, the expert is qualified in the particular area, and the testimony is reliable, may the trial court admit the evidence and permit the jury to assign it such weight as it deems appropriate.") (internal citations omitted); State v. White, 382 S.C. 265, 274, 676 S.E.2d 684, 689 (2009) (observing that the "familiar evidentiary mantra that a challenge to evidence goes to 'weight, not admissibility' may be invoked only after the trial court has vetted the matters of qualifications and reliability and admitted the evidence").

(ii) Regarding denial Defendant's motions for a mistrial on account of the subject of insurance being raised in the presence of the jury, to include the Court's curative instruction to the jury and, later, jury charge regarding insurance

When the Court denied Defendant's first motion for a mistrial (made after Plaintiff herself raised the subject of insurance in front of the jury), the Court announced its belief that Plaintiff's reference to insurance was inadvertent and, to the best of Defendant's counsel's

recollection, cited Brazeale v. Piedmont Mfg. Co., 184 S.C. 471, 193 S.E. 39, 44 (1933) (a case wherein a witness, not a party to the action, "volunteered" a statement about insurance, in support of its decision); *see also* id. at 184 S.C. 471, 193 S.E. at 44 (wherein the Brazeale Court noted that the fact that the subject of insurance was injected into the proceedings by a **witness, "for which the plaintiff is not responsible," as opposed to a party**: "Of course, in cases of this kind, **if plaintiff should bring out** on examination of the witnesses that the defendant carried indemnity insurance, **our decisions are to the effect that a mistrial should be ordered**. These decisions, however, several of which are cited by the appellant, are not controlling under the facts of this case. Where improper reference is made to insurance, or an insurance agent, by the witness, as was here done, **and for which the plaintiff is not responsible**, it seems that the only remedy that the court can give is to grant a motion to strike out the objectionable testimony and to instruct the jury to disregard it."); Keller v. Pearce-Young-Angel Co., 253 S.C. 395, 398-99, 171 S.E.2d 352, 354 (1969) (describing the holding of Brazeale as being consistent with the following: "'[I]f counsel propounds a question which calls for proper evidence, the fact that an irresponsive or inadvertent answer includes a reference to insurance will not be ground for declaring a mistrial.'"); *cf.* Rule 411, SCRE (providing: "Evidence that a person was or was not insured against liability is not admissible upon the issue whether the person acted negligently or otherwise wrongfully. This rule does not require the exclusion of evidence of insurance against liability when offered for another purpose, such as proof of agency, ownership, or control, or bias or prejudice of a witness.").

As for whether Plaintiff's reference to liability insurance was inadvertent, Defendant first notes that, in addition to being the wife of a trial lawyer, Plaintiff herself was present in the court room when, just the day before, her own counsel argued to the Court that, if Defendant tried to

evoke sympathy from the jury via evidence of its/its principal's lack of financial means, Plaintiff should be able to introduce evidence of Defendant's liability coverage; so, of course, Plaintiff, who has a master's degree, knew or should have known the subject of insurance was not to be injected into the trial—and, at that, Plaintiff's counsel had the ability to instruct Plaintiff not to mention insurance in preparing Plaintiff to testify. Additionally, to the best of Defendant's counsel's recollection, Plaintiff's reference to insurance was not responsive to the question actually posed to her by Defendant's counsel. Plaintiff was asked if her husband had threatened legal action the day after the Subject Accident. The question was based upon a letter dated June 7, 2011, i.e. the day after the Subject Accident, wherein plaintiff's husband wrote Defendant, on Plaintiff's husband's law firm's letterhead, making reference only to his "client," not specifically his wife, advising that his "client" had fallen on the on the sidewalk in front of the Premises the previous day. (*See* Letter of William M. Connelly, Esquire, dated June 7, 2011 (a copy of which is attached hereto as **Exhibit H**).)[13] This letter expressly stated: "Please have your attorney call me . . . . Should I not hear from you, I will assume you prefer the more formal route of filing a complaint at law. . . . Also, please advise Karen Nelson, John Edelen, Clark Design Group and Daniel Island Realty of my accusation against the owners and agents of this property." (Id.) Nowhere in the letter is any mention of insurance. (Id.)

Most respectfully, Defendant contends the Court's denial of a mistrial was erroneous and that this error and the prejudice to Defendant was only compounded by the Court's denial of a mistrial upon the second mention of insurance in the presence of the jury, i.e., during Dr. Funcik's testimony, the Court's sua sponte curative instruction regarding insurance thereafter, and the Court's jury charge (over Defendant's objection) in the form of a curative instruction

[13] A copy of this letter, **Exhibit H**, was marked as a Court's exhibit.

about insurance.[14] Under the circumstances, Plaintiff's reference to liability insurance cannot reasonably be viewed as inadvertent and, in any event, Brazéale provides no support for excusing Plaintiff's own improper reference of insurance on the basis of its supposed inadvertent nature; it is fundamentally unjust for Plaintiff to introduce the subject matter of insurance into the trial of the case in this way with the Defendant—now facing a $325,000 judgment a result of the trial—left without any meaningful recourse for Plaintiff having done so—which, of course, only rewards Plaintiff for her own undeniably improper actions and, more broadly, shows other plaintiffs that they may engage in this tactic with impunity. Consequently, for the reasons stated herein, and, for that matter, the reasons set forth in 2.(a) above, the Court should alter, amend, and/or reconsider its decisions in this regard and grant Defendant a new trial absolute.

(iii) Regarding granting Plaintiff a partial directed verdict

Most respectfully, for the reasons set forth in 1.(a) above, the Court's grant of partial directed verdict in favor of Plaintiff was erroneous; the Court should alter, amend, and/or reconsider its decision in this regard and grant Defendant a new trial absolute.

(iv) Regarding refusal of Defendant's requested jury charges pertaining to premises liability and § 343A.

"'Ordinarily, a trial judge has a duty to give a requested instruction that correctly states the law applicable to the issues and evidence.'" Fairchild v. S.C. Dep't of Transp., 398 S.C. 90, 104, 727 S.E.2d 407, 414 (2012) (citation omitted). "'Where a request to charge is timely made and involves a controlling legal principle, a refusal by the trial judge to charge the request constitutes reversible error.'" Id. "'Moreover, when general instructions to the jury are

[14] Again, to be clear, Defendant's position is, and has been, that it was not, in fact, possible to cure the prejudice to Defendant via instruction and that further reference of insurance to the jury via "curative" instruction only further infected the trial with prejudice against Defendant.

insufficient to enable the jury to understand fully the law of the case and issues involved, a refusal to give a requested charge is reversible error.'" Id.; *see also* Berberich v. Jack, 392 S.C. 278, 709 S.E.2d 607 (2011) ("A jury charge consisting of irrelevant and inapplicable principles may confuse the jury and constitutes reversible error where the jury's confusion affects the outcome of the trial." Cole v. Raut, 378 S.C. 398, 404, 663 S.E.2d 30, 33 (2008).

Most respectfully, for the reasons set forth in 1.(a) above, the Court's refusal of Defendant's requested jury charges pertaining to premises liability and § 343A was erroneous; the Court should alter, amend, and/or reconsider its decision in this regard and grant Defendant a new trial absolute.

3. An Even Lesser Alternative: Motion for New Trial *Nisi* Remittitur

Pursuant to Rule 59(a), and, for that matter, Rule 59(e), for the reasons set forth below, Defendant moves for a new trial nisi remittitur. *See also* Rule 50(b).

"The trial court has wide discretionary power to reduce the amount of a verdict which in his or her judgment is excessive." Rush v. Blanchard, 310 S.C. 375, 381, 426 S.E.2d 802, 806 (1993). "The decision of the trial judge to reduce the verdict will not be disturbed unless it clearly appears that the exercise of discretion was controlled by a manifest error of law." Id. "The trial judge who heard the evidence and is more familiar with the evidentiary atmosphere at trial possesses a better-informed view of the damages than this Court." Id. "Accordingly, great deference is given to the trial judge, especially in the area of intangible elements of damages, as were presented in this case." Id.

Most respectfully, for the reasons set forth in 2.(a) above, Defendant requests that the Court find the jury's verdict to be unduly liberal and grant Defendant a new trial *nisi* remittitur,

with the verdict reduced to an appropriate amount so as to do substantial justice in this case in view of the evidence presented.

CONCLUSION

WHEREFORE, Defendant moves for relief as set forth herein.

Respectfully submitted,

YOUNG CLEMENT RIVERS, LLP

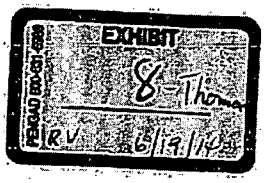
By: _____

Stephen L. Brown
Russell G. Hines
P.O. Box 993
Charleston, SC 29402
(843) 720-5488
SBrown@ycrlaw.com
RHines@ycrlaw.com
Attorneys for Defendant Winsor Custom Homes, LLC

Charleston, South Carolina

Dated: 9/8/15

Daniel Island
ARCHITECTURAL
REVIEW BOARD



CONSTRUCTION GUIDELINES

General Rules

The following rules apply to all employees of Daniel Island contractors and service personnel while on Daniel Island premises. Infractions of any of these rules may result in penalties of the complete construction deposit(s) being withheld.

1. The construction traffic will be allowed Monday through Friday, from 7:00 am until 6:00 pm and 7:00 am until 7:00 pm during daylight savings time. Construction traffic is permitted on Saturdays from 8:30 am to 4:30 pm. All construction related activities are prohibited on Sundays* and major holidays. *After Hours and Sunday work permits may be requested for an additional fee for inside quiet work only.
2. Contractors are required to keep their job sites as neat and clean as possible. Trash and discarded materials must be removed weekly. There will be no stockpiling or dumping on adjacent lots or on streets. Construction materials are to be neatly piled on site; debris and rubbish are to be contained and periodically removed; tall, unsightly weeds are to be routinely cut back, streets adjoining a construction site are to be frequently swept clean of dirt and construction trash. Fines will be deducted from the Construction Deposit for messy job sites.
3. Install erosion control measures (silt fencing) to the perimeter of the property.
4. Builders are required to place a dumpster on site during construction. Should a builder be working on two adjacent homes, one dumpster can service both properties. Builders may use recycling services instead of a dumpster on a job site but the Builder is ultimately responsible for flying debris.
5. All vacant property shall be kept neat and cleared of debris, and shall be well and continuously maintained in its natural condition until construction commences on the property.
6. Contractors will use only the utilities provided on the immediate site on which they are working.
7. Any damage to streets and curbs, drainage inlets, streetlights, street markers, mailboxes, walls, etc. is the responsibility of the owner/builder.
8. There will be no washing of any truck on the streets. Any concrete delivery truck washed out must be on the construction site.
9. Operators of vehicles are required to see that they do not spill any damaging materials while within Daniel Island. If spillage occurs, operators are responsible for cleaning up. Cleanups done by Daniel Island personnel will be charged to the responsible party. Please report any spills as soon as possible to the ARB.
10. If any telephone, cable, TV, electrical, or water lines are cut, it is the builder's responsibility to report such an accident to the community association and appropriate utility within 30 minutes.

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Exhibit A

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11. Loud radios or noise will not be allowed within the neighborhoods. This is distracting and discomforting to property owners. Normal radio levels are acceptable. Do not mount speakers on vehicles or outside of homes under construction.
12. No vehicles (trucks, vans, cars, etc.) may be left in the job area overnight. Construction equipment may be left on the site while needed, but must not be kept on the street. Parking should be off streets whenever possible.
13. No contractor personnel will be permitted to bring pets on the property.

The following list represents a schedule of fines for homes during construction. These fines will be collected from the construction deposit.

a.	Littered site/No dumpster	$250.00
b.	Damage to right-of-way	$100.00, plus restoration
c.	Parking or dumpster on adjacent property or major road without designated parking spaces	$100.00 per violation
d.	Building material or equipment on adjacent property	$100.00
e.	No temporary sanitary facilities	$100.00
f.	Nonconforming job sign	$100.00
g.	Damage to natural areas	$1500.00 plus restoration deducted from deposit
h.	Damage to common areas	$1500.00 plus restoration deducted from deposit
i.	Unauthorized plan change (minor)	$250.00
j.	Unauthorized plan change (major)	$1500.00
k.	Unauthorized finishes, ie. (paint, stain, roof material)	$1500.00
l.	Silt fences not installed or maintained properly	$250.00
m.	Clearing site without permit	$1500.00
n.	Fill placed on tree roots	$250.00

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o.	Working on a Sunday without a permit	$500.00
p.	Working After Hours without a permit	$500.00
q.	Working on a Holiday	$1000.00
r.	Site fill or installation of landscaping without approval	$1500.00
t.	Lot damage to adjacent property	$500.00, plus restoration deducted from deposit
u.	Dirt/Trash in the Street	$100.00
v.	Dumpster overflowing more than 3 business days	$500.00
w.	Unauthorized tree removal	$1500.00, plus mitigation
x.	Failure to maintain lot	$100.00

ARB will assess fines on a case-by-case basis and may pursue legal action if necessary. The amounts of the fines given above are subject of periodic increases at the sole discretion of the ARB.

****Builder shall have 24 hours to remedy violation, unless otherwise noted by the ARB, before fines are doubled.**

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Daniel Island ARB Inspection Timeline

1. Meet ARB staff on site to review site conditions (silt fencing, tree protection, etc.) prior to commencement of construction
2. Provide ARB with copy of City of Charleston building permit within 10 business days of permit issuance
    a. $500 fine for copy of permit received after 10 business days
3. Within 10 days of City foundation sign-off provide ARB with stamped foundation survey and schedule meeting with ARB staff for foundation inspection
    a. $500 fine for foundation survey not submitted within 10 business days of survey being stamped by a registered land surveyor
4. Within 10 business days of City framing sign-off provide ARB with proof of city approval and contact ARB staff for framing inspection
    a. $500 fine for ARB staff not contacted within 10 business days of city approval
5. Provide ARB with copy of Certificate of Occupancy (CO) within 10 days of issuance
    a. $500 fine if not submitted within 10 business days of CO issuance
6. Request ARB perform final inspection within 90 calendar days of issuance of CO by City of Charleston
    a. If final inspection is not requested within 90 calendar days of issuance of CO, builder's construction deposit will be forfeited

*Site conditions, Foundation and Framing inspections will be required for each home constructed on Daniel Island and may be waived at the ARB's sole and absolute discretion. Final inspections will never be waived.
*If inspections are waived all documentation must still be submitted to the ARB within the times prescribed above

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Exhibit A

Building Photographs

See Instructions for Item A6.

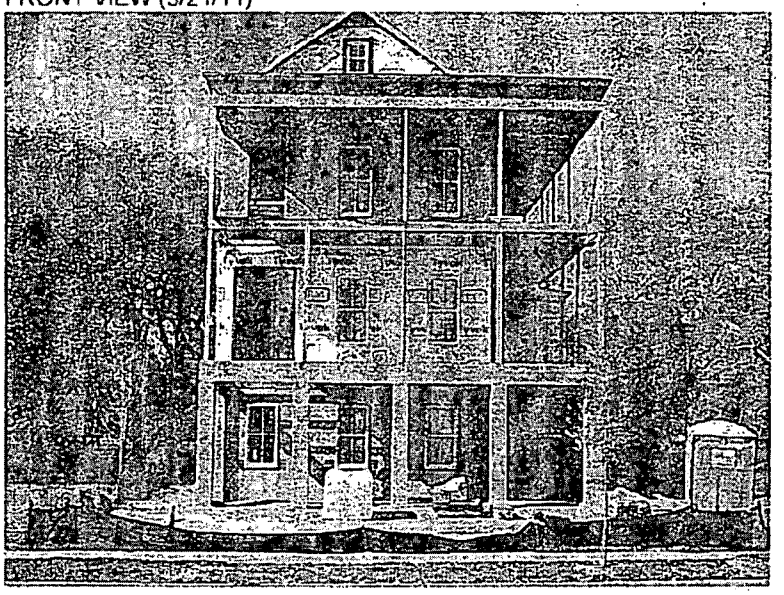
Building Street Address (including Apt., Unit, Suite, and/or Bldg. No.) or P.O. Route and Box No.

REDACTED

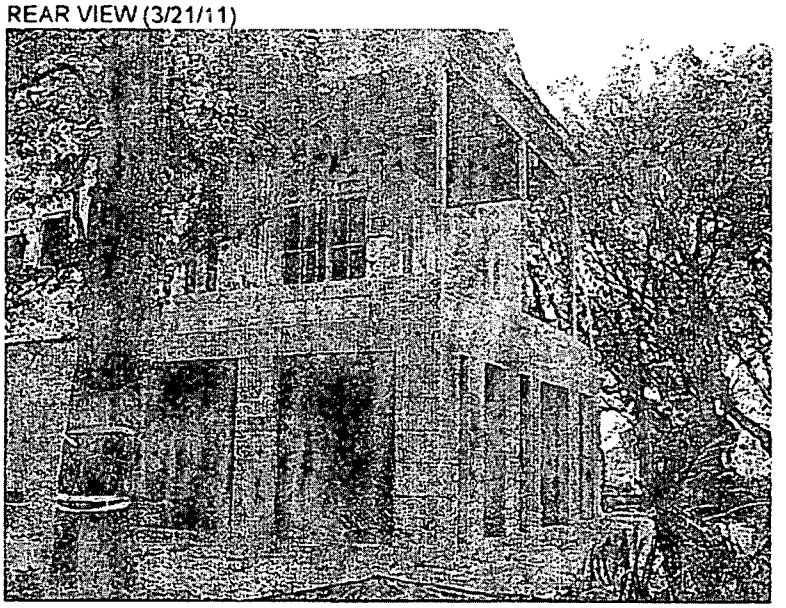
City CHARLESTON State SC ZIP Code 29492

[redacted]

FRONT VIEW (3/21/11)



REAR VIEW (3/21/11)



2013-0494 0302

Exhibit B

Exhibit C

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF CHARLESTON	)	CASE NO.: 2013-CP-10-3251
ROSEMARY CONNELLY,	)	
Plaintiff,	)	
	)	
v.	)	**PLAINTIFF'S PROPOSED JURY CHARGES**
	)	
WINSOR CUSTOM HOMES, LLC., THE DANIEL ISLAND COMPANY, INC., CLARKE DESIGN GROUP, LLC, KAREN A. NELSON, and JOHN W. EDELEN	)	
Defendants.	)	

Plaintiff requests the following jury charges be given:

I. Stipulations

A stipulation is an agreement, admission or concession made in judicial proceedings by the parties thereto or their attorneys. Stipulations, of course, are binding upon those who make them. The court and jury must accept stipulations as binding upon the parties. If counsel for the parties have stipulated to any fact, or any fact has been admitted by counsel, you will regard that fact as being conclusively proved as to the party or parties making the stipulation or admission.

See Porter v. South Carolina Pub. Serv. Comm'n, 333 S.C. 12, 507 S.E.2d 328 (1998); Kirkland v. Allcraft Steel Co., 329 S.C. 389, 496 S.E.2d 624 (1998); Webster v. Holly Hill Lumber Co., 268 S.C. 416, 234 S.E.2d 232 (1977); South Carolina Dep't of Transp. v. Richardson, 335 S.C. 278, 516 S.E.2d 3 (Ct. App. 1999); State v. Anderson, 318 S.C. 395, 458 S.E.2d 56 (Ct. App. 1995) (generally, a stipulation is an agreement between the parties to which there must be mutual assent); Black's Law Dictionary 1415 (6th ed.1990)(defining a stipulation as a "[v]oluntary agreement between opposing counsel concerning disposition of some relevant point so as to obviate need for proof or to narrow range of litigable issues.").

Exhibit D

II. Expert Witnesses

Although lay witnesses are limited to testifying about facts within their knowledge and are not allowed to give opinions, certain witnesses, who, by training, education or experience are considered experts in a particular field, may give opinions in that field based upon the facts of a matter. Their conclusions and opinions constitute evidence to be considered by you in connection with all of the other testimony and evidence in the case. That is to say, you may consider the expert's opinion just as you do all other evidence in the case and it is for you, the jury, to give it such weight as you, in your experience and discretion, may determine. By this, I mean that you must weigh such evidence and accept or reject it in the same manner that you treat all other evidence in the case. In determining the weight to be given the expert's opinion, you should consider the qualifications and credibility of the expert and the reasons given for his opinion.

The testimony of experts on a subject which is little known to the general public is entitled to consideration. Such testimony, however, must be submitted to your judgment and consideration, to be weighed by you as a part of the evidence in connection with all the other facts in this case. The testimony of experts is to aid and assist you as jurors, not to dominate or control you in the decision of questions of facts. Their opinions and deductions from the evidence before you, and their judgments and opinions, do not preclude yours. You are required to decide disputed questions after comparison and consideration of all the evidence in this case.

See Rules 701, 702, 703, 704, and 705, Fed.R.Evid.; Tiller v. National Health Care Ctr., 334 S.C. 333, 513 S.E.2d 843 (1999); Means v. Gates, 348 S.C. 161, 558 S.E.2d 921 (Ct. App. 2001);, 329 S.C. 448, 494 S.E.2d 835 (Ct. App. 1998); Hawkins v. Greenwood Development Corp., 328 S.C. 585, 493 S.E.2d 875 (Ct. App. 1997); Doe v. Greenville Hosp. Sys., 323 S.C. 33, 448 S.E.2d 564 (Ct. App. 1994).

Exhibit D

III. Negligence

The Plaintiff claims that the Defendant was negligent and should compensate the Plaintiff for the injuries the Plaintiff suffered as a result of the Defendant's negligence. In order to prove that the Defendant was negligent, the Plaintiff must prove by a preponderance, or greater weight, of the evidence four things.

First, the Plaintiff must prove by a preponderance, or greater weight, of the evidence that the Defendant owed the Plaintiff a duty of care.

Next, the Plaintiff must prove by a preponderance, or greater weight, of the evidence that the Defendant breached that duty by a negligent act or omission. Negligence means that a person has done something that a reasonable person would not have done or has failed to do something that a reasonable person would have done in the same situation.

The Plaintiff must also prove by a preponderance, or greater weight, of the evidence that she suffered damages as a result of the Defendant's breach of duty.

Finally, the Plaintiff must prove by a preponderance, or greater weight, of the evidence that the damages were proximately caused by the Defendant's breach of duty. Proximate cause is something that produces a natural chain of events that, in the end, brings about the injury. It is the direct cause of the injury.

See Thomasko v. Poole, 349 S.C. 7, 561 S.E.2d 597 (2002); Thomas v. Atlantic Greyhound Corp., 204 S.C. 247, 29 S.E.2d 196 (1944); Crolley v. Hutchins, 300 S.C. 355, 387 S.E.2d 716 (Ct. App. 1989); Small v. Pioneer Mach., Inc., 329 S.C. 448, 494 S.E.2d 835 (Ct. App. 1997); Hughes v. Children's Clinic, P.A., 269 S.C. 389, 237 S.E.2d 753 (1977).

Exhibit D

IV. Concurring Causes

There may be more than one cause of an injury and more than one person may be responsible for the injury. If the negligence of two or more persons combines to cause an injury, each person involved may be held responsible as if that person alone caused the injury. Causes are concurrent if the individual acts of negligence combine to cause the injury. If an injury occurs through the concurrent negligence of two or more persons and would not have happened without the negligence of either person, the negligence is the proximate cause of the injury and both people are responsible.

If the acts happened one after the other but were not related to each other, they would not be concurring causes. In that case, only the person whose negligence actually caused the injury would be responsible.

See Davis v. Tripp, 338 S.C. 226, 525 S.E.2d 528 (Ct. App. 1999); Player v. Thompson, 259 S.C. 600, 193 S.E.2d 531 (1972).

V. Agency

An agency is a consensual relationship where one person or entity, the agent, acts on behalf of another, the principal, and is subject to the control of the principal. An agent is a person who represents and acts for another under a contract or a relationship of agency. An agent acts by the authority and on account of the principal.

A principal is the person or entity represented by the agent and is the source of the agent's authority. An agent may only act within the scope of the authority given by the principal.

What the principal does through an agent, the law considers the act of the principal. Therefore, while the agents are acting within the scope of their employment, a principal is liable for any negligent acts or omissions of its agents that proximately cause injury to another person.

Exhibit D

In order to hold a principal responsible for the negligent acts or omissions of another, the Plaintiff must first prove by a preponderance, or greater weight, of the evidence that there was an agency relationship.

The Plaintiff must also prove that the agent was acting within the scope of authority when the agent caused the injury. Whether the agent was acting within the scope of authority should be determined in light of all of the surrounding circumstances, including written or spoken words or conduct by the principal that would cause the Plaintiff to believe that the principal consented to the agent acting for the principal. An agent's authority is determined by the scope of the business, and the agent has the authority to do what is customary in furthering the principal's business and anything that is reasonably related to furthering that business. Unless the Plaintiff knew of restrictions on the agent's authority, the Plaintiff had the right to presume that the agent's authority was what it appeared to be. However, the Plaintiff has the duty to use due care to determine the scope of the agent's authority.

See Frasier v. Palmetto Homes of Florence, Inc., 323 S.C. 240, 473 S.E.2d 865 9(t. App. 1996); South Carolina Law Enforcement Div. v. The "Michael and Lance", 281 S.C. 339, 315 S.E.2d 171 (Ct. App. 1984); Rickborn v. Liberty Life Ins. Co., 321 S.C. 291, 468 S.E.2d 292 (1996); Frasier v. Palmetto Homes of Florence, Inc., 323 S.C. 240, 473 S.E.2d 865 (Ct. App. 1996).

VI. Unsafe Condition

The Plaintiff claims that an unsafe condition on the Defendant's premises injured the Plaintiff. In order to recover damages for this injury, the Plaintiff must first prove by a preponderance, or greater weight, of the evidence that an unsafe condition existed on the Defendant's premises.

Exhibit D

VII. Notice

Next, the Plaintiff must show that the unsafe condition was caused by an agent or employee of the Defendant or that the Defendant had actual or constructive notice of the unsafe condition. There are two varieties of actual notice recognized in South Carolina: express and implied notice.

Express actual notice may be proven by showing that the Defendant embraced not only knowledge, but also that which is communicated by direct information, either written or oral, from those who are cognizant of the fact communicated.

Implied actual notice may be proven by showing that Defendant had knowledge of facts so informing that a reasonably cautious person would be led by them to the ultimate fact; that which, if prosecuted with ordinary diligence, will furnish information of fact.

Constructive notice may be proven by showing that the unsafe condition had existed for a long enough time for the Defendant to have discovered and fixed it. Just because an unsafe condition existed, this is not enough, in and of itself, to show that the Defendant had notice of the unsafe condition.

Strother v. Lexington Cnty. Recreation Comm'n, 332 S.C. 54, 504 S.E.2d 117 (1998); Milligan v. Winn-Dixie Raleigh, Inc., 273 S.C. 118, 120-21, 254 S.E.2d 798, 799 (1979) (quoting Pennington v. Zayre Corp., 252 S.C. 176, 165 S.E.2d 695 (1969).

VIII. Latent Dangers

The Defendant has the duty to warn an invitee of hidden dangers of which the defendant knows or should know.

See Larimore v. Carolina Power & Light, 340 S.C. 438, 531 S.E.2d 535 (Ct. App. 2000).

Exhibit D

IX. Sidewalks

An owner or occupant of a building owes a duty to pedestrians walking on public sidewalks to keep the sidewalk in a reasonably safe condition. The owner or occupant is not, however, an insurer of the safety of pedestrians using the sidewalk.

The Defendant is responsible for the injury suffered by the Plaintiff if the Plaintiff proves by a preponderance, or greater weight, of the evidence that the Defendant knew or should have known by the exercise of reasonable diligence that the sidewalk was in a dangerous condition.

See Milligan v. Winn-Dixie Raleigh, Inc., 273 S.C. 118, 254 S.E.2d 798 (1979).

X. Proximate Cause

Finally, the Plaintiff must prove that the Defendant's negligence proximately caused the Plaintiff's damages.

Proximate cause is something that produces a natural chain of events that, in the end, brings about the injury. It is the direct cause of the injury.

To prove that the Defendant's negligence proximately caused the Plaintiff's injury, the Plaintiff must first prove causation in fact. This is proven by showing that the injury would not have occurred but for the Defendant's negligence.

The Plaintiff must also prove legal cause. Legal cause is proven by showing that the injury was foreseeable. This means that the injury occurred as a natural and probable consequence of the Defendant's negligence. The Plaintiff must prove that some injury from the Defendant's negligence was foreseeable, but does not have to prove that the particular injury that occurred was foreseeable. However, the Defendant cannot be held responsible for something which could not be expected to happen.

Exhibit D

Proximate Cause does not mean the only cause. There may be more than one proximate cause. The Defendant's act can be a proximate cause of the Plaintiff's injury if it was at least one of the direct, concurring causes of the injury.

See Small v. Pioneer Mach., Inc., 329 S.C. 448, 494 S.E.2d 835 (Ct. App. 1997).

XI. Circumstantial Evidence

Negligence may be proved by circumstantial evidence and in determining the sufficiency of circumstantial evidence, the facts and circumstances shown are to be reckoned with in the light of ordinary experience and such conclusions deduced therefrom as common sense dictates.

See McQuillen v. Dobbs, 204 S.E.2d 732 (S.C. 1974); Anderson v. Winn-Dixie Greenville, Inc., 257 S.C. 75, 184 S.E.2d 77 (1971); Crolley v. Hutchins, 300 S.C. 355, 387 S.E.2d 716 (Ct. App. 1989); Small v. Pioneer Mach., Inc., 329 S.C. 448, 494 S.E.2d 835 (Ct. App. 1997); Hughes v. Children's Clinic, P.A., 269 S.C. 389, 237 S.E.2d 753 (1977).

XII. Elements of Damages

When one person is injured by the negligent acts of another, the injured person is entitled to be fully compensated for all injuries directly or proximately resulting from any negligent acts or omissions by the defendant.

In determining the amount of compensation for injuries suffered by the plaintiff as a result of the defendant's negligence, it is proper for you to consider and award past, present, and future damages for:

(1) medical expenses, including physicians, hospital, medicines, physical therapy expenses and rehabilitation expenses,

(2) loss of family services;

(3) alteration of lifestyle;

(4) psychological trauma;

Exhibit D

(5) mental anguish;

(6) ~~mental distress;~~

(7) ~~apprehension;~~

(8) ~~anxiety;~~

(9) ~~emotional injury;~~

(10) ~~psychological injury;~~

(11) permanent disability;

(12) pain and suffering;

(13) loss of enjoyment of life.

The plaintiff bears the burden of proving these elements by the preponderance of the evidence.

See Bates v. Merritt Seafood, Inc., 663 F. Supp. 915 (D.S.C. 1987); McNeill v. United States, 519 F. Supp. 283 (D.S.C. 1981); Baldowski v. United States, 111 F. Supp. 653 (D.S.C. 1953); Boan v. Blackwell, 343 S.C. 498, 541 S.E.2d 242 (2001) (where there is evidence of "loss of enjoyment of life," South Carolina juries should be charged this loss is a compensable element, separate and apart from pain and suffering, of a damages award); Oliver v. Blakeney, 244 S.C. 565, 137 S.E.2d 772 (1964); Edwards v. Lawton, 244 S.C. 276, 136 S.E.2d 708 (1964); Watson v. Wilkinson Trucking Co., 244 S.C. 217, 136 S.E.2d 286 (1964); Doremus v. Atlantic Coast Line R.R., 242 S.C. 123, 130 S.E.2d 370 (1963) (loss or impairment of earning capacity resulting from personal injuries is proper element of compensation and fact that injured party was unemployed at time of injury complained of does not deprive him of right to receive damages for such impairment); Harper v. Bolton, 239 S.C. 541, 124 S.E.2d 54 (1962) (pain and suffering is recognized by courts as a very material element of damages on which recovery may

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be bottomed; damages for pain and suffering are unliquidated and indeterminate in character and assessment of unliquidated damages must rest in sound discretion of jury, controlled by discretionary power of trial judge); Haselden v. Atlantic Coast Line R.R., 214 S.C. 410, 53 S.E.2d 60 (1949); Rorrer v. P.J. Club, Inc., 347 S.C. 560, 556 S.E.2d 726 (Ct. App. 2001); Gasque v. Heublein, Inc., 281 S.C. 278, 315 S.E.2d 556 (Ct. App. 1984); 22 Am. Jur. 2d Damages 133-34, 139 (1988); F. Patrick Hubbard and Robert L. Felix, *The South Carolina Law of Torts* 555-566 (2d Ed. 1997).

XIII. Actual Damages

If you decide that the Plaintiff is entitled to a verdict, your next step would be to decide how much money the Defendant should be required to pay.

Actual damages are properly called compensatory damages, meaning to compensate, to make the injured party whole, to put him in the same position he was in prior to the damages received insofar as this is monetarily possible. In other words, actual or compensatory damages include compensation for all injuries which are naturally the proximate result of the alleged wrongful conduct of the defendant.

Actual damages are awarded to a litigant in compensation for his actual loss or injury. Actual damages are such as will compensate the party for injuries suffered or losses sustained. They are such damages as will simply make good or replace the loss caused by the wrong or injury. Actual damages are damages in satisfaction of, or in recompense for, loss or injury sustained. The goal is to restore the injured party, as nearly as possible through the payment of money, to the same position he was in before the wrongful injury occurred.

The basic measure of actual damages is the amount needed to compensate the plaintiff for the losses proximately caused by the defendant's wrong so that the plaintiff will be in the same

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position he would have been in if there had been no wrongful injury. Actual damages include compensation for all injuries which are naturally the proximate result of the alleged wrongful conduct of the defendant.

The existence, causation, or amount of damages cannot be left to conjecture, guesswork or speculation. However, proof of amount of loss with absolute or mathematical certainty is not required. Damages must be proved with a reasonable degree of certainty. The evidence presented by the plaintiff must enable you, the jury, to determine what amount is fair, just and reasonable.The plaintiff bears the burden of proving by the preponderance of the evidence that he is entitled to compensatory damages.

See Clark v. Cantrell, 339 S.C. 369, 529 S.E.2d 528 (2000); Baughman v. American Tel. and Tel. Co., 306 S.C. 101, 410 S.E.2d 537 (1991); Barnwell v. Barber-Colman Co., 301 S.C. 534, 393 S.E.2d 162 (1989); Whisenant v. James Island Corp., 277 S.C. 10, 281 S.E.2d 794 (1981) (in order for damages to be recoverable, evidence should enable jury to determine amount thereof with reasonable certainty and cannot be left to conjecture, guess, and speculation); Piggy Park Enters., Inc. v. Schofield, 251 S.C. 385, 162 S.E.2d 705 (1968); Laird v. Nationwide Ins. Co., 243 S.C. 388, 134 S.E.2d 206 (1964); Hutchison v. Town of Summerville, 66 S.C. 442, 45 S.E. 8 (1903) (actual damages are when the wrongful act has caused loss or injury which can be assessed in money; universal and cardinal principle being that the person injured shall receive compensation commensurate with his loss or injury and no more); Carrigg v. Blue, 283 S.C. 494, 323 S.E.2d 787 (Ct. App. 1984); 22 Am. Jur. 2d Damages 23, 24 (1988); Black's Law Dictionary 390 (6th ed. 1990).

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XIV. Personal Injuries

The Plaintiff must prove that expenses caused by the injury were necessary and reasonable.

Actual damages for a Plaintiff who has been physically injured include pain and suffering – both past and future – as well as mental anguish, impairment of health or physical condition, and disfigurement. The Plaintiff may also claim lost wages due to absence from work and reduced earning ability for the future.

In determining the amount of compensation for personal injuries, it is proper to consider past and present aspects of the injury. This would include physical and mental pain and suffering, expenses incurred for necessary medical treatment, loss of time and income that resulted from the impairment of the ability to work and earn a livelihood, the loss of enjoyment of life suffered as a result of the injury, and any other losses which are reflected by the character of the injury.

The injured party may recover for those future damages that are reasonably sure to result from the injuries. The principle underlying compensation for future damages is that only one action can be brought and, therefore, only one recovery had. It is proper to include in the estimate of future damages compensation for loss of capacity for work or attention to the Plaintiff's ordinary business, future medical expenses, and pain and suffering that will, with reasonable certainty, result.

See Sossamon v. Nationwide Mut. Ins. Co., 243 S.C. 552, 135 S.E.2d 87 (1964); Boan v. Blackwell, 343 S.C. 498, 541 S.E.2d 242 (2001).

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XV. Medical Bills

In personal injury actions, the general rule is that the plaintiff may recover for the necessary and reasonable expenses caused by the injury, such as amounts necessarily incurred for medicine, medical services, hospital expense and care, and nursing. A person who suffers personal injuries because of the negligence of another is entitled to recover the reasonable value of medical care and expenses incurred for the treatment of the injuries to the time of trial. Accordingly, a plaintiff may recover amounts incurred for past medical care, including hospital, physician, and nursing care costs; medicine; and other out-of-pocket and anticipated expenses, such as vocational, physical and other rehabilitation efforts. If you determine from the evidence and under the law as I have instructed you that the plaintiff is entitled to recover damages, including medical, hospital, or other health care costs, then the plaintiff can only recover such sums as you determine from the evidence to be both reasonable and necessary.

See Pearson v. Bridges, 344 S.C. 366, 544 S.E.2d 617 (2001); Haltiwanger v. Barr, 258 S.C. 27, 186 S.E.2d 819 (1972); Sossamon v. Nationwide Mut. Ins. Co., 243 S.C. 552, 135 S.E.2d 87 (1964); Haselden v. Davis, 341 S.C. 486, 534 S.E.2d 295 (Ct. App. 2000), cert. granted, Jan. 11, 2001; Campbell v. Paschal, 290 S.C. 1, 347 S.E.2d 892 (Ct. App. 1986) (to recover for future medical expenses, the expenses must be established with reasonable certainty); Gasque v. Heublein, Inc., 281 S.C. 278, 315 S.E.2d 556 (Ct. App. 1984); 22 Am. Jur. 2d Damages 197 (1988) (if plaintiff has proven entitlement to medical expenses, failure of jury to award damages requires reversal); 22 Am. Jur. 2d Damages 198 (1988); 22 Am. Jur. 2d Damages 207 (1988) (in personal injury action, general rule is that plaintiff may recover reasonable value of medical services made necessary by injury, providing the injury was result of defendant's fault).

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XVI. Loss of Enjoyment of Life

Loss of the capacity to enjoy life, resulting from a personal injury, is a proper element of damages. If you find evidence of "loss of enjoyment of life," you may award damages for this loss. Damages for "loss of enjoyment of life" compensate for the limitations, resulting from the defendant's negligence, on the injured person's ability to participate in and derive pleasure from the normal activities of daily life, or for the individual's inability to pursue his talents, recreational interests, hobbies, or avocations. "Loss of enjoyment of life" damages compensate the plaintiff not only for the subjective knowledge that one can no longer enjoy all of life's pursuits, but also for the objective loss of the ability to engage in these activities.

See Boan v. Blackwell, 343 S.C. 498, 541 S.E.2d 242 (2001) (where there is evidence of "loss of enjoyment of life," South Carolina juries should be charged that this loss is a compensable element, separate and apart from pain and suffering, of a damages award; holding that, where supported by the evidence, jury shall be charged injured person is entitled to recover damages for "loss of enjoyment of life"); 22 Am. Jur. 2d Damages 272 (1988).

XVII. Mental Anguish

An injured party may recover for mental anguish brought about by bodily injury and suffering. Where a party's negligence is directly responsible for physical injury to another, the injured party may recover both for actual physical injury sustained and for concomitant mental and emotional suffering which flow as a natural consequence of the wrongful act.

When connected with a physical injury, the term "mental anguish" includes both the resultant mental sensation of pain and also the accompanying feelings of distress, fright, and anxiety. That is, mental anguish covers not only the pain associated with the injury but also the mental reaction to that pain and to the possible consequences of the injury. "Mental anguish" is

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more than mere disappointment, anger, worry, resentment, or embarrassment, although it may include all of these, and it includes mental sensation of pain resulting from such painful emotions as grief, severe disappointment, indignation, wounded pride, shame, despair, and humiliation. "Mental anguish" can be composed of fright, nervousness, grief, anxiety, worry, mortification, humiliation, embarrassment, terror, or ordeal.

If you find the injured party is entitled to recover damages, you may consider as an element of those damages such mental anguish as you find. In assessing mental anguish, you may take into account anxiety or worry about possible future occurrences or conditions resulting from the injuries that the plaintiff received. You may award damages for mental anguish where the evidence shows, for example, that the plaintiff suffered shock, fright, emotional upset, and/or humiliation as the result of the defendant's negligence.

See Boan v. Blackwell, 343 S.C. 498, 541 S.E.2d 242 (2001); 22 Am. Jur. 2d Damages 28, 251, 254-56 (1988); 22 Am. Jur. 2d Damages 252 (1988) (damages for mental suffering may be properly awarded where plaintiff has suffered physical injury); Black's Law Dictionary 985-86 (6th ed. 1990).

XVIII. Pain and Suffering

Pain and suffering is a material element of damages on which a recovery may be based. The plaintiff is entitled to compensation for her pain and suffering directly resulting from the wrongful acts of the defendant.

An award for pain and suffering compensates the injured person for the physical discomfort and the emotional response to the sensation of pain caused by the injury itself. In making an estimate of damages to be awarded for pain and suffering, you may consider:

(1) the nature and extent of the injuries and the suffering occasioned by them and its duration or prospective duration;

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(2) the age, health, habits, and condition of the injured party before the injury as compared with his condition afterwards;

(3) the plaintiff's use of sedatives and other drugs to relieve pain and their effect; and

(4) any aggravation of pre-existing disorders by the incident in question.

Pain and suffering have no market price. They are not capable of exact measurement, and there is no fixed rule or standard whereby damages for them can be measured. The amount of damages to be awarded for pain and suffering must be left to the judgment of you, the jury. Additionally, you may include such damage for pain and suffering as it is reasonably certain will of necessity result in the future from the injury. Future pain and suffering on the part of the plaintiff in consequence of the injury constitute a proper element of the damages which may be allowed, provided there is the requisite certainty that such pain and suffering will result.

See Boan v. Blackwell, 343 S.C. 498, 541 S.E.2d 242 (2001); Haltiwanger v. Barr, 258 S.C. 27, 186 S.E.2d 819 (1972); Edwards v. Lawton, 244 S.C. 276, 136 S.E.2d 708 (1964); Harper v. Bolton, 239 S.C. 541, 124 S.E.2d 54 (1962); Campbell v. Hall, 210 S.C. 423, 43 S.E.2d 129 (1947); Mims v. Florence Co. Ambulance Serv. Comm'n, 296 S.C. 4, 370 S.E.2d 96 (Ct. App. 1988) (amount of damages jury may award for physical pain and suffering and for mental pain and suffering is incapable of exact measurement and is therefore left for determination by jury); Cohen v. Allendale Coca-Cola Bottling Co., 291 S.C. 35, 351 S.E.2d 897 (Ct. App. 1986); 22 Am. Jur. 2d Damages 239, 244, 260 (1988); 22 Am. Jur. 2d Damages 247 (1988) (compensation for future pain and suffering is, by the nature of the award, made in advance of actual pain and suffering; plaintiff is being compensated prior to his damage; because of this, it has been urged that any award for future pain and suffering should be reduced to its

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present value); 22 Am. Jur. 2d Damages 262 (1988) (setting out factors considered by jury in awarding damages for pain and suffering).

XIX. Permanent Injury

If you find that the Plaintiff was permanently injured as a result of the Defendant's actions, you must then decide how, if at all, that injury will affect the rest of the Plaintiff's life. A person's life expectancy is determined by a life expectancy table which is a part of the laws of this state. The life expectancy table is only an estimate of the probable average remaining life of the life of all persons in our state of a given age. The Plaintiff is a sixty (60) year old female with a life expectancy, according to the life expectancy table, of twenty-four and eight hundredths (24.08) years, or eighty-four and eight hundredths (84.08) years total. This fact is to be considered by you along with any other facts and circumstances in evidence bearing on the Plaintiff's life expectancy including occupation, habits, and health at the time of injury in deciding the amount of damages to be awarded to the Plaintiff.

See S.C. Code Ann. § 19-1-150; Haselden v. Davis, 341 S.C. 486, 534 S.E.2d 295 (Ct. App. 2000), cert. granted, January 11, 2001.

XX. Punitive Damages

In this case, the Plaintiff seeks punitive damages in addition to actual damages. Punitive damages, also known as exemplary damages, are imposed as punishment. They are not intended to compensate. Punitive damages are allowed in the interest of society in the nature of punishment and as a warning and example to deter the wrongdoer and others from committing like offenses in the future. Moreover, they serve to vindicate a private right by requiring the wrongdoer to pay money to the injured party.

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Punitive damages serve at least three important purposes: punishment of the Defendant's reckless, willful, wanton, or malicious conduct; deterrence of similar future conduct by the defendant or others; and compensation for the reckless or willful invasion of the plaintiff's private rights. The paramount purpose for awarding punitive damages is not to compensate the plaintiff, but to punish and set an example for others.

What would justify an award of punitive damages? As you consider the issue of punitive damages, the highest burden of proof known to the civil law is applicable. Section 15-33-135 of the South Carolina Code provides: "In any civil action where punitive damages are claimed, the plaintiff has the burden of proving such damages by clear and convincing evidence."

Punitive damages can only be awarded where the Plaintiff proves by clear and convincing evidence the Defendant's actions were willful, wanton, malicious, or in reckless disregard of the Plaintiff's rights. A conscious failure to exercise due care constitutes willfulness. It is the present consciousness of wrongdoing that justifies the assessment of punitive damages against the wrongdoer. Punitive damages will be allowed even when the Defendant does not realize he is invading the plaintiff's rights so long as the act is committed in such a manner that a person of ordinary prudence would conclude it was done in reckless disregard of the rights of another.

The Plaintiff cannot recover punitive damages based on negligent conduct. Negligence is the doing of some act that a person of ordinary prudence would not have done under similar circumstances or failure to do what a person of ordinary prudence would have done under similar circumstances. Mere negligence will not support a punitive damages award.

To recover punitive damages, the Plaintiff must prove by clear and convincing evidence that the Defendant's actions were willful, wanton, or reckless. The words recklessness,

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willfulness, and wantonness are synonymous. The terms are used to describe a conscious failure to exercise and observe reasonable or due care.

Recklessness is distinguished from negligence. Negligence is the failure to use due care. Negligence is carelessness. Negligence is failure by omission or commission to exercise due care as a person of ordinary reason and prudence would exercise in the same circumstances.

Recklessness is a higher degree of culpability and responsibility. Recklessness signifies a conscious failure to exercise due care. Recklessness is a conscious indifference to the rights of the Plaintiff, or a reckless disregard of the rights of the Plaintiff. Recklessness is an awareness of wrongful conduct and a continuation to act regardless of consequences.

The test for determining whether a tort may be deemed reckless, willful, or wanton is whether it has been committed in such a manner and under such circumstances that a person of ordinary reason or prudence would have been conscious of it as an invasion of the rights of the injured party.

Before you can award punitive damages, you must first find the Plaintiff is entitled to actual or nominal damages. There must be an award of actual or nominal damages for a verdict of punitive damages to be supported. This rule is premised on the fact that liability must be established before a Plaintiff can seek punitive damages. Therefore, if you do not award actual or nominal damages, then you cannot award punitive damages.

There is no formula or standard that can be used as a measure for assessing punitive damages. However, factors relevant to your consideration of punitive damages are:

(1) the character of the Defendant's acts;

(2) the nature and extent of the harm to Plaintiff that Defendant caused or intended to cause;

(3) Defendant's degree of culpability;

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(4) the punishment that should be imposed;

(5) duration of the conduct;

(6) Defendant's awareness or concealment;

(7) the existence of similar past conduct;

(8) likelihood the award will deter the Defendant or others from like conduct;

(9) whether the award is reasonably related to the harm likely to result from such conduct; and

(10) Defendant's wealth or ability to pay.

The financial condition of a Defendant is a factor you should consider in awarding punitive damages. However, there is no requirement that the Defendant be a person of means before you are justified in awarding punitive damages. While the wealth of a Defendant is a relevant factor in assessing punitive damages, it is not necessarily controlling. In other words, the financial worth of a Defendant is a fact properly to be considered by you in determining the amount to be awarded as punitive damages, but evidence of net worth is not a prerequisite to a punitive damage award.

When under proper allegations a Plaintiff proves, by clear and convincing evidence, a willful, wanton, reckless, or malicious violation of his rights, it is not only the right but the duty of the jury to award punitive damages. Accordingly, if you should find that the Plaintiff is entitled to recover punitive damages in addition to actual damages, it would be your duty to include such damages in your verdict and award such an amount as you may deem reasonable and proper in light of the facts and circumstances.

See McCourt By and Through McCourt v. Abernathy, 318 S.C. 301, 309, 457 S.E.2d 603, 608 (1995) (holding "[n]owhere in *Gamble* did we require the factors to be considered in

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post-trial review of a punitive damage award be included in the jury charge."). McGee v. Bruce Hosp. Sys., 344 S.C. 466, 545 S.E.2d 286 (2001); Clark v. Cantrell, 339 S.C. 369, 529 S.E.2d 528 (2000) (purposes of punitive damages are to punish wrongdoer and deter wrongdoer and others from engaging in similar reckless, willful, wanton, or malicious conduct in the future); Taylor v. Medenica, 324 S.C. 200, 479 S.E.2d 35 (1996) (trial court is not required to make findings of fact for each factor to uphold punitive damage award); Gamble v. Stevenson, 305 S.C. 104, 406 S.E.2d 350 (1991) (to ensure that punitive damage award is proper, trial court shall conduct post-trial review and may consider the following: (1) defendant's degree of culpability; (2) duration of conduct; (3) defendant's awareness or concealment; (4) existence of similar past conduct; (5) likelihood award will deter defendant or others from like conduct; (6) whether award is reasonably related to harm likely to result from such conduct; (7) defendant's ability to pay; and (8) "other factors" deemed appropriate); *Id.* (upon completing its review, dedicated to the postulate that no award be grossly disproportionate to severity of offense, trial court shall set forth its findings on the record; amount of damages, actual or punitive, remains largely within discretion of jury, as reviewed by trial judge); Barnwell v. Barber-Colman Co., 301 S.C. 534, 393 S.E.2d 162 (1989); Graham v. Whitaker, 282 S.C. 393, 321 S.E.2d 40 (1984) (issue of punitive damages must be submitted to jury if more than one reasonable inference can be drawn from evidence as to whether defendant's behavior was reckless, willful, or wanton); Martin v. Martin, 262 S.C. 168, 203 S.E.2d 385 (1974) (test for determining whether a tort may be deemed reckless, willful or wanton is whether it has been committed in such a manner and under such circumstances that a person of ordinary reason or prudence would have been conscious of it as an invasion of the rights of the injured party); Harris v. Burnside, 261 S.C. 190, 199 S.E.2d 65 (1973); Gilbert v. Duke Power Co., 255 S.C. 495, 179 S.E.2d 720 (1971); Hicks v. Herring, 246

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S.C. 429, 144 S.E.2d 151 (1965); Carroway v. Johnson, 245 S.C. 200, 139 S.E.2d 908 (1965); Laird v. Nationwide Ins. Co., 243 S.C. 388, 134 S.E.2d 206 (1964); Norton v. Ewaskio, 241 S.C. 557, 129 S.E.2d 517 (1963); Fennell v. Littlejohn, 240 S.C. 189, 125 S.E.2d 408 (1962) (one of the chief purposes in awarding damages of this class is to punish the wrongdoer, not only to prevent by him a recurrence of the wrongful act, but to deter others from conduct of the same or similar kind); Rogers v. Florence Printing Co., 233 S.C. 567, 106 S.E.2d 258 (1958); Hicks v. McCandlish, 221 S.C. 410, 70 S.E.2d 629 (1952); Charles v. Texas Co., 199 S.C. 156, 18 S.E.2d 719 (1942) (defendant's financial ability to pay is always a factor to be considered by jury in awarding punitive damages); Sample v. Gulf Refining Co., 183 S.C. 399, 191 S.E. 209 (1937); Cook v. Atlantic Coast Line R.R., 183 S.C. 279, 190 S.E. 923 (1937) (where pleadings allege and evidence shows conscious and willful violation, invasion, or infringement of legal right, law will presume damages sufficient to sustain action, even though such damages may be only nominal and not capable of exact measurement, and in such case verdict for punitive damages without finding of actual damages will be sustained); Mellen v. Lane, 377 S.C. 261, 659 S.E.2d 236 (Ct. App. 2008); Austin v. Specialty Transp. Services, Inc., 358 S.C. 298, 594 S.E.2d 867 (Ct. App. 2004); Welch v. Epstein, 342 S.C. 279, 536 S.E.2d 408 (Ct. App. 2000) (issue of punitive damages must be submitted to jury if more than one reasonable inference can be drawn from evidence as to whether defendant's behavior was reckless, willful, or wanton); Scott v. Porter, 340 S.C. 158, 530 S.E.2d 389 (Ct. App. 2000) (amount of punitive damages awarded is largely within jury's discretion, though reviewable by trial judge; trial judge is not required to make findings of fact for each factor to uphold punitive damages award).

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XXI. Punitive Damages – Negligence Actions

The Plaintiff claims that the Defendant acted with recklessness, willfulness, and wantonness and that, therefore, the Plaintiff is entitled to punitive damages from the Defendant. Recklessness means a conscious failure to use reasonable care. A person who is negligent acts carelessly. However, a person who acts recklessly, willfully, and wantonly is not only careless, but is also aware that he or she is being careless.

See Parker v. Simmons, 163 S.C. 42, 161 S.E. 169 (1931).

XXII. Act of God

The Defendant claims that the Plaintiff's injuries were caused by an Act of God. An Act of God is an unusual, extraordinary, sudden, and unexpected demonstration of the forces of nature. It is an event in nature that is so extraordinary that the history of variations in the climate and other conditions in the particular locality would provide no reasonable warning of the event.

An Act of God is one caused solely by the violence of nature. If you find that the damage was caused in part by the participation of man, either from active intervention, neglect, or failure to act, the act is not an Act of God.

See Funderburke v. Johnson, 253 S.C. 430, 171 S.E.2d 597 (1969); Belue v. City of Greenville, 226 S.C. 192, 84 S.E.2d 631 (1954); Belue v. City of Greenville, 226 S.C. 192, 84 S.E.2d 631 (1954); Morgan v. Greenville County, 189 S.C. 368, 1 S.E.2d 144 (1939).

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GRUENLOH LAW FIRM
Counsel for the Plaintiff

By: _____

Wm. M. Gruenloh, SCBAR #12418
Brian R. Holmes, SCBAR # 102052
Patrick Aulton Chisum, SCBAR # 100571
192 E. Bay Street, Suite 202
Charleston, South Carolina 29401
(843) 577-0027
(843) 577-0721 (facsimile)

Date: August 24, 2015
Charleston, South Carolina

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Provider	Date	Procedure	Notes	Amount	Subtotal	Total
Nason Medical Center	6/10/11	Office/outpatient visit		$ 206.00		
		X-ray Exam Knee		$ 77.00		
		Ct scan, cervical spine, w/o contrast		$ 785.00		
		Ct Scan, Head/Brain, w/o contrast		$ 575.00		
		Ct Scan, maxiflofacial, w/o costrast		$ 710.00		
					$ 2,353.00	
Carolina Radiology						
Assocaites, LLC	6/10/11	Radex KNE Compl		$62.00		
	6/10/11	CT Head/BRN C-Matrl		$248.00		
	6/10/11	CT CRV SPI C-MATRL		$289.00		
	6/20/11	CT MAXLFCL		$289.00		
					$888.00	
Thcobold Family Chiro	6/15/11	Spine entire a/p LAT		$ 65.00		
		Typ. Prob. Roc.		$ 15.00		
		Paraspinal Images		$ 30.00		
		Spnl Adjstmt 3-4 area		$ 35.00		
	6/17/11	Spnl Adjstmt 3-4 area		$ 35.00		
	6/22/11	Spnl Adjstmt 3-4 area		$ 35.00		
	6/27/11	Spnl Adjstmt 3-4 area		$ 35.00		
	7/1/11	Spnl Adjstmt 3-4 area		$ 35.00		
	7/12/11	Spnl Adjstmt 3-4 area		$ 35.00		
	7/15/11	Spnl Adjstmt 3-4 area		$ 35.00		
	7/19/11	Spnl Adjstmt 3-4 area		$ 35.00		
	7/22/11	Spnl Adjstmt 3-4 area		$ 35.00		
	7/29/11	Spnl Adjstmt 3-4 area		$ 35.00		
	8/2/11	Spnl Adjstmt 3-4 area		$ 35.00		
	8/9/11	Spnl Adjstmt 3-4 area		$ 35.00		
	8/17/11	Spinal adjustment(s)		$ 25.00		
	6/17/13	Spnl Adjstmt 3-4 area		$ 35.00		
	6/19/13	Spnl Adjstmt 3-4 area		$ 35.00		
	6/25/13	Spnl Adjstmt 3-4 area		$ 35.00		
	6/27/13	Spnl Adjstmt 3-4 area		$ 35.00		
	7/25/13	Spnl Adjstmt 3-4 area		$ 35.00		
	7/31/13	Spnl Adjstmt 3-4 area		$ 35.00		
	8/2/13	Spnl Adjstmt 3-4 area		$ 35.00		
	8/6/13	Spnl Adjstmt 3-4 area		$ 35.00		
	9/25/13	Spnl Adjstmt 3-4 area		$ 35.00		
	10/2/13	Spnl Adjstmt 3-4 area		$ 35.00		
	9/25/13	Spnl Adjstmt 3-4 area		$ 35.00		
	11/8/13	Spnl Adjstmt 3-4 area		$ 35.00		
	11/15/13	Spnl Adjstmt 3-4 area		$ 35.00		
	11/21/13	Spnl Adjstmt 3-4 area		$ 35.00		
	1/31/14	Spnl Adjstmt 3-4 area		$ 35.00		
					$ 1,080.00	
Charleston ENT Associates	4/10/13	Dr. Ghegan - 1317233U		$146.00		
	4/10/13	CT Scan		$553.00		
	4/30/13	Dr. Hester - 1325104U		$542.00		
	6/10/13	Dr. Ghegan - 10002871611U		$20.00		
	6/30/14	CT Scan		$553.00		
	7/14/14	Dr. Dozier - 1584079U		$353.00		
	7/23/14	CT Scan		$553.00		
					$2,720.00	
Thomas Funcik	6/6/11	Estabilish Comprehensive		$151.60		
		Emergency work in		$100.00		
	12/6/11	Established Comprehensive		$151.60		
		Exc. trnk, arm, leg .6 - 1.0 cm		$149.00		
		Exc. trnk, arm, leg 1.1 - 2.0 cm		$165.00		
		Exc. Lesion 2.1 to 3.0		$190.50		
		Ex. face, ear, el, nose, lip .6 - 1.0		$250.00		
		Ex. face, ear, el nose, lip .6 - 1.0		$250.00		
		Medical Supplies		$100.00		
		Procedure Tray		$50.00		
Coastal Fiacial Plastic Surgery	8/24/11	Open Reduction of Nasal Fracture		$2,846.00		
		Prvate Surgical Suite & Anesthesia Service & Supplies		$1,800.00		
					$6,203.70	
						$ 13,244.70

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Charleston ENT Associates, L.L.C.
EAR-NOSE-THROAT-HEAD AND NECK SURGERY
PLASTIC AND RECONSTRUCTIVE SURGERY
180 Wingo Way, Suite 103, Mt. Pleasant, SC 29464
Phone (843) 216-8774 Fax (843) 216-8779

Edward G. Behrens, M.D., Ph.D.
Eugene G. Brown, III, R.Ph., M.D.
Thomas S. Dozier, M.D.
Mark D. Ghegan, M.D.
T. Oma Hester, M.D., F.A.C.S.
Edward L. McNellis, R.Ph., M.D.
Ronald J. McVicar, D.O., F.A.C.S.
Keith A. Meetze, M.D.
Michael C. Noone, M.D.
Matthew D. Scarlett, M.D.
C. Willy Schwenzfeier, M.D., F.A.C.S.
Shaun N. Scott, M.D.
Erik R. Swanson, M.D.

Anna Maria Kammeyer, PA-C
S. Blair Brewer, PA-C
Roxanne E. Hall, PA-C

Natalie M. Bickley, AuD, CCC-A
Salley B. Davidson, M. AuD., CCC-A
Melissa A. Franklin, M.A., CCC-A
Kati Hinrichsen, AuD., CCC-A
Vanhphenh (Penny) S. Leong, M.S., CCC-A
Brittany C. Milligan, AuD., CCC-A
Karen M. Moore, AuD., CCC-A, F-AAA
Emily C. Pastore, AuD., CCC-A

April 4, 2013

Patient: **Rosemary Connelly**
DOB: REDACTED
Chart#:

I had the pleasure of seeing **ROSEMARY CONNELLY** in the clinic today. She is a 57-year-old who presents with chief complaint of decreased sense of smell and taste.

History of Present Illness: She states she has noticed it for the past six months but feels like it may have been present for the past couple of years. She states that she broke her nose and had a concussion from a fairly significant fall about two years ago. She did have repair of the nasal bone fracture with Dr. Funcik. She feels like that may have been when her symptoms of decreased smell started. She states she uses a little spearmint oil under her nose which seems to help with mild nasal congestion that she has had. She does not feel like she has much trouble with allergies.

Please see the Patient History and Review of Systems form for the patient's past medical history, prior hospitalizations and surgeries, family history, social history, review of systems, and current medications. This form is reviewed in detail with the patient.

Physical Examination:

General:	The patient is pleasant and cooperative with examination.
Ears:	Ear canals are clear bilaterally. Tympanic membranes are translucent and mobile.
Nose:	There is a mild septal deviation and mild inferior turbinate hypertrophy, but without active inflammation or evidence of acute purulent drainage. Mucosa is pink and moist.
Throat:	Oral cavity/oropharyngeal exam reveals no mucosal lesions or masses. Uvula is midline. Palate is symmetric.
Neck:	Neck is supple. There are no palpable masses or lesions.
Lymphatics:	There is no evidence of cervical adenopathy.
Psychiatric:	The patient is alert and oriented.
Head:	Head is normocephalic, atraumatic with symmetric facial movements. Inspection of the skin reveals no suspicious lesions, masses, or scars.
Neurologic:	Cranial nerves are grossly intact.
Eyes:	Extraocular movements are intact. Pupils are equal, round and reactive to light and

Exhibit F

accommodation.

Radiograph:
CT scan of the sinuses is obtained given her decreased sense of smell to look for a conductive component. The septum is relatively midline. There is moderate to severe inferior turbinate hypertrophy but the paranasal sinuses, including the ethmoids, are clear.

Impression:
1. Anosmia.
2. Turbinate hypertrophy.

Recommendations:
I have given her a sample of nasal steroid spray to see if that will help with the turbinate hypertrophy and help her nasal airway. We discussed that I think most likely her decreased sense of smell, and subsequent decreased taste, are result of the trauma a couple of years ago. We also discussed that it could be a viral etiology as well. We discussed the likelihood off fully recovering is low since it has been a while since her symptoms began. She will let us know if the symptoms get worse and we can discuss the possibility of additional imaging studies such as an MRI scan to rule out an intracranial process, but she would like to hold off on that for now.

Mark D. Ghegan, M.D.
MDG/kls

Exhibit F

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Emily C. Pastore, AuD., CCC-A

April 26, 2013

Patient: **Rosemary Connelly**
DOB: REDACTED
Chart#:

I had the pleasure of meeting **ROSEMARY CONNELLY** in the clinic today, with a chief complaint of smell and taste dysfunction.

History of Present Illness:
The patient presents, today, for a second opinion regarding decreased smell and taste. She relates this primarily to a fall she had on 06/03/2011. She was jogging around a construction site in the Daniel Island area and tripped on some type of debris. She ended up fracturing her nose and had bloody nasal discharge, but no loss of consciousness. She saw a plastic surgeon that day and, 4 months later, underwent repair of her nasal fracture. Eight months ago, she began to notice that she did not have a good sense of taste or smell. She says she can sense a little bit of salty taste and some sweet taste, but otherwise, she does not feel like she has any taste. Everything seems to be bland. She denies any URI or other closed-head injuries in association with this sense of anosmia and dysgeusia 8 months ago. She denies any prior similar episodes. She was recently seen and evaluated by Dr. Ghegan and had a CT scan of her sinuses done. This showed evidence of turbinate hypertrophy, but clear paranasal sinuses. I did review this imaging, today, as well.

Please see the Patient History and Review of Systems form for the patient's past medical history, prior hospitalizations and surgeries, family history, social history, review of systems, and current medications. This form was reviewed in detail with the patient.

Physical Examination:
General: The patient is pleasant and cooperative with examination.
Ears: Ear canals are clear bilaterally. Tympanic membranes are translucent and mobile.
Nose: There is a mild septal deviation, with mild inferior turbinate hypertrophy. No purulence or polyposis is noted. Mucosa is generally pink and moist. See procedure note below.

Exhibit F

Throat:	Oral cavity and oropharynx exams reveal no mucosal lesions or masses. Uvula is midline. Palate is symmetric.
Neck:	Neck is supple. There are no palpable masses or lesions.
Lymphatics:	There is no evidence of cervical adenopathy.
Psychiatric:	The patient is alert and oriented.
Head:	Head is normocephalic and atraumatic. Inspection of the skin reveals no suspicious lesions, masses, or scars.
Neurologic:	Cranial nerves II-XII are grossly intact.
Eyes:	Extraocular movements are intact, without nystagmus. Pupils are equal, round, and reactive to light.

Procedure:
Diagnostic endoscopy was performed today, after topical anesthesia and decongestion, with a zero-degree endoscope. This revealed some persistent congestion of the mucosa throughout the nasal passage, but nothing that appeared to be significantly obstructing superiorly, and no polyps or purulence was noted.

Impression:
1. Anosmia.
2. Dysgeusia.
3. Turbinate hypertrophy.

Recommendations:
The patient would like to proceed with an MRI, which was discussed previously. I think that is appropriate. We will go ahead and get that scheduled and will contact her with the results. The identification of the taste and smell disturbance was only 8 months ago, which certainly leaves the question of the possibility of some return of function. If, however, the onset of this was actually related to the trauma, then, at this point, I would not expect a recovery. We will contact her with the results of the MRI as noted.

T. Oma Hester, M.D., F.A.C.S.
TOH/kns

Exhibit F

Charleston ent
Ear, Nose & Throat

Patient: Rosemary H. Connelly
DOB: REDACTED
Chart#:

06/26/2014 I saw **ROSEMARY CONNELLY** back in followup today regarding chief complaint of decreased smell and taste. **HISTORY OF PRESENT ILLNESS:** She states that about three years ago, she was running on Daniel Island, tripped on some construction debris, fell, and hit her shoulder and face. She suffered a nasal fracture and several months later underwent a rhinoplasty to correct it. Her main complaint now is the decrease of smell and taste. This has been going on for two years. She has seen Dr. Ghegan and Dr. Hester in our practice for evaluation. She states she can smell very strong smells such as ammonia and occasional curry will give her some stimulation of a taste sensation, but in general she has significant difficulties smelling, and this has been present for quite some time. She has been having nasal congestion, facial pressure, dental pain, and a foul odor in her nose. She has been treated with two rounds of oral antibiotics recently. She does not use any allergy medications and has not generally felt like she had significant allergies. Review of the ENT and allergy systems is otherwise negative. **EXAM:** ***General:*** The patient is pleasant and cooperative with examination. ***Ears:*** Ear canals are clear bilaterally. Tympanic membranes are translucent and mobile. ***Nose:*** See nasal endoscopy below. ***Throat:*** Oral cavity exam reveals no mucosal lesions or masses. ***Neck:*** Neck is supple. There are no palpable masses or lesions. No thyromegaly detected. ***Lymphatics:*** There is no evidence of cervical adenopathy. ***Head:*** Head is normocephalic, atraumatic, with symmetrical facial movements. **PROCEDURE:** The nose is decongested and anesthetized and a flexible nasal endoscopy is performed. There is mucosal edema and hyperemia but no active mucopurulence. There are no mucosal masses or crusting on the right side to explain the foul odor. **RADIOGRAPHS:** A CT scan of the sinuses is performed which shows clear paranasal sinuses with no evidence of intranasal masses or obvious skull base fractures. She does have significant inferior turbinate hypertrophy on the scan. **ASSESSMENT:** (1) Anosmia and dysgeusia. (2) No evidence of sinusitis on CT scan. (3) Nasal obstruction, facial pressure, and dental pain. **PLAN:** I have discussed with the patient that I think she may have developed some allergies. I would like to try her on some Mupirocin nasal spray, and I would like to get her set up for an allergy skin test. Based on the results, we will make some recommendations. I am thinking that her turbinate hypertrophy is so severe that she may have drying of normal nasal secretions leading to the foul odor and that perhaps the Mupirocin spray will change the bacterial milieu of her nasal cavity and hopefully alleviate these symptoms.

TSDozier

Thomas S. Dozier, M.D.
TSD/krc

cc: Thomas Funcik, M.D.
Jennifer Pullano, M.D.

PATIENT NOTE

NAME: Rosemary Connelly
DATE: 05/28/13

Rosemary came in today for Dysport and Restylane. She mentioned that she has had hyposmia since her injury. When I saw her, it was a couple of days after her injury, and she denied loss of consciousness. She has seen a couple of ENTs to document this. They did an examination of the upper cribriform plate area with vasoconstriction to rule out sinus tumor, etc. They suggested possibly an MRI if it persists or worsens to rule out a tumor in this area.

Using an artificial skull as a teaching aid, I explained to Rosemary the anatomy of the cribriform plate and explained how a frontal injury may sometimes result in some disruption in some of the branches of the olfactory nerve.

Thomas Funcik, M.D.

TF/ppi

Exhibit G

CONNELLY & VOGELZANG LLC
LAW OFFICES IN: CHICAGO, ILLINOIS | CHARLESTON, SOUTH CAROLINA
FIRM LICENSED IN AZ, IL, MO, SC, TX, WI, WV

June 7, 2011

VIA FACSIMILE (843) 856-1874 & EMAIL: winsor@winsorcustomhomes.com
The Office of Winsor South, LLC
Winsor Custom Homes, LLC
234 Seven Farms Dr., Ste. 201-C
Daniel Island, SC 29492

RE: house construction at REDACTED

To whom it may concern,

My client fell on the sidewalk on 6/6/2011 in front of this construction site due to the dangerous conditions which as of this morning still exists. Your company still has dangerous debris on the pedestrian walk. She may have a broken nose. She has multiply cuts and abrasions to her face, arms, and shoulder and is currently under a doctor's care.

Please have your attorney call me at 843-REDACTE Should I not hear from you, I will assume you prefer the more formal route of filing a complaint at law. Regardless, please promptly make the pedestrian walk safe from all your construction debris so another person is not injured.

Also, please advise Karen Nelson, John Edelen, Clark Design Group and Daniel Island Reality of my accusation against the owners and agents of this property. I informed Daniel Island Reality this morning of the conditions since this is the only phone number listed on the only construction sign on the property.

Sincerely,

William M. Connelly

William M. Connelly

WMC/lm

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON	)	CASE NO.: 2013-CP-10-3251
ROSEMARY CONNELLY,	)	
Plaintiff,	)	**PLAINTIFF'S MEMORANDUM IN OPPOSITION TO DEFENDANT'S POST-TRIAL MOTIONS FOR: (1) JNOV; OR (2) NEW TRIAL ABSOLUTE; OR (3) NEW TRIAL *NISI* REMITTITUR**
v.	)	
WINSOR CUSTOM HOMES, LLC,	)	
Defendant.	)	

FILED
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CHARLESTON COUNTY

TO: THE HONORABLE J.C. NICHOLSON, JR., presiding circuit judge, and Defendant WINSOR CUSTOM HOMES, LLC, by and through its attorneys of record STEPHEN L. BROWN, ESQUIRE, and RUSSELL G. HINES, ESQUIRE, both of YOUNG CLEMENT RIVERS, LLP.

COMES NOW the Plaintiff, Rosemary Connelly (hereinafter "Plaintiff"), by and through her undersigned counsel, who respectfully submits this memorandum in opposition to Defendant Winsor Custom Homes, LLC's (hereinafter "Defendant") Post-Trial Motions for (1) JNOV or (2) New Trial Absolute, or (3) New Trial *Nisi* Remittitur. For the reasons set forth herein, Defendant's motions should be denied.

FACTS AND PROCEDURAL HISTORY

This case arises out of an incident that occurred on Monday, June 6, 2011, on the public sidewalk adjacent to REDACTED Street, Daniel Island, South Carolina REDACTED (hereinafter the "Premises"). On that date, Defendant was serving as the general contractor for the purposes of constructing a home located on the Premises on behalf of Karen Nelson and John Edelen (hereinafter collectively the "Owners"). In the due course of conducting its construction activities on the Premises, Defendant erected a black plastic barrier fence (hereinafter "the Fence"), also known as a silt fence, around the perimeter of the construction site. The purpose of the Fence was, at least in part, to keep construction debris from encroaching onto the public

sidewalk and the property of others. Defendant did not properly maintain the Fence, and on June 6, 2011 the Fence was not properly secured and was in a state of disrepair.

On June 6, 2011 at approximately 9:15 am, Plaintiff was jogging down the sidewalk on Daniel Island with her friend, Ms. Cori Smith (hereinafter "Smith"). Plaintiff and Smith's route took them past the Premises, and, while passing the construction site, a gust of wind caught the Fence and caused it to suddenly and unexpectedly encroach onto the sidewalk. The Fence entangled Plaintiff's leg, causing her to fall head first onto the ground. As a result of her fall, Plaintiff sustained severe injuries including a broken nose; injuries to her back and neck; abrasions to the skin on her nose and forehead; a concussion; and, most notably, a loss of her senses of smell (anosmia) and taste (dysgeusia).

On June 4, 2013, Mrs. Connelly filed a complaint with regards to the June 6, 2011 incident against Defendant, the Owners, Clarke Design Group, LLC, and the Daniel Island Company, Inc. All parties other than Defendant settled out of court prior to trial, leaving Defendant as the sole defendant remaining in this action. The case was set for a date-certain trial during the term of court beginning Monday, August 24, 2015.

On August 24, 2015, the Court heard pre-trial motions by Defendant regarding the expert qualification of Dr. Thomas Funcik and Dr. Mark Ghegan, two of Plaintiff's treating physicians, and their ability to testify as to the cause of Plaintiff's anosmia and dysgeusia. The Court ruled in favor of Plaintiff on both pre-trial motions and held that both doctors were qualified to testify as to the cause of Plaintiff' anosmia and dysgeusia. Both doctors were unavailable to testify at trial, and as such their *de bene esse* depositions were taken and videotaped the week prior pursuant to Rule 30(I) of the South Carolina rules of Civil Procedure. A list of necessary edits was made by Plaintiff's counsel and submitted to Defendant's counsel the night of August 24, 2015.

Defendant's counsel had the opportunity to review the list of proposed edits and lodged no objection to the proposed edits. At trial, both videotaped depositions were played in their entirety subject to the agreed upon list of edits.

During the course of the trial, Defendant made two motions to declare a mistrial regarding the subject of insurance being raised in the presence of the jury. The first motion was made in response to Plaintiff's testimony regarding correspondence that was sent by her husband to Defendant following the June 6, 2011 incident. In this correspondence, Plaintiff's husband inquired as to whether or not Defendant possessed any liability insurance coverage that may be relevant to the June 6, 2011 incident.[1] See Exhibit A, Defendants Proposed Trial Exhibit Number 1. When directly questioned by Defendant's counsel during cross-examination, Plaintiff testified that her husband had sent the correspondence and enquired whether or not Defendant had insurance. The specific question asked was if the correspondence was a legal claim – to which the Plaintiff replied something to the effect of – I don't think it's a legal claim, I think what is happening is that he is asking whether there is insurance. Significantly, it was never mentioned that Defendant did or did not have insurance. In response to this testimony, Defendant immediately moved for a mistrial. The Court denied Defendant's motion and ruled that the mention of insurance was merely inadvertent. Defendant declined to have the Court read a curative instruction to the jury at this time.

[1] Defendants had previously marked as an exhibit the correspondence between Plaintiff's husband and Jeff Thomas. The correspondence contains a letter, an email (which attached the letter) and a series of replies. Plaintiff objected to the exhibit prior to trial and Defendant withdrew the correspondence from its exhibit list. No further discussion was had about this correspondence by counsel nor was any reference made to this correspondence at trial until Defendant questioned Plaintiff on the correspondence during cross-examination in an apparent attempt to show the jury that Plaintiff's husband is a lawyer and that he immediately made a claim for Plaintiff when she was injured.

Defendant's second motion for mistral occurred during the playing of Dr. Funcik's videotaped deposition. In the deposition, Dr. Funcik makes an oblique reference to Plaintiff's health insurance coverage. Upon this portion of the videotape being played to the jury, Defendant immediately moved for a mistrial on the grounds of raising the subject of insurance in the presence of the jury.[2] The Court denied Defendant's motion and proceeded to provide a curative instruction to the jury regarding the subject of insurance.

At the close of both the Plaintiff's case and the Defendant's case, Defendant moved for a directed verdict. The court denied both of Defendant's motions for directed verdict. At the close of Defendant's case, Plaintiff moved for a directed verdict on the subject of negligence. During trial, Defendant's corporate representative, Jeffrey Thomas (hereinafter "Thomas"), admitted: (1) the Fence was erected by the Defendant, (2) it was Defendant's sole duty to maintain the Fence, (3) he was aware that his own workers often walked across the Fence causing it to come down, (4) it was foreseeable that the fence could become airborne in the wind if allowed to become detached from its stakes, (5) he had received warnings prior to the accident that the fence was in disrepair, and (6) that the Fence was in a state of severe disrepair on the date of June 6, 2011. Defendant brought no witnesses to rebut any of these admissions. The Court partially granted Plaintiff's motion for directed verdict as to negligence, holding that Defendant had not provided any evidence to rebut the presumption that Defendant had a duty to maintain the Fence and, in allowing the fence to fall into a state of disrepair on June 6, 2011, breached that duty.

The Plaintiff initially provided the Court with instructions regarding both general negligence principles and premises liability principles. The Defendant initially only provided the

[2] Defendants made this motion despite the fact that, in advance of the testimony being played for the jury, Defendants knew every line of testimony that would be played and agreed to Plaintiff's proposed edits. At no time prior to the video being played did Defendants raise this issue or any similar objection.

Court with proposed jury instructions regarding general negligence principles. Prior to the jury being charged, Plaintiff withdrew its proposed jury instructions as to premises liability, and Defendant withdrew its proposed jury instructions on general negligence principles and set forth proposed jury instructions regarding premises liability principles. Following closing arguments, Defendant contended that the jury should be instructed only on premises liability principles as they were the only potential viable theory of liability under which Plaintiff could proceed. The Court, in its discretion, elected to apply general negligence principles and instructed the jury accordingly.

The trial concluded on Friday, August 28, 2015 with the jury entering a verdict in favor of Plaintiff. The jury found Plaintiff's damages to be in the amount of Five-Hundred Thousand Dollars ($500,000.00). The jury also determined that Plaintiff was comparatively negligent and reduced its award by Thirty-Five Percent (35.00%). The Court thereafter announced a judgment against the Defendant in an amount of Three-Hundred Twenty-Five Thousand Dollars ($325,000.00).

Defendant filed its Post-Trial Motions for (1) JNOV or (2) New Trial Absolute, or (3) New Trial *Nisi* Remittitur on September 8, 2015; these motions are the subject of this memorandum.

ARGUMENT

Defendant makes three different post-trial motions, presented in the alternative and in descending order of Defendant's preference. First and primarily, Defendant makes a motion for JNOV/judgment as a matter of law. Should the Court deny Defendant's primary motion, Defendant moves for a new trial absolute. Finally, Defendant contends that should the Court

deny both of the aforementioned motions, Defendant moves for a new trial *nisi* remittitur. Plaintiff will address each of these motions in turn.

Additionally, Defendant informally moves in footnote two of its post-trial motions for the Court to alter, amend, and/or reconsider any of its applicable rulings pursuant to Rule 59(e) of the South Carolina Rules of Civil Procedure. However, Defendant has failed to successfully identify any abuse of discretion by the Court on any specific ruling during the course of the trial and so any argument under Rule 59(e) must be denied.

I. Defendant's Post-Trial Motion for JNOV/Judgment as a Matter of Law.

Defendant asserts in its post-trial motion that it is entitled to JNOV/judgment as a matter of law on various alternative grounds. The crux of Defendant's argument is that Defendant owed no duty to the Plaintiff. As a second argument, the Defendant asserts that Plaintiff could not possibly be found to bear less than Fifty-One Percent (51.00%) of the fault for the June 6, 2011 incident due to the open and obvious nature of the Fence and its condition. Plaintiff addresses each of these arguments in turn.

a. Standard of Review

In ruling on a JNOV motion or motion for new trial absolute, the trial court is required to view the evidence and the inferences that reasonably can be drawn therefrom in the light most favorable to the non-moving party. Law v. S.C. Dept. of Corrections, 368 S.C. 424, 434, 629 S.E.2d 642, 648 (2006); Swicegood v. Lott, 379 S.C. 346, 351, 665 S.E.2d 211, 213 (Ct. App. 2008); Israel v. Carolina Bar-B-Que, Inc., 292 S.C. 282, 287, 356 S.E.2d 123, 127 (Ct. App. 1987). The court must deny the motion for JNOV when the evidence yields more than one inference or its inference is in doubt. Id.; Steinke v. South Carolina Dep't of Labor, Licensing, &

Regulation, 336 S.C. 373, 386, 520 S.E.2d 142, 148 (1999). The jury's verdict may not be overturned if any evidence sustains the factual findings implicit in its decision. Welch v. Epstein, 342 S.C. 279, 300, 536 S.W.2d 408, 419 (Ct. App. 2000); Smalls v. South Carolina Dep't of Educ., 339 S.C. 208, 215, 528 S.E.2d 682, 686 (Ct. App. 2000). A new trial is warranted only if the trial court determines that the verdict is contrary to the fair preponderance of the evidence. *See* Dent v. Redd, 270 S.C. 585, 243 S.E.2d 460 (1978).

b. Defendant owed Plaintiff a duty of care to properly maintain the Fence.

As set forth above, the Court, in its discretion, elected to instruct the jury to utilize general negligence principles in its deliberations of this matter. Defendant contends that Plaintiff failed to establish that Defendant owed Plaintiff a duty of care under general negligence principles.[3]

"An essential element in a cause of action for negligence is the existence of a legal duty of care owed by the defendant to the plaintiff." Bishop v. S.C. Dep't of Mental Health, 331 S.C. 79, 86, 502 S.E.2d 78, 81 (1998). The duty of care is that standard of conduct the law requires of an actor to protect others against the risk of harm from his actions. Carter v. R.L. Jordan Oil Co., 294 S.C. 435, 444, 365 S.E.2d 324, 329 (Ct.App.1988), *rev'd on other grounds,* 299 S.C. 439, 385 S.E.2d 820 (1989). This common law duty of due care includes the duty to avoid damage or injury to foreseeable plaintiffs. Dorrell v. South Carolina Dept. of Transp., 361 S.C. 312, 318, 605 S.E.2d 12, 15 (2004) (*citing* Terlinde v. J.F. Neely, Sr., 275 S.C. 395, 399, 271 S.E.2d 768, 770 (1980) (stating that the "key inquiry" in determining whether to impose liability is "foreseeability, not privity"). "The tortfeasor's liability . . . rests upon the tortfeasor's duty to

[3] In so arguing, Defendant states that it may owe a duty to Plaintiff as it pertains to the maintenance of the Fence under premises liability principles, but that this duty does not exist under general negligence principles.

exercise due care." Dorrell, 361 S.C. at 318, 605 S.E.2d at 15 (2004) (*citing* Barker v. Sauls, 289 S.C. 121, 122, 345 S.E.2d 244, 244 (1986)). The common law duty of care may be appropriately applied to general negligence principles and is not strictly limited in its application to premises liability principles. McKissick v. J.F. Cleckley & Co., 325 S.C. 327, 345, 479 S.E.2d 67, 76 (Ct. App. 1996) (stating that it was proper for the trial judge to charge the jury with the elements of common law negligence to determine whether a paving company negligently performed its work, indicating that the paving company owed a duty of care based in common law).

Defendant's corporate representative admitted that Defendant was responsible for the Fence. Plaintiff provided evidence at trial that the Fence was down and in a significant state of disrepair on June 6, 2011. Plaintiff also provided evidence that Defendant knew or reasonably should have known that the Fence was down and in a significant state of disrepair. Defendant admitted that it was aware that the Fence material could become airborne if it was detached from its stakes. Defendant admitted that the most likely cause of the Fence coming down was its own workers and subcontractors using the Fence as a shortcut to enter onto the site. Finally, Defendant admitted that it had received warnings prior to the accident from the Daniel Island Architectural Review Board regarding the disrepair of the Fence and the failure to provide a construction entrance onto the site.

Defendant failed to rebut any of this. As such, Plaintiff met its burden in proving that Defendant was responsible for the Fence, was aware of the condition of the Fence, and that incidents such as the one that occurred on June 6, 2011 were foreseeable. Reviewing these facts in the light most favorable to the Plaintiff, sufficient evidence was set forth at trial to establish that the Defendant possessed a common law duty of due care to the Plaintiff. Furthermore, it is appropriate for this common law duty to be applied to the general negligence principles applied

by the Court at trial. As such, Defendant's Motion for JNOV/Judgment as a Matter of Law should be denied.

c. The jury's determination of comparative negligence was appropriate and Plaintiff's recovery is not barred.

Defendant further contends that it should be granted a JNOV/judgment as a matter of law as Plaintiff could not be found to be less than Fifty-One Percent (51.00%) at fault for the June 6, 2011 incident. In support of this assertion, Defendant states that the condition of the Fence was open and obvious, and as such Plaintiff was negligent for jogging near the Fence and is therefore more responsible than Defendant for the June 6, 2011 incident.

A pedestrian has the legal right to assume that public streets and sidewalks are in a safe condition. Harrison v. Gallivan Const. Co., 188 S.C. 304, 304 199 S.E. 307, 309 (1938) (sufficient question of fact existed to submit defendant contractor's actionable negligence to the jury after boards were placed across a public sidewalk to aid the passage of construction trucks). No duty is imposed on a member of the general public to examine a public street or sidewalk to see if there is a defect or obstruction therein. *See* Id. However, should a member of the general public fail to observe ordinary care in avoiding a known danger, they may be held to be comparatively negligent. *See* Id. (while the principles are virtually identical, this case discusses the obsolete standard of contributory negligence that South Carolina courts have phased out in favor of comparative negligence).

It is well settled in South Carolina law that comparison of the plaintiff's negligence with that of the defendant is a question of fact for the jury to decide. Creech v. South Carolina Wildlife and Marine Resources Dep't, 328 S.C. 24, 32, 491 S.E.2d 571, 575 (1997); *accord* Brown v. Smalls, 325 S.C. 547, 481 S.E.2d 444 (Ct. App. 1997). In a comparative negligence

case, the trial court should only determine judgment as a matter of law if the sole reasonable inference that may be drawn from the evidence is that the plaintiff's negligence exceeded fifty percent. Creech, 328 S.C. at 33, 491 S.E.2d at 575 (discussing directed verdict standard); *see also* Hopson v. Clary, 321 S.C. 312, 314, 468 S.E.2d 305, 307 (Ct. App. 1996) ("If the evidence as a whole is susceptible to only one reasonable inference, no jury issue is created" and a directed verdict motion is properly granted). Therefore, granting a motion for JNOV/judgment as a matter of law is generally not appropriate in a comparative negligence case. *See* Bloom v. Ravoira, 339 S.C. 417, 422, 529 S.E.2d 710, 713 (2000) (stating that summary judgment is normally inappropriate in a comparative negligence case).

In the instant case and viewing the evidence set forth at trial in a light most favorable to the Plaintiff, sufficient facts have been established to indicate that Defendant was more than Fifty-One Percent (51.00%) at fault for the June 6, 2011 incident. At trial, Plaintiff testified that, although she had seen the Fence on occasion prior to the incident, she could not specifically recall what condition she observed it in. Plaintiff testified that she was not familiar with silt fences, their construction, or the fact that an unsecured silt fence could catch the wind and become airborne. Plaintiff and Smith testified that they were not distracted at the time of the accident, were watching where they were running, and ran to the outer side of the sidewalk as they passed the partially downed Fence. They testified that the movement of the Fence in the wind as they approached it was very minimal and that the Fence moved suddenly and abruptly, ensnaring Plaintiff's foot just as they were passing. While Plaintiff testified that she saw the Fence in disrepair and slightly fluttering in the breeze before jogging past it, she lacked the necessary knowledge to understand just how serious a hazard the Fence posed to pedestrians on the sidewalk – specifically that it could be come airborne and ensnare her foot as she passed by.

Defendant failed to elicit any facts at trial to rebut Plaintiff's testimony regarding her knowledge of the Fence, the condition of the Fence, or even the general weather conditions on June 6, 2011. In short, Defendant offered no evidence of the Plaintiff's fault aside from the simple fact that she was jogging on the sidewalk and fell. Comparatively, Defendant admitted that he had knowledge that the Fence could become airborne, was aware of silt fences coming down, was aware that his workers were responsible for bring down the Fence, and the Fence was down prior to the accident – all of which is information that the Plaintiff did not have.

The question of comparative negligence was properly submitted to the jury for their deliberations. The jury received instructions from the Court on both comparative negligence and open and obvious danger. The jury form which was submitted to the jury required the jury to determine the percentage fault that Plaintiff bore for the incident due to her own negligence, and the jury determined that she was Thirty-Five Percent (35.00%) responsible for the June 6, 2011 incident. As such, the jury had all the information needed to properly make their own determination as to who was more than Fifty-One Percent (51.00%) at fault for the June 6, 2011 incident, and Defendant's Motion for JNOV/Judgment as a Matter of Law should be denied.[4]

II. Defendant's Post-Trial Motion for New Trial Absolute.

Defendant argues that, should the Court deny its Post-Trial Motion for JNOV/Judgment as a Matter of Law, it should instead grant a new trial absolute for various reasons. First and foremost, Defendant contends that a new trial is appropriate as the jury's verdict in this case was "shockingly excessive." Additionally, Defendant asserts that the evidence presented at trial does

[4] While there is ample evidence of the Defendant's comparatively greater knowledge of the danger the Fence presented and the reasonable precautions Plaintiff took to avoid the accident – there was precious little evidence presented of Plaintiff's fault other than the fact that she was jogging on the sidewalk and fell. Given the weight of the evidence, if any change is made to the jury's determination it ought to be a reduction of Plaintiff's fault.

not justify the verdict and therefore the Court should exercise the thirteenth juror doctrine. Additionally, Defendant asks the Court to grant a new trial or, in the alternative to alter, amend, and/or reconsider, based upon its rulings at trial, including the qualification of Plaintiff's treating physician's ability to testify as to the cause of Plaintiff's loss of her senses of smell and taste, the denial of Defendant's motions for mistrial regarding the inadvertent mention of insurance, the granting of partial directed verdict on the topic of negligence, and the Court's decision to elect to utilize general negligence jury charges in lieu of Defendant's proposed premises liability jury charges. Plaintiff will address each of these arguments in turn.

a. A new trial absolute is inappropriate as the jury's verdict was not grossly excessive, and the Plaintiff presented sufficient facts at trial exercise of the thirteenth juror doctrine is unwarranted.

"The jury's determination of damages is . . . entitled to substantial deference." Vinson v. Hartley, 324 S.C. 389, 477 S.E.2d 715 (1996) (*citing* Rush v. Blanchard, 310 S.C. 375, 426 S.E.2d 802 (1993)). "The trial judge must grant a new trial a new trial absolute if the amount of the verdict is . . . excessive so as to shock the conscience of the court and clearly indicates the figure reached was the result of passion, caprice, prejudice, partiality, corruption or some other improper motives." Id. The grant of a new trial is within the trial judge's sole discretion, and that decision will not be overturned without a showing of a clear abuse of discretion unfounded in the evidence. Id.

"The thirteenth juror doctrine is a vehicle by which the trial court may grant a new trial absolute when he finds that the evidence does not justify the verdict. This ruling has also been termed granting a new trial upon the facts." Folkens v. Hunt, 300 S.C. 251, 254, 387 S.E.2d 265, 267 (1990) (*citing* S.C. Highway Dept. v. Townsend, 265 S.C. 253, 217 S.E.2d 778 (1975)). As

the thirteenth juror, the trial judge can hang the jury by refusing to agree to the jury's otherwise unanimous verdict. Id.

Defendant presents a wide array of factual allegations regarding the insufficiency of the evidence elicited at trial in an attempt to assert that the jury's verdict was unsupported by the evidence. However, many of these facts were not set forth by Defendant's counsel at trial. In effect, Defendant is attempting to re-try this case on paper. In comparison, Plaintiff provided a wealth of evidence at trial to substantiate her claims, including but not limited to direct testimony from no less than six fact witnesses, two of which were treating physicians who were qualified as experts by the Court, as well as numerous pages of documents and photographs.

The juxtaposition of Defendant's sparse evidentiary offering against the sheer volume of relevant and credible evidence offered by Plaintiff at trial is illuminating. Defendant brought only a single witness. Remarkably, Defendant chose not to call Thomas, the person who had arguably the most knowledge about the Fence and presumably a number of other issues vital to the Defendant's positions. Thomas was, however, called by the Plaintiff and, as noted above, he made a number of admissions, including (1) the Fence was erected by the Defendant, (2) it was Defendant's sole duty to maintain the Fence, (3) he was aware that his own workers often walked across the Fence causing it to come down, (4) it was foreseeable that the fence could become airborne in the wind if allowed to become detached from its stakes, (5) he had received warnings prior to the accident that the fence was in disrepair, and (6) that the Fence was in a state of severe disrepair on the date of June 6, 2011. Even in the face of these admissions, Defendants chose not to ask Mr. Thomas any questions. Defendant also offered very little in the way of documentation, proffering very few documents and photos, many of which were duplicative of Plaintiff's own exhibits.

Defendant specifically takes issue with the cause of Plaintiff's loss of her senses of smell and taste, the timeline by which Plaintiff became aware of the loss, and the effect said loss has had on Plaintiff's quality of life. Plaintiff provided recorded testimony from two of Plaintiff's treating physicians, Dr. Funcik and Dr. Ghegan, both of whom are board certified otolaryngologists – also known as an ENT – who were qualified by the Court to testify as to the diagnosis and cause of Plaintiff's injuries. Both the Plaintiff's treating physicians testified unequivocally that the trauma that Plaintiff sustained during the June 6, 2011 accident was the cause of Plaintiff's loss of her senses of smell and taste. In its post-trial motions, Defendant notes in Footnote 11 a number of factual issues that it believes refute any determination that Plaintiff's injuries were caused by the trauma. Defendant cross-examined Plaintiff's treating physicians for many hours on these subjects and the entire, unedited cross-examinations were played for the jury. During the cross-examinations, the treating physicians were adamant in their opinions that the accident had caused the Plaintiff's injuries and their opinions were reinforced if not strengthened. In any case, the Defendant had ample opportunity to develop all of the factual issues it cites in its memorandum. Defendant failed to do so, however, while Plaintiff provided more than sufficient evidence for the jury to find as it did.

In addition to Plaintiff's treating physicians, Plaintiff; Smith; and Plaintiff's daughter, Christina Connelly, all testified as to the timeline of Plaintiff's gradual, dawning awareness that her senses of smell and taste were. Furthermore, Plaintiff's witnesses and even Defendant's own expert, Dr. Rodney Schlosser, all testified that Plaintiff's injuries were permanent, and that they would have a major impact on the quality of her life.

Despite Defendant's attempts to highlight various inconsistencies in the evidence, these arguments do not negate the evidence elicited by Plaintiff at trial and, if anything, such

arguments only appropriately affect the weight that the jury was able to give such evidence in making its deliberations. Furthermore, Defendant's assertions that the actual medical expenses of Thirteen-Thousand Two-Hundred Forty-Four Dollars and Seventy Cents ($13,244.70) somehow indicate that the jury's verdict was grossly excessive ring hollow. As Defendant points out in its memorandum, the most significant element of Plaintiff's damages is the loss of her senses of smell and taste. All of the physicians involved – again including Defendant's own expert – acknowledge that there is no treatment for this condition. As a result, the medical bills and cost of future care are relatively minor as compared to the Plaintiff's permanent loss of two of her five senses – a condition which Defendants only witness agreed would have a major impact on the quality of Plaintiff's life. Furthermore, Defendant fails to identify any ulterior motive, passion, or prejudice that may have motivated the jury in conducting its deliberations.

Based upon the foregoing, Defendant has failed to make a showing that the jury's verdict was grossly excessive or otherwise inspired by some ulterior motive, and has also failed to show that the jury's verdict is unsupported by the evidence as set forth at trial. As such, Defendant's Post-Trial Motion for a New Trial Absolute should be denied.

b. The Court properly qualified Dr. Funcik and Dr. Ghegan to testify as to the cause of Plaintiff's anosmia and dysgeusia.

Defendant next argues that Plaintiff's witnesses, Dr. Funcik and Dr. Ghegan, should not have been qualified by the Court to testify as to the cause of Plaintiff's loss of her senses of smell and taste. Expert testimony may be used to help the jury to determine a fact in issue based on the expert's specialized knowledge, experience, or skill and is necessary in cases in which the subject matter falls outside the realm of ordinary lay knowledge. Watson v. Ford Motor Co., 389 S.C. 434, 445, 699 S.E.2d 169, 175 (2010). The trial court serves as the gatekeeper and must decide

whether the evidence submitted by a party is admissible pursuant to the Rules of Evidence as a matter of law. Id. (citing Bailey v. Peacock, 318 S.C. 13, 14, 455 S.E.2d 690, 692 (1995)). Once the trial court makes a ruling that the particular evidence is admissible, then it is exclusively within the jury's province to decide how much weight the evidence deserves. Id. Importantly, the trial court is never permitted to second-guess the jury in their fact-finding responsibilities unless compelling reasons justify invading the jury's province. Id.

In determining whether or not a witness may be qualified to testify as an expert, South Carolina courts utilize a three-pronged inquiry. First, the trial court must find that the subject matter is beyond the ordinary knowledge of the jury, thus requiring an expert to explain the matter to the jury. Id. (citing State v. Douglas, 380 S.C. 499, 671 S.E.2d 606 (2009) (holding that the witness was improperly qualified as a forensic interviewing expert where the nature of her testimony was based on personal observations and discussions with the child victim)). Next, while the expert need not be a specialist in the particular branch of the field, the trial court must find that the proffered expert has indeed acquired the requisite knowledge and skill to qualify as an expert in the particular subject matter. Id. (citing Gooding v. St. Francis Xavier Hosp., 326 S.C. 248, 252-53, 487 S.E.2d 596, 598 (1997) (observing that to be competent to testify as an expert, a witness must have acquired by reason of study or experience such knowledge and skill in a profession or science that he is better qualified than the jury to form an opinion on the particular subject of his testimony)). Finally, the trial court must evaluate the substance of the testimony and determine whether it is reliable. Id. (citing State v. Council, 335 S.C. 1, 20, 515 S.E.2d 508, 518 (evaluating whether expert testimony on DNA analysis met the reliability requirements).

In the instant case, Dr. Funcik and Dr. Ghegan both are treating physicians of Plaintiff and are also board certified ENTs. Dr. Funcik is the board certified ENT that the Plaintiff went to immediately after the accident and who repaired the Plaintiff's broken nose. Dr. Ghegan is the board certified ENT at Charleston ENT who Plaintiff went to for the purpose of determining the diagnosis and cause of her lost senses of smell and taste. In that capacity, both physicians physically examined Plaintiff, listened to her subjective complaints, and were able to utilize their medical knowledge and experience to diagnose a cause for Plaintiff's loss of her senses of smell and taste. Defendant's expert Dr. Scholsser agreed that Plaintiff's treating physicians had more information than him and that they were qualified to render opinions as to the cause of Plaintiff's injuries.[5]

Defendant contended at trial and appears to renew in its post-trial motions that, due to perceived inconsistencies in both physicians' testimony and their degree of involvement with Plaintiff's treatment, their testimony is somehow unreliable. Defendant confuses the standard as required by South Carolina law, as the reliability prong of the expert qualification pertains to the reliability of the underlying science or methodology that the expert is proposing to testify about and not to their overall credibility or the consistency of their opinions. Both physicians clearly stated that they were qualified to diagnose the cause of anosmia and associated dysgeusia, and there was undisputed testimony that the underlying methodology used to make such a diagnosis was reliable. Dr. Funcik testified at trial that the science for diagnosing the cause of anosmia is reliable and that there have been no significant advances in the field in decades. Simply put,

[5] Dr. Schlosser was qualified by the Court strictly based on his credentials as a board certified ENT, despite the fact that Dr. Schlosser never conducted a physical examination of Plaintiff and merely performed a cursory record review.

there is no specialty other than a board certified ENT better qualified to make a reliable determination of the cause of Plaintiff's injuries.

As such, the Court properly qualified both Dr. Funcik and Dr. Ghegan to testify as to the cause of Plaintiff's loss of her senses of smell and taste and Defendant's Post-Trial Motion for New Trial Absolute should be denied.

c. The Court properly denied Defendant's motions for mistrial based upon the mention of insurance.

Defendant further contends that the Court erred in denying both its motions for mistrial based on the inadvertent mention of the word insurance by the Plaintiff during her testimony and the mention of health insurance by Dr. Funcik during his videotaped trial testimony. Rule 411 of the South Carolina Rules of Evidence states "[e]vidence that a person was or was not insured against liability is not admissible upon the issue whether the person acted negligently or otherwise wrongfully. This rule does not require the exclusion of evidence of insurance against liability when offered for another purpose, such as proof of agency, ownership, or control, or bias or prejudice of a witness." SCRE 411. "By weight of authority, if counsel propounds a question which calls for proper evidence, the fact that an irresponsive or inadvertent answer includes a reference to insurance will not be ground for declaring a mistrial." Keller v. Pearce-Young-Angel Co., 253 S.C. 395, 398, 171 S.E.2d 352, 354 (1969). " . . . A motion for a mistrial, because of anything occurring during the trial, is one addressed to the sound discretion of the trial judge, whose ruling thereabout will not be disturbed in the absence of an abuse of discretion amounting to an error of law." Id. at 398, 354.

Defendant asserts that Plaintiff's allusion to liability insurance during her testimony at trial is more than inadvertent, and therefore the Court committed reversible error in denying its

motion for a mistrial[6]. In so arguing, Defendant gives significant weight to the distinction between a party to a proceeding making an inadvertent reference to liability insurance and a third party witness doing the same, and argues that Plaintiff bears more responsibility for her slip of the tongue than a third party witness. In support of this distinction, Defendant relies upon Brazeale v. Piedmont MFG. Co., which was cited by the trial judge in denying the Defendants motion. 184 S.C. 471, 193 S.E. 39 (1937). Defendant's recollection of the trial judge's ruling is incomplete, however, as the Court also relied upon Keller v. Pearce-Young-Angel Co. in so ruling on Defendant's motion. 253 S.C. 395, 398, 171 S.E.2d 352, 354 (1969).

In Keller, the plaintiff, who was a passenger in a truck, was injured in a collision with another vehicle being driven by the Defendant. Id. at 396, 353. As a result of the collision, the plaintiff lost tools that were necessary for him to work, and as such lost wages due to the collision. Id. at 397, 353. At trial, defense counsel asked the Plaintiff about his lost wages, and the Plaintiff, in explaining how the accident had affected his ability to work, inadvertently stated " . . . I called this insurance adjuster, I imagine it was, for [defendant] and he was supposed to come over." Id. The trial judge denied a motion for mistrial, ruling that the mention of insurance was merely an inadvertent "slip of the tongue" and noted "nearly everybody knows that nearly everybody has got insurance." Id. at 397, 353-54. On appeal, the Supreme Court of South Carolina found that there was no abuse of discretion by the trial judge in denying the appellant's

[6] Defendant writes at length about Plaintiff Counsel's responsibility to advise the Plaintiff not to mention insurance at trial and Plaintiff's level of sophistication – all apparently in an attempt to suggest that Plaintiff's mention of insurance was somehow not inadvertent. As pointed out above, Plaintiff was asked a question on cross-exmination by Mr. Hines about a series of communications between her husband and Thomas. The correspondence specifically mentions the subject of insurance. The specific question asked was if the correspondence was a legal claim – to which the Plaintiff replied something to the effect of – I don't think it's a legal claim, I think what is happening is that he is asking whether there is insurance.

motion for mistrial and that appellant failed to establish that the inadvertent mention of insurance by the plaintiff resulted in any prejudice to the appellant.

Here we are faced with a situation very similar to the one presented in Keller. Plaintiff was asked a direct question regarding correspondence sent by her husband, a trial attorney, to the Defendant after the June 6, 2011 incident. When pressed to comment on the content of this correspondence via a direct question, she made the statement that it was her belief that her husband was inquiring as to whether or not the Defendant had insurance. No further testimony was elicited as her cross-examination was immediately stopped for the Defendant's motion for mistrial. Significantly, it was never mentioned that Defendant did or did not have insurance. Plaintiff did not purposefully inject the issue of liability insurance into the trial for any nefarious or prejudicial purposes, and merely answered as to her honest impression of the correspondence in question when pressed by Defendant's counsel on cross-examination. Furthermore, Defendant's contention that Plaintiff should be held more accountable for her response due to her level of education or her husband's profession is completely irrelevant. Plaintiff herself is not an attorney, nor has she received any specialized legal education. Defendant's counsel was very much aware that insurance was mentioned in the correspondence he chose to question Plaintiff about and Counsel asked Plaintiff an open ended question specifically asking her to characterize the correspondence. Defendant's own fault in eliciting insurance on cross-examination should be measured against Plaintiff's inadvertent mention of the word. Based on the foregoing, the Court did not abuse its discretion in denying Defendant's first motion for mistrial.

Defendant also contends that its second motion for mistrial, which was made in response to Dr. Funcik's mention of health insurance during his videotaped deposition, was denied in error. First and foremost, Rule 411 of the South Carolina Rules of Evidence applies only to

evidence of liability insurance, and there is no rule of evidence barring the mention of health insurance at trial. Additionally, Defendant's Counsel was provided with a list of proposed cuts to the videotaped deposition of Dr. Funcik on the night of August 24, 2015, and were given as much time as Plaintiff to review the deposition and proposed cuts for any necessary omissions. Defendant did not lodge any objections to these proposed cuts, nor did they propose any additional cuts that needed to be made. Based on the foregoing, the Court did not abuse its discretion in denying Defendant's second motion for mistrial.

As such, the Court properly denied both of Defendant's motions for mistrial based on the inadvertent injection of the topic of insurance at trial and Defendant's Post-Trial Motion for New Trial Absolute should be denied.

d. The Court properly partially granted Plaintiff's directed verdict as to negligence.

Defendant further contends that the trial court erred in partially granting Plaintiff's motion on the topic of negligence at the close of Defendant's case, thereby instructing the jury that Defendant possessed a duty to Plaintiff and breached that duty. On appeal from an order granting a directed verdict, this Court views the evidence and all reasonable inferences deductible therefrom in a light most favorable to the party against whom the directed verdict was granted. If the evidence as a whole is susceptible of more than one reasonable inference, a jury issue is created and the motion should have been denied. Whelan v. Welch, 304 S.C. 548, 550, 405 S.E.2d 836, 837 (Ct. App. 1991) (citing Claytor v. General Motors Corp., 277 S.C. 259, 286 S.E.2d 129 (1982).

As set forth fully in Sections II(a) and III of this memorandum, which are incorporated by reference, Defendant made a sparse evidentiary showing at trial. Defendant's corporate

representative Thomas admitted during Plaintiff's counsel's direct examination of him that (1) the Fence was erected by the Defendant, (2) it was Defendant's sole duty to maintain the Fence, (3) he was aware that his own workers often walked across the Fence causing it to come down, (4) it was forseeable that the fence could become airborne in the wind if allowed to become detached from its stakes, (5) he had received warnings prior to the accident that the fence was in disrepair and (6) the Fence was in a state of severe disrepair on the date of June 6, 2011. Defendant has failed, both at trial and in its post-trial motion, to identify any specific evidence or facts that would rebut the existence of a duty owed by Defendant to Plaintiff, and that Defendant breached that duty in allowing the Fence to deteriorate into a state of disrepair. Notably, Defendant chose not to ask any questions of Jeffrey Thomas and brought no witnesses to testify on any subject other than medical causation (Dr. Scholsser). As such, the Court properly partially granted Plaintiff's motion for directed verdict and Defendant's Post-Trial Motion for New Trial Absolute should be denied.

e. The Court properly instructed the jury on general negligence principles.

As a final matter, Defendant argues that the Court committed reversible error in refusing to instruct the jury on premises liability principles. As set forth above in Section II of this memorandum and as thoroughly explored in Defendant's post-trial motions, Plaintiff withdrew her proposed jury charges as to premises liability and chose to proceed strictly on general negligence principles upon indication of the Court. As Plaintiff elected not to proceed under a premises liability theory, the Defendant's jury charges regarding premises liability theories were irrelevant and inapplicable. As such, the Court properly instructed the jury on general negligence principles and Defendant's Post-Trial Motion for New Trial Absolute should be denied.

III. Defendant's Post-Trial Motion for New Trial *Nisi* Remittitur.

Defendant alleges that, should all of its prior post-trial motions fail, it is entitled to a new trial *nisi* remittitur as the jury's verdict is unduly liberal. While the trial court has the discretionary power to reduce an award which is deemed to be excessive, " . . . the trial court must evaluate the adequacy of the verdict in light of the evidence presented." Becker v. Wal-Mart Stores, Inc., 339 S.C. 629, 637, 529 S.E.2d 758, 762 (Ct. App. 2000). "The jury's determination of damages is . . . entitled to substantial deference . . . ." Vinson, 324 S.C. at 389, 477 S.E.2d at 715 (1996) (citing Rush v. Blanchard, 310 S.C. 375, 426 S.E.2d 802 (1993)).

In the instant case, the jury's award of Five-Hundred Thousand Dollars ($500,000.00) was neither excessive nor unduly liberal. Plaintiff's damages are not merely aches and pains that will heal with time. Plaintiff successfully provided evidence at trial that Plaintiff has permanently lost her sense of smell and suffers from a permanent significant impairment to her sense of taste. As human beings, our five senses are the only means by which we experience the world around us, and are the primary source of our ability to enjoy life. While the senses of smell and taste are not as outwardly noticeable when lost as the senses of sight or hearing, they are no less important to Plaintiff's enjoyment of life. Plaintiff must endure this permanent impairment for the rest of her life, which, as set forth by the life expectancy table in S.C. Code Ann. § 19-1-150, is another Twenty-Four and Eight Hundredths (24.08) Years.

Furthermore, Plaintiff provided the jury with a reasonable range of value in its closing arguments. By means of a hypothetical, the jury was asked to think about what hourly wage they would accept to permanently lose their sense of smell and taste. The result of this hypothetical left the jury with a range of proposed value, with Four-Hundred Twenty-One Thousand Eight-Hundred Eighty-One Dollars ($421,881.00) on the bottom of the spectrum and Nine-Hundred

Eighty-Four Thousand Three-Hundred Eighty-Nine Dollars ($984,389.00) at the top. The jury's verdict of Five-Hundred Thousand Dollars ($500,000.00) is very low on this proposed spectrum and is conservative considering the severity of Plaintiff's injuries. Further reducing this verdict due to the jury's assessment of comparative negligence results in a very conservative award given that Plaintiff will not be able to smell anything or taste much for the rest of her life. As such, Defendants Motion for New Trial *Nisi* Remittitur should be denied.

CONCLUSION

Based upon the foregoing, Plaintiff hereby opposes Defendant's Post-Trial Motions for: (1) JNOV; or (2) New Trial Absolute; or (3) New Trial *Nisi* Remittitur, and respectfully requests that the Court deny each of Defendant's motions.

GRUENLOH LAW FIRM

Counsel for the Plaintiff

By: _____

Wm. M. Gruenloh, SCBAR #12418
Patrick Aulton Chisum, SCBAR # 100571
Brian R. Holmes, SCBAR # 102052
192 E. Bay Street, Suite 202
Charleston, South Carolina 29401
(843) 577-0027
(843) 577-0721 (facsimile)

Date: September 25, 2015
Charleston, South Carolina

EXHIBIT A

CONNELLY & VOGELZANG LLC

LAW OFFICES IN: CHICAGO, ILLINOIS | CHARLESTON, SOUTH CAROLINA
FIRM LICENSED IN AZ, IL, MO, SC, TX, WI, WV

June 7, 2011

VIA FACSIMILE (843) 856-1874 & EMAIL: winsor@winsorcustomhomes.com
The Office of Winsor South, LLC
Winsor Custom Homes, LLC
234 Seven Farms Dr., Ste. 201-C
Daniel Island, SC 29492

RE: house construction at REDACTED

To whom it may concern,

My client fell on the sidewalk on 6/6/2011 in front of this construction site due to the dangerous conditions which as of this morning still exists. Your company still has dangerous debris on the pedestrian walk. She may have a broken nose. She has multiply cuts and abrasions to her face, arms, and shoulder and is currently under a doctor's care.

Please have your attorney call me at 843 REDACTED Should I not hear from you, I will assume you prefer the more formal route of filing a complaint at law. Regardless, please promptly make the pedestrian walk safe from all your construction debris so another person is not injured.

Also, please advise Karen Nelson, John Edelen, Clark Design Group and Daniel Island Reality of my accusation against the owners and agents of this property. I informed Daniel Island Reality this morning of the conditions since this is the only phone number listed on the only construction sign on the property.

Sincerely,

William M. Connelly

William M. Connelly

WMC/lm

From: Winsor Custom <winsor@winsorcustomhomes.com>
Sent: Tuesday, June 07, 2011 5:33 PM
To: 'Lark McDonald Killerman'
Subject: RE: REDACTED - Construction site

Yeah. Just got this email. Sidewalk is and has been clean, but we don't own the sidewalk. Find it hard to believe someone fell there but I hope they are OK. Will pass on information to owners of property.

From: Lark McDonald Killerman [mailto:LMcDonald@convoglaw.com]
Sent: Tuesday, June 07, 2011 12:11 PM
To: winsor@winsorcustomhomes.com
Cc: Bill Connelly
Subject: REDACTED - Construction site

Attached please find correspondence re: above. Please advise as soon as possible.
William M. Connelly
(Dictated Not Read)

Lark McDonald
Paralegal
Connelly & Vogelzang, LLC
13 Cumberland St.
Chas., SC 29401
(843) 727-0199
(843) 793-3214 (fax)
CONNELLY VOGELZANG

No virus found in this message.
Checked by AVG - www.avg.com
Version: 10.0.1382 / Virus Database: 1511/3686 - Release Date: 06/07/11

From: Bill Connelly <BConnelly@convoglaw.com>
Sent: Wednesday, June 08, 2011 12:48 PM
To: Winsor Custom
Subject: RE: REDACTED

Driveway rock,clear plastic sheets and black plastic sheets. You didn't see that when you cleaned up?

From: Winsor Custom [mailto:winsor@winsorcustomhomes.com]
Sent: Wednesday, June 08, 2011 12:40 PM
To: Bill Connelly
Subject: RE: REDACTED REDA

What construction material?

From: Bill Connelly [mailto:BConnelly@convoglaw.com]
Sent: Wednesday, June 08, 2011 12:33 PM
To: winsor@winsorcustomhomes.com
Cc: Lark McDonald Killerman
Subject: REDACTED

Yes, that is the problem your construction material was all over the public sidewalk or right of way and it appeared that condition was there for awhile. Also no caution sign was present. We have taken photos of the mess. Don't really understand why you believe someone could not fall from all this debris. Please have owners contact me with insurance information or their attorney may contact me. Pleased that you cleaned the debris from sidewalk. Will advise if MD decides if she broke her nose.

No virus found in this message.
Checked by AVG - www.avg.com
Version: 10.0.1382 / Virus Database: 1511/3688 - Release Date: 06/08/11

No virus found in this message.
Checked by AVG - www.avg.com
Version: 10.0.1382 / Virus Database: 1511/3688 - Release Date: 06/08/11

Certificate of Counsel

The undersigned counsel for Appellant certifies that, in accordance with Rule 210(c), SCACR, this **Record on Appeal** contains all material proposed to be included by any party that was presented to the lower court and not any other material. The undersigned also certifies that this **Record on Appeal** complies with the Supreme Court of South Carolina's Revised Order Concerning Personal Identifying Information and Other Sensitive Information in Appellate Court Filings issued April 15, 2014.

Respectfully submitted,
YOUNG CLEMENT RIVERS, LLP

By: _____

Stephen L. Brown (SC Bar No. 66468)
Russell G. Hines (SC Bar No. 72100)
25 Calhoun Street, Suite 400
Charleston, South Carolina 29401
P.O. Box 993 (29402)
(843) 720-5488

Attorneys for Appellant
Winsor Custom Homes, LLC

Charleston, South Carolina

Dated: 1/27/17

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JAN 30 2017
SC Court of Appeals