

RECORD ON APPEAL

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

RECEIVED
DEC 01 2017
SC Court of Appeals

Court of Common Pleas

Honorable L. Casey Manning, Circuit Court Judge

Case No. 2016-002268

Taliah Shabazz, ...Appellant,

v.

Bertha Rodriguez, ...Respondent

RECORD ON APPEAL

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STATE OF SOUTH CAROLINA

COUNTY OF RICHLAND

Taliah K. Shabazz,

Plaintiff,

vs.

Bertha Isela Rodriguez,

Defendant.

IN THE COURT OF COMMON PLEAS
FIFTH JUDICIAL CIRCUIT

CASE NO.: 2015-CP-40-02395

**MOTION AND ORDER INFORMATION
FORM AND COVERSHEET**

Plaintiff's Attorney: J. Tyler Lee, Jr., Bar No. 75443 Address: McWhirter, Bellinger & Associates, P.A. 119 East Main Street, Lexington, SC 29072 Phone: 803-359-5523 Fax 803-996-9080 E-mail: tyler@mcwhirterlaw.com Other:		Defendant's Attorney: Allyce Bailey, Bar No. _____ Address: Tymer, Padgett, Graham & Laney, P.A. PO Box 1473, Columbia, SC 29201 Phone: 803-227-4329 Fax _____ E-mail: abailley@turnerpadgett.com Other:	
☒ MOTION HEARING REQUESTED (attach written motion and complete SECTIONS I and III) ☐ FORM MOTION, NO HEARING REQUESTED (complete SECTIONS II and III) ☐ PROPOSED ORDER/CONSENT ORDER (complete SECTIONS II and III)			
SECTION I: Hearing Information Nature of Motion: Plaintiff's Motion for a New Trial NISI Additute or a New Trial Absolute Estimated Time Needed: 15 Minutes Court Reporter Needed: ☒ YES ☐ NO			
SECTION II: Motion/Order Type ☒ Written motion attached ☐ Form Motion/Order I hereby move for relief or action by the court as set forth in the attached proposed order. Signature of Attorney for ☒ Plaintiff / ☐ Defendant Date submitted: 9/8/16			
SECTION III: Motion Fee ☒ PAID - AMOUNT: \$ ☐ EXEMPT: (check reason) ☐ Rule to Show Cause in Child or Spousal Support ☐ Domestic Abuse or Abuse and Neglect ☐ Indigent Status ☐ State Agency v. Indigent Party ☐ Sexually Violent Predator Act ☐ Post-Conviction Relief ☐ Motion for Stay in Bankruptcy ☐ Motion for Publication ☐ Motion for Execution (Rule 69, SCRPC) ☐ Proposed order submitted at request of the court, or, reduced to writing from motion made in open court per judge's instructions. Name of Court Reporter: _____ ☐ Other: _____			
JUDGE'S SECTION ☐ Motion Fee to be paid upon filing of the attached order. ☐ Other:		JUDGE CODE _____ Date: _____	
CLERK'S VERIFICATION Collected by: _____ Date Filed: _____ ☐ MOTION FEE COLLECTED: \$ _____ ☐ CONTESTED - AMOUNT DUE: \$ _____			

SCCA 233 (11/2003)

STATE OF SOUTH CAROLINA)
COUNTY OF RICHLAND)

Taliah K. Shabazz,

Plaintiff,

vs.

Bertha Isela Rodriguez,

Defendant.

IN THE COURT OF COMMON PLEAS

CA NO.: 2015-CP-40-02395

**PLAINTIFF'S NOTICE OF MOTION
AND MOTION FOR NEW TRIAL *NISI Additur*
OR A NEW TRIAL ABSOLUTE**

RICHLAND COUNTY
FILED
2016 SEP-8 PM 1:25
JEANETTE M. MCBRIDE
CLERK, P. & G.S.

YOU WILL PLEASE TAKE NOTICE that ten (10) days after service of this notice upon you, or as soon thereafter as counsel may be heard, the undersigned attorney for Plaintiff will move before the presiding judge of the Richland County Court of Common Pleas for an Order granting her Motion for a New Trial *Nisi Additur*, or in the alternative her motion for a New Trial Absolute. Plaintiff asserts that compelling reasons exist to either reform the verdict by way of a New Trial *Nisi Additur* or grant her a New Trial Absolute.

Pursuant to Rule 59 of the *South Carolina Rules of Civil Procedure*, Plaintiff Taliah K. Shabazz, by and through her attorneys, moves this honorable Court for an Order granting a New Trial *Nisi Additur*, or, in the alternative, a New Trial Absolute. Plaintiff asserts that this Court should grant these motions based on the following reasons: the jury's verdict of \$12,500.00 is grossly inadequate in light of Plaintiff's documented monetary damages and other Actual damages and, therefore, the verdict is contrary to the preponderance of the evidence; and, the jury considered matters outside the scope of the evidence presented.

FACTS PRESENTED TO THE JURY

The matter before this Court was an admitted-liability wreck case in which damages were the only issue. The jury was to determine which injuries were related to the wreck as well as the other elements of Actual damages, including pain and suffering, future pain and suffering, mental anguish, loss of enjoyment of life, and permanency. Punitive damages were not an issue.

Plaintiff testified that she was taken via EMS to Palmetto Health Richland Hospital where she was treated for shoulder and neck pains. She then treated with her primary care physician at

Waverly Family Practice for continued shoulder pains. Ms. Shabazz then sought treatment with Dr. Kevin Nahigian at Carolina Shoulder & Knee Specialists for her shoulder. Dr. Nahigian referred her to physical therapy, which she participated in for six (6) months. Due to constant headaches and continuing neck and shoulder pain, Ms. Shabazz testified that she was referred to a neurologist who related her headaches to the collision.

Plaintiff introduced her medical records, testimony regarding medical bills amounting to \$16,230.44, and Dr. Eleanya Ogburu-Ogbonnaya's deposition, who assigned a 2 percent upper extremity impairment rating, a 1 percent whole person impairment rating, and opined that to a reasonable degree of medical certainty that Plaintiff's treatment for headaches was related to the automobile collision. Additionally, Ms. Taliah Shabazz's mother testified regarding how the wreck has affected the Plaintiff's life.

The defense argued that, because there was no evidence of headaches in the medical records until one year after the wreck, the jury should not consider the medical expenses related thereto. However, critically, Dr. Ogburu-Ogbonnaya testified that he would have provided the same treatment to Ms. Shabazz even if she had not had any headaches at all, because he was also treating her neck and shoulder complaints.

ARGUMENT

A. *The verdict was inconsistent and arbitrary.*

The jury returned a verdict in favor of Ms. Shabazz but awarded her damages of only \$12,500.00. This amount does not correlate with any figures presented. Ms. Shabazz's medical bills amounted to \$6,184.28 prior to her first appointment with her neurologist. The verdict bears no relationship to this amount. Defendant's counsel requested that the jury return a verdict of approximately \$8,800.00 – the verdict bears no relationship to that amount. If the jury were only looking at the appointments from the neurologist forward, this amount would total \$10,046.16. Again, this amount bears no relationship to the \$12,500.00 verdict. Therefore, the verdict of \$12,500.00 bears no logical or rational relationship to Ms. Shabazz's damages. The verdict appears, therefore, to be totally arbitrary.

For the jury to award a defense verdict in a stipulated liability case with as much evidence of damages as was presented to this jury is contrary to reason and can only be explained by failure to understand the law as it was charged.

"Verdicts which are irreconcilably inconsistent should not stand, and a new trial should be granted, because the parties and the judge 'should not be required to guess as to what the jury sought to render.'" *Daves v. Cleary*, 355 S.C. 216, 231, 584 S.E.2d 423, 430 (Ct. App. 2003) (quoting *Prego v. Hobart*, 287 S.C. 116, 118, 336 S.E.2d 725, 726 (Ct. App. 1985)).

With regard to the issue of inadequacy, "The trial judge alone has the power to grant a New Trial Nisi when he finds the amount of the verdict to be merely inadequate...." *McCourt by and through McCourt v. Abernathy*, 318 S.C. 301, 308, 457 S.E.2d 603, 607 (1995) (citing *O'Neal v. Bowles*, 314 S.C. 525, 431 S.E.2d 555 (1993)). "If the amount of the verdict is so grossly inadequate or excessive that it shocks the conscience of the court and clearly indicates the amount was the result of passion, caprice, prejudice, partiality, corruption or some other improper motives, the trial judge is required to grant a new trial absolute." *Waring v. Johnson*, 341 S.C. 248, 257, 533 S.E.2d 906, 911 (Ct. App. 2000.) (emphasis added) (citing *Cock-N-Bull Steak House, Inc. v. Generali Ins. Co.*, 321 S.C. 1, 466 S.E.2d 727 (1996)).

B. The jury considered matters outside the scope of the evidence presented at trial in violation of the law charged to them by the trial court.

After one-and-a-half days of trial, the jury was charged with the law of the case, and sent back to begin deliberations. Approximately thirty (30) minutes later, the jury was brought back into the courtroom for the judge to address a written question that the foreman presented to the bailiff. See EXHIBIT A. The question was as follows: "1) Has the cost of the 1st year's appointments, BEFORE THE NEUROLOGY APPOINTMENTS BEGAN, already been covered by Mrs. Rodriguez's insurance?" (sic).

In response to their question, the jurors were instructed, as they had been instructed before commencing deliberations, that they could not base their verdict on sympathy or other factors, but that their verdict must be based only on the evidence and testimony presented; that they had heard all the testimony and seen all the evidence that it was going to hear or see; that their questions raised improper matters not in evidence and not to be considered; that the matters were not to be discussed further; and that they were to continue deliberations based on the testimony and evidence presented. Less than ten (10) minutes after being sent back to re-commence deliberations, the jury announced that it had reached a verdict. That verdict was for \$12,500.00.

This jury improperly considered insurance in their deliberations. Additionally and importantly, it is clear, based on the short amount of time before the foreperson sent out the note,

that insurance and other matters outside the scope of the evidence were discussed at the commencement of or at least very early in the first, brief deliberation. The jury then, for the second time, disregarded the Court's instruction, returning a verdict in less than ten (10) minutes following being instructed to re-commence deliberation.

In spite of the Court's original and subsequent instructions, it is indisputable that the jury improperly considered factors other than the testimony and evidence that was presented in the trial and that they did so twice. The only remedy for a verdict infected by improper considerations outside the scope of the evidence presented by the parties is a new trial. *O'Neal v. Bowles*, 314 S.C. 525, 431 S.E.2d 555 (1993).

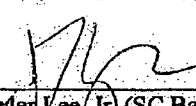
In the unfortunate circumstance where, as here, the jury renders a verdict in utter disregard of the instructions given by the trial court, it is error for the court, on motion, not to grant a new trial. *Southeastern Mobile Homes, Inc. v. Walicki*, 282 S.C. 298, 317 S.E.2d 773 (Ct. App. 1984).

CONCLUSION

For the foregoing reasons, Plaintiff respectfully requests that this court issue an Order granting a New Trial *Nisi Additur* or, in the alternative, to issue an Order granting a New Trial Absolute.

Respectfully Submitted,

McWHIRTER, BELLINGER, & ASSOCIATES, P.A.

BY: 

J. Tyler Lee, Jr. (SC Bar # 75443)
1807 Hampton Street
Columbia, South Carolina 29201
(803) 252-5523 Phone
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Attorney for the Plaintiff

Columbia, South Carolina
September 7, 2016

STATE OF SOUTH CAROLINA)

COUNTY OF RICHLAND)

Taliah K. Shabazz,)

Plaintiff,)

-vs-)

Bertha Isela Rodriguez,)

Defendant.)

IN THE COURT OF COMMON PLEAS
FIFTH JUDICIAL CIRCUIT

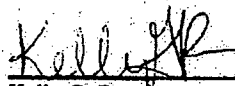
Case No: 2015-CP-40-02395

CERTIFICATE OF MAILING

RICHLAND COUNTY
FILED
2016 SEP -8 PM 1:25
JEANNETTE W. MCBRIDE
C.C.P. & G.S.

The undersigned hereby certifies that she is the paralegal for J. Tyler Lee Jr., attorney for the Plaintiff in the above-entitled action, and that the foregoing Plaintiff's Notice of Motion and Motion for New Trial Absolute, or, in the alternative, New Trial *nisi additur* was served upon the persons listed below by depositing a copy thereof in the United States Mail, with sufficient postage annexed thereto, addressed as follows:

Allyce Bailey, Esquire
Turner, Padgett, Graham, & Laney, P.A.
PO Box 1473
Columbia, SC 29201



Kelly G. Purvis

September 8, 2016

STATE OF SOUTH CAROLINA
COUNTY OF RICHLAND

IN THE COURT OF COMMON PLEAS
Civil Action No. 2015-CP-40-02395

Taliah Shabazz,

Plaintiff,

vs.

Bertha Rodriguez,

Defendant.

ORDER DENYING PLAINTIFF'S MOTION
FOR NEW TRIAL *NISI ADDITUR* OR A
NEW TRIAL ABSOLUTE

FILED
OCT 10 AM 10:35
RICHLAND COUNTY
CLERK W. NOBLE
C.C.P. & G.S.

This matter comes before me on Plaintiff's Motion for a New Trial *Nisi Additur* or a New Trial Absolute, pursuant to Rule 59 of the South Carolina Rules of Civil Procedure.

For the reasons set forth below, the Plaintiff's motion is DENIED.

STATEMENT OF THE CASE

The retrial of this case was conducted before me on August 29 and 30, 2016. The case is one of admitted liability in which the defendant admits to failing to yield the right of way to Plaintiff's vehicle causing the collision that brings this suit to bar.

The Plaintiff was taken to Palmetto Health Richland Hospital after the accident, where she treated for soft tissue shoulder and neck pain. Plaintiff followed up this initial medical attention with visits to her primary care physician at Waverly Family Practice, where she continued to treat for soft tissue shoulder pain issues. Plaintiff then sought additional treatment for her shoulder with Dr. Kevin Nahigian at Carolina Shoulder & Knee Specialist. Dr. Nahigian referred Plaintiff to physical therapy which she participated in for six (6) months.

Almost a full year after the accident, Plaintiff began complaining of chronic migraine headaches and sought treatment with a pain management specialist, Dr. Elcanya Ogburu-

SCANNED

Ogbonnaya. At trial, Plaintiff introduced her medical bills into evidence amounting to \$16,230.44. Defense counsel argued that the migraine headaches, that Plaintiff did not begin to treat for until nearly a year after the accident, were not causally related to the accident. Dr. Ogburu-Ogbonnaya testified that if the Plaintiff genuinely had been suffering from the migraine headaches from the date of loss, she should have mentioned them much earlier on in her treatment. Additionally, he testified that he did not think that it was likely that someone suffering from the types of headaches of which the Plaintiff was complaining would be able to sustain them for nearly a year without mentioning them during any doctor's visits throughout the year or seeking treatment for the headache issue earlier. Accordingly, defense counsel requested that the jury award a verdict around \$8800.00 that excluded the treatment with Dr. Eleanya Ogburu-Ogbonnaya for the migraine headaches.

The jury seemingly agreed with the defense's version of the facts— that the headaches were unrelated to the accident— and awarded a verdict of \$12,500.00.

Plaintiff subsequently filed this motion for new trial *nisi additur* or a new trial absolute.

LEGAL STANDARDS AND ANALYSIS

"Power of the court" is the power to determine the law, whereas the 'power of the jury' is the power to determine the facts." Dimick v. Schiedt, 293 U.S. 474, 55 S. Ct. 296, 79 L. Ed. 603 (1935).

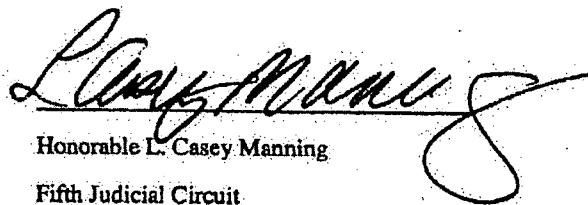
"The grant or denial of a motion for a new trial nisi rests within the discretion of the trial judge and his decision will not be disturbed on appeal unless his findings are wholly unsupported by the evidence or the conclusions reached are controlled by error of law." Waring v. Johnson, 341 S.C. 248, 533 S.E.2d 906 (Ct. App. 2000).

Both Plaintiff and Defendant had the opportunity to make their case to the jury. After the presentation of the evidence, the jury sided with the defense and determined that the Plaintiff had not met her burden of proof. Accordingly, the verdict reached compensates the Plaintiff for the medical expenses the jury concluded were causally connected to this accident and also awarded approximately \$4,000.00 in general damages.¹

CONCLUSION

For all of the reasons set forth above, the Plaintiff's motion for a new trial *nisi additur* or a new trial absolute is DENIED.

AND IT IS SO ORDERED.


Honorable L. Casey Manning
Fifth Judicial Circuit

October 10, 2016
Columbia, South Carolina

¹ Plaintiff contends the jury considered matters outside of the scope of the evidence presented. Plaintiff bases this contention on a question posed by the jury regarding whether insurance covered any of plaintiff's medical expenses. The trial judge strictly instructed the jury to only consider the evidence that was presented during the trial and to continue their deliberations as if the question regarding insurance had never been asked. No mention of insurance was made during the trial and plaintiff's counsel did not object to the instruction given to the jury regarding the question.

STATE OF SOUTH CAROLINA

COUNTY OF RICHLAND

Tallah K. Shabazz,

Plaintiff(s)

VS.

Bertha I. Rodriguez,

Defendant(s)

IN THE COURT OF COMMON PLEAS

CIVIL ACTION COVERSHEET

2015-CP-40-0395

Submitted By: J. Tyler Lee, Jr.
Address: McWhirter, Bellinger, & Associates, PA
119 East Main Street, Lexington, SC 29072

SC Bar #: 75443
Telephone #: 803-359-5523
Fax #: 803-996-9080
Other:
E-mail: tyler@mcwhirterlaw.com

NOTE: The coversheet and information contained herein neither replaces nor supplements the filing and service of pleadings or other papers as required by law. This form is required for the use of the Clerk of Court for the purpose of docketing. It must be filled out completely, signed, and dated. A copy of this coversheet must be served on the defendant(s) along with the Summons and Complaint.

DOCKETING INFORMATION (Check all that apply)

*If Action is Judgment/Settlement do not complete

- ☒ JURY TRIAL demanded in complaint. ☐ NON-JURY TRIAL demanded in complaint.
☐ This case is subject to ARBITRATION pursuant to the Court Annexed Alternative Dispute Resolution Rules.
☒ This case is subject to MEDIATION pursuant to the Court Annexed Alternative Dispute Resolution Rules.
☐ This case is exempt from ADR. (Proof of ADR/Exemption Attached)

NATURE OF ACTION (Check One Box Below)

- | | | | |
|--|---|--|--|
| ☐ Contracts
☐ Constructions (100)
☐ Debt Collection (110)
☐ Employment (120)
☐ General (130)
☐ Breach of Contract (140)
☐ Other (199) | ☐ Torts - Professional Malpractice
☐ Dental Malpractice (200)
☐ Legal Malpractice (210)
☐ Medical Malpractice (220)
Previous Notice of Intent Case #
20 - N/A
☐ Notice/File Med Mal (230)
☐ Other (299) | ☐ Torts - Personal Injury
☐ Assault/Slander/Libel (300)
☐ Conversion (310)
☒ Motor Vehicle Accident (320)
☐ Premises Liability (330)
☐ Products Liability (340)
☐ Personal Injury (350)
☐ Wrongful Death (360)
☐ Other (399) | ☐ Real Property
☐ Claim & Delivery (400)
☐ Condemnation (410)
☐ Foreclosure (420)
☐ Mechanic's Lien (430)
☐ Partition (440)
☐ Possession (450)
☐ Building Code Violation (460)
☐ Other (499) |
| ☐ Inmate Petitions
☐ PCR (500)
☐ Mandamus (520)
☐ Habeas Corpus (530)
☐ Other (599) | ☐ Administrative Law/Relief
☐ Reinstatement License (800)
☐ Judicial Review (810)
☐ Relief (820)
☐ Permanent Injunction (830)
☐ Forfeiture-Petition (840)
☐ Forfeiture-Consent Order (850)
☐ Other (899) | ☐ Judgments/Settlements
☐ Death Settlement (700)
☐ Foreign Judgment (710)
☐ Magistrate's Judgment (720)
☐ Minor Settlement (730)
☐ Transcript Judgment (740)
☐ Lis Pendens (750)
☐ Transfer of Structured Settlement Payment Rights Application (760)
☐ Confession of Judgment (770)
☐ Petition for Workers' Compensation Settlement Approval (780)
☐ Other (799) | ☐ Appeals
☐ Arbitration (900)
☐ Magistrate-Civil (910)
☐ Magistrate-Criminal (920)
☐ Municipal (930)
☐ Probate Court (940)
☐ SCDOT (950)
☐ Worker's Comp (960)
☐ Zoning Board (970)
☐ Public Service Comm. (990)
☐ Employment Security Comm (991)
☐ Other (999) |
| ☐ Special/Complex/Other
☐ Environmental (600)
☐ Automobile Arb. (610)
☐ Medical (620)
☐ Other (699) | ☐ Pharmaceuticals (630)
☐ Unfair Trade Practices (640)
☐ Out-of-State Depositions (650)
☐ Motion to Quash Subpoena in an Out-of-County Action (660)
☐ Sexual Predator (510) | | |

Submitting Party Signature: J. Tyler Lee

Date: Apr 17, 2015

Note: Frivolous civil proceedings may be subject to sanctions pursuant to SCRPC, Rule 11, and the South Carolina Frivolous Civil Proceedings Sanctions Act, S.C. Code Ann. §15-36-10 et. seq.

STATE OF SOUTH CAROLINA)
COUNTY OF RICHLAND)

IN THE COURT OF COMMON PLEAS
IN THE FIFTH JUDICIAL CIRCUIT

Taliah Shabazz,

Case No: 2015-CP-40-_____

Plaintiff,

-vs-

SUMMONS
(JURY TRIAL REQUESTED)

Bertha Rodriguez,

Defendant.

TO: BERTHA RODRIGUEZ, THE DEFENDANT ABOVE-NAMED:

YOU ARE HEREBY SUMMONED and required to answer the Complaint in the action, a copy of which is herewith served upon you, and to serve a copy of your Answer to the said Complaint on the Plaintiff, or her attorney, J. Tyler Lee, Jr., at his office 119 East Main Street, Lexington, South Carolina 29072, within thirty (30) days after the service hereof, exclusive of the day of such service, and if you fail to answer the Complaint within the time aforesaid, the Plaintiff in this action will apply to the Court for the relief demanded in this Complaint.

McWHIRTER, BELLINGER, & ASSOCIATES, P.A.

BY:

J. Tyler Lee, Jr.
(Tyler Lee, Jr., (S.C. Bar No. 75443))
119 East Main Street
Lexington, South Carolina 29072
Office: (803) 359-5523
Fax: (803) 996-9080
tyler@mcwhirterlaw.com
Attorney for the Plaintiff

Lexington, South Carolina
April 17, 2015

2015 APR 17 PM 4:01
JENNIFER W. HARRIS
C.C.P. & G.S.
RICHLAND COUNTY
FILED

STATE OF SOUTH CAROLINA)

COUNTY OF RICHLAND)

IN THE COURT OF COMMON PLEAS
IN THE FIFTH JUDICIAL CIRCUIT

Taliah Shabazz,)

Plaintiff,)

-vs-)

Bertha Rodriguez,)

Defendant.)

Case No: 2015-CP-40-_____

**COMPLAINT
(JURY TRIAL REQUESTED)**

RICHLAND COUNTY
FILED
2015 APR 17 PM 1:01
JEROME W. HODGINS
C.C.P. & C.S.

TO: BERTHA RODRIGUEZ, THE DEFENDANT ABOVE-NAMED:

Upon information and belief, Plaintiff alleges the following:

1. The Plaintiff is a citizen and resident of the County of Fairfield, State of South Carolina.
2. The Defendant is a citizen and resident of the County of Richland, State of South Carolina.
3. Defendants are properly named herein.
4. Venue is proper pursuant to S.C. Code Ann. §15-7-30(C)(1976).
5. On or about May 8, 2012, Plaintiff was driving a 2000 Suzuki, bearing license plate number 8WA500.
6. On or about the same date and time, Defendant was driving a 2006 Dodge, bearing license plate number 5TSA191.
7. Plaintiff was traveling southbound on US 321 in the left lane.
8. Defendant was on a private drive. Defendant attempted to make a left turn to head northbound on US 321.

9. Defendant failed to yield the right of way to the Plaintiff while making said left turn, in violation of S.C. Code Ann. §56-5-2320, constituting negligence *per se*, and causing Plaintiff to strike the driver's side of Defendant's vehicle.
10. As a result of the Defendant's acts or omissions stated above, Plaintiff suffered great physical harm and injury to her head, shoulder, neck, and to other body parts which has caused and will in the future cause Plaintiff to undergo much physical pain, suffering, mental anguish, emotional distress, and permanent impairment of health and bodily efficiency, and has and will in the future cause Plaintiff to have to spend money for medical services.
11. Plaintiff's injuries and damages were directly and proximately caused by the Defendant, specifically, by her careless, negligent, and/or grossly negligent acts and/or omissions in the following particulars:
 - a) In failing to maintain a proper lookout;
 - b) In entering the intersection with vehicles approaching so close as to constitute an immediate hazard;
 - c) In failing to yield the right of way to oncoming traffic;
 - d) In failing to take evasive action so as to avoid colliding with Plaintiff's vehicle;
 - e) In failing to properly and timely apply his brakes, if any she had;
 - f) In failing to sound her horn;
 - g) In driving said vehicle in utter disregard of the rights and safety of the Plaintiff and others lawfully using the public highway at the time and place aforesaid; and

h) In other such particulars as the evidence at trial may show.

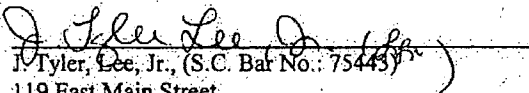
All of which were the direct and proximate cause of the injuries and damages suffered by the Plaintiff, said acts being in violation of the Statute and Common Laws of the State of South Carolina.

12. The Plaintiff is informed and believes she is entitled to judgment in this matter.

WHEREFORE, Plaintiff prays for judgment in a sum sufficient to satisfy actual damages, for punitive damages in an appropriate amount, for the costs of this action, and for such other and further relief as the Court may deem just and proper.

McWHIRTER, BELLINGER, & ASSOCIATES, P.A.

BY:


J. Tyler, Lee, Jr., (S.C. Bar No.: 75443)
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Lexington, South Carolina 29072
Office: (803) 359-5523
Fax: (803) 996-9080
tyler@mcwhirterlaw.com
Attorney for the Plaintiff

Lexington, South Carolina
April 17, 2015

STATE OF SOUTH CAROLINA)
COUNTY OF RICHLAND)

IN THE COURT OF COMMON PLEAS
IN THE FIFTH JUDICIAL CIRCUIT

Taliah Shabazz,

Case No: 2015-CP-40-_____

Plaintiff,

-vs-

**PLAINTIFF'S FIRST SET OF
INTERROGATORIES TO DEFENDANT**

Bertha Rodriguez,

Defendant.

TO: BERTHA RODRIGUEZ, THE DEFENDANT ABOVE-NAMED:

The Plaintiff, by and through her undersigned attorney, requests that you answer the following Interrogatories pursuant to Rule 33 of the South Carolina Rules of Civil Procedure:

1. Give the names and addresses of persons known to the parties or counsel to be witnesses concerning the facts of the case and indicate whether or not written or recorded statements have been taken from the witnesses and indicate who has possession of such statements.
2. Set forth a list of photographs, plats, sketches, video(s) or other prepared documents in possession of the Defendant that relate to the claim or the defense in this case.
3. Set forth the names and addresses of all insurance companies which have liability insurance coverage relating to the claim, and set forth the number or numbers of the policies involved and the amount or the amounts of liability coverage provided in each policy.
4. List the names and addresses of any expert witnesses whom the Defendant proposes to use as a witness at the trial of this case.
5. For each person known to the Defendant or counsel to be a witness concerning the facts of this case, set forth either a summary sufficient to inform the other party of the important

RICHLAND COUNTY
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2015 APR 17 PM 3:01
JEANNETTE W. HERR
C.C.P. & G.

facts known to or observed by such witness, or provide a copy of any written or recorded statements taken from such witnesses.

6. List the name and address of each person or entity to which the insurance adjuster responsible for this case has spoken or written while investigating the matters set forth in plaintiff's Complaint.

7. List each document, electronic or otherwise, which mentions or refers to the adjuster's contact or the content thereof with each person identified in response to the previous interrogatory.

8. State where the Defendant was coming from and going to at the time of the said accident.

9. State what traffic citation(s) the Defendant received as a result of this accident and note its disposition.

10. State whether or not the Defendant was working in the course of his employment at the time of the accident. If so, state the employer name and nature of said employment.

11. If the Defendant is improperly identified, give the proper identification and state whether counsel will accept service of an Amended Summons and Complaint reflecting the correct information.

12. Please identify all social and business networking websites, internet groups, forums, organizations, or other entities of which Defendant is a member, has an account or profile, or otherwise participates. This interrogatory is intended to include all account or identifying information concerning internet websites such as, but not limited to, Facebook, My Space, Twitter, LinkedIn, etc.

13. Please identify any information, material, writings, posts, updates, correspondence, photographs, email, and other items that have been deleted from any account or profile identified above after the date of the incident giving rise to this lawsuit.

14. Pursuant to S.C. Code Ann. 15-38-15 (D), please identify any person or entity, whether a party or not, whom you allege contributed to any injury or damages to the Plaintiff (or Plaintiff's Decedent).

15. Please provide the carrier(s) and telephone number(s) for any and all cellular telephones present in the vehicle at the time of the wreck, whether business or personal in nature.

16. Do you contend that the Plaintiff violated any traffic law at the time of or immediately prior to the collision in question? If so, please describe either by statute number or generally what you contend to be such traffic violations.

17. Describe in your own words how the collision occurred and state specifically and in detail what the claim or contention of the Defendant will be regarding any cause or contributing cause of the collision, including a statement in detail of the facts or information upon which this contention is based.

18. Describe in detail what damage was done to your vehicle in the collision, and give the cost or repair of your vehicle.

19. During the time period from 10 minutes prior to the wreck until the time of the wreck, which is at issue, state the following:

- a. Did you have on glasses or sunglasses?
- b. Did you have anything in your hands or were you eating or drinking anything?
- c. Were you talking on a mobile telephone?

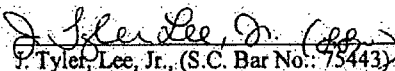
- d. Did you have a mobile telephone in your vehicle?
- e. Was there a pet in your vehicle?
- f. Was your radio, tape player, CD player or I-pod playing?
- g. Is there a GPS in your vehicle? If so, were you using it at the time of the wreck?

20. Identify all documents obtained by the defendant(s) or anyone acting on his behalf via Subpoena *duces tecum*, signed authorization form, FOIA request, or other legal process. This is intended as an ongoing request pursuant to SCRPC 34 and 45(c)(2)(A) and applies to any Subpoena *duces tecum* or other request, form, or process issued or sent either before or after these Interrogatories.

These interrogatories shall be deemed to continue from the time of service until the trial of the case and any information obtained whether by the Defendant or their attorney shall be promptly submitted to the undersigned.

McWHIRTER, BELLINGER, & ASSOCIATES, P.A.

BY:



J. Tyler Lee, Jr., (S.C. Bar No.: 75443)

119 East Main Street

Lexington, South Carolina 29072

Office: (803) 359-5523

Fax: (803) 996-9080

tyler@mcwhirterlaw.com

Attorney for the Plaintiff

Lexington, South Carolina
April 17, 2015

STATE OF SOUTH CAROLINA)
COUNTY OF RICHLAND)

IN THE COURT OF COMMON PLEAS
IN THE FIFTH JUDICIAL CIRCUIT

Taliah K. Shabazz,
Plaintiff,

Case No: 2015-CP-40-_____

-vs-

Bertha I. Rodriguez,
Defendant.

PLAINTIFF'S FIRST SET OF
REQUESTS FOR PRODUCTION
TO DEFENDANT

RICHLAND COUNTY
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2015 APR 17 PM 1:02
JEANNETTE W. MCBRIDE
Clerk of Court

TO: BERTHA I. RODRIGUEZ, THE DEFENDANT ABOVE-NAMED:

Pursuant to Rule 34 of the South Carolina Rules of Civil Procedure, the Plaintiff, above-named, hereby requests that the Defendant respond within thirty (30) days after the service hereof to the following request, to-wit, that the Defendant produce and permit the undersigned attorney for said Plaintiff to inspect, copy or photograph each of the following documents or things, which may be in the possession, custody or control of the Defendant or his attorney:

1. All photographs, diagrams, drawings, or other similar material relating to the incident as set forth in the Complaint.
2. All affidavits and statements of possible witnesses, whether written, oral, summarized, or otherwise reproduced in any manner, relating to the incident as set forth in the Complaint.
3. All repair bills, estimates, reports, or other written or printed documents relating to any damage to personal or real property.
4. All surveillance on any party or witness.

5. All documents and things obtained pursuant to any and all subpoenas issued in this action.

6. All documents and things referred to in Defendant's Answers to Plaintiff's Interrogatories.

7. Copies of all documents obtained by the defendant(s) or anyone acting on his behalf via Subpoena Duces Tecum, signed authorization form, FOIA request, or other legal process. This is intended as an ongoing request pursuant to SCRCP 34 and 45(c)(2)(A) and applies to any Subpoena Duces Tecum or other request, form, or process issued or sent either before or after these Request for Production.

McWHIRTER, BELLINGER, & ASSOCIATES, P.A.

BY:

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J. Tyler, Lee, Jr., Esquire (S.C. Bar No.: 75443)
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Fax: (803) 996-9080
tyler@mcwhirterlaw.com
Attorney for the Plaintiff

Lexington, South Carolina
April 17, 2015

STATE OF SOUTH CAROLINA)
COUNTY OF RICHLAND)

IN THE COURT OF COMMON PLEAS
IN THE FIFTH JUDICIAL CIRCUIT

Taliah K. Shabazz,

Case No: 2015-CP-40-_____

Plaintiff,

-vs-

PLAINTIFF'S REQUEST FOR
ADMISSIONS TO DEFENDANT

Bertha I. Rodriguez,

Defendant.

2015 APR 17 PM 1:02
JENNIFER W. MCORRISTE
CLERK, P. & C.S.
RICHLAND COUNTY
FILED

Plaintiff makes the following Requests for Admissions, pursuant to Rule 36 of the South Carolina Rules of Civil Procedure, and demands that within thirty (30) days after the service of these Requests on the Defendant or attorney, the Defendant specifically admit under oath or deny under oath the following facts. A failure to specifically answer any requests or the statement of an evasive answer to any request will be taken as an admission of the truth of such request.

1. Admit that the wreck in question was caused by the negligence of Defendant.
2. Admit that the Plaintiff was not contributorily negligent.
3. Admit that the Plaintiff was not comparatively negligent.

McWHIRTER, BELLINGER, & ASSOCIATES, P.A.

BY:

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tyler@mcwhirterlaw.com
Attorney for the Plaintiff

Lexington, South Carolina
April 17, 2015

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FORM 1
NOTICE OF APPEAL IN A CIVIL CASE

THE STATE OF SOUTH CAROLINA
In The Court of Appeals
[Judgement in a Civil Case]

APPEAL FROM RICHLAND COUNTY
Court of Common Pleas

Honorable L. Casey Manning, Circuit Court Judge

Case No. 2015-CP-40-02395

Allyce Bailey Attorney for
Bertha Rodriguez/ Liberty
Mutual Insurance Company

Respondent,

v.

Taliah K. Shabazz

Appellant.

NOTICE OF APPEAL

Taliah K. Shabazz appeals the order denying motion for a new trial and motion for an additur by the Honorable Casey L. Manning dated October 10, 2016. Appellant received written notice of entry of this order denying the motion for a new trial and motion for an additur on October 18, 2016.

November 8, 2016

Taliah K. Shabazz
6289 U.S Highway 321 S.
Winnsboro, South Carolina 29180
(803) 635-1457
Appellant

Other Counsel of Record:
Allyce Bailey
Post Office Box 1473
Columbia, South Carolina 29202
Attorney for Bertha Rodriguez/ Liberty Mutual Insurance Company
(803) 227-4329

RECEIVED
NOV 08 2016
SC Court of Appeals

FORM 7
PROOF OF SERVICE OF A NOTICE OF APPEAL

THE STATE OF SOUTH CAROLINA
In The Court of Appeals
[JUDGEMENT IN A CIVIL CASE]

APPEAL FROM RICHLAND COUNTY
Court of Common Pleas

Honorable Casey L. Manning, Circuit Court Judge

Case No. 2015-CP-40-02395

RECEIVED

NOV 08 2016

SC Court of Appeals

Allyce Bailey, Attorney for
Bertha Rodriguez / Liberty
Mutual Insurance Company

Respondent,

v.

Taliah K. Shabazz

Appellant.

PROOF OF SERVICE

I certify that I have served the Notice of Appeal on Bertha Rodriguez / Liberty Mutual Insurance Company by depositing a copy of the Notice of Appeal in the United States Mail, postage prepaid, on November 8, 2016, addressed to their attorney of record, Allyce Bailey, Post Office Box 1473, Columbia South Carolina 29202.

November 8, 2016

s/ Taliah K. Shabazz

Taliah K. Shabazz

6289 U. S Highway 321 S

Winnsboro, South Carolina, 29180

(803) 635-1457

Appellant

1 going to be a very short trial. It's consistent in this
2 state that jurors don't take notes because if you do so and
3 write down a mistake in error, it might be more detrimental
4 rather than helpful in reaching a verdict in this case. So
5 your responsibility is to listen carefully individually,
6 that way collectively, you can make a very just decision and
7 that's all anybody wants in this case.

8 Now, with that in mind, there's one little change,
9 we're going to hear the opening statements on behalf of the
10 parties and then we're going to conclude for the day. We'll
11 start testimony in the morning. Is that fair enough to
12 everybody?

13 All right, Mr. Lee, you may proceed, sir.

14 MR. LEE: Good afternoon, everybody. I'm Tyler
15 Lee and I represent Ms. Shabazz, who is here today with her
16 mother (indicating). And y'all are going to hear their
17 testimony tomorrow.

18 I know that it's hard for you to be here.
19 Everybody here is losing time from something to be here and
20 serve on the jury, but it is extremely important that we
21 have this court. And the only reason we have this court is
22 because of people like y'all who are willing to take the
23 time to be here and fulfill your duty. And this court is
24 how we resolve disputes and how we start to make things
25 right when one person has injured another in some kind of

1 way and this case, it's through a car wreck.

2 We've got some basic rules in society. We have
3 laws, but each law can, basically, be broken down into a
4 common sense rule. And one of those major rules is that no
5 one is allowed to needlessly endanger the public, which is
6 kind of a fancy way of saying you've got to follow the
7 safety rules when you're doing an activity. If you're a
8 professional, like a medical doctor, you've got to make sure
9 you follow all the rules to treat someone safely. And even
10 when you're doing something as simple as driving a car,
11 there's a lot of rules that we're supposed to follow. The
12 State puts out a booklet. You remember all those rules in
13 driver's ed? And you follow all the rules. And if
14 everybody follows the rules, then it's a relatively safe
15 activity. If someone breaks those rules, then the law says
16 that they are responsible for the harms that have been
17 created by them breaking those rules. And it is your job as
18 the jury in a case like this to enforce those rules.

19 What does it mean to enforce the rules? Well, it
20 means that if someone breaks the rules that there's a
21 consequence. And the way you enforce those rules is you
22 give a verdict that fairly compensates Ms. Shabazz for all
23 of the harms that were created by Ms. Rodriguez. And that's
24 all that we're going to be asking y'all to do today and
25 tomorrow, is to listen to the evidence and come up with a

1 figure that you think fairly represents the harms that were
2 created. Because in this case, like Judge Manning said,
3 Ms. Rodriguez, through her attorney, has already admitted
4 that the wreck was her fault, so you're not going to have to
5 even take that into consideration.

6 You're going to hear from Ms. Shabazz and from her
7 mother, what she's been through. And you're going to hear
8 from Dr. Ogburu through his deposition testimony a little
9 bit more about the medical expenses -- or not expenses, but
10 treatment that she has received.

11 And the reason that the law requires you to do
12 this is two-fold, one is so that the Defendant will not be
13 rewarded by getting a free pass for breaking the safety
14 rules. There will be consequences and incentive for people
15 to follow the rules. And the other is to make things right
16 for Ms. Shabazz and take care of a member of our community.

17 We're going to talk more about this wreck. The
18 evidence is going to show you this happened on May 8th,
19 2012. Ms. Shabazz was on her way to Midlands Tech and the
20 Defendant, Bertha Rodriguez, she was driving a big van,
21 pulled out in front of Ms. Shabazz on 321. Ms. Shabazz was
22 on her way, actually, to take her final exams. And the
23 evidence will show that lady pulled out in front of her.
24 Ms. Shabazz had no time to avoid it and there was a
25 collision. I did not drag y'all in here for a fender

1 bender, okay. I've got photographs and stuff to show you
2 that Ms. Shabazz's car was very seriously damaged. The
3 airbags came out and all this other stuff. It was a major
4 impact. And I'm also going to submit medical records and
5 the testimony of the doctor that, unfortunately, Ms. Shabazz
6 was very seriously injured in this wreck. And even more
7 importantly, at age 19, her doctor opined that -- gave an
8 opinion that she has a permanent injury. The degree of
9 injury that's never going to 100 percent go away.

10 After the wreck, you will see the evidence that
11 the ambulance came to get her. They took her to the
12 emergency room. She had pain at a ten out of ten in her
13 neck. We'll talk more about that. The pain scale, one
14 being the least amount of pain and 10 being the worst. She
15 was having the worst amount of pain. She had seatbelt burns
16 on her neck and chest according to the medical records. It
17 was so bad that a month later, she had to go see an
18 orthopedic surgeon, Dr. Nahigian. You'll get to see those
19 records and we'll talk about that. You'll be able to read
20 for yourself the words that he wrote, there's a substantial
21 high energy injury to her shoulder and her neck, a
22 tremendous amount of muscle spasm, severe pain. That
23 surgeon sent her to physical therapy, which she did almost
24 constantly for about the first three months. And,
25 eventually, Dr. Ogburu is going to testify to you that due

1 to having constant pain in her neck and left shoulder when
2 she had that high energy injury, she developed these
3 crippling headaches, unfortunately, that she had three to
4 five times a week. She still suffers from pain in her neck,
5 her shoulder and still has these headaches. So, ultimately,
6 she had to go and see an actual neurologist for that. And
7 that's the doctor who said that she's permanently injured in
8 her neck at age 19, unfortunately.

9 After we present all of that evidence to you, I am
10 going to get back up here and I'm going to ask you to render
11 us a verdict that you think is fair that takes into
12 consideration all of the harms that she has suffered and
13 that enforces the rule that keeps us all safe on the road
14 and to make sure that we have consequences for not following
15 those rules. Thank you.

16 THE COURT: Ms. Bailey.

17 MS. BAILEY: May it please the Court?

18 THE COURT: Yes, ma'am.

19 MS. BAILEY: Good afternoon, everyone. While I am
20 well aware there are numerous people in this room that chose
21 to be a part of the legal system, whether that be myself,
22 the Judge, the bailiffs in this room and Plaintiff's
23 counsel, none of you guys chose to be here. And I am
24 confident there is somewhere else each of you want to be
25 today other than sitting in this courtroom. So I am

1 genuinely thankful that you all have chosen to accept your
2 service as jurors and appreciate your time and we are hoping
3 to not keep you here too long.

4 Judge Manning has already addressed one of the
5 elephants in the room and that's there's no one sitting at
6 the table with me. Ms. Rodriguez is not here. But if she
7 was here, I would be standing before you admitting the exact
8 same thing that Plaintiff's counsel and Judge Manning have
9 already mentioned, that we admit that we are at fault for
10 this accident. The only reason that we are here today is to
11 talk about whether or not the injuries that Ms. Shabazz
12 received and the treatment that she underwent, whether or
13 not it was reasonable, whether or not her injuries were
14 caused by our accident, and how much money, if any, she
15 should be awarded from Ms. Rodriguez because of that
16 accident. Ms. Rodriguez is not a doctor. She's not a
17 lawyer. And therefore, she wouldn't really be able to add
18 too much more to testimony today outside of admitting that
19 she was at fault for the accident, which we have already
20 done. So I would appreciate us all just focusing on what's
21 important today and that's Ms. Shabazz. We are all here to
22 focus on resolving this case for Ms. Shabazz so we can all
23 get back to our lives.

24 This accident happened on May 8th, 2012. May 8th,
25 2012, Ms. Shabazz went to the emergency room and she

1 complained of three symptoms. She complained of neck pain,
2 shoulder pain and wrist pain. She treated with a physician
3 for eight months, from May 8th, 2012, to January 9th, 2013.
4 And every single time she went to the doctor from May 8th,
5 2012, to January 9th, 2013, she complained of the exact same
6 three symptoms, that neck pain, that shoulder pain and that
7 wrist pain. On January 9, 2013, Ms. Shabazz stopped going
8 to the doctor. She stopped going to any doctor. And four
9 and a half months went by and she eventually went back to a
10 physician. And at that next visit, she still complained of
11 the same exact three symptoms, shoulder pain, neck pain and
12 wrist pain.

13 But on that next visit, a year after the accident,
14 on May 24th, 2013, Ms. Shabazz had a new symptom of chronic
15 migraine headaches. An entire year went by, she went to the
16 doctor consistently for eight months and never mentioned a
17 chronic migraine headache. I'm not disputing that
18 Ms. Shabazz suffers from migraines. I am not someone who
19 suffers from those. I hear they're awful and I would not
20 wish them on my worst enemy. I do not believe that she is
21 lying about suffering from those headaches. I am disputing
22 whether or not our accident is what caused those migraine
23 headaches. Four and a half months went by between her
24 visiting any type of doctor. A lot can happen in four and a
25 half months and a lot can happen in a year after the

1 accident, whether that's allergy season, an old eyeglass
2 prescription or just stress from college classes. We just
3 aren't sure what caused those migraine headaches.

4 All I'm asking you to do today and tomorrow as you
5 listen to the evidence is pay attention to all of the
6 evidence that you hear and ask yourself if the Plaintiff has
7 proven to you that these headaches were caused by our
8 accident beyond just asking you to assume that if she didn't
9 have the headaches before the accident, they must have been
10 caused by our accident. Listen to the evidence, use your
11 reasonableness and your common sense. And that's
12 essentially all I'm asking you to do.

13 At the end of this case, I'm going to ask you to
14 do the same thing that I'm asking you to do now and that is
15 just be fair and reasonable. I'm not asking you to give
16 Mr. Shabazz zero dollars. I'm asking you to be fair and
17 reasonable based upon whether or not she has proven these
18 headaches and the treatment she received as a result of
19 those headaches was related to our accident.

20 Thank you very much for your attentiveness and I
21 hope that we can get you out of here shortly.

22 THE COURT: Now, members of the jury, it's a
23 little bit earlier than we anticipated, but it was my
24 decision to decide to start this case, that is the evidence,
25 the presentation of the evidence in the morning. So I'm the

- 1 gone on for more than a year.
- 2 Q. And what is an impairment rating?
- 3 A. Impairment rating is assessment of patient's long term
- 4 procedural disability, something like that, you know,
- 5 that whatever it's like from their normal state as to
- 6 being a problem.
- 7 Q. When you assign someone an impairment rating, is that
- 8 the same as saying that they have a permanent injury?
- 9 A. Most likely it suggest they have a permanent injury.
- 10 Q. And in this case, it looks like you assigned class one,
- 11 grade B. What is that referring to?
- 12 A. This is all from the Sixth Edition of the Disability
- 13 and Impairment Rating Book. I think this more or less
- 14 talk about whatever the book says about a class one.
- 15 Q. And what book are we talking about?
- 16 A. The Sixth Edition of the Disability Rating book.
- 17 Q. And who publishes the Disability Rating Book?
- 18 A. I think it's the AMA.
- 19 Q. Is that the American Medical Association?
- 20 A. Yes.
- 21 Q. Is that a book that doctors use to help them say what
- 22 someone's permanent injury is?
- 23 A. Yes.
- 24 Q. And it looks like you assigned UEI?
- 25 A. Upper extremity.

- 1 Q. All right. And converts to one percent WPI?
- 2 A. Whole body.
- 3 Q. Okay.
- 4 A. Whole body impairment rating.
- 5 Q. Thank you. Now, if we can move ahead to our next visit
- 6 a month later on 8/15/2013?
- 7 A. Okay.
- 8 Q. How was she doing on that visit?
- 9 A. The same thing, headache, neck pain and shoulder --
- 10 shoulder pain.
- 11 Q. Do you have the history of present illness?
- 12 A. Yes. A 21-year-old female present today for scheduled
- 13 followup visit with complaint of migraine and neck
- 14 pain. She describes the pain as aching, shooting,
- 15 sharp, throbbing. Pain is constant -- level is fair.
- 16 Pain level is six over 10. Patient has a history of
- 17 left shoulder blade pain, was involved in MVA in 2012.
- 18 Having about four headaches per week. Headache lasting
- 19 up to three hours before feeling any type of relief.
- 20 Note tightness and spasm to the center of the scapula
- 21 area. She notes taking Soma for relief. Notes
- 22 interest in cortisone injections. No seizure, no loss
- 23 of consciousness or any hospitalization.
- 24 Q. So you say notes taking Soma for relief, what is Soma?
- 25 A. Soma is a antispasmodic, a muscle relaxer.

1 print it and when you type it in, it looks totally
2 different. If I see before then, I can go back in
3 there and then correct the exact date based on what the
4 patient says is the beginning date.

5 Q. So if she had told you that her headaches started
6 before January 10th, 2014, would you have put a
7 different date down there?

8 A. Yeah, I would have put a different date. So I think
9 that information would probably appear in the history
10 of present illness.

11 Q. This is another one of your records from May 9th, 2014.
12 You noted there that she was having headaches and
13 blurry vision there. Again, just a simple general
14 question, would you say that an outdated glasses
15 prescription could potential cause headaches?

16 A. Yes.

17 Q. My final question for you, Doctor, is that now that
18 you're aware that Ms. Shabazz did not complain of these
19 headaches for a year, do you still believe that to a
20 reasonable degree of medical certainty that the
21 accident that she was involved in caused these
22 headaches?

23 A. All you can say probably is that it did contribute
24 somehow because she still has some kind of neck and
25 shoulder pain. So those things, the cervical strain

1 and cervical spasms can still give you a reflex
2 headache, but it may not. It depends on the
3 individual. It may be bad to the point that it may go
4 on for a while. As far as the neck and shoulder
5 problem, you can have a reflex headache which continues
6 for a long period of time.

7 Q. Would you consider a reflex headache and a migraine the
8 same thing?

9 A. You have to understand, you know, when on the present
10 illness, you go by whatever the patient says. So if
11 the patient says, you know, I'm having a headache or a
12 migraine, then that's what you type in. Do you
13 understand? Even though you evaluate the patient and
14 you may now think it meets the criteria for a classic
15 migraine or a complex headache because most people when
16 you talk about a headache, they just, you know, if it
17 goes on for long time, they call it a migraine even
18 though it may not by our definition meet that criteria.

19 Q. So it's your understanding if a -- what you're saying
20 is that if a client came into your office and stated
21 they had a migraine, that's what you would have written
22 down in your notes?

23 A. No. No. On the history of present illness, when
24 you're gathering -- history of present is provided by
25 the patient. So, basically, you're writing down what

- 1 the patient says. Under treatment plan, you know,
2 that's when -- you know, and your own assessment,
3 that's when you began to make clarification as to what
4 kind of headache does the patient have.
- 5 Q: So what kind of headaches did Ms. Shabazz have?
- 6 A: I think she may have had musculoskeletal-type headache
7 proximate to cervical spasm. I know there's an
8 prescription that may have worsened the problem. If it
9 was severe muscle spasm or neck pain, it is more likely
10 some people would have headaches from that.
- 11 Q: Do you think that it's likely that someone with the
12 type of headache of the severity that Ms. Shabazz
13 complained of would be able to suffer through that type
14 of pain without mentioning it to any physician for a
15 year?
- 16 A: I don't think so. I don't think so unless you have
17 neck pain that's so severe that she's only paying
18 attention to that. When she's -- neck is feeling a
19 little better, then maybe she be aware of the headache
20 or something else made her become aware of the
21 headache. But most likely, I think she would have
22 mentioned something about, you know, prior to that
23 date.
- 24 MS. BAILEY: Can you just read that again? You
25 said -- just reread it again and be very close to -- just

1 at least mentioned it to somebody, but somehow that's
2 how she got that.

3 MS. BAILEY: It's back to you.

4 THE PLAINTIFF: Okay.

5 REDIRECT EXAMINATION

6 BY MR. LEE:

7 Q. Dr. Ogburu, you treated her for symptoms other than
8 just headache, right?

9 A. Yes. I got into what she was complaining about, yes.

10 Q. And that would be pain in the shoulder blade or
11 suprascapula area?

12 A. Uh-huh, and the neck.

13 Q. And the neck?

14 A. Yes.

15 Q. All right. Are those problems that you addressed with
16 her on every visit?

17 A. Yes.

18 Q. All right. So even if her headaches were not related,
19 you would agree that the treatment she had with you
20 was, is that correct?

21 A. Yes.

22 Q. All right. And just to clear something up, my
23 colleague, Ms. Bailey, pointed out your note on January
24 10th, 2014, where it appears that the onset date of all
25 her problems was January 10th of 2014. She, of course,

1 had seen you several times prior to January 10, 2014;
2 is that right?

3 A. Yeah. We upgraded to the electronic medical system, so
4 I think probably by now I'm getting used to it, you
5 know. The problem is every time you enter it in, it
6 logs it there and unless somebody is aware and goes
7 back and put the right date, it locks it. If I go
8 there and put some, you know, it locks it. If I've
9 seen someone for 20 years about neck pain and I said
10 something about it and it locks it -- or excuse me,
11 then it locks it.

12 Q. So we believe that this is a computer error?

13 A. Yeah, that's computer error, yes.

14 Q. All right. I don't have any more questions. Thank
15 you.

16 THE COURT: Anything further from this witness?

17 MS. BAILEY: No, Your Honor.

18 THE COURT: All right. You may step down, Doctor.
19 Anything further from the Plaintiff?

20 And it's all wrapped up in one ball, right?

21 MS. BAILEY: Yes.

22 THE COURT: Members of the jury, I think you've
23 heard all the evidence you shall receive in this case. We
24 sort of combined it all in one, both the Plaintiff's and the
25 Defendant's case through cross-examination. That makes

TABLE 15-5 Shoulder Regional Grid: Upper Extremity Impairments

Shoulder Regional Grid					
IMPAIRMENT CLASS	CLASS 0	CLASS 1	CLASS 2	CLASS 3	CLASS 4
IMPAIRMENT RANGES (upper extremity %)	0	1%-13% UE	14%-25% UE	26%-49% UE	50%-100% UE
GRADE		A B C D E	A B C D E	A B C D E	A B C D E
SOFT TISSUE*					
Shoulder pain,* nonspecific shoulder pain following injury or occupational exposure	0 No significant symptoms or signs at MMI	0 0 1 1 1 History of painful injury, residual symptoms without consistent objective findings (this impairment can only be given once in an individual's lifetime).			
Shoulder contusion or crush injury* with healed minor soft tissue or skin injury		1 2 2 2 3 Residual symptoms and consistent objective findings at MMI.			
Shoulder bursitis					
MUSCLE/TENDON*					
Shoulder pain* nonspecific shoulder pain post acute injury or surgery (not otherwise specified)	0 No significant symptoms or signs at MMI	0 0 1 1 1 History of painful injury, residual symptoms without consistent objective findings (this impairment can only be given once in an individual's lifetime).			
Sprain/strain* No residual instability or loss of motion but persisting pain at MMI.	0 No significant objective abnormal findings of muscle or tendon injury at MMI	0 1 1 2 2 History of painful injury, residual symptoms without consistent objective findings (this impairment can only be given once in an individual's lifetime).			

(continued)

Dr. Ogburu assigned Miss Shabazz an impairment rating Soft tissue column: shoulder contusion or crush injury with minor soft tissue or skin injury. Class 1 grade B 2% UEI. **Note only measured Class 0 and Class 1. Shoulder Contusion category MMI measured 1%- 3%.**

CHAPTER 3

Pain-Related Impairment

Chapter 3

- 3.1 Definition and Classification of Pain
- 3.2 Controversies Surrounding Pain-Related Impairment
- 3.3 The Rating System
- 3.4 Future Directions—Need for Research and Dialogue to Establish the Validity of Rating Pain-Related Impairment
- 3.5 Conclusion
- 3.6 Examples
- 3.7 Appendixes

Introduction

The assessment of impairment associated with chronic pain creates vexing problems for any impairment rating system. Experts have disagreed about the usefulness and questioned the validity of the rating systems for pain-related impairment (PRI) described in previous editions of the *Guides*, and these difficulties have continued throughout the development of the current chapter.

Several factors contribute to the controversies that have surrounded PRI:

- There are fundamental conceptual problems when pain is construed as a cause of impairment, primarily because there is no objective way to quantify pain or its variable effects on the individual.
- Empirical data are sparse about the role of pain in impairment. As a result, both proponents and opponents of PRI must rely on rhetoric rather than scientific data when they support their positions.
- Whereas much of the AMA *Guides'* system reflects consensus among experts in various areas of medicine, consensus about the appropriate role of PRI

Chapter 3 explains impairment rating system and what it means for a patient with a PRI. Pain Related Impairment. Pages 31-41.

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has been lacking. At one extreme, some experts in pain medicine have argued that PRI should be given a prominent role in the *Guides*, and that the PRI rating system should permit high percentages of whole person impairment (WPI) to be awarded for chronic pain. In contrast, others have argued that PRI should be dispensed with altogether:

- The arguments for and against the inclusion of PRI in the *Guides* have not been articulated in published articles and thus have not been subjected to the public scrutiny that would be expected for such an important topic. A consequence is that the present authors have had to rely primarily on informal data sources as we discuss the arguments for and against PRI.

3.1 Definition and Classification of Pain

3.1a Definition of Pain

The International Association Study of Pain defines pain as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage."² Pain is a prominent symptom in many acute injuries and illnesses, and often subsides as the medical condition resolves. Since such acute pain is usually short lived, it is not a problem that is considered in an impairment rating system. However, chronic pain is a problem that potentially could be the cause for an impairment rating. The definition of chronic pain is imprecise but, in a general way, it refers to pain that persists over time. For the purposes of the *Guides*, chronic pain is defined as pain that persists beyond the expected healing time of the medical disorder thought to have initiated the pain. For many sections in the *Guides*, chronic pain will be pain that persists beyond 3 months, as most common conditions affecting the musculoskeletal and other organ systems will substantially heal in this time frame. The nervous system is a notable exception. Although any time point is arbitrary, 3 months should encompass the expected healing time in most situations where there is tissue injury but will allow for situations in which there is no expected healing time.³

3.1b Chronic Pain Syndrome

In both the Fourth and Fifth Editions of the *Guides*, a definition of *chronic pain syndrome* (CPS) was included that captured the major *biopsychosocial* characteristics of chronic pain. Indeed, the *biopsychosocial* approach to chronic pain and disability is

Definition of pain and chronic pain syndrome (CPS). The symptom and problems patients incur when dealing with (CPS).

currently viewed as the most heuristic perspective to the understanding, assessment, and treatment of chronic pain disorders, and has replaced the outdated biomedical reductionist perspective.⁴ This biopsychosocial approach views chronic pain as a complex and dynamic interaction among biological, psychological, and social factors that perpetuates, and may even worsen, the clinical presentation. Each person will experience a chronic pain condition uniquely, thus accounting for the great individual differences in how pain is expressed. The complexity of a chronic pain disorder is especially evident when it persists over time, as a range of psychosocial and economic factors can interact with pathophysiology to modulate a patient's report of discomfort and disability associated with chronic pain. Moreover, even as healing occurs, all patients experience some degree of *physical deconditioning* associated with stiffness and muscle atrophy in the injured area. Risk factors for profound deconditioning with the injured area becoming a "weak link" include extended periods of inactivity, inhibition of function due to pain, and *fear avoidance*. In striking contrast, the traditional and outdated biomedical approach assumes that all pain symptoms have specific physical causes, and attempts to eradicate the cause directly by identifying and rectifying the presumed pathophysiology. However, chronic pain can rarely be understood by the linear, nociceptive mechanism. As will be discussed later in this chapter, there is often an absence of a documentable relationship between pain and pathophysiology.

With the above biopsychosocial perspective in mind, CPS can be described as pain that continues beyond the normal healing time for the patient's diagnosis and includes significant psychosocial dysfunction. It should be noted that this definition does not include any specific time frame to use in making the diagnosis of CPS. This omission is intentional and reflects clinical reality, in that some conditions would be expected to resolve in several days and others in several months or even years. The diagnosis of CPS should then be temporally connected to the point at which a given condition or conditions were expected to have resolved, rather than to any arbitrary time period for an injury or event. Regardless of when it occurs, CPS is a condition that ultimately adversely affects the patient's well-being, level of function, and quality of life. The major characteristics associated with CPS include the following, with 3 or more required for a diagnosis:

- Use of prescription drugs beyond the recommended duration and/or abuse of or dependence on prescription drugs or other substances.
- Excessive dependence on health care providers, spouse, or family.

- Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain.
- Withdrawal from social milieu, including work, recreation, or other social contacts.
- Failure to restore pre-injury function after a period of disability, such that the physical capacity is insufficient to pursue work, family, or recreational needs.
- Development of psychosocial sequelae after the initial incident, including anxiety, fear-avoidance, depression, or nonorganic illness behaviors.

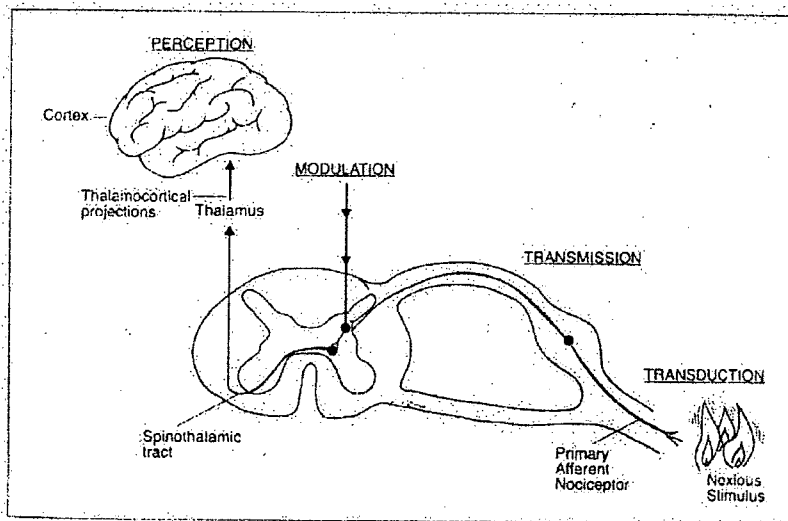
3.1c Nociceptive Pain

Nociception refers to the normal series of physiologic events that links tissue injury to the perception of pain (Fig 3-1). The process begins with *transduction* of a stimulus at the site of injury; chemical, mechanical, and thermal stimuli all can elicit responses in specific subsets of neurons that carry pain stimuli. These stimuli result in increased fir-

ing rates in pain-specific neurons that are connected to the spinal cord. The next step in nociception—*transmission* of pain signals—occurs through the conduction of nerve impulses along the peripheral nerves to the dorsal horn of the spinal cord, where the impulses activate second-order neurons that, in turn, relay the pain signals through the thalamus to the cerebral cortex where pain *perception* occurs. *Modulation* of the incoming pain signal can occur at many points along the nociceptive pathway, and many of the pain treatments available today influence the perception of pain by influencing the degree of modulation of the incoming pain signals. Thus, *nociceptive pain* refers to pain that arises through the normal activation of pain pathways (ie, the nociceptive system). Nociceptive pain serves as an essential protective mechanism. It alerts the individual to the presence of potentially damaging stimuli and warns that person to protect the affected area until tissue healing ensues. Once the inciting stimulus is removed and tissue healing has ensued, nociceptive pain typically resolves.

FIGURE 3-1
Nociception

Sequence of normal physiologic events leading to pain perception begins with *transduction* of a potentially tissue-damaging noxious stimulus (chemical, thermal, or mechanical) into nerve impulses. *Transmission* of nerve impulses occurs along the peripheral nerve toward the dorsal horn of the spinal cord, where signals are relayed via second-order neurons to the cerebral cortex, where they result in pain *perception*. The magnitude of the incoming pain stimuli undergoes *modulation* by descending inhibitory traffic; this modulation is the mechanism underlying the analgesia produced by both endogenous and exogenous opioid analgesics.



Adapted from Katz N, Ferrante FM. Nociception. In: Ferrante FM, VadeBoncouer TR (editors). *Postoperative Pain Management*. New York, NY: Churchill Livingstone, 1993.

3.1d Neuropathic Pain

Traditionally, neuropathic pain has been defined as pain caused by abnormal function of the nervous system due to injury or disease. A key feature of neuropathic pain is that, although an affected individual perceives pain as emanating from some bodily structure (eg, the distal lower extremity in sciatica, the radial aspect of the hand in carpal tunnel syndrome), the pathophysiologic basis for the pain is an abnormality in the functioning of the nervous system, rather than an abnormality in the "end-organ" where the pain is perceived. Thus, the simple relation between end-organ damage and pain perception found in nociceptive pain is absent in neuropathic pain.

Neurobiologic research during the past 20 years has conclusively demonstrated that injury and accompanying nociception can induce functional changes in the nervous system that lead to something akin to neuropathic pain. Activation of peripheral nociceptive nerve fibers almost immediately modifies the nerve's response to further stimuli. Nociceptive stimulation results in the release of neurotransmitters and peptides that increase the excitability or "sensitize" sensory neurons.⁹ This peripheral sensitization is associated with an increased sensitivity to mechanical and thermal stimuli, and results in reports of pain to normally nonpainful stimuli (allodynia) and an increase in the magnitude of pain caused by noxious stimuli (hyperalgesia). Increased input from peripheral nociceptive neurons, in turn, leads to alterations in the spinal cord dorsal horn, both disinhibition and increased responsiveness of central neurons.⁹ This central sensitization can lead to a number of symptoms and signs, including spontaneous pain, spreading pain, and hypersensitivity to touch and extremes of temperature. Indeed, such increased responsiveness to stimuli has been demonstrated in patients with chronic pain following whiplash injury and in those with fibromyalgia.¹¹ The processes of peripheral and central sensitization are a normal consequence of tissue injury, and they offer significant protection to the organism; after tissue injury, sensitization serves as a reminder that the region is injured and should be closely guarded until the tissue has healed. However, the same neuronal mechanisms can lead to persistent pain even after all evidence of the initial inciting disease or injury have resolved. This persistent sensitization can subserve pain perceptions that share key features with neuropathic pain as defined above, including:

- **Spontaneous Pain**—pain that occurs without a specific sensory stimulus (eg, the sudden lancinating pain described by those with postherpetic neuralgia).

- **Paresthesia/dysesthesia**—abnormal pain distant from the site of actual tissue injury that may be spontaneous or evoked (eg, the radiating pain associated with lumbar nerve root compression).
- **Hyperalgesia**—an exaggerated painful response to a normally noxious stimulus (eg, light pinprick leads to extreme and prolonged pain).
- **Allodynia**—a painful response to a normally nonnoxious stimulus (eg, light touch causes pain).

Pain specialists and neurobiologists are divided on the question of whether pain secondary to nervous system sensitization, such as that believed to occur in patients with fibromyalgia, should be construed as a form of neuropathic pain.¹² For purposes of rating PRI, however, pain associated with nervous system sensitization is similar to neuropathic pain in that an individual's perceptions of pain are dissociated from end-organ injury or dysfunction. If anything, pain associated with nervous system sensitization is even more elusive than traditional neuropathic pain. The reason for this is that, although the link between end-organ dysfunction and pain is severed in neuropathic pain, there is typically objectively measurable damage to the nervous system. In contrast, individuals suffering from pain associated with nervous system sensitization frequently do not have objective evidence of damage or dysfunction, either in the end-organ where the pain is perceived or in the nervous system.

3.1e Persistent Pain as a Disease Entity

Persistent pain is a major health problem, with between 18% and 50% of the population reporting continuous pain for at least 3 of the last 6 months.¹³⁻¹⁵ Chronic pain has been linked with significant disability.¹⁶ Although pain has been traditionally regarded as a symptom that serves as a warning signal of an underlying disease process, there is accumulating evidence that persistent pain should be considered a disease entity in its own right.¹⁷ Indeed, permanent changes in the responsiveness of both the peripheral and central nervous systems can persist even after all tissue healing has ensued; thus, persistent pain can become a self-perpetuating condition. The individual is often left with ongoing pain without identifiable signs of the original inciting disease process that initiated the pain. This results in a multitude of consequences that can lead to significant impairment for the individual affected, including physical impairment, mood dysfunction, and social disruption. This is in keeping with the earlier biopsychosocial perspective of CPS.

3.2 Controversies Surrounding Pain-Related Impairment

3.2a Practical Problems With Rating Pain-Related Impairment

Subjectivity of Pain

Impairment is defined in Chapter 1 of the *Guides* as "a significant deviation, loss, or loss of use, of any body structure or body function in an individual with a health condition, disorder, or disease." An impairment rating is defined as a "consensus-derived percentage estimate of loss, which reflects severity of impairment for a given health condition, and the degree of associated limitations in terms of ADLs" as traditionally defined by the domains of personal mobility and self-care.

As these definitions indicate, impairments are viewed as biomedical abnormalities that can be analyzed at the level of organs or body parts. Also, the implicit assumption throughout the *Guides* is that impairments should be assessed on the basis of objective medical data, rather than on the basis of the self-reporting of patients. Thus, for example, a physician could assess renal impairment on the basis of creatinine clearance or cardiac impairment on the basis of ejection fraction.

A key feature of pain is its subjectivity. Physicians and other observers can make inferences about a patient's pain but cannot directly experience it. To examine the significance of this feature of pain, it is useful to conceptually divide factors that might be considered in impairment ratings into 2 groups: (1) objective factors such as atrophy of a limb or reduced ejection fraction and (2) subjective factors such as pain. Whereas objective medical factors are assessed via methods (eg, laboratory assays or imaging studies) that are unrelated to the subjective experiences and communications of a patient, the assessment of subjective factors requires an examiner to interpret the communications of the patient, and to use these communications to infer the patient's subjective experiences.

In terms of the dichotomy between objective and subjective factors, the *Guides* strive to base impairment ratings on objective factors insofar as possible. This principle is violated by any system that rates impairment associated with pain. Some experts argue that such a violation represents a fundamental deviation from the central purpose of the *Guides* and question why the basic logic of the *Guides* should be compromised in order to include pain in impairment ratings.

Pain is the subjective factor that is considered in this chapter for the practical reason that it is the one most commonly encountered when impairment ratings according to the *Guides* are performed. However, it is not the only subjective factor that can contribute to the burden of illness imposed by a medical condition. For example, in addition to pain, the burden of illness associated with medical disorders can be increased by other subjective factors such as fatigue or emotional distress. Moreover, psychiatric disorders are characterized by subjective processes such as anxiety or hallucinations that are not amenable to assessment via objective methods such as laboratory or imaging studies. Thus, the challenge of assessing subjective factors is crucial to the determination of impairment associated with mental illness.

Level of Analysis: Body Parts vs Whole Person

Another conceptual problem with any PRI is that pain and its effects need to be analyzed at the level of the whole person, rather than at the level of a specific organ or body part. People with chronic pain typically attribute their pain and activity limitations to dysfunction of an organ or body part. But these subjective reports are difficult to assess precisely because examination of the involved organ or body part often does not identify abnormalities that make the pain reports inevitable.¹² It often appears to an observer that the affected organ or body part is capable of functioning, but that the patient *does not use it normally* because of pain. In keeping with the biopsychosocial perspective, the observer must consider the person as a whole in order to make sense of the situation. Thus, the assessment of incapacitation secondary to pain violates the tenet that impairment evaluations should assess the functioning of organs or body parts, rather than the functioning of an individual as a whole. However, this tenet, which is based on the outdated biomedical reductionist approach, needs to be seriously questioned in light of the more recent heuristic biopsychosocial approach to chronic pain.

Pain as Isolated Problem vs. Component of Medical Conditions

Another conceptual challenge related to PRI is that pain is not something completely distinct from organ or body part dysfunction. Rather, it is usually most appropriate to construe pain as a "component" of a medical disorder. From this perspective, it is arbitrary to examine the significance of pain in isolation from the medical condition underlying the pain, just as it would be arbitrary to evaluate shortness of breath in isolation from congestive heart failure. It would be more conceptually appropriate to evaluate a medical disorder as an

entity with characteristic signs, symptoms, pathophysiology, and potential organ or body part dysfunction. An impairment rating based on such an evaluation would take into account all the manifestations of the disorder, including pain. In fact, this edition of the *Guides* does, for the most part, construe pain as one of many manifestations of injuries or diseases, and impairment ratings attempt to take into account the pain that typically occurs in various disorders. Unfortunately, this intuitively plausible approach to incorporating pain into impairment ratings sometimes runs into either of 2 complicating situations. First, it may well be the case that pain severity does not correlate well with objective indicators of organ or body part dysfunction. In fact, empirical scientific research has consistently demonstrated that there is often a low concordance or correlation among self-report of pain, behavioral functioning, such as ADLs, and physiologic indexes.¹²³ In such a situation, impairment ratings based strictly on objective factors are likely to fail to capture the burden of illness of the disorder.

A second and more difficult situation is that some conditions are associated with severe pain but are not amenable to conventional impairment ratings because they are not associated with unequivocal objective factors. In these conditions, it is not possible to make impairment ratings on the basis of objective factors. Common examples include headache disorders and fibromyalgia.

Resolution of Conceptual Conundrums

Some people might conclude that the problems listed in this section are conceptual conundrums that preclude the incorporation of PRI into the *Guides* system. However, we believe that the conceptual foundation of the AMA *Guides* (as articulated in Chapters 1 and 2) is compatible with the inclusion of PRI as long as certain clarifications are made. A key to the resolution of the conceptual issues described earlier comes from close inspection of the definition of an impairment rating as a "consensus-derived percentage estimate of loss of activity reflecting severity for a given health condition, and the degree of associated limitations in terms of ADLs" as traditionally defined by the domains of personal mobility and self-care. This definition implies that severity of impairment depends on 2 criteria: (1) the severity of dysfunction in the relevant organ or body part and (2) the extent to which the condition being evaluated affects the ability of the individual to perform ADLs. Chronic pain can reasonably be interpreted as a factor that causes deficits in an individual's ability to perform ADLs, even in settings where objective indicators of organ or body part dysfunction are modest or even nonexistent. Thus, we believe that

the inclusion of PRI in the *Guides* is compatible with the overall conceptualization of the AMA system presented in Chapters 1 and 2.

3.2b Fundamental Concepts in Determining Pain-Related Impairment

Specious Issues

Even if one accepts the premise that PRI can be construed as a type of impairment because pain can diminish an individual's ability to perform ADLs, several arguments against the inclusion of a system for rating PRI can be raised. As discussed below, we consider some of these arguments to be specious, but others to be crucial. Arguments that have been raised by proponents and opponents of including PRI in the *Guides* are described in Appendix 3-3 at the end of this chapter.

- The argument that PRI should not be included in the *Guides* because of the subjectivity of pain is a theoretical one, related to the fundamental purpose of the *Guides*. If this purpose is solely to evaluate an abstract construct labeled "impairment," the argument is valid. However, we believe that the ultimate purpose of impairment rating is to determine the burden of illness borne by individuals with various medical problems, so that they can be compensated fairly. The burden of illness associated with a medical condition is best approximated by the impact of the condition on an individual's ability to perform ADLs. From this perspective, all factors that influence ADLs—including subjective ones—should, in principle, be included in the AMA system.
- The argument that PRI should not be included in the AMA system because of a lack of empirical evidence sounds plausible but is actually specious when one considers the *Guides* as a whole. The key issue is that most of the conventional ratings in the *Guides* are not validated by empirical research. Although the goal of buttressing impairment ratings on the basis of empirical research is laudable, this goal should not be applied selectively to the assessment of PRI.
- Most pain specialists would challenge the argument that PRI is unnecessary because conventional ratings in the *Guides* already include pain. As discussed below, we believe that the conventional rating system does provide appropriate ratings for many patients with chronic pain. However, the problem of PRI cannot be dismissed completely, because some painful conditions cannot be rated on the basis of the conventional system.

- The argument that a PRI rating system might cause problems for the insurance industry may well be valid, but we believe that the need for a system that fairly compensates individuals with long-term functional deficits outweighs the desire of the insurance industry to simplify their benefit packages.
- We agree with the argument that the PRI system described in the *Guides*' Fifth Edition was overly complex and believe that this practical concern should inform the development of the PRI assessment system for the Sixth Edition. However, we do not believe that this practical concern bears on the fundamental question of whether the *Guides* should include a PRI rating.

Crucial Issues

In our opinion, the most powerful arguments against the inclusion of PRI in the *Guides* are that (1) PRI assessments are likely to be unreliable and (2) they might lead to systematic errors in assessment, such that persuasive patients can "game the system" and get inappropriately high impairment awards. Both of these arguments derive from the premise that it is very difficult for examiners to determine the extent to which patients are affected by their pain. These difficulties were succinctly captured by Scarry¹ when she said: "To have great pain is to have certainty; to hear that another person has pain is to have doubt." The problem of reliability and validity of PRI assessment is much more than an academic problem in measurement theory. The *Guides* serves the societal role of providing an equitable method of compensating individuals whose ability to function has been compromised by a medical condition. For the *Guides* to carry out this role, it must be perceived as fair. To be perceived as fair, the *Guides* must employ assessment procedures that are reliable and valid, rather than capricious ones that can be manipulated by persuasive patients. Thus, regardless of how severely pain affects individuals with various medical conditions, a PRI assessment system must have reasonable reliability and validity to accomplish the societal goal of fairly compensating them.

In fact, the key issue separating proponents and opponents of impairment due to pain is the weight they place on *ease of measurement of PRI vs. relevance of PRI*. Advocates for PRI emphasize that pain has great relevance to the ability to function of individuals who have various medical conditions, but these advocates tend to downplay the problems of measuring PRI. Opponents tend to emphasize problems in measurement but ignore the issue of relevance. In principle, empirical research could be

performed to determine the strength of the independent contribution that pain makes to the burden of illness borne by individuals with various medical conditions, and whether examiners can reliably and validly assess PRI. Considerable research has been done on the first issue, at least for some common painful conditions such as disorders of the lumbar spine. Unfortunately, though, essentially no research has been done on the issue of determining the reliability and validity of PRI assessments. Construct validation research is greatly needed in this area. At this time, as a practical matter, decisions regarding PRI for purposes of the *Guides*' Sixth Edition must be based on judgment rather than empirical data.

How Much Weight Should Be Given to Pain in Impairment Ratings?

Whether or not to include PRI in the *Guides* can be framed as a qualitative yes or no question. However, it is more fruitful to frame the issue in quantitative terms by asking the following question: How much weight should be given to pain in impairment ratings? Opponents of PRI, in effect, argue that pain (and other subjective factors) should be given zero weight, so that impairment ratings reflect only objective factors. Many proponents of including PRI in the *Guides* argue not only that pain should be considered in impairment ratings but also that a PRI system should permit patients with severe pain to receive impairment awards with high WPI percentages. An impairment rating system could make a "cautious foray into the difficult waters" of PRI assessment by permitting awards to be made for PRI, but capping these awards at a modest level. This describes the strategy used in the *Guides*' Fifth Edition, in which PRI was capped at 3% WPI. In the absence of persuasive empirical research on the extent to which pain affects the ability of people with medical conditions to function or the measurement problems that arise when PRI is assessed, any decision about caps for PRI will be perceived as arbitrary.

3.3 The Rating System

3.3a The Problem of Credibility and Consistency in Rating Pain-Related Impairment

Whenever examiners conduct impairment evaluations, they must consider the consistency and interpretability of the clinical data for a patient. For example, a primary step in radiographic interpretation is an evaluation of the quality of the image.

Incorrect exposure, motion artifact, and other technical deficiencies (including poor interrater reliability between radiologists reading the radiographs) may weaken the conclusions that can be drawn from it. More generally, examiners using the techniques described in Chapters 4 to 17 must consider whether diagnostic studies have been performed appropriately, and whether a patient presents with a coherent set of symptoms and signs that clearly point to the diagnosis of a well-accepted medical condition.

Most experts believe that the problem of interpreting clinical data is greater for patients undergoing PRI assessment than for ones being rated according to principles in Chapters 4 to 17. The principal gauge of pain is its associated behaviors, which include verbal reports and nonverbal pain behaviors such as limping. The challenge for an examiner is to decide whether these pain behaviors accurately reflect a patient's experiences. Inappropriate pain behavior, embellishment, and symptom magnification are not uncommon, particularly in medicolegal circumstances and entitlement programs. In evaluating the reliability and credibility of pain behaviors among patients undergoing PRI assessments, examiners should consider the following:

- Congruence with established conditions.
- Consistency over time and situation.
- Consistency with anatomy and physiology.
- Agreement between observers.
- Inappropriate illness behavior.

Congruence With Established Conditions

In phantom pain, the patient describes pain in an absent extremity. While this might be expected to evoke incredulity, it does not, because this condition has been well described for decades, long before its pathophysiology was understood. Similarly, the person with complex regional pain syndrome (previously called reflex sympathetic dystrophy, Sudek's disuse atrophy, or causalgia) may describe exquisite pain on light touch of a healthy appearing extremity following a trivial injury. A constellation of associated signs and symptoms, such as cold sensitivity, autonomic changes, trophic changes, dystonic phenomena, and others help to confirm that the pain complaint is consistent with a known clinical syndrome. Intolerance of light touch over a region of the lower back in patients with mechanical low back pain is not consistent with a defined disease process and thus fails to meet this criterion. Most known conditions have such expected concomitants. Typically,

a patient would not watch television or read while waiting for a migraine to abate, and there would be an expected response to ergots, triptans, or other antimigraine preparations. A patient with neuropathic pain would likely, but not always, show some response to certain antiepileptic drugs (eg, gabapentin, carbamazepine) or antidepressants (eg, tricyclics). A person with persistent pain of pancreatitis would be unlikely to gain weight.

Consistency Over Time and Situation

There is a risk of placing unwarranted confidence in the validity of assessments that are numerical and therefore often considered "objective" and "scientific." Such confidence is challenged by such observations as a person who can tolerate only 40° forward flexion while standing, yet can sit with legs outstretched and touch his or her toes. Similarly, a person may demonstrate collapsing with pain on manual testing of plantar flexion, yet be able to tiptoe. Others may limp on one leg walking forward, the other walking backward, and not at all on a treadmill. Grip strength may be measured repeatedly and coefficients of variation calculated, although these methods have been criticized.²⁶ Rapid exchange grip strength testing may provide similar information.²⁷ Isokinetic strength testing may discriminate between maximal and submaximal effort.²⁸ Complaints and dysfunction should be relatively independent of the observers present and should generally persist despite distraction.

Consistency With Anatomy and Physiology

One would expect a patient who claims to be unable to use an arm at all to show some signs of atrophy or decreased muscle tone. A patient with inability to bear weight on one leg or who has a limp should show evidence of differential shoe wear patterns. Although evaluating whether there is clear physical evidence of pain-related dysfunction is ideal, there are also numerous "tests" that can be performed to assess whether pain behaviors are more likely to be accounted for by patient expectations than by organic pathology, with Waddell's signs perhaps the best known of these indicators.²⁹⁻³² One example is that of axial rotation, in which the standing patient's hips are rotated in each direction by the examiner. This essentially affects only the hips and ankles, leaving the pelvis and all above it to move as a unit. Exacerbation of back pain by this maneuver is considered abnormal. It is important, however, when using this method to rate the patient not on one abnormal test only, and to place the response in the context of the totality of the patient's history, physical examination findings, and cultural background.

Interobserver Agreement

Collateral information from relatives and other evaluating professionals is of critical value in determining the consistency of patient behaviors. This information may confirm that a patient's pain behaviors reflect a relationship to perceived pain, and that they vary little with changes in observers. Alternatively, the information may expose major inconsistencies that raise questions about the factors underlying the patient's pain behaviors.

Inappropriate Illness Behavior

It may be difficult to judge whether behavior is compatible with perceived pain. For example, since one cannot know how much leg pain a patient experiences on walking, it is hard to know whether an antalgic gait is exaggerated. Inappropriate illness behavior may be suspected, however, if the patient demonstrates dysfunction in unrelated domains. For example, except in extreme situations, a patient with back pain should not require that the spouse complete the patient's questionnaire—or his or her sentences. Chronic pain does not often preclude making one's own phone calls to the doctor, paying bills, and so forth. When a person has delegated these functions to others, abnormal illness behavior is likely.

The PRI assessment system described in this chapter assigns a presumptive impairment rating based on self-report data by a patient. Examiners are asked to modify this rating on the basis of their clinical judgment regarding the consistency and reliability of these self-report data. Examiners are advised to consider the issues outlined above when they make these judgments. A word of caution is in order here. Although no one would conclude that, because an X-ray was of poor quality, there was unlikely to be pathology of concern, this non sequitur frequently occurs in the case of aberrant pain behaviors. Such behaviors should properly cause the physician to be uncertain but not automatically dismissive. Behavior is affected by many factors. As discussed earlier, the heuristic *biopsychosocial approach* to pain would predict differences in pain behavior across individuals because of unique interactions among physical, psychological, and social factors that become even more complex when pain is chronic. The appearance of symptom exaggeration can be created by fear or by having learned that certain actions or positions provoke pain. "Nonphysiologic" signs may occur in dementia. Excessive or exaggerated pain behaviors can be a response to feeling discounted or mistrusted, so that one must emphasize symptoms to persuade the physician of their reality. Anyone might dramatize a problem in an effort to have it taken

seriously. Thus, symptom magnification can be an iatrogenic phenomenon that occurs when patients feel mistrusted or poorly cared for.

3.3b Rating Impairment When Pain Accompanies Objective Findings of Injury or Illness That Permit Rating Using Another Chapter in the Guides

The PRI system that was developed for the Sixth Edition of the *Guides* makes a basic distinction between assessing pain in conditions that can be rated according to principles outlined in Chapters 4 through 17, vs ones that cannot be rated. The PRI system outlined in this chapter is used *only* if a patient presents with a painful condition and cannot be rated according to principles outlined in Chapters 4 to 17. It should also be noted that patients' subjective experiences regarding their conditions are considered in the ratings described in Chapters 4 to 17. Specifically, patients are asked to fill out functional assessment instruments in which they indicate the impact of their condition on their ability to function. Although responses to such instruments reflect a variety of factors, it is assumed that pain will influence them. Thus, we believe that the impairment ratings described in the remaining chapters of this book can capture the burden imposed by pain that is construed as a component of a ratable disorder. As discussed in Chapter 1, patients' responses on functional assessment instruments will act as modifiers of the percentage impairment they are awarded, but the awards will, in general, primarily reflect objective factors. This is in keeping with the general strategy of the *Guides* to consider PRI but to limit the amount of impairment that is awarded for subjective factors. In no circumstances should the PRIs developed using this chapter be considered as an add-on to impairment determinations based on the criteria listed in Chapters 4 to 17. In essence, the PRIs derived according to this chapter (see methodology described in the next section) are determined in a stand-alone fashion.

3.3c Rating Impairment When Pain Is Not Accompanied by Objective Findings

In response to criticisms of the complexity of the PRI system developed for the previous edition of the *Guides*, the system to be used in the *Guides* Sixth Edition is simple. A patient is awarded a presumptive percentage WPI on the basis of his or her responses on the Pain Disability Questionnaire (PDQ; Appendixes 3-1 and 3-2 in Section 3.7). The PDQ was developed as a measure of functional status of patients with pain, such as those

with chronic disabling musculoskeletal disorders. The psychometric properties are excellent, demonstrating strong reliability, validity, and responsiveness, relative to many other existing measures of functional status. The focus of the PDQ, much like other health inventories, is primarily on how pain affects disabilities and ADLs. Moreover, it is based on the earlier reviewed *biopsychosocial approach* to pain. Therefore, an important core of the PDQ will include psychosocial variables (which empirical research has consistently shown to play an integral role in the development and maintenance of chronic pain and disability).²⁷

The PDQ consists of 15 items that are scored on a 10-point scale, for a maximum total score of 150. In a subsequent study by Gatchel and colleagues,²⁸ total PDQ score was broken down into 4 categories based on the maximum score (high pain and disability) of 150 and a minimum score of 0: mild (0-70); moderate (71-100); severe (101-130); and extreme (131-150). Results of this categorization showed a linear trend for decreasing positive outcomes (eg, return-to-work and work retention) as the PDQ score categories increased.

Using the PDQ scoring method, the examiner can then modify this presumptive award on the basis of his or her clinical assessment of the reliability of the patient's self-reports and assigns a final PRI award. A cap of 3% WPI is used for conditions that are rated with the PRI system.

3.3d Steps of Assessment

1. Determine that the patient meets the general criteria for performing an impairment rating, as described in Chapter 2. In particular, determine that the patient is medically stable (ie, has reached Maximum Medical Improvement, or MMI).
2. Determine that the patient meets eligibility criteria for rating PRI. They are:
 - a. Pain has been determined to have a reasonable medical basis, for example, can be described by generally acknowledged medical syndromes.
 - b. Pain has been identified by the patient as a major problem.
 - c. The patient's condition cannot be rated according to principles described in Chapters 4 to 17.
 - d. The PRI rating is not specifically excluded by relevant jurisdiction.
3. If the patient meets criteria for PRI assessment, have him or her fill out the PDQ (Appendix 3-1).

TABLE 3-1

Pain-Related Impairment and Whole Person Impairment Based on Pain Disability Questionnaire

Degree of Pain-Related Impairment	Pain Disability Questionnaire Score	Whole Person Impairment (%)
None	0	0
Mild	1-70	0
Moderate	71-100	1
Severe	101-130	2
Extreme	131-150	3

Instructions for scoring the PDQ appear in Appendix 3-2.

4. Determine the patient's presumptive WPI percentage by consulting Table 3-1. As can be seen, by using the categorization of PDQ scores reviewed in Section 3.3c, one can quantify the functional status of the patient.
5. Make a clinical judgment about the reliability and credibility of the patient's presentation, and modify the presumptive award accordingly, within the range available for PRI (0% to 3% WPI). Usually, the modification will be in the direction of lowering the award for a patient whose credibility is suspect. However, the examiner has the option of increasing the award (within the limits of the allowable cap) if he or she concludes that a patient has understated the burden of illness.

3.4 Future Directions—Need for Research and Dialogue to Establish the Validity of Rating Pain-Related Impairment

Based on responses to Chapter 18 of the *Guides* Fifth Edition, we anticipate that responses to the PRI system outlined here will fall into familiar patterns. Skeptics of any system for rating PRI will attack the system for being unscientific and for violating the principle that impairment ratings should be based on objective indexes of organ dysfunction. Proponents of PRI will attack the system for capping the size of PRI awards. In order to move past this fruitless dichotomy of opinion, we believe that it is crucially important to consider the issues underlying the dichotomy in a systematic way before the

Seventh Edition of the *AMA Guides* is developed. Specifically, we recommend the following:

1. Empirical research could be performed to determine the strength of the independent contribution that pain makes to the burden of illness borne by individuals with various medical conditions and the ability of examiners to assess PRI reliably and validly. Considerable research has been done on the first issue, at least for some common painful conditions such as disorders of the lumbar spine.⁶ In contrast, we are not aware of systematic research on the reliability of the PRI system developed for the Fifth Edition of the *Guides*, or of any other system for evaluating PRI. This issue should be explored empirically before another edition of the *Guides* is published.
2. As noted above, a striking feature of the "debate" over the appropriate role of PRI in the *AMA Guides* system is that, to date, there has been no real debate. We are not aware of any published article or symposium in which enthusiasts and skeptics have debated the appropriateness of PRI. It is time for such a debate to occur, so that the issues separating proponents and opponents can be articulated and methods of assessing the validity of the arguments can be developed.

3.5 Conclusion

The stakes in deciding how and whether to include PRI in the *Guides* system are high. Discussions about PRI need to be framed within the broader context of discussions about the appropriate role of subjective factors in the evaluation of impairment and disability. Although pain is a commonly reported cause of activity limitation among individuals undergoing rating of impairment with the *AMA Guides*, various other subjective experiences (eg, fatigue or fear of reinjury) can also act as barriers to activity. If these subjective factors are to be considered in impairment ratings, examiners have no choice but to rely at least in part on communications by patients about their experiences. Moreover, the assessment of psychiatric impairment relies heavily on communications by patients. Taken together, the above groups represent an enormous number of individuals whose activity limitations are incomprehensible if an impairment system relies strictly on objective medical factors and excludes reports by patients about their subjective experiences.

Everything about rating impairment in those with chronic pain engenders controversy except that the suffering of these individuals is real. Our view is that an enormous number of people are limited by "unbearable sensations" as they attempt to engage in activities⁷ and that these subjective factors cannot be fully assessed by any system that relies strictly on objective factors. The issue for the future will be to develop impairment rating systems that take into account both the importance of subjective factors and the difficulties inherent in the evaluation of another person's subjective experiences.

3.6 Examples

EXAMPLE 3-1 NON-SPECIFIC PAIN AFFECTING RIGHT LOWER EXTREMITY

A 43-year-old man reported ongoing burning pain in his right foot and ankle following an ankle sprain 3 years earlier. At the time of the initial injury, plain X rays of the ankle revealed no evidence of fracture. Subsequent plain X rays, a 3-phase bone scan, electromyography (EMG) and nerve conduction velocity (NCV) testing, and magnetic resonance imaging (MRI) of the ankle are all without identifiable abnormalities. The man indicates that his symptoms become worse with weight-bearing activities and that he is significantly limited with respect to walking, climbing stairs, and prolonged standing. He reports ongoing, intermittent swelling associated with color and temperature asymmetries between the left and right ankles. He has no other pain complaints and no general medical problems. His physical examination is normal; there are no identifiable sensory abnormalities, swelling, or color or temperature asymmetries when the affected and unaffected ankles are compared. The examiner judges him to be credible with respect to his pain complaints. His score on the Pain-Disability Questionnaire is 72. The examiner concludes that the patient has moderate PRI and awards 12% WPI.

Comment: The pathophysiologic basis of this man's pain is unknown; however, he reports a constellation of symptoms that are suggestive of complex regional pain syndrome, type 1. He does not, however, meet the diagnostic criteria for this as specified elsewhere in the Extremity Chapters. On physical examination and in all laboratory testing and imaging studies, there are no identifiable abnormalities. The examiner judges him to be credible, but there are no identifiable objective findings of organ or body part derangement. Thus, if he is to receive any impair-

Note Shoulder Example 15-10: Non Specific Shoulder Pain Impairment.

CLASS 1

1% to 13% Impairment of the Upper Extremity

EXAMPLE 15-9: DISTAL BICEPS TENDON RUPTURE

Subject: 55-year-old man.

History: While lifting a tire onto a truck, the patient experienced a popping sensation and acute onset of pain in the antecubital region. Initial exam was consistent with ruptured distal biceps tendon. Surgical treatment was recommended, but the patient refused. At MMI, the patient had some complaints of decreased strength of the arm and pain with normal activity.

Functional Assessment: Patient was administered a QuickDASH questionnaire. The QuickDASH score was 30.

Physical Exam: Tenderness was noted in the antecubital fossa. Strength in flexion and supination was diminished to 4/5. 1 cm atrophy of upper arm compared to opposite. Range of motion of the elbow was normal.

Clinical Studies: An MRI of the elbow confirmed a tear of the distal biceps tendon.

Impairment Rating: Regional Impairment: Diagnosis of distal biceps tendon rupture and per criteria of residual loss of strength and normal range of motion, assigned to class 1 UEI with midrange default value of 5% UEI. Adjustment Grids: Functional History: Grade modifier 2 (pain with normal activity); Physical Examination: Grade modifier 1 due to muscle atrophy of 1 cm. Clinical Studies: n/a since defines the diagnosis criteria (biceps tendon rupture). Numerical adjustment is +1. Moved 1 position to the right of default value C to grade D. 6% UEI. Converts to 4% WPI.

Class 1 Example Calculation: Default for Diagnosis = 5% UEI*			
CDX	GMFH	GMPE	GMCS
1	2	1	n/a
$(GMFH - CDX) (2 - 1) = 1$ $(GMPE - CDX) (1 - 1) = 0$ $(GMCS - CDX) n/a$			
Net adjustment = 1			
Adjustment of +1 equals 1 position to the right of default grade C and results in			
Class 1, Grade D = 6% UEI			

* CDX indicates Class of diagnosis; GMFH, grade modifier for functional history; GMPE, grade modifier for physical examination; GMCS, grade modifier for clinical studies; and UEI, upper extremity impairment.

Comment: For the functional history grade modifier the QuickDASH score of 30 fits criteria for grade modifier 1. Pain with normal activity reflects a grade modifier 2, and highest value is used, so in this instance functional history grade modifier is 2.

Shoulder Examples

CLASS 1

1% to 13% Impairment of the Upper Extremity

EXAMPLE 15-10: NONSPECIFIC SHOULDER PAIN

Subject: 26-year-old man.

History: The patient was trimming trees and fell from a ladder, landing on his shoulder. He is able to perform overhead work and requires an NSAID on an occasional basis to manage pain. Diffuse shoulder pain with moderate activity.

Functional Assessment: A QuickDASH Score of 50.

Physical Examination: Mild tenderness diffusely with palpation of shoulder girdle muscles, no loss of motion.

Diagnosis: Shoulder contusion

Clinical Tests: No abnormalities noted on X ray.

Impairment Rating: Regional Impairment: Diagnosis: "Shoulder contusion or crush injury with healed minor soft tissue or skin injury" and per criteria for "Residual symptoms and consistent objective findings at MMI," assigned to class 1 with midrange default of 2% UEI. Adjustment Grids: Functional History: Grade modifier 2 for QuickDASH score of 50; Physical Examination: Grade modifier 0 (although there are palpatory findings these are diffuse, non-anatomic and not consistently documented); Clinical Studies: Grade modifier 0. Net adjustment compared with diagnostic class is -1. Moved 1 position to the left of default value C to grade B. 2% UEI. Converts to 1% WPI.

1 decision on.

2 I think with that in mind, unless I need to ask
3 something else, I would invite your keen and close attention
4 to the final arguments, first, from Mr. Lee, followed by Ms.
5 Bailey, then Mr. Lee will have an opportunity to respond.

6 Mr. Lee, you may proceed, sir.

7 MR. LEE: Thank you, Your Honor. May it please
8 the Court.

9 I appreciate y'all being here and staying the
10 whole time and listening to all of the evidence. I saw that
11 y'all were all paying attention and listening to Ms. Shabazz
12 and her mother and the doctor. And we just appreciate your
13 time again. Without y'all and people like you, we don't
14 have a court where we can come and get decisions made where
15 people can't agree among themselves. Y'all are the final
16 word on that and we really appreciate you being here.

17 Like I said at the beginning, the rule is no one
18 is allowed to needlessly endanger the public. That's a
19 fancy way of saying every person who drives on our roads has
20 a duty to everybody else that they're going to follow all
21 the rules of safe driving. They're going to make sure that
22 it's clear to go before they go. If there's a stop sign,
23 they're going to stop. In this case, what Ms. Rodriguez
24 failed to do was make sure it was safe for her to go and she
25 pulled out right in front of Ms. Shabazz. And she broke the

1 rules, there's no question about that. They've admitted
2 that. When they say liability is admitted, that's what
3 they're talking about.

4 As a followup to that rule, if somebody breaks
5 those rules, what is the consequence? The consequence is
6 that they're responsible for all of the harms they created
7 by breaking that rule. What are the harms? Well, the law
8 really gives you one way and only one way to say what those
9 harms are and that's putting a dollar amount on the harms
10 that were caused by Ms. Rodriguez to Ms. Shabazz. By doing
11 that, you're going to be enforcing the rules of safe driving
12 in our community.

13 It's not perfect. It's not a perfect system. You
14 don't have the power to take away the pain that she
15 suffered. We can't go back in time and make this not
16 happen, no amount of money can do that. No amount of money
17 can heal her permanent injury she's going to have for the
18 rest of her life or give her her time back. All those trips
19 to the doctor, physical therapy, an even, lately, massage
20 therapy, all those things, that's all the time she's not
21 going to get back. It's not going to give her back, you
22 know, the hours she's had to spend with those headaches and
23 not enjoy her life and do the things she wanted to do, and
24 the neck pain and the shoulder pain. If you had the power
25 to do that, we'd be asking you to do that instead of come up

1 with a verdict, but we don't have that power. All you can
2 do is what the law ask you to do, which is to make it right
3 by coming up with what you think is a fair verdict. And
4 whatever that verdict is, as long as you give it your full
5 consideration and take it seriously, we'll be satisfied with
6 that as long as it speaks to all of the harm she's suffered.
7 I'm going to break that down a little bit in this argument
8 to you.

9 I want to clarify a couple of things. One of the
10 issues we have in this case is Ms. Shabazz's headaches and
11 whether they're related to the car wreck. We say they are,
12 the Defense says they're not, so y'all are going to have to
13 make the decision as to whether you think the headaches are
14 related and what difference that makes, also. It is true
15 that there are -- and you're going to have -- let me also
16 tell you this, you're going to have all the medical records
17 and the bills. They're in a stack right there. You'll have
18 them with you in the jury room. You take a look at all of
19 those things and see what you think about them.

20 But it is true that there's nothing in those
21 medical records that say the word headache until May 6th of
22 2013, which is two days short of a year after the wreck
23 happened. And the Defense's position is, you know, that's
24 because she wasn't having headaches and things that come up
25 a year later are not to be related to the case. Our

1 position is and what she testified to is she started having
2 those headaches a lot sooner than that and they got worse
3 and worse until finally she went back to the doctor.

4 But how can you know for sure? How can you know
5 for sure that these headaches were caused by the wreck or,
6 you know, the shoulder pain and neck pain aggravating her
7 until she built up these headaches? You cannot know for a
8 hundred percent certain. I can't know for a hundred percent
9 certain and I'm her lawyer. The doctor doesn't know for a
10 hundred percent certain. There really isn't any way to know
11 that with a hundred percent certainty unless you are Taliah
12 Shabazz and you were there.

13 But the Judge is going to instruct you on the
14 burden of proof. How certain do you have to be before
15 Taliah has made her case to you. And the rule is it's a
16 preponderance of the evidence. And if you look at a set of
17 scales, a preponderance of the evidence means the scales tip
18 ever so slightly, at least, in Taliah's favor. If you think
19 probably the headaches are related to the wreck, then she's
20 met her burden of proof at that point.

21 Dr. Ogburu, the neurologist who treated her, said
22 they are probably rebound headaches caused by the pain in
23 her neck and her shoulder, meaning that the headaches --
24 excuse me, the neck pain and the shoulder pain and the
25 muscle spasms over time caused her to develop these

1 headaches. There's no medical records from before this
2 wreck showing she had any sort of problem with any of this.
3 And I can guarantee that -- you know, one of the things that
4 we have when we file a lawsuit is called the right of
5 discovery. And I have the power to issue a subpoena and get
6 any kind of records or documents of things that I think are
7 relevant to the case. The Defense also has that power, so
8 they have the right to order Ms. Shabazz's medical records
9 when she was a child, for example. And if there -- there
10 aren't any, but if there were any medical records that shows
11 she had neck pain, shoulder pain or headaches, they would be
12 presented to you by Ms. Bailey, who is very competent.

13 So we know she didn't have the headaches before
14 the wreck. We know the doctor has told us that he thinks
15 they are caused her wreck and her injuries subsequent to
16 that wreck. And I would argue to you that that more than
17 makes the scales tip slightly in her favor. There's really
18 no evidence to the contrary except speculating that maybe
19 they're not. But all of the evidence you've heard says that
20 they are.

21 That's the legal argument, but, also, y'all are
22 here just for the basic issue of right and wrong. Who
23 should get the benefit of the doubt here? I mean, should it
24 be Ms. Rodriguez that y'all give the benefit of the doubt
25 to? She caused this wreck. We've never even seen her. You

1 know, she's never even apologized. Why should we give her
2 the benefit of the doubt? I would ask you to give Taliah
3 the benefit of the doubt. She's come here before you and
4 told you about all of this stuff and submitted all of this
5 stuff to you. I don't think it's fair that you give
6 Ms. Rodriguez the benefit of the doubt.

7 Another thing, if you're not convinced about the
8 headaches, Dr. Ogburu said in his deposition, which you'll
9 also be able to look at in the jury room, that her treatment
10 with him was also for the shoulder and neck on all of those
11 visits and all of those things he recommended for her
12 treated her shoulder and neck. So even if she didn't have
13 the headaches, she would have had the same treatment. So
14 all the medical bills and stuff that we submitted to you
15 from Dr. Ogburu, I would argue, even if you decide the
16 headaches weren't related, you'd have to agree that they --
17 that he treated her for the shoulder and neck. And nobody's
18 arguing that's not related to the wreck.

19 So what is a fair verdict? Ultimately, it's going
20 to be whatever y'all say, okay. No one else on this earth
21 has the power to change it. Whatever y'all say the verdict
22 is, that's what it's going to be. You're going to put the
23 price tag on it.

24 This is her one chance to do it. She doesn't get
25 to come back in 20 years if the pain gets worse or something

1 like that, this is it. For her life, y'all are going to say
2 what's fair in this case. I can give you some ideas about
3 what might be fair, but, ultimately, y'all do whatever you
4 want do and, again, we appreciate y'all doing that.

5 We've submitted the medical bills into evidence
6 and they total a little over \$17,000. That is what the
7 doctor's care was for what happened to Taliah. If you award
8 a \$17,000 verdict and all those medical bills are related,
9 then she doesn't get anything. Her portion of this starts
10 at \$17,000 and goes up. So I'm going to ask you to put a
11 price tag on what you think that the pain caused by
12 Ms. Rodriguez should be worth, which -- and there's no book
13 that we can look in and say a day of pain is worth X amount
14 of dollars or two years of pain or a lifelong injury. It's
15 going to have to be whatever y'all think is fair. I have
16 some suggestions, but it's going to be up to you.

17 In some cases, juries award hundreds of thousands
18 of dollars for pain and suffering, or even millions of
19 dollars. I'm not asking y'all for that, okay, I'm just
20 telling you that's one way -- that's a place to start. I
21 mean, that would be a case where somebody is in horrible,
22 unrelenting pain that never goes away and they never have
23 any relief whatsoever. I do lot of worker's comp law and
24 see people who have failed back surgeries and multiple
25 surgeries and they can't get any relief at all. They can't

1 sit. They can't stand. Unfortunately, some of them have to
2 go to pain doctors to get, you know, basically, morphine
3 injections. In a case like that, you know, to balance that
4 out, you're going to have to give them hundreds of thousands
5 or millions of dollars, depending on how hurt they are.

6 In other cases, it might be kind of a minimal
7 pain, you know, a nagging pain or an occasional ache. You
8 can't even really tell for sure it's not something they
9 would have had anyway. And that might be worth, like, a
10 couple thousand dollars, okay. So it's going to be in your
11 judgment to decide where on that scale does Taliah's case
12 fall. I would submit to you that we're not talking about
13 minimal pain. We're not talking about occasional pain.
14 But then, she was in 10 out of 10 pain at the hospital.
15 You're going to get to see the pictures of her vehicle and
16 see just how damaged it was. She got hit by the airbag. It
17 was a hard enough impact to burn her skin with the seatbelt.
18 And later, with treatment, her pain went down a little bit,
19 but it was still bad enough that she had to go to an
20 orthopedic surgeon. I mean, that's not something you just
21 happen to walk into. She was having terrible pain. Her
22 family doctor, you will see in the records, he saw her
23 twice. He saw her once and then on the second visit, he
24 sent her to a surgeon to get checked out because she was
25 having so much pain and problems in her shoulder and neck.

1 She went to physical therapy pretty much constantly all
2 summer. And, know, that requires a lot of effort. You've
3 got to go to physical therapy and do physical therapy, I
4 guess, for an hour or so and drive home. You've got to wait
5 when you get there. It's not something somebody's going to
6 do if they're not in a lot of pain. That wouldn't make any
7 sense.

8 And a year after that, a year after that, she's
9 still having so much pain, she goes back to the orthopedic
10 surgeon and tells them about her problems and now he thinks
11 he's got to send her to a neurologist because she's having

12 so much pain and trouble. And she's got to take all these
13 medications. She's got to go to a chiropractor and massage
14 therapy she told you about. It's one thing after another.
15 And as lately as this summer, she's had to go and get
16 treatments and such like that. This is not a just a nagging
17 pain. This is really a serious problem. Again, you can't
18 know for certain how bad her pain is without being her, but
19 the legal standard is, again, it has to tip in her favor.

20 This is a person with pain that disrupts her life.
21 It intrudes on the things that she does. It hurts her when
22 she's working hard at school. It keeps her up at night.
23 She's got knots in her shoulder blades. She's got these
24 crippling headaches. And the doctor ultimately said she has
25 a permanent injury. That means it's not going to go away.

1 She's 24 years old now. She's been suffering with this
2 since she was 19 and the doctor says that it's permanent.
3 And again, that's his opinion, okay. He looks in the book
4 and he says okay, I believe she has a permanent injury and
5 that gives me this two percent, one percent. It doesn't
6 mean this it's impossible that she could get better as time
7 goes by, she could get better. It's also possible that she
8 could get worse. Which of those things is going to happen,
9 we don't know. Y'all couldn't know and there's no way you
10 can know for sure, but we have to look at the evidence. We
11 have a neurologist who's been practicing 20 or 22 years who
12 says in his opinion it's probably not going to get better.
13 And I would suggest that that should be good enough for
14 y'all to award her part of her verdict based on that.

15 What we do know for sure, again, is that this is
16 her one chance to have justice, for this to be made right
17 for her. And again, I would just ask you if there's any
18 question about anything, ask yourself who should bear the
19 risk here of uncertainty, should it be Taliah or should it
20 be Ms. Rodriguez?

21 So in this case, you know, in my argument to you,
22 it's not just a minimal ache and pain and it's not a
23 lifelong crippling pain where she can't do anything, it's
24 somewhere in the middle. And I would submit to you that in
25 this case, her pain and suffering is worth, at least, as

1 much or more than the medical bills. That's what the
2 doctors are going to get. To make up for the pain that
3 she's suffered, I have to ask you for a verdict in the tens
4 of thousands of dollars, wherever you think it should fall.
5 That's from age 19 to now. We're also talking about
6 somebody who's supposed to live 50 or 60 more years. I'd
7 ask you to give her the benefit of the doubt and give her
8 something to make up for that pain she's going to have the
9 rest of her life. She does not get to come back. This is
10 it. This is your one chance to make this situation right.

11 The law, the Judge will also tell you, requires
12 you to consider emotional distress or mental anguish. That
13 is compensation for the effects of the injury and pain she's
14 suffering on her life, the frustration that she's got to
15 feel when she feels this pain again at the end of a long
16 day. Having another headache coming on, more neck and
17 shoulder pain. I would just add, if I knew I had a
18 permanent injury that the doctor said is not likely to get
19 better, I would be angry that this Defendant doesn't seem to
20 care even enough to be here today. That would make me very
21 emotionally distressed.

22 And loss of enjoyment of life is another thing the
23 Judge will tell you about. This is supposed to be the best
24 time of her life. She's made it to the school she's always
25 wanted to go to. It's one of the best ones in the country

1 for what she wants to do. She's meeting friends, hopefully,
2 she will be friends with for the rest of her life. She's
3 learning her profession. But clearly, her enjoyment of time
4 is not what it could be or not what it should be. It's not
5 what it would have been if Ms. Rodriguez had watched where
6 she was going and not pulled out right in front of her and
7 caused this wreck.

8 You know, the Defense mentioned at some point it
9 looks Taliah only went to the doctor when it was convenient.
10 I mean, based on what she's saying and what these medical
11 records say she's in pain all the time. If she went to the
12 doctor every time she had pain, she would never have
13 accomplished anything. She wouldn't have graduated from
14 Midlands Tech. She wouldn't have made it into this school.
15 She dealt with it the best she could do, got to the doctor
16 when she could. And, you know, she's a bright young person
17 and made it to one of the best schools in the country. And
18 it's sad that her enjoyment of this has to be diminished
19 when she comes home everyday and is having all this pain.

20 I would ask you whatever you decide for the pain
21 and suffering that you add the same amount again for the
22 mental anguish and loss of enjoyment of life. But whatever
23 you decide is fair, as long as you take all of the evidence
24 in consideration, that will be a fair verdict. When you do
25 that, you're going to be sending a couple of messages. One,

1 you send a message in our community that people don't get a
2 free pass for breaking the safety rules. If they break the
3 safety rules and hurt somebody, they to have pay for the
4 harms that were created. All of those harms that I told you
5 about that the law requires. And you tell our community
6 that when someone has something like this happen to them
7 that they can get justice by going to court and putting
8 their care in front of a jury. Thank you.

9 THE COURT: Ms. Bailey.

10 MS. BAILEY: May it please the Court?

11 THE COURT: Yes, ma'am.

12 MS. BAILEY: Beg the Court's indulgence for just a
13 moment.

14 (Pause.)

15 MS. BAILEY: Well, ladies and gentlemen,
16 congratulations. You guys made it to the end of this trial
17 and, hopefully, you all will be out of here shortly. This
18 is my last opportunity to speak with you and I just want to
19 go over a couple of things that you heard throughout this
20 trial. At the beginning of this trial, I admitted to you
21 that Ms. Rodriguez caused this accident. So we have taken
22 that burden off of your shoulders to determine who's at
23 fault in this accident.

24 Plaintiff's counsel said that Ms. Rodriguez isn't
25 here because she's not sorry. There's no requirement that

1 she be here and just because she's not here that does not
2 mean that she's not sorry. She's very sorry for this
3 accident and I'm here on her behalf today to admit that and
4 apologize for having caused this accident.

5 So let's get back to focusing on Ms. Shabazz and
6 her treatment and getting this resolved for her. Let's
7 discuss what you did not hear throughout this trial. Ms.
8 Shabazz didn't break any bones. She didn't have any
9 surgeries. She's not going to need any surgeries in the
10 future. The permanent injury that her neurologist mentioned
11 in the deposition is that she's going to have aches and pain
12 from now -- you know, now and then. She's going to have
13 headaches every now and then. And he gave her an impairment
14 rating. I'm not going to bore you, but I do want to explain
15 these things to you so you have this information when you
16 get back there to deliberate. He gave her an impairment
17 rating for her entire body and one for her upper extremity.

18 And so to explain that, the American Medical
19 Association defines impairment in relevant part as a loss of
20 body function in an individual with a health condition,
21 disorder or disease. Her neurologist defined impairment as
22 a patient's long term procedural disability. Essentially,
23 how the person is affected on the scale of one percent to
24 100 percent. Dr. Ogburu, the Plaintiff's neurologist, gave
25 her a one percent impairment rating for her entire body, one

1 percent on a scale of one to 100. For her upper extremity,
2 he gave her an impairment rating of two percent, two percent
3 on the scale of one to 100. You didn't hear any evidence
4 from her doctors stating that anything would have caused her
5 headaches to be onset later or to not appear further down
6 the line. Keep that in mind.

7 I also want to point this out, you may not even be
8 thinking about this, but this is my last chance to talk to
9 you. When we were reading the deposition of the doctor, he
10 was reading some of the records that are going to be in that
11 stack right there, and he misread one of the records. It's
12 printed very, very, very lightly and it's kind of not the
13 best, so he says somewhere -- in reading one of the records,
14 he says something to the effect of, I guess this says head.
15 And, in fact, the record actually says it was her neck. So
16 I just wanted to throw it out there so you understand that
17 she did not actually complain of having head pain during the
18 EMS or during the ER record. You will have those records
19 with you and I just wanted to point that out to you. You
20 heard her physician also say that it's not likely that
21 someone that was headache free for a year would suddenly
22 develop these headaches. And that if she was experiencing
23 these headaches for the entire year, she probably should
24 have said something sooner. Just things I want you to keep
25 in mind.

1 You have an important job to do today and here in
2 the State of South Carolina, you're to award Ms. Shabazz
3 money if you believe that the injuries she sustained were
4 caused by this accident. And if you do believe that, the
5 money that you are to award her is to put her in the same
6 position that she was in prior to this accident. We
7 understand that she had to experience some inconveniences,
8 but this is not an opportunity for Ms. Shabazz to get rich.
9 She should be placed back in the same place that she was in
10 prior to this accident. And that is all that I'm asking you
11 to do.

12 I want to show you something. These are all of
13 the Plaintiff's medical records. This list was given to me
14 by Plaintiff's counsel. You have all of the medical records
15 in that stack. You have every provider that she went to and
16 you have the amount of money that each of those bills were.
17 I want you to stop at January 9th, 2013, that's a year after
18 the accident when she began complaining about those chronic
19 migraine headaches. That is all of the treatment after that
20 period. This, I want you to pay for. I think that she
21 deserves to be paid for all of this medical treatment for
22 injuries she sustained as a result of our accident. If
23 that's what she claims, I want you to pay her every cent of
24 this and award a verdict in the amount of \$8,851.14.

25 Your verdict needs to be to put Ms. Shabazz back

1 in the situation that she was in prior to this accident, not
2 to punishment Ms. Rodriguez. She's already very sorry for
3 this accident. All I'm asking you to do is be reasonable
4 and fair as you're deliberating back there and just keep in
5 mind whether or not the Plaintiff actually proved to you
6 that these headaches were actually caused by this accident.
7 She doesn't even know herself when the headaches actually
8 started and she testified that today. Once you come to the
9 conclusion that these headaches weren't caused by the
10 accident, I'd ask that you keep that figure in mind and
11 award a verdict of \$8,851.14. Thank you very much.

12 THE COURT: Mr. Lee.

13 MR. LEE: I believe they've heard everything from
14 me.

15 THE COURT: Beg your pardon?

16 MR. LEE: They've heard everything from me.

17 THE COURT: Very well.

18 Do you mind moving that?

19 MS. BAILEY: Sure.

20 THE COURT: Now, Mr. Foreman, members of the jury,
21 you have heard the evidence and the arguments of both
22 parties. I will now explain to you the law that applies to
23 this action. Ms. Shabazz, the Plaintiff, claims that she
24 was injured, and, in fact, she was, by the negligence of
25 Ms. Rodriguez. Now, in bringing this lawsuit, the Plaintiff

1 claims that the Defendant, Ms. Rodriguez, will compensate
2 her for her injuries.

3 Now, members of the jury, under the constitution
4 and code of laws, only you can make the findings of fact in
5 this case. I am not permitted to indicate to you how I may
6 feel about the testimony and the evidence which has been
7 presented and throughout this trial. I've intended to be
8 fair and impartial to each of the parties involved.

9 Now, to determine the facts of this case, you will
10 have to evaluate the credibility, which means the
11 believability of each witness. Now, some of the things you
12 may consider as you decide whether or not to believe a
13 witness's testimony about a particular matter include what
14 was the manner and appearance of the witness who testified?
15 Was he or she straightforward or hesitant in answering? Was
16 the testimony of a witness consistent or inconsistent? How
17 did the witness come to know the facts that he or she
18 testified to or what was his or her ability to know these
19 facts? Is there some reason a witness would want to give
20 testimony which would help or hurt one side or the other?
21 In other words, was the witness bias or prejudice? And was
22 the testimony of a witness strengthened or weakened by other
23 testimony or evidence?

24 Now, members of the jury, you can believe as much
25 or as little of each witness's testimony as you think

1 proper. You may believe the testimony of a single witness
2 against that of many witnesses or just the opposite. Of
3 course, you do not determine the credibility by counting the
4 number of witnesses presented by each side. Throughout this
5 process, you have but one objective, to seek the truth
6 regardless of its source.

7 Now, the same constitution and laws which
8 designate and make you the finders of the facts as I've
9 explained also make me the instructor of the law and you
10 must accept the law as I give it to you. If I'm wrong,
11 there's another time and place for that error to be
12 corrected, but for this case, you must apply the laws as I
13 give it to you. And this means that you should not be
14 concerned with what you may think the law should be, but
15 only with what the law is as I tell it to you.

16 Now, Mr. Foreman, members of the jury, the
17 Plaintiff has the burden of proving her claims in this case.
18 She must meet this burden by proving her claims by the
19 greater weight or the preponderance of the evidence. Now,
20 what we mean by the greater weight of the evidence can be
21 illustrated by imagining a traditional set of scales. When
22 the case begins, the scales are even. After all of the
23 testimony has been presented, if the scales should remain
24 even or if they should tip even slightly in favor of the
25 Defendant, then the Plaintiff would have failed to meet her

1 burden of proof and your verdict would be for the Defendant.

2 Let me explain that a little bit. We know she's
3 entitled to a verdict, but this goes to the amount of the
4 verdict. Does that make sense to you?

5 (All jurors nodded.)

6 THE COURT: Okay. Now, on the other hand, if the
7 scales should tip even slightly in favor of the Plaintiff,
8 then she would have met her burden of proof and your verdict
9 would be for the Plaintiff. Of course, there's no way to
10 weigh evidence except through the exercise of your good
11 common sense and judgment. It is entirely a mental process
12 and the evidence you should give the most weight to is that
13 which convinces you of its truth, regardless of from whom or
14 what source it may come.

15 Now, in this particular case, ladies and
16 gentlemen, we are concerned with what we refer to as actual
17 damages. Now, actual damages are to compensate the
18 Plaintiff for the Plaintiff's injuries or loss and to put
19 the Plaintiff as near as possible in the same position that
20 the Plaintiff was in before the incident occurred. In other
21 words, actual damages would be the actual losses and
22 expenses which the Plaintiff has suffered because of the
23 Defendant's negligence.

24 Now, what are some of the elements of damages?
25 Pain and suffering. Pain and suffering compensates the

1 Plaintiff for physical discomfort and emotional response to
2 the sensation of pain caused by the injury itself. There is
3 no definite standard by which to compensate the Plaintiff
4 for pain and suffering. You have the authority to determine
5 the amount, if any, to be allowed for pain and suffering
6 using calm and reasonable judgment to ensure that the
7 damages are just and reasonable in light of the testimony
8 and the evidence presented in this case.

9 Loss of enjoyment of life. Loss of enjoyment of
10 life compensates the Plaintiff for limitations on the
11 Plaintiff's ability to participate in and derive pleasure
12 from the normal activities of daily life. The Plaintiff
13 must prove that expenses caused by the injury were necessary
14 and reasonable. Actual damages for Plaintiff -- for a
15 Plaintiff who has been physically injured include pain and
16 suffering, both past and future, as well mental anguish,
17 impairment of health or physical condition, and
18 disfigurement, if applicable.

19 In determining the amount of compensation for
20 personal injuries, it is proper to consider past and present
21 aspects of the injury. This would include physical and
22 mental pain and suffering, expenses incurred for necessary
23 medical treatment, the loss of enjoyment of life suffered as
24 a result of the injury, and any other losses which are
25 reflected by the character of the injury.

1 The injured party may recover for those future
2 damages that are reasonably sure to result from the
3 injuries. The principle underlying compensation for future
4 damages is that only one action can be brought and,
5 therefore, only one recovery had. It is proper to include
6 in the estimate of future damages compensation for future
7 medical expenses, pain and suffering which will reasonable
8 certain result in the future. A plaintiff is never entitled
9 to recover conjectural or speculative damages, but if you
10 find that the Plaintiff is entitled to a verdict for actual
11 damages, and she is, your verdict should include an amount
12 to cover any past, present and future damages which were
13 proximately caused by the Defendant. Any future damages
14 must be reasonably certain to occur in the future as a
15 result of the Defendant's negligence or act. Actual damages
16 need not be proven to a mathematical certainty or be based
17 on evidence of the precise amount of damages the Plaintiff
18 is suffering. Instead, the evidence must allow you to
19 determine what amount of damages is fair, just and
20 reasonable. Any future damages must be reasonable
21 calculated to have resulted from the alleged injury or
22 damages sustained in this case. Future damages must be
23 reduced to their present day value.

24 Mental suffering is another aspect of damages you
25 may consider -- or should consider, members of the jury.

1 Mental suffering, apprehension, shock, fright, emotional
2 upset, humiliation and anxiety, either present or expected
3 in the future, can be properly considered as an element of
4 damages. The amount of damages for mental suffering cannot
5 be exactly measured.

6 Now, if you find that the Plaintiff has -- if you
7 find that the Plaintiff was permanently injured as a result
8 of the Defendant's actions, you must then decide how, if at
9 all, that injury will affect the rest of the Plaintiff's
10 life. A person's life expectancy is determined by a life
11 expectancy table, which is a part of the laws of this state.
12 The life expectancy table is only an estimate of the
13 probable average remaining length of the life of the
14 person -- of a person in our state of a given age.

15 The Plaintiff, Ms. Shabazz, is 24 years of age.
16 Now, according to the life expectancy table, she has an
17 additional 53.28 years to live. This factor is to be
18 considered by you along with any other facts and
19 circumstances in evidence bearing on the Plaintiff's life
20 expectancy, including occupation, habits and health at the
21 time of the injury in deciding the amount of damages to be
22 awarded to the Plaintiff.

23 Now, I need to tell you about expert witnesses,
24 the doctor, whose deposition was read to you. The rules of
25 evidence ordinarily do not permit witnesses to testify to

1 opinions or conclusions. An exception to this rule exist
2 for witnesses we call expert witnesses. A witness who by
3 education and experience has become expert in some art,
4 science or profession may give an opinion as to the subject
5 the witness claims to be an expert in and may also give the
6 reasons for the opinion. You should consider any expert
7 opinion given by a witness and, like any other evidence,
8 give it the weight you think it deserves. If you decide
9 that an expert witness's opinion is not based on sufficient
10 education and experience, if you decide that the reasons
11 given in support of the opinion are not sound, or that the
12 opinion is outweighed by other evidence, you may disregard
13 the opinion entirely. And expert's opinion is to be given
14 no greater weight than that of any other witness simply
15 because the witness is an expert. And you do not have to
16 accept an expert opinion even though it is uncontradicted.

17 The testimony of the expert was by deposition,
18 okay. Testimony in this case was presented to you by
19 deposition. A deposition is a document containing sworn
20 testimony given by a witness outside of the court in the
21 presence of lawyers for each party who may ask questions of
22 the witness. This testimony is entitled to the same
23 consideration and to be judged as to credibility and weighed
24 by you in the same way as if the witness were present and
25 gave the testimony to you from the witness stand. It is

1 then for you, the jury, to decide or to determine the
2 effect, value, weight and truth of the testimony given in
3 the deposition.

4 I charge you, Mr. Foreman, members of the jury, a
5 verdict in this case cannot be based upon sympathy, passion,
6 prejudice or emotion or some other consideration not found
7 in the evidence.

8 Now, Mr. Foreman, members of the jury, whatever
9 your verdict, it must be unanimous, that means all 12 of you
10 have to agree. And to this end, Mr. Foreman, I have
11 prepared what we commonly refer to as a verdict form. I
12 will read it to you real quick. It says the State of South
13 Carolina, County of Richland, Taliah Shabazz, Plaintiff, vs.
14 Bertha Rodriguez, Defendant, verdict form of the court of
15 common pleas. And it says we, the jury, by unanimous
16 consent find for the Plaintiff in the amount of blank actual
17 damages.

18 And there's a line above the word foreperson, you
19 will see your name above that, Mr. Foreperson, you will
20 date it and that should conclude your services on this case.

21 No enemies to punish, no friends to reward. It's
22 one of the few times in your life you have an opportunity to
23 do what you really feel by way of your conscience and based
24 on the evidence and the record, the arguments of the lawyers
25 to do what you think is the right thing to do. And I'm sure

1 you will do that.

2 In the meantime, I need to ask you to go to the
3 jury room. Don't start discussing this case until you
4 receive the signal to do so and that will be when the
5 bailiff shows up with this verdict form along with all of
6 the exhibits that have been introduced into evidence.
7 That's your signal to begin your deliberations. Until
8 then, once again, I've got to ask you not to start talking
9 about this case. Thank you all so very much. Go to the
10 jury room. Once again, until you get the verdict form along
11 with the exhibits, don't start talking about the case.
12 Thank you all so very much.

13 (WHEREUPON, the jury left the courtroom
14 at 2:44 p.m.)

15 THE COURT: All right. Any exceptions or
16 additions from the Plaintiff?

17 MR. LEE: No, Your Honor.

18 THE COURT: From the Defense?

19 MS. BAILEY: None from the Defense, Your Honor.

20 THE COURT: All right. What y'all need to do is
21 double check one more time all of the exhibits, take a look
22 at the verdict form one more time. And if everything is in
23 order and looks fine to y'all, go ahead.

24 Bring me the alternate -- don't bring him out yet.

25 (WHEREUPON, a short recess was held.)

1 THE COURT: Has the cost of the first year's
2 appointments before the neurology appointments began already
3 been covered by Ms. Rodriguez's insurance? That's the
4 question.

5 Make copies for everybody and we'll mark it.

6 (WHEREUPON, Court's Exhibit No. 1 was
7 marked for identification.)

8 THE COURT: I'm inclined to say, ladies and
9 gentlemen, you've got to make your decision based on the law
10 and the evidence presented, nothing else and let it go. But
11 y'all talk about what y'all want.

12 Y'all thought about it?

13 MS. BAILEY: I would be fine with you bringing
14 them back in and simply charging them what you said you
15 would say.

16 THE COURT: All right. Good. I'll bring them
17 back out and we can all eyeball them a little bit better.

18 Bring the jury back in.

19 THE BAILIFF: Yes, Your Honor.

20 (WHEREUPON, the jury returned to the
21 courtroom at 3:04 p.m.)

22 THE BAILIFF: Your Honor, the jury is present and
23 seated.

24 THE COURT: Welcome back, Mr. Foreman, members of
25 the jury. I thought I'd bring you back so there would be no

1 misunderstanding if I sent you a written note. I will
2 repeat the question for the record, Has the cost of the
3 first year's appointments before the neurology appointments
4 began already been covered by Ms. Rodriguez's insurance?

5 Now, the last thing I said to you was your
6 decision cannot be based on passion, prejudice, emotion or
7 something not found in the evidence. Not found in the
8 evidence. Nothing outside of this courtroom you can
9 consider. If it's not in the evidence, you can't consider
10 it. This question you can't consider. You need to wipe it
11 out of your mind and begin over as if you never asked me
12 this question because it's not in the evidence.

13 I'm not upset, but this is the rules that we all
14 have to play by. And in order to be fair to both sides, you
15 have to dissuade yourself of this question, start as if you
16 never asked me the question, blank sheet of paper, began
17 again with that in mind. Only what's from this witness
18 stand, the exhibits, the arguments of the lawyers and the
19 charge I gave to you on the law. You can't consider
20 anything else at all. It will be unfair to the Plaintiff,
21 unfair to Ms. Rodriguez and everybody else involved. Those
22 are the rules and I don't make them up. And I'm not yelling
23 at you, but it's important enough to explain. Wipe that out
24 and out of your mind and begin over.

25 If you can't wipe it out of your mind and begin

1 over, Mr. Foreman, it's your duty to let me know, okay?

2 MR. FOREMAN: Yes, Your Honor.

3 THE COURT: Thank you all so very much. Go back,
4 but don't resume your deliberations until the bailiff tells
5 you to do so. Thank you.

6 (WHEREUPON, the jury left the courtroom
7 at 3:07 p.m.)

8 THE COURT: Any exceptions or additions from the
9 Plaintiff?

10 MR. LEE: No, Your Honor.

11 MS. BAILEY: None from the Defense, Your Honor.

12 THE COURT: All right. Let's keep our fingers
13 crossed. I hope they can wipe -- it's kind of hard, but I
14 hope they do that. I think they're honest. I don't think
15 they meant any harm, so I hope I didn't yell at them too
16 much. If I did, it's too late now.

17 (Laughter.)

18 THE COURT: We'll be at ease.

19 (WHEREUPON, a short recess was held.)

20 THE COURT: I understand we have a verdict, ladies
21 and gentlemen.

22 You may invite them to come back.

23 THE BAILIFF: Yes, Your Honor.

24 (WHEREUPON, the jury returned to the
25 courtroom at 3:21 p.m.)

1 THE BAILIFF: Your Honor, the jury is present.

2 THE COURT: All right. Welcome back, members of
3 the jury.

4 THE CLERK: Mr. Foreman, if the jury has reached a
5 verdict, would you hand it to me, please?

6 MR. FOREMAN: Sure.

7 THE CLERK: Thank you, sir.

8 THE COURT: All right. You may publish it.

9 THE CLERK: The State of South Carolina, County of
10 Richland in the Court of Common Pleas, case number
11 2015-CP-40-2395, Taliah K. Shabazz, Plaintiff vs. Bertha
12 Rodriguez, Defendant, the verdict is we, the jury, by
13 unanimous consent find for the Plaintiff in the amount of
14 \$12,500 actual damages, signed by the foreperson, Joshua
15 Bixler on this August 30th, 2016.

16 Mr. Foreman, is this your verdict and the verdict
17 of the entire jury?

18 MR. FOREMAN: That's correct. That is my verdict
19 and the verdict of the entire jury.

20 THE CLERK: Thank you, sir.

21 THE COURT: All right. Anything further from this
22 jury on behalf of the Plaintiff?

23 THE PLAINTIFF: No, Your Honor.

24 THE COURT: The Defense?

25 MS. BAILEY: No, Your Honor.

Exhibits Photo



Exhibits Photo 2



Exhibit 1: ER Medical Record



PRID:18761620	Call #:000932841
Service: Richland County EMS	Date: May 8, 2012
Base: HQ	Team: ALS
Unit: S214	Crew 1: Driver
Shift: C	*Tillison, Deana
Vehicle: Grid: Crane Church	Crew 2: Primary Caregiver
Type of Svc: Scene Unscheduled	Charping, Clarence
Response Code: Lights and Siren	* designates an ALS Provider
Mode to Ref: Lights / Sirens	Mode to Rec:
Moved Via: Stretcher	Moved From: Stretcher
Position: Fowlers	Pt. Condition: Unchanged
Outcome: Treated COUNTY RESIDENT, Transported by EMS	
Location: FAIRFIELD Monteith St / Fairfield Rd COLUMBIA, SC 29203	Receiving: Hospital: Palmetto Richland Memorial Emergency Department 5 Richland Medical Park Columbia, SC 29203-6863 803-434-1662
Scene Grid: Crane Church	Dest. Grid: HQ

Last Name: SHABAZZ First: TALIAH
 Address:
 City: WINNSBORO ST: SC Zip: 29810
 County: Fairfield
 Citizenship: United States
 Phone: (803) 635-1457
 DOB: [REDACTED] SSN: [REDACTED]
 Age: 19y Sex: M Weight:
 Height:
 Subscriber: No
 Race: Black, non-Hispanic
 Billing Information:
 None Given

Odometer	Times
Id Miles: 3.8	Received: 10:29
	Dispatch: 10:31
	EnRoute: 10:34
	At Ref: 10:36
	Leave Ref: 10:46
	At Rec: 10:55
	Available: 11:08

Consent Signed: No
 PCS / Medical Necessity Signed: No

Scene Information		
Description: PT WALKING AROUND ON SCENE		
Patient Belongings: PTS PURSE LEFT WITH PT IN ER WITH PT		
Other Agencies: Not Applicable / None		
Chief Complaint (Category: Pain)		
SHOULDER PAIN		
Duration: 30 Minutes		
Anatomic Location: Extremity - Upper		
ALS Assessment: Not Required		
History of Present Illness		
ROS TO FIND 19 YO FEMALE CC OF LEFT SHOULDER PAIN AND ALSO PAIN WHERE THE SEATBELT WAS OVERLAYING. PT AMBULATORY ON SCENE AFTER 2 CAR MVA WITH AIRBAG DEPLOYMENT AND MAJOR DMAGE. PT DENIES ANY LOC OR NECK OR BACK PAIN. PT TRANSFERRED TO STRETCHER TO TRUCK. VITALS TAKEN. PT STATES PAIN IS 9 OUT OF 10. PT TAKEN TO RICHLAND ER WITH REPORT GIVEN IN ROUTE. PT CARE LEFT WITH ER NURSE.		
Medical History	Current Medications	Allergies
None	None Listed	None
Obtained From: Patient		
Neurological Exam		

<https://www.emscharts.com/recordprint.cfm?rid=18761620>

2/14/2014

Neurological Exam																											
Level of Consciousness: Alert					Loss of Consciousness: No																						
Chemically Paralyzed: No																											
Neurological Present: Normal																											
Mental Present: Normal																											
					<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="4" style="text-align: center;">Glasgow Coma Scale</th> </tr> <tr> <td style="text-align: center;">E</td> <td style="text-align: center;">V</td> <td style="text-align: center;">M</td> <td style="text-align: center;">Tot</td> </tr> <tr> <td style="text-align: center;">Int: 4</td> <td style="text-align: center;">5</td> <td style="text-align: center;">6</td> <td style="text-align: center;">= 15</td> </tr> </table>					Glasgow Coma Scale				E	V	M	Tot	Int: 4	5	6	= 15						
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Pupils																											
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Size: Normal	Normal																										
React: Reactive	Reactive																										
Motor	Sensory																										
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RL: Normal	Normal																										
Motor Comments: With purpose																											
Airway					Respiratory																						
Status: Patent					Effort: Normal																						
					Sounds: L: Clear R: Clear																						
					Sounds: Bilaterally equal and clear																						
Cardiovascular																											
JVD: Not					Cap. Refill: Less than 2																						
Appreciated					Seconds																						
Edema: Not Appreciated																											
					<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="2" style="text-align: center;">Pulses</th> </tr> <tr> <td style="text-align: center;">Left</td> <td style="text-align: center;">Right</td> </tr> <tr> <td>Carotid: Not Checked</td> <td>Not Checked</td> </tr> <tr> <td>Radial: Strong</td> <td>Strong</td> </tr> <tr> <td>Femoral: Not Checked</td> <td>Not Checked</td> </tr> <tr> <td>Dorsalis: Normal</td> <td>Normal</td> </tr> </table>					Pulses		Left	Right	Carotid: Not Checked	Not Checked	Radial: Strong	Strong	Femoral: Not Checked	Not Checked	Dorsalis: Normal	Normal						
Pulses																											
Left	Right																										
Carotid: Not Checked	Not Checked																										
Radial: Strong	Strong																										
Femoral: Not Checked	Not Checked																										
Dorsalis: Normal	Normal																										
MVI					Injury Details																						
Involved: 2					Reason for Encounter: Injury/Trauma																						
Position: Driver					Drugs/Alcohol?: None																						
Seat Row: 1					Risk Factors Present: Not Applicable																						
Vehicle Impact: Left Front (Driver)																											
Initial Physical Findings																											
Injuries																											
Upper Extremities																											
Impression / Diagnosis																											
System: Extremities																											
Symptoms: Pain																											
Impression: Not Available																											
Activity																											
Time	H.R.	B.P.	SaO2	Resp	Rhythm	ECG Method	Pain	CRW																			
	Method	Method		Effort																							
Action	Comment																										
10:53	78	118 / 78		18	(REG)		9	12																			
		Auto. Off.		Normal																							
* Assessment made by:																											
Response Factors Affecting Care: None																											
Scene Factors Affecting Care: None																											
Transportation Factors Affecting Care: None																											

Exhibit 2: ER Medical Record**Emergency Dept****SHABAZZ, TALIAH KA'REEMAH - R005807114**

Result type: Emergency Dept
Result date: 08 May 2012 14:40
Result status: Auth (Verified)
Result title: Emergency Dept
Performed by: Fraser PA, Meghan C on 08 May 2012 14:40
Verified by: Shelton MD, Stephen L on 15 May 2012 06:53
Encounter info: R1212901163, Richland, ERR-Emergency Room, 05/08/12 - 05/08/12
Contributor system: Softmed

Emergency Dept (Verified)

PATIENT: SHABAZZ, TALIAH
MR #: 005307114
ADMITTED: 05/08/2012
ACCOUNT #: 1212901163
SITE: Meghan Carrawell Fraser, PA
DOB: _____
PT. LOC: FDI

DATE OF VISITATION: 05/08/2012

ACCOUNT NUMBER: 1212901163

ATTENDING PHYSICIAN: Stephen L. Shelton, MD

MODE OF ARRIVAL: EMS.

CHIEF COMPLAINT: Neck pain, shoulder pain.

HISTORY OF PRESENT ILLNESS: The patient is a 19-year-old African-American female, presenting to the emergency department via EMS after being involved in a motor vehicle crash this morning. She was the restrained driver of her vehicle when she ran into another vehicle that ran a red light. After coming to a stop, the airbags did deploy. She is now complaining of the left-sided C6/T6 burning in her neck, nonradiating, with a stiffness that is quickly increasing. She also is complaining of a 1/10 sore sensation in her proximal right wrist. She denies any numbness or tingling, any bowel or bladder incontinence, or any previous history of problems with her neck. She is currently not complaining of any back pain or headaches. The patient is also complaining of an 8/10, sharp pain in her anterior medial clavicle area with a "burning" sensation of the overlying skin. Her shoulder is also sore with movement radiating into her anterior upper chest area.

MEDICATIONS: Denies.**ALLERGIES:** No known drug allergies.**PAST MEDICAL HISTORY:** Denies.**FAMILY HISTORY:** Diabetes.**SURGICAL HISTORY:** Denies.

Printed by: Cantey, Precious K
Printed on: 05/30/13 12:08

Page 1 of 4
(Continued)



Emergency Dept

SHABAZZ, TALIAH KAREEMAH - R005807114

SOCIAL HISTORY: The patient goes to Waverly Women's. She attends Midland Tech and had her final exam today. She denies any smoking, alcohol, or illicit drug use.

REVIEW OF SYSTEMS: The patient denies any abdominal pain, chest pain, or shortness of breath. Please see HPI. All other systems are negative for pertinent positives, except as otherwise mentioned.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature 98.4, pulse 85, respirations 12, blood pressure 120/85, and pulse ox 99% on room air.

GENERAL: The patient is a young, African-American female, alert, and oriented x3, in no acute distress, nontoxic appearing.

NECK: Supple, with no lymphadenopathy or thyromegaly. Trachea midline. See musculoskeletal exam.

CARDIOVASCULAR: Heart regular rate and rhythm. No murmurs appreciated. No JVD or edema.

CHEST: Lung clear to auscultation bilaterally, with symmetric chest rise. No retractions or accessory muscle use. No deformities noted. Chest wall is mildly tender to palpation in the anterior left lateral area, extending into the shoulder. Please see musculoskeletal exam.

SKIN: No diaphoresis, pallor, or cyanosis. Turgor with good recoil. No rashes or lesions. There is a very small contusion just proximal to the patient's right wrist on the volar aspect of her arm. This is slightly tender to palpation with no deformities or swelling. Please see musculoskeletal exam.

MUSCULOSKELETAL: The patient ambulates without difficulty. Muscle strength 5/5 in upper and lower extremities, equal bilaterally. No cervical, thoracic, or lumbar midline tenderness. The patient's left side of her neck is exquisitely tender to palpation, extending out in a trapezius distribution and though her sternocleidomastoid down to her clavicle. There are no obvious deformities. She has pain in this area with rotation of her neck, as well as a forward flexion. Back has full range of motion with no pain elicited on exam. The patient's left clavicle at the sternoclavicular joint is very mildly swollen with no obvious deformity. This area is mildly tender to palpation. There is overlying seatbelt abrasion. Her shoulder is diffusely tender to palpation with no specific tenderness over the AC joint. No swelling of the clavicle. She has pain with abducting her arm above 90 degrees in any direction. This pain seems to be isolated more to the anterior chest into the anterior shoulder. The patient's right wrist does not show any deformities or swelling. She has full range of motion with no pain elicited on exam. She is neurovascularly intact in all her distal extremities.

TEST RESULTS: X-ray of the patient's neck clavicle and shoulder do not show any abnormalities.

MEDICAL DECISION MAKING: This patient presented to the emergency department after being involved in a motor vehicle crash. It appears as though she may have a rotator cuff injury, as there is no injury on x-ray, they can be seen. We will be placing her in a sling, with instructions to ice her shoulder, and if she sees no improvement in the next 7 to 10 days she is to follow up with her primary care doctor for orthopedic referral. Regarding the patient's

Emergency Dept

SHABAZZ, TALIAH KAREEMAH - R005807114

neck, again there were no findings on x-ray. She does not have any visible tenderness or neurological symptoms; however, her mother did insist on getting an x-ray. I have encouraged her to apply heat to this area. She does have quite a bit of muscle spasming, and is very tender. I believe she had quite a bit of whiplash. I will be giving her some Anaprox and Flexeril, and I told her not to driver work/go to school while taking Flexeril due to its sedative effects. The patient's wrist does not seem to have anything more than contusion and she does not seem concerned about as I do not believe any further intervention is warranted.

CLINICAL IMPRESSION:

1. Acute neck strain, secondary to motor vehicle crash.
2. Left shoulder pain, secondary to motor vehicle crash with possible rotator cuff injury.
3. Right wrist contusion.
4. Abrasions.

PLAN: Ice, shoulder sling, follow up in 7 to 10 days if no improvement in shoulder, heat to the neck. Flexeril 10 mg 3 times daily $\pm$ 5, and Anaprox 650 with saline #30. School note.

DISPOSITION: This patient was discharged from the emergency department in stable condition in the care of her mother after receiving 10 mg of Flexeril and 600 mg of ibuprofen, which did improve her pain.

On: 05/08/2012 14:37 T: 05/08/2012 14:40 CIP: en
 Job #: 10282096
 cc: Meghan Casswell Fraser, PA
 cc: Stephen L. Shelton, MD

NP/PA note reviewed. I agree with findings and plan as written.

Signature Line

Electronically Signed & Verified on 05/10/2012 20:17
 by Fraser PA, Meghan C

Electronically Signed & Verified on 05/15/12 06:53
 by Shelton MD, Stephen L

Completed Action List:

- * Perform by Fraser PA, Meghan C on 08 May 2012 14:40
- * Sign by Fraser PA, Meghan C on 10 May 2012 20:17 Requested on 08 May 2012 18:43
- * Modify by Shelton MD, Stephen L on 15 May 2012 06:53
- * Sign by Shelton MD, Stephen L on 15 May 2012 06:53 Requested by Fraser PA, Meghan C on 10 May 2012 20:17
- * VERIFY by Shelton MD, Stephen L on 15 May 2012 06:53

Printed by: Cantey, Precious K.
 Printed on: 05/30/13 12:08

Page 3 of 4
 (Continued)

Note Page 4 not printed because it was blank.

Exhibit 3: Primary Physician D. Floyd Medical Record

TALIAH SHABAZZ 3087

5/10/2013

TALIAH SHABAZZ, Gender: F, DOB: [REDACTED], Encounter Date and Time: 5/31/2012

11:00AM, Examiner: Dean A. Floyd, MD

Chief complaint

The Chief Complaint is: MVA.

History of present illness

TALIAH SHABAZZ is a 19 year old female. Source of patient information was patient. 19 year old Black lady who is following up for motor vehicle accident; she is overall better than last visit. Her neck is sore on the left side. The left shoulder is 'sore.' Her usual activity such as dressing has to be modified because she guards the shoulder. She had an x ray of the shoulder at Fairfield Memorial Hospital on the day of the wreck. She is afraid to drive.

Physical findings

Vital Signs:

Vital Signs/Measurements	Value	Date
Oral temperature	98.2 F	5/31/2012
RR	18 per min	5/31/2012
PR	86 bpm	5/31/2012
Blood pressure	97/70 mmHg	5/31/2012
Weight	132 lbs	5/31/2012

General Appearance:

* Alert. * Oriented to time, place, and person. * Well developed. * In no acute distress.

Musculoskeletal System:

General/bilateral: * Musculoskeletal system: The neck has full range of motion with mild tenderness on the left.

The left shoulder reveals guarding and severe tenderness over the AC joint anteriorly.

Assessment

- Sprained left shoulder. She is still having a significant amount of pain and immobility.
- Neck strain on left side.

Therapy

Allergies Reviewed.

Allergies and Adverse Reactions:

No Known Allergies.

Plan

- An MRI of the upper extremity other than a joint, with contrast.
- Follow-up visit 6 week(s)
- Consultation with a specialist Orthopedics, Orthopedic Surgery

Practice Management

Etab outpatient focused h&p - straightforward decisions MRI of left shoulder will be ordered and she will be referred to ortho.

Exhibit 3: Primary Physician D. Floyd Medical Record page 2

TALIAH SHABAZZ 3087

5/10/2013

5/16/2012 9:40:00 AM

TALIAH SHABAZZ, Gender: F, DOB: [REDACTED] Counter Date and Time: 5/16/2012

09:40AM, Examiner: Dean A. Floyd, MD

Chief complaint

The Chief Complaint is: Car accident on 05-08-2012 left shoulder, neck, and back pain and right arm as well.

History of present illness

TALIAH SHABAZZ is a 19 year old female. Source of patient information was patient. 19 year old Black lady who was involved in a motor vehicle accident on 5/8/12 in which she was forced to hit a van. She went RMH ER via EMS. She had X rays of the left clavicol, neck and leg shoulder. She is still sore better. She was give Rx for Flexeril and Naproxen. The Flexeril made her sleepy and naproxen made her stomach hurt.

Personal history

Behavioral: Never a smoker.

Physical findings

Vital Signs:

Vital Signs/Measurements	Value	Date
Oral temperature	97.6	5/16/2012
RR	18 per min	5/16/2012
PR	98 bpm	5/16/2012
Blood pressure	100/70 mmHg	5/16/2012
Weight	137.4 lbs	5/16/2012

General Appearance:

* Alert. * Oriented to time, place, and person. * Well developed. * In no acute distress.

Musculoskeletal System:

General/bilateral: * Musculoskeletal system: The left shoulder is mildly diffusely tender; there is slightly limited abduction; there is tenderness over the scapula.

Lesions there are 'seat belt' burns along the left neck and chest; this area is tender.

Assessment

- Shoulder sprain
- Neck strain

Allergies and Adverse Reactions

No Known Allergies.

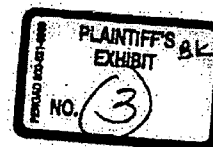
Plan

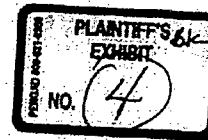
Follow-up visit 2 week(s)

- Flexeril 10 mg Tablet. 1 tablet by Oral route 3 times per day PRN. Dispense: 30. Refill: 0

Practice Management

Estab outpatient expanded h&p - low complexity decisions.





CAROLINA SHOULDER & KNEE SPECIALISTS

RECONSTRUCTIVE & ARTHROSCOPIC SURGERY / SPORTS MEDICINE

Name: TALIAH SHABAZZ MRN#: 103216. REF. DR.: FLOYD, DEAN,
MD Age: 19 DOB: 06/19/12

SUBJECTIVE

Chief Complaints: shoulder pain, left.

History of Present Illness

Patient is a 19 yr. old Female who presents with:

pain in the left anterior, posterior shoulder none, which resulted from
MVA/Driver/Restrained/T Bone another vehicle/ No LOC/ No extrication
needed/Immediate shoulder pain, and occurred 05/08/2012. Her frequency is described as
unpredictable. It is aggravated by use of arm and relieved by medication, heat, rest.
Associated sign and symptoms are stiffness, decrease range of motion, decreased
strength. Comments: has x-rays.

Past Medical History: Illnesses - No prior illnesses; Infectious diseases - No infectious diseases;
Surgeries (Non-Ortho) - No prior surgeries; Ortho Surgeries - No orthopedic surgeries;

Family History: Relative - Cancer, Diabetes, Unknown Type, Hypertension.

Social History: Alcohol use - Denies consumption of alcohol; Tobacco Use - Denies use
of tobacco; Dominant hand - right;

Review of Systems

General

Denies fever, or chills

08/01/2014 13:21 Carolina shoulder and knee

(FAX)8 195526

P.003/007

ASSESSMENT

Impression

1) Left Possible SLAP Tear, /Shoulder and neck strain

Diagnosis

PLAN

Miss Shabazz has had a substantial high level energy injury to her shoulder and neck. We would like to place her in organized physical therapy and try some topical modalities, cervical traction, topical massage and peri-scapular strengthening. We placed her on anti-inflammatory medication. We will see how she does over the next 3-4 weeks. If she fails to improve, we will consider repeating an MRI, this time with contrast which will be more helpful to rule out a SLAP tear. She has a tremendous amount of spasm over her supra-serratus and supraspinous fossa. She may have a hematoma in this area which is further adding to her discomfort level. Upon return in four weeks, an x-ray series of the shoulder should be taken prior to being seen by a physician to check for any heterotopic bone formation.

cc: Dr. Dean Floyd

Medication

New : Nabumetone 750 Mg Tablet 1 tablet by mouth twice a day TAKE WITH A FULL STOMACH 60 Q Refill: 0

Orders

Return in 5 Weeks () - Initiated

Physical Therapy Shoulder

Modalities	Modalities of choice
Freq/Duration	1X week for 3 Weeks
Start Date	ASAP

cc: Dr. Dean Floyd



CAROLINA SHOULDER & KNEE SPECIALISTS

RECONSTRUCTIVE & ARTHROSCOPIC SURGERY / SPORTS MEDICINE

Name: TALIAH SHABAZZ MRN#: 103218. REF. DR.: FLOYD, DEAN,
MD Age: 19 DOB: 07/24/12

SUBJECTIVE

Chief Complaints: shoulder pain, left.

History of Present Illness

Patient is a 19 yr. old Female who presents with:

pain in the left anterior, posterior shoulder non radiating, which resulted from MVA/Driver/Restrained/T Bone another vehicle/ No LOC/ No extrication needed/Immediate shoulder pain, and occurred 05/08/2012. Her frequency is described as unpredictable. TALIAH reports her progression as much better. It is aggravated by use of arm and relieved by medication, heat, rest. Associated sign and symptoms are stiffness, decrease range of motion, decreased strength. Prior treatments have included physical therapy. Testing on the patient has comprised of x ray and mri w/out contrast. Comments: repeated x rays today.

Past Medical History: Illnesses - No prior illnesses; Infections - No serious infections;
Surgeries (Non-Ortho) - No prior surgeries; Ortho Surgeries - No prior surgeries;

Social History: Alcohol use - Denies consumption of alcohol; Tobacco Use - Denies use of tobacco; Dominant hand - right;

Review of Systems

General

Denies fever, or chills

Exhibit 4: Orthopedics K. Nahigian Medical Record page 4

05/07/2014 13:22 Carolina Shabazz R Knee

130020

13071007

Palpation	minimal over the biceps tendon/anterior posterior joint line
ROM	near full active range of motion w/pain
Stability	no evidence of instability
Special Tests	positive belly press test, compression rotation test
Strength	strength 5-5 rotator cuff muscles, no obvious atrophy
Sensation	sensation intact to light touch
Vascular	pulses intact
Reflexes	2+ and symmetrical
Lymph	no lymphadenopathy

ASSESSMENT

Impression

1) Left Possible SLAP Tear, /Shoulder and neck strain-Improved

Diagnosis

1. Sprains/strains; superior glenoid labrum lesion(840.7) - . Primary Diagnosis, Onset,

PLAN

Miss Shabazz has improved dramatically over the last several weeks. We would like to transition to a home exercise program. As long as she continues to improve, no scheduled followup will be necessary. I would be happy to see her back for 6-8 weeks for one last check and release to make sure she is out of the woods for medical/legal purposes. If this is not needed by her insurance company or lawyer, no additional followup will be necessary. Upon return, no x-rays will be necessary.

Treatment Discussion Knee

Comments: Encouraged topical ice massage, Home theraband program given

cc: Dean Floyd, MD

Exhibit 4: Orthopedics K. Nahigian Medical Record page 5

08/01/2014 13:22 carolina snouder no knee

(FAX)81196626

P.006/007

Skin	Denies rash, new skin lesions, or change in moles
Eyes	vision problems
Ears / Nose / Throat	Denies ear pain, or difficulty hearing
Cardiovascular	Irreg. heartbeat/palpitation
Respiratory	Denies shortness of breath, cough, or wheezing
Gastrointestinal	Denies abdominal pain, melena, or bright red blood, nausea, vomiting, diarrhea, constipation
Genitourinary	Denies dysuria, frequency of urination, urgency, or hesitancy
Musculoskeletal	see HPI
Neurological	numbness, tingling
Psychiatric	depression, anxiety, low energy level
Endocrine	fatigue
Hemato / Lymph	Denies easy bruising, bleeding, oral ulcerations or recurrent infections
Immunologic	No lymphadenopathy

Medication

Tylenol 500 mg capsule
 Nabumetone 750 Mg Tablet, 1 tablet by mouth twice a day TAKE WITH A FULL STOMACH
 Flexeril 10 Mg Tablet, 1 tablet by mouth every 6 hours

Allergies

No Known Drug Allergies, reaction Not Applicable

OBJECTIVE

Vital Signs

BP 1 - 95 / 70 - Wt. - 135 lb. 0.0 oz. Ht. - 5 ft. 7.00 in. BMI - 21.1 Tobacco Use - Never smoker

Exam: Shoulder

Left

Skin	no surgical scars
Inspection	no gross abnormalities



**CAROLINA SHOULDER
& KNEE SPECIALISTS**

A Lexington Medical Center Physician Practice

Lexington County Health Sys
2720 Sunset Boulevard
West Columbia, SC 29169
(803) 791-2000

Patient: TALIAH SHABAZZ

WINNSBORO, SC 29180

DOS: 05/06/2013

DOB

Gender: F

MR#: 1689577

Provider: Kevin K. Nahigian MD

Chief Complaint

left shoulder pain

History of Present Illness

Shoulder Problem: The patient is being seen for follow-up of a shoulder problem. Symptoms: stiffness. Shoulder pain: Symptoms are located in left shoulder and which resulted from MVA/Driver/restrained/ T bone another vehicle/ no LOC. Onset was immediately after the injury and 5/8/12. Relieving factors: stretching and exercise. Patient complains of knots in chest and back, along with frequent headaches.

Vitals

Vital Signs [Data Includes: Current Encounter]

Recorded by : at 06May2013 03:44PM

Height: 5 ft 7 in

Weight: 135 lb

BMI Calculated: 21.19

BSA Calculated: 1.71

Blood Pressure: 95 / 70

Review of Systems

Complete-Female:

Constitutional: no fever and no chills.

Head and Face: no facial pain.

Eyes: no eye pain and no visual changes.

ENT: no earache, no change in hearing and no tinnitus.

Cardiovascular: no chest pain, no lower extremity edema, no palpitations, no orthopnea, no lightheadedness, no peripheral vascular disease, no claudication and no syncope.

Respiratory: no shortness of breath, no cough, no wheezing and no dyspnea.

Gastrointestinal: no abdominal pain, no nausea, no vomiting, no constipation, no bright red blood per rectum, no melena and no diarrhea.

Genitourinary: no dysuria, no urinary frequency, no hematuria, no urinary urgency, no urinary hesitancy and no urinary incontinence.

Musculoskeletal: as noted in HPI.

Integumentary and Breasts: no rashes, no new skin lesions and no change in a mole.

Neurological: no limb weakness, no tingling and no numbness.

Psychiatric: no anxiety, no substance abuse, no depression and not suicidal.

Endocrine: denies weight gain / loss, denies heat / cold intolerance and no increasing thirst.

Hematologic and Lymphatic: no tendency for easy bleeding, no tendency for easy bruising and no oral ulcerations.

Immunologic: no recurrent infections and no lymphadenopathy.

Results/Data

All Results [Data Includes: Current Encounter]

06May2013 04:06PM

Exhibit 4: Orthopedics K. Nahigian Medical Record page 7

Date of Service: 05/06/2013
Patient Name: TAJIAH SHABAZZ
Patient DOB
MR#: 1689577
Gender: F
Provider: Kevin K. Nahigian MD

XR Shoulder Left Axillary View

XR Shoulder Left Axillary View: The report for these images resides in the Doctor's Office Electronic Health Record that performed the exam.

Physical Exam:

Physical Exam: Exam of the left shoulder finds much global improvement with strength range of motion and scapular tracking. She continues to have periscapular discomfort and muscular spasm. Rotator cuff strength is back to her baseline she has no other upper extremity muscle deficiency. Her arm is without swelling her hand is neurovascularly intact. She does complain of frontal facial headaches.

Impression one year status post motor vehicle accident with shoulder and head complaints.

Plan: The patient was sent to a neurologist to assess her headache complaints. I have no doubt that with time her muscular and fascial inflammation will improve with time stretching and continue strengthening. A anti-inflammatory medication Relafen was sent in to the pharmacy today. He will take his medication of the back several weeks to help calm her inflammatory symptoms. Nodes schedule followup will be necessary at this time.

Plan

1. Nabumetone 750 MG Oral Tablet, TAKE 1 TABLET TWICE DAILY AFTER MEALS.
Therapy: 06May2013 to (Evaluate:04Aug2013); Last Rx:06May2013 Ordered
2. XR Shoulder Left Axillary View Done: 06May2013 04:06PM

Signatures

Electronically signed by: Kevin Nahigian, MD, May 6 2013 4:43PM EST

Exhibit 4: Orthopedics/Physical Therapy K. Nahigian Medical Record page 8

15/14/2014 12:12:29PM

Transaction Report

For Account #: 107365 - TALIAH SHABAZZ

DOS	DESCRIPTION	AMOUNT
06/20/2012 06/20/2012 06/20/2012	INITIAL EVALUATION	100.00
06/21/2012	THERAPEUTIC EXERCISE	75.00
06/25/2012	THERAPEUTIC EXERCISE	75.00
06/27/2012 06/27/2012	THERAPEUTIC EXERCISE	75.00
06/28/2012	THERAPEUTIC EXERCISE	75.00
07/02/2012	THERAPEUTIC EXERCISE	75.00
07/06/2012 07/06/2012	THERAPEUTIC EXERCISE	75.00
07/09/2012	THERAPEUTIC EXERCISE	75.00
07/13/2012 07/13/2012	THERAPEUTIC EXERCISE	75.00
07/16/2012	THERAPEUTIC EXERCISE	75.00
07/23/2012 07/23/2012	THERAPEUTIC EXERCISE	126.00

Exhibit 4: Orthopedics/Physical Therapy K. Nahigian Medical Record page 9

15/14/2014 12:12:29PM

For Account #: 107365 - TA

DOS	DESCRIPTION	AMOUNT
07/25/2012	97110 THERAPEUTIC EXERCISE	75.00
07/27/2012	97110 THERAPEUTIC EXERCISE	75.00
07/31/2012	97110 THERAPEUTIC EXERCISE	75.00
08/07/2012	97110 THERAPEUTIC EXERCISE	75.00
08/13/2012	97110 THERAPEUTIC EXERCISE	75.00
08/17/2012	97110 THERAPEUTIC EXERCISE	75.00
08/21/2012	97110 THERAPEUTIC EXERCISE	75.00
08/24/2012	97110 THERAPEUTIC EXERCISE	75.00
08/24/2012	97035 ULTRASOUND	15.00
10/05/2012	97110 THERAPEUTIC EXERCISE	75.00

Exhibit 4: Orthopedics/Physical Therapy K. Nahigian Medical Record page 10

05/14/2014 12:12:29PM

T

For Account #: 107365 - TALIAH SHAE

DOS	DESCRIPTION	AMOUNT
01/09/2013	THERAPEUTIC EXERCISE	75.00

Exhibit 5: Neurologist Dr. Ogburu Medical Record

MIDLANDS NEUROLOGY & PAIN ASSOCIATES
 ELEANYA OGBURU-OGBONNAYA, MD.
 4801 NORTH MAIN STREET
 COLUMBIA, SC 29203
 803-788-0038 PHONE
 803-788-0655 FAX



Taliah Shabazz — 23 yrs.

05/24/2013

WINNSBORO, SC 29180

Current Allergies:
 NKDA

Current Medications:
 Lovaza - 1 gram 3 tabs po daily
 riboflavin - 100 mg 4 tabs daily
 Topamax - 25 mg 1 tab daily x 1
 week then bid thereafter
 Mobic - 15 mg QD (# per day:
 1.00)
 Voltaren - 1 % apply to area of
 pain bid

Vitals:
 HT: 68 in.
 WT: 136 lbs.
 BMI: 20.7
 R: 18
 T: 97.9
 P: 60 regular

Previous BP: 110/76
 BP 1: 104/67

Past History:
 MEDICAL: Chronic pain
 INJURIES: none
 HOSPITALIZATIONS /
 SURGERIES: none
 TREATMENTS: physical
 therapy

Family History:

Social History:
 single with no children
 education given, discussed
 ALCOHOL USE: Patient denies
 alcohol use.
 DRUG USE: Patient denies
 drug use.
 CAFFEINE: Patient denies

Problem List:

Code	Description	Onset	Status	Status Date
346.71	CHRONIC MIGRAINE NO	01/10/2014	Chronic	01/10/2014
461.9	ACUTE SINUSITIS, UNS	01/10/2014	Chronic	01/10/2014
719.41	PAIN IN JOINT, SHOUL	01/10/2014	Chronic	01/10/2014
723.0	SPINAL STENOSIS IN C	01/10/2014	Chronic	01/10/2014
724.4	THOR/LUMBOSACRL NURI	01/10/2014	Chronic	01/10/2014
729.1	UNSPECIFIED MYALGIA	01/10/2014	Chronic	01/10/2014
784.0	HEADACHE	01/10/2014	Chronic	01/10/2014
E812.0	OTH MOTR VEH COLL W/	01/10/2014	Chronic	01/10/2014

Primary Care Physician:

Referring Physician:
 Dean Floyd M.D.

Dear Doctor

Thank you very much for the opportunity of seeing this pleasant patient.

Reason for Consultation:

Patient is schedule for a initial consultation with c/o headaches. Patient was referred here by Dean Floyd M.D. from Eau Cooperative Health due to left shoulder pain, back pain and headache.

History of Present Illness:

Ms. Shabazz is a 20 year old female who presents today for a schedule initial consultation with c/o headaches, low back and shoulder pain since Motor Vehicle Accident on 5/08/2012. Patient was referred here by Dean Floyd M.D. from Eau Cooperative Health due to chronic left shoulder pain, headache and low back pain. Patient was involve in a MVA on 05/08/2012. Notes patient was the driver with seat belt on. Notes patient was driving a small car and hit by a van with loss of consciousness with possible head injury. Notes air bag deployed and hit her on the face. Notes blurry vision. Notes patient wears contact lenses. Notes patient was taken to PRMH. Notes patient headaches are located over the left temporal. Notes patient has greater than 5 headaches per month. Notes patient headaches last 3 to 5 hours before she begins to feel any relief. Notes patient is having tenderness to the left side of her neck. Notes weakness and shoulder pain left > rt since Motor Vehicle Accident and pain extending into the upper extremities and suprascapular area and collar bone. Notes patient c/o symptoms of numbness and tingling sensations. Notes no bowel/bladder dysfunction. She also c/o about mid back pain

Page 1 of 4

Exhibit 5: Neurologist Dr. Ogburu Medical Record page 2

MIDLANDS NEUROLOGY & PAIN ASSOCIATES
ELEANYA OGBURU-OGBONNAYA, MD
4801 NORTH MAIN STREET
COLUMBIA, SC 29203
803-788-0038 PHONE
803-788-0655 FAX

Taliah Shabazz — 23 yrs.

05/24/2013

WINNSBORO, SC 29180

caffeine use.
EMPLOYMENT: Unemployed

esp over the interscapular area. She noted that she was seen by orth surgeon.
LOCATION: neck and left shoulder blade pain.
QUALITY: aching, shooting, sharp, tiring, throbbing, exhausting and unbearable.
SEVERITY: severe.
DURATION: 1 year.
TIMING: constant.
CONTEXT: MVA 2012.

ROS:

Positive and pertinent negative responses below. All other areas negative.

EYES: vision/glasses, headache, blurry vision.

GASTROINTESTINAL: persistent nausea.

MUSCULOSKELETAL: joint pain any joint, back pain.

PSYCHIATRIC: anxious / nervous, depressed.

Pending Studies:

none

none

Any med/injection given:

none

Exam:

GENERAL: alert and oriented x3, pleasant, well groomed, healthy and in no apparent distress

HEENT: Normocephalic. Pupils are normal. Conjunctivae normal. Mucous membranes normal. No cyanosis or icterus. Trachea central.

RESP: Lungs clear to auscultation, no labored breathing, without wheezes, no rales or rhonchi.

CARDIO: Regular rate & rhythm, no murmurs, ectopy or rubs. No JVD evaluation @45°.

ABDOMEN: Soft no masses or organomegaly. No abdominal pulsations or bruits. Femoral pulse intact and equal bilaterally. Normal bowel sounds.

SKIN: No skin rash, subcutaneous nodules, lesions or ulcers observed. Skin is warm and dry with normal turgor.

MUSCULOSKELETAL: tenderness in the shoulder and c-spine with paraspinal spasm.

MENTAL STATUS: Recent and remote memory is intact. Attention span, concentration, language and fund of knowledge sufficient.

GAIT / STATION: Normal gait, normal stance and swing phase with no antalgic component.

CERVICAL - Appearance: strain pattern

CERVICAL - Palpation: tender, stiff

CERVICAL - Range of Motion: limited flexion, limited extension

THORACIC - Appearance: within normal limits

Exhibit 5: Neurologist Dr. Ogburu Medical Record page 3

MIDLANDS NEUROLOGY & PAIN ASSOCIATES
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 803-788-0655 FAX

Taliah Shabazz — 23 yrs.

05/24/2013

WINNSBORO, SC 29180

THORACIC - Palpation: non tender
 LUMBAR - Appearance: within normal limits
 LUMBAR - Palpation: non tender
 LUMBAR - Range of Motion: within normal limits
 UPPER EXTREMITIES - Appearance: limited - left shoulder
 UPPER EXTREMITIES - Palpation: tenderness over left shoulder
 UPPER EXTREMITIES RANGE OF MOTION - Left: Within normal limits
 UPPER EXTREMITIES RANGE OF MOTION - Right: Within normal limits
 LOWER EXTREMITIES - Appearance: within normal limits
 LOWER EXTREMITIES - Palpation: non tender
 LOWER EXTREMITIES RANGE OF MOTION - Left: Within normal limits
 LOWER EXTREMITIES RANGE OF MOTION - Right: Within normal limits
 COORDINATION - UPPER: Bilaterally equal, within normal limits
 MOTOR - UPPER: Bilaterally equal, within normal limits. Motor 5 / 5
 REFLEXES - UPPER: Deep tendon reflexes bilaterally equal, within normal limits
 SENSORY - UPPER: Sensation bilaterally intact to touch
 COORDINATION - LOWER: Bilaterally equal, within normal limits
 MOTOR - LOWER: Bilaterally equal, within normal limits. Motor 5 / 5
 REFLEXES - LOWER: Deep tendon reflexes bilaterally equal, within normal limits
 SENSORY - LOWER: Sensory exam normal

Cranial Nerves:

CN II - NORMAL: CN II-XII grossly intact
 CERVICAL SPINE - ABNORMAL: tender
 BACK - NORMAL: unremarkable
 LOWER BACK - NORMAL: unremarkable

Medical Decision/Time:

Code	Description	Onset	Status	Status Date
346.71	CHRONIC MIGRAINE NO	01/10/2014	Chronic	01/10/2014
461.9	ACUTE SINUSITIS, UNS	01/10/2014	Chronic	01/10/2014
718.41	PAIN IN JOINT, SHOUL	01/10/2014	Chronic	01/10/2014
723.0	SPINAL STENOSIS IN C	01/10/2014	Chronic	01/10/2014
724.4	THOR/LUMBOSACRL NURI	01/10/2014	Chronic	01/10/2014
729.1	UNSPECIFIED MYALGIA	01/10/2014	Chronic	01/10/2014
784.0	HEADACHE	01/10/2014	Chronic	01/10/2014
E812.0	OTH MOTR VEH COLL W/	01/10/2014	Chronic	01/10/2014

Lab Results:

uds

Diagnosis: Code	Description	Onset	Status	Status Date
346.71	CHRONIC MIGRAINE NO	01/10/2014	Chronic	01/10/2014
461.9	ACUTE SINUSITIS, UNS	01/10/2014	Chronic	01/10/2014

Exhibit 5: Neurologist Dr. Ogburu Medical Record page 4

MIDLANDS NEUROLOGY & PAIN ASSOCIATES
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Taliah Shabazz — 23 yrs.

05/24/2013

WINNSBORO, SC 29180

719.41	PAIN IN JOINT, SHOUL	01/10/2014	Chronic	01/10/2014
723.0	SPINAL STENOSIS IN C	01/10/2014	Chronic	01/10/2014
724.4	THOR/LUMBOSACRL NURI	01/10/2014	Chronic	01/10/2014
729.1	UNSPECIFIED MYALGIA	01/10/2014	Chronic	01/10/2014
784.0	HEADACHE	01/10/2014	Chronic	01/10/2014
E812.0	OTH MOTR VEH COLL W/	01/10/2014	Chronic	01/10/2014

Plan:

RTC in 4 weeks, Pain contract discussed and reviewed at length. Pt verbalized understanding. Patient was counseled about opioid dependence, addiction, and side effects, schedule apt with Clinical Social worker, 3 x week group and individualized counseling. UDS and PMP ordered to eval for aberrant behavior issues and monitoring, Confirmatory testing ordered to verify results of urine drug test. Need MRI of the brain, Pain contract discussed and reviewed at length. Pt verbalized understanding. full body bone scan, EMG/NCV upper extremities, ans, MRI cervical spine, Botox, Occipital Nerve Block, Trigger point, physical and aquatic therapy, will try soma, ibuprofen, floricet and Zoloft. may consider cortisone inj of shoulder. emg and ncv completed

cc to referral physician

Electronically Signed: DR ELEANYA OGBURU-OGBONNAYA on/at 8/26/2015 11:05:40 AM

Exhibit 5: Neurologist Dr. Ogburu Medical Record page 5

MIDLANDS NEUROLOGY & PAIN ASSOCIATES
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Taliah Shabazz — 23 yrs.

06/10/2013

WINNSBORO, SC 29180

Current Allergies:
NKDA

Current Medications:

Lovaza - 1 gram 3 tabs po daily
riboflavin - 100 mg 4 tabs daily
Topamax - 25 mg 1 tab daily x 1
week then bid thereafter
Mobic - 15 mg QD (# per day:
1.00)
Voltaren - 1 % apply to area of
pain bid

Vitals:

HT: 68 in.
WT: 132 lbs.
BMI: 20.1
R: 16
T: 98.6
P: 90 regular

Previous BP: 110 / 76
BP 1: 104 / 70

Past History:

MEDICAL: Chronic pain
INJURIES: none
HOSPITALIZATIONS /
SURGERIES: none
TREATMENTS: physical
therapy

Family History:

Social History:

single with no children
education given, discussed,
ALCOHOL USE: Patient denies
alcohol use.
DRUG USE: Patient denies
drug use.
CAFFEINE: Patient denies

Problem List:

Code	Description	Onset	Status	Status Date
346.71	CHRONIC MIGRAINE NO	01/10/2014	Chronic	01/10/2014
461.9	ACUTE SINUSITIS, UNS	01/10/2014	Chronic	01/10/2014
719.41	PAIN IN JOINT, SHOUL	01/10/2014	Chronic	01/10/2014
723.0	SPINAL STENOSIS IN C	01/10/2014	Chronic	01/10/2014
724.4	THOR/LUMBOSACRL NURI	01/10/2014	Chronic	01/10/2014
729.1	UNSPECIFIED MYALGIA	01/10/2014	Chronic	01/10/2014
784.0	HEADACHE	01/10/2014	Chronic	01/10/2014
E812.0	OTH MOTR VEH COLL W/	01/10/2014	Chronic	01/10/2014

Primary Care Physician:

Referring Physician:
Dean Floyd, M.D.

Dear Doctor

Thank you very much for the opportunity of seeing this pleasant patient.

Reason for Consultation:

Patient is schedule for a routine follow up visit with c/o lower back, upper back and headaches. Patient has a history of neck and left shoulder blade pain.

History of Present Illness:

Ms. Shabazz is a 20 year old female who presents today for a schedule routine follow up visit with c/o lower back and upper back pain. Patient has a history of neck, headaches and left shoulder blade pain. Functional level is good with a pain level of 0/10. Notes her pain level increase in the morning and at night. Notes no seizures. Notes headaches are 3 times per week. Notes headaches last up to 4 hours before you begins to feel any relief. Notes episodes of syncope over the weekend and was examine at Fairfield Memorial Hospital. Notes she is having difficulties maintaining sleep at night. Notes no recent studies done. Notes no voiding. Notes difficulties urinating. Otherwise no changes.

LOCATION: neck, left shoulder blade pain, headaches.

QUALITY: aching, shooting, sharp, ting, throbbing, exhausting and unbearable.

SEVERITY: severe

DURATION: more than a year.

TIMING: constant

CONTEXT: MVA 2012.

Exhibit 5: Neurologist Dr. Ogburu Medical Record page 6

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803-788-0655 FAX

Taliah Shabazz — 23 yrs.

06/10/2013

WINNSBORO, SC 29180

caffeine use.
EMPLOYMENT: Unemployed

ROS:

Positive and pertinent negative responses below. All other areas negative.

EYES: vision/glasses, headache, blurry vision.

GASTROINTESTINAL: persistent nausea.

MUSCULOSKELETAL: joint pain any joint, back pain.

PSYCHIATRIC: anxious / nervous, depressed.

Pending Studies:

nonenotic

none

Any med/injection given:

none

Exam:

GENERAL: alert and oriented x3, pleasant, well groomed, healthy and in no apparent distress.

HEENT: Normocephalic. Pupils are normal. Conjunctivae normal. Mucous membranes normal. No cyanosis or icterus. Trachea central.

RESP: Lungs clear to auscultation, no labored breathing, without wheezes, no rales or rhonchi.

CARDIO: Regular rate & rhythm, no murmurs, ectopy or rubs. No JVD evaluation @45°.

ABDOMEN: Soft no masses or organomegaly. No abdominal pulsations or bruits. Femoral pulse intact and equal bilaterally. Normal bowel sounds.

SKIN: No skin rash, subcutaneous nodules, lesions or ulcers observed. Skin is warm and dry with normal turgor.

MUSCULOSKELETAL: tenderness in the shoulder, tenderness to c-spine with paraspinous spasm, tenderness to the L-spine with Para spinal spasm, tenderness over the bilat shoulder area.

MENTAL STATUS: Recent and remote memory is intact. Attention span, concentration, language and fund of knowledge sufficient.

GAIT / STATION: Normal gait, normal stance and swing phase with no antalgic component.

CERVICAL - Appearance: strain pattern

CERVICAL - Palpation: non tender,

CERVICAL - Range of Motion: limited extension, limited flexion

THORACIC - Appearance: within normal limits

THORACIC - Palpation: non tender

LUMBAR - Appearance: strain pattern

LUMBAR - Palpation: tender - bilateral

LUMBAR - Range of Motion: painful

UPPER EXTREMITIES - Appearance: limited - left shoulder

UPPER EXTREMITIES - Palpation: tenderness over left shoulder

UPPER EXTREMITIES RANGE OF MOTION - Left: Within normal limits.

Exhibit 5: Neurologist Dr. Ogburu Medical Record page 7

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Taliah Shabazz — 23 yrs.

06/10/2013

WINNSBORO, SC 29180

UPPER EXTREMITIES RANGE OF MOTION - Right: Within normal limits.
LOWER EXTREMITIES - Appearance: within normal limits
LOWER EXTREMITIES - Palpation: non tender
LOWER EXTREMITIES RANGE OF MOTION - Left: Within normal limits.
LOWER EXTREMITIES RANGE OF MOTION - Right: Within normal limits.
COORDINATION - UPPER: Bilaterally equal, within normal limits.
MOTOR - UPPER: Bilaterally equal, within normal limits. Motor 5 / 5.
REFLEXES - UPPER: Deep tendon reflexes bilaterally equal, within normal limits.
SENSORY - UPPER: Sensation bilaterally intact to touch.
COORDINATION - LOWER: Bilaterally equal, within normal limits.
MOTOR - LOWER: Bilaterally equal, within normal limits. Motor 5 / 5.
REFLEXES - LOWER: Deep tendon reflexes bilaterally equal, within normal limits.
SENSORY - LOWER: Sensory exam normal.

Cranial Nerves:

CN II - NORMAL: CN II-XII grossly intact

CERVICAL SPINE - ABNORMAL: tender

BACK - NORMAL: unremarkable

LOWER BACK - ABNORMAL: paraspinal spasm - left, paraspinal spasm - right

Medical Decision/Time:

>30min spent with pt. mod-complex decision making, pt counseled, labs and PMP reviewed. Based upon evaluation, history and physical examination, and improved and maintained functional improvement goal, it is my medical opinion that the benefits of outpatient tx for this pt for chronic pain outweigh the risk at present.

Lab Results:

UDS

Diagnosis: OTH MOTR-VEH COLL WMV-DRIVER - E812.0

CHRONIC MIGRAINE NO W/INTRACT NO SM - 346.71

UNSPECIFIED MYALGIA AND MYOSITIS - 729.1

HEADACHE - 784.0

ACUTE SINUSITIS, UNSPECIFIED - 461.9

PAIN IN JOINT, SHOULDER REGION - 719.41

SPINAL STENOSIS IN CERVICAL REGION - 723.0

THOR/LUMBOSACRL NURIT/RADICULIT UNS - 724.4

Plan:

RTC in 4 months, Continue current plan of care, UDS, Pharmacy sweep, refer to deep tissue massage therapy. Patient has reached MMI and patient is doing well, patient will then be discharged, may need myofascial release pm, good body mechanics and ergonomic posture maintenance, may use baclofen 10mg, Mobic 15mg, and lovaza 3gm, with great care and may need to Mobic during menstrual cycle due to anemia and heavy bleeding. Patient had shoulder strain with healed

Page 3 of 4

Exhibit 5: Neurologist Dr. Ogburu Medical Record page 8

MIDLANDS NEUROLOGY & PAIN ASSOCIATES
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803-788-0038 PHONE
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Taliah Shabazz — 23 yrs.

06/10/2013

WINNSBORO, SC 29180

soft tissue injury with consistent objective finding at mmi suggest class 1, grade b =
2%wei and converts to 1% WPI. (6TH EDITION)

cc to referral physician

Electronically Signed: DR ELEANYA OGBURU-OGBONNAYA on/at 9/17/2015 11:52:07 AM

Exhibit 5: Neurologist Dr. Ogburu Medical Record page 9

MIDLANDS NEUROLOGY & PAIN ASSOCIATES
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803-788-0038 PHONE
803-788-0655 FAX

Taliah Shabazz — 23 yrs.

07/17/2013

WINNSBORO, SC 29180

Current Allergies:
NKDA

Current Medications:
Lovaza - 1 gram 3 tabs po daily
riboflavin - 100 mg 4 tabs daily
Topamax - 25 mg 1 tab daily x 1
week then bid thereafter
Mobic - 15 mg QD (# per day:
1.00)
Voltaren - 1 % apply to area of
pain bid

Vitals:
HT: 68 in.
WT: 137 lbs.
BMI: 20.8
R: 18
T: 98.2
P: 67 regular

Previous BP: 110 / 76
BP 1: 110 / 70

Past History:
MEDICAL: Chronic pain
INJURIES: none
HOSPITALIZATIONS /
SURGERIES: none
TREATMENTS: physical
therapy

Family History:

Social History:
single with no children
education given, discussed
ALCOHOL USE: Patient denies
alcohol use.
DRUG USE: Patient denies
drug use.
CAFFEINE: Patient denies

Problem List:

Code	Description	Onset	Status	Status Date
346.71	CHRONIC MIGRAINE NO	01/10/2014	Chronic	01/10/2014
461.9	ACUTE SINUSITIS, UNS	01/10/2014	Chronic	01/10/2014
719.41	PAIN IN JOINT, SHOUL	01/10/2014	Chronic	01/10/2014
723.0	SPINAL STENOSIS IN C	01/10/2014	Chronic	01/10/2014
724.4	THOR/LUMBOSACRL NURI	01/10/2014	Chronic	01/10/2014
729.1	UNSPECIFIED MYALGIA	01/10/2014	Chronic	01/10/2014
784.0	HEADACHE	01/10/2014	Chronic	01/10/2014
E812.0	OTH MOTR VEH COLL W/	01/10/2014	Chronic	01/10/2014

Primary Care Physician:

Referring Physician:
Dean Floyd, M.D.

Dear Doctor,

Thank you very much for the opportunity of seeing this pleasant patient.

Reason for Consultation:

Patient is schedule for a routine follow up visit with c/o headaches, neck and left shoulder blade pain.

History of Present Illness:

Ms. Shabazz is a 23 year old female who presents today for a schedule routine follow up visit with c/o headaches, neck and left shoulder blade pain. Functional level is good with a pain level of 0/10. Notes patient had EEG performed on 06/10/13. Notes testing was repeated today. Notes patient does not like to take meds. Notes patient takes Soma for relief. Notes patient refusing psychiatry. Notes no further complaints. Notes straighten of the cervical spine alignment. Notes she is currently taking soma for the spasms.

LOCATION: headaches, neck and left shoulder blade.

QUALITY: aching, shooting, sharp, tiring, throbbing, exhausting and unbearable.

SEVERITY: severe.

DURATION: more than a year.

TIMING: constant

MODIFYING FACTORS: MVA 2012.

ROS:

Exhibit 5: Neurologist Dr. Ogburu Medical Record page 10

MIDLANDS NEUROLOGY & PAIN ASSOCIATES
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Taliah Shabazz — 23 yrs.

07/17/2013

WINNSBORO, SC 29180

caffeine use.
EMPLOYMENT: Unemployed

Positive and pertinent negative responses below. All other areas negative.
EYES: vision/glasses, headache, blurry vision.
GASTROINTESTINAL: persistent nausea.
MUSCULOSKELETAL: joint pain any joint, back pain.
PSYCHIATRIC: anxious / nervous, depressed.

Pending Studies:
none

none

Any med/injection given:
none

Exam:

GENERAL: alert and oriented x3, pleasant, well groomed, healthy and in no apparent distress
HEENT: Normocephalic. Pupils are normal. Conjunctivae normal. Mucous membranes normal. No cyanosis or icterus. Trachea central.
RESP: Lungs clear to auscultation, no labored breathing, without wheezes, no rales or rhonchi.
CARDIO: Regular rate & rhythm, no murmurs, ectopy or rubs. No JVD evaluation @45'.
ABDOMEN: Soft no masses or organomegaly. No abdominal pulsations or bruits. Femoral pulse intact and equal bilaterally. Normal bowel sounds.
SKIN: No skin rash, subcutaneous nodules, lesions or ulcers observed. Skin is warm and dry with normal turgor.
MUSCULOSKELETAL: tenderness to the cervical spine with paraspinal spasm. tenderness to left shoulder
MENTAL STATUS: Recent and remote memory is intact. Attention span, concentration, language and fund of knowledge sufficient.
GAIT / STATION: Normal gait, normal stance and swing phase with no antalgic component.
CERVICAL - Appearance: strain pattern.
CERVICAL - Palpation: tender, stiff
CERVICAL - Range of Motion: limited extension, limited flexion
THORACIC - Appearance: within normal limits.
THORACIC - Palpation: non tender
LUMBAR - Appearance: within normal limits.
LUMBAR - Palpation: non tender
LUMBAR - Range of Motion: within normal limits
UPPER EXTREMITIES - Appearance: limited - left shoulder
UPPER EXTREMITIES - Palpation: tenderness over left shoulder
UPPER EXTREMITIES RANGE OF MOTION - Left: shoulder abduction limited
UPPER EXTREMITIES RANGE OF MOTION - Right: Within normal limits.
LOWER EXTREMITIES - Appearance: within normal limits.
LOWER EXTREMITIES - Palpation: non tender

Page 2 of 4

Exhibit 5: Neurologist Dr. Ogburu Medical Record page 11

MIDLANDS NEUROLOGY & PAIN ASSOCIATES
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803-788-0655 FAX

Taliah Shabazz — 23 yrs.

07/17/2013

WINNSBORO, SC 29180

LOWER EXTREMITIES RANGE OF MOTION - Left: Within normal limits.
LOWER EXTREMITIES RANGE OF MOTION - Right: Within normal limits.
COORDINATION - UPPER: Bilaterally equal, within normal limits.
MOTOR - UPPER: Bilaterally equal, within normal limits. Motor 5 / 5.
REFLEXES - UPPER: Deep tendon reflexes bilaterally equal, within normal limits.
SENSORY - UPPER: Sensation bilaterally intact to touch.
COORDINATION - LOWER: Bilaterally equal, within normal limits.
MOTOR - LOWER: Bilaterally equal, within normal limits. Motor 5 / 5.
REFLEXES - LOWER: Deep tendon reflexes bilaterally equal, within normal limits.
SENSORY - LOWER: Sensory exam normal.

Cranial Nerves:

CN II - NORMAL: CN II-XII grossly intact
CERVICAL SPINE - ABNORMAL: tender
BACK - NORMAL: unremarkable
LOWER BACK - NORMAL: unremarkable

Medical Decision/Time:

>30min spent with pt. mod-complex decision making, pt counseled, labs and PMP reviewed. Based upon evaluation, history and physical examination, and improved and maintained functional improvement goal, it is my medical opinion that the benefits of outpatient tx for this pt for chronic pain outweigh the risk at present.

Lab Results:

Diagnosis: OTH MOTR VEH COLL W/MV-DRIVER - E812.0
CHRONIC MIGRAINE NO WINTRACT NO SM - 346.71
UNSPECIFIED MYALGIA AND MYOSITIS - 729.1
HEADACHE - 784.0
ACUTE SINUSITIS, UNSPECIFIED - 461.9
PAIN IN JOINT, SHOULDER REGION - 719.41
SPINAL STENOSIS IN CERVICAL REGION - 723.0
THOR/LUMBOSACRL NURIT/RADICULIT UNS - 724.4

Plan:

RTC in 4 months. Continue current plan of care, UDS, Pharmacy sweep, refer to deep tissue massage therapy. Patient has reached MMI and patient is doing well patient will then be discharged, may need myofascial release pm, good body mechanics and ergonomic posture maintenance, may use baclofen 10mg, Mobic 15mg, and lovaza 3gm, with great care and may need to Mobic during menstrual cycle due anemia and heavy bleeding. Patient had shoulder strain with healed soft tissue injury with consistent objective finding at mmi suggest class 1, grade b = 2%uel and converts to 1% WPI. (6TH EDITION)

Page 3 of 4

Exhibit 5: Neurologist Dr. Ogburu Medical Record page 12

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803-788-0655 FAX

Taliah Shabazz — 23 yrs.

07/17/2013

WINNSBORO, SC 29180

cc to referral physician

Electronically Signed: DR ELEANYA OGBURU-OGBONNAYA on/at 9/17/2015 11:52:49 AM

Exhibit 5: Neurologist Dr. Ogburu Medical Record page 13

MIDLANDS NEUROLOGY & PAIN ASSOCIATES
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803-788-0038 PHONE
803-788-0655 FAX

Taliah Shabazz — 23 yrs.

08/15/2013

WINNSBORO, SC 29180

Current Allergies:
NKDA

Current Medications:
Lovaza - 1 gram 3 tabs po daily
riboflavin - 100 mg 4 tabs daily
Topamax - 25 mg 1 tab daily x 1
week then bid thereafter
Mobic - 15 mg QD (# per day:
1.00)
Voltaren - 1 % apply to area of
pain bid

Vitals:
HT: 68 in.
WT: 133 lbs.
BMI: 20.2
R: 16
T: 98.2
P: 77 regular

Previous BP: 110 / 76
BP 1: 113 / 73

Past History:
MEDICAL: Chronic pain
INJURIES: none
HOSPITALIZATIONS /
SURGERIES: none
TREATMENTS: physical
therapy

Family History:

Social History:
single with no children
education given, discussed
ALCOHOL USE: Patient denies
alcohol use.
DRUG USE: Patient denies
drug use.
CAFFEINE: Patient denies.

Problem List:

Code	Description	Onset	Status	Status Date
348.71	CHRONIC MIGRAINE NO	01/10/2014	Chronic	01/10/2014
461.9	ACUTE SINUSITIS, UNS	01/10/2014	Chronic	01/10/2014
719.41	PAIN IN JOINT, SHOUL	01/10/2014	Chronic	01/10/2014
723.0	SPINAL STENOSIS IN C	01/10/2014	Chronic	01/10/2014
724.4	THOR/LUMBOSACRL NURI	01/10/2014	Chronic	01/10/2014
729.1	UNSPECIFIED MYALGIA	01/10/2014	Chronic	01/10/2014
784.0	HEADACHE	01/10/2014	Chronic	01/10/2014
E812.0	OTH MOTR VEH COLL W/	01/10/2014	Chronic	01/10/2014

Primary Care Physician:

Referring Physician:
Dean Floyd, M.D.

Dear Doctor

Thank you very much for the opportunity of seeing this pleasant patient.

Reason for Consultation:

Patient is schedule for a routine follow up visit with c/o migraine and neck pain.
Patient has a history of left shoulder blade pain.

History of Present Illness:

Ms. Shabazz is a 21 year old female who presents today for a schedule routine follow up visit with c/o migraine and neck pain. She describes her pain as aching, shooting, sharp and throbbing. Patient pain is constant. Functional level is fair with a pain level of 6/10. Patient has a history of left shoulder blade pain. Notes patient following up on MVA in 2012. Notes patient is experiencing having 4 headaches per week. Notes headaches last up to 3 hours before feeling any type of relief. Notes tightness and spasms to the center of scapula region. Notes taking soma for relief. Notes interested in Cortisone Injections. Notes no seizures. Notes no Hospital or ER visit. Notes no loss of consciousness. Otherwise no changes.
LOCATION: migraine and neck.
QUALITY: aching, shooting, sharp, tiring, throbbing, exhausting and unbearable.
SEVERITY: severe.
DURATION: more than a year.
TIMING: constant.
CONTEXT: MVA 2012.

Exhibit 5: Neurologist Dr. Ogburu Medical Record page 14

MIDLANDS NEUROLOGY & PAIN ASSOCIATES
ELEANYA OGBURU-OGBONNAYA, MD
4801 NORTH MAIN STREET
COLUMBIA, SC 29203
803-788-0038 PHONE
803-788-0655 FAX

Taliah Shabazz — 23 yrs.

08/15/2013

WINNSBORO, SC 29180

caffeine use:
EMPLOYMENT: Unemployed

ROS:

Positive and pertinent negative responses below. All other areas negative.
EYES: vision/glasses, headache, blurry vision.
GASTROINTESTINAL: persistent nausea.
MUSCULOSKELETAL: joint pain any joint, back pain.
PSYCHIATRIC: anxious / nervous, depressed.

Pending Studies:

none

none

Any med/injection given:

Exam:

GENERAL: alert and oriented x3, pleasant, well groomed, healthy and in no apparent distress.
HEENT: Normocephalic. Pupils are normal. Conjunctivae normal. Mucous membranes normal. No cyanosis or icterus. Trachea central.
RESP: Lungs clear to auscultation, no labored breathing, without wheezes, no rales or rhonchi.
CARDIO: Regular rate & rhythm, no murmurs, ectopy or rubs. No JVD evaluation @45'.
ABDOMEN: Soft no masses or organomegaly. No abdominal pulsations or bruits. Femoral pulse intact and equal bilaterally. Normal bowel sounds.
SKIN: No skin rash, subcutaneous nodules, lesions or ulcers observed. Skin is warm and dry with normal turgor.
MUSCULOSKELETAL: tenderness to cervical spine with paraspinal spasms.
MENTAL STATUS: Recent and remote memory is intact. Attention span, concentration, language and fund of knowledge sufficient.
GAIT / STATION: Normal gait, normal stance and swing phase with no antalgic component.
CERVICAL - Appearance: strain pattern.
CERVICAL - Palpation: tender, stiff.
CERVICAL - Range of Motion: limited extension, limited flexion.
THORACIC - Appearance: within normal limits.
THORACIC - Palpation: non tender.
LUMBAR - Appearance: within normal limits.
LUMBAR - Palpation: non tender.
LUMBAR - Range of Motion: within normal limits.
UPPER EXTREMITIES - Appearance: within normal limits.
UPPER EXTREMITIES - Palpation: non tender.
UPPER EXTREMITIES RANGE OF MOTION - Left: Within normal limits.
UPPER EXTREMITIES RANGE OF MOTION - Right: Within normal limits.
LOWER EXTREMITIES - Appearance: within normal limits.

Exhibit 5: Neurologist Dr. Ogburu Medical Record page 15

MIDLANDS NEUROLOGY & PAIN ASSOCIATES
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4801 NORTH MAIN STREET
COLUMBIA, SC 29203
803-788-0038 PHONE
803-788-0655 FAX

Taliah Shabazz — 23 yrs.

08/15/2013

WINNSBORO, SC 29180

LOWER EXTREMITIES - Palpation: non tender.
LOWER EXTREMITIES RANGE OF MOTION - Left: Within normal limits.
LOWER EXTREMITIES RANGE OF MOTION - Right: Within normal limits.
COORDINATION - UPPER: Bilaterally equal, within normal limits.
MOTOR - UPPER: Bilaterally equal, within normal limits. Motor 5 / 5.
REFLEXES - UPPER: Deep tendon reflexes bilaterally equal, within normal limits.
SENSORY - UPPER: Sensation bilaterally intact to touch.
COORDINATION - LOWER: Bilaterally equal, within normal limits.
MOTOR - LOWER: Bilaterally equal, within normal limits. Motor 5 / 5.
REFLEXES - LOWER: Deep tendon reflexes bilaterally equal, within normal limits.
SENSORY - LOWER: Sensory exam normal.

Cranial Nerves:

CN II - NORMAL: CN II-XII grossly intact
CERVICAL SPINE - ABNORMAL: tender
BACK - NORMAL: unremarkable.
LOWER BACK - NORMAL: unremarkable

Medical Decision/Time:

>30min spent with pt. mod-complex decision making, pt counseled, labs and PMP reviewed. Based upon evaluation, history and physical examination, and improved and maintained functional improvement goal, it is my medical opinion that the benefits of outpatient tx for this pt for chronic pain outweigh the risk at present.

Lab Results:

Diagnosis: OTH MOTR VEH COLL W/MV-DRIVER - E812.0
CHRONIC MIGRAINE NO W/INTRACT NO SM - 346.71
UNSPECIFIED MYALGIA AND MYOSITIS - 729.1
HEADACHE - 784.0
ACUTE SINUSITIS, UNSPECIFIED - 461.9
PAIN IN JOINT, SHOULDER REGION - 719.41
SPINAL STENOSIS IN CERVICAL REGION - 723.0
THOR/LUMBOSACRL NURIT/RADICULIT UNS - 724.4

Plan:

RTC 4 weeks and pain perception ordered to eval for tx options. Confirmatory testing ordered to verify results of urine drug test, schedule apt with Clinical Social worker, 3 x week group and individualized counseling. Pain contract discussed and reviewed at length. Pt verbalized understanding. Patient was counseled about opioid dependence, addiction, and side effects also on narcotic risk and genetic testing. UDS and PMP ordered to eval for aberrant behavior issues and monitoring. Pharmacy sweep. Continue current plan of care. Schedule Trigger Injection and

Page 3 of 4

Exhibit 5: Neurologist Dr. Ogburu Medical Record page 16

MIDLANDS NEUROLOGY & PAIN ASSOCIATES
ELEANYA OGBURU-OGBONNAYA, MD
4801 NORTH MAIN STREET
COLUMBIA, SC 29203
803-788-0038 PHONE
803-788-0655 FAX

Talliah Shabazz — 23 yrs.

08/15/2013

WINNSBORO, SC 29180

Occipital Nerve Block:

cc to referral physician

Electronically Signed: DR ELEANYA OGBURU-OGBONNAYA on/at 9/17/2015 11:53:15 AM

Exhibit 5: Neurologist Dr. Ogburu Medical Record page 17

MIDLANDS NEUROLOGY & PAIN ASSOCIATES
ELEANYA OGBURU-OGBONNAYA, MD
4801 NORTH MAIN STREET
COLUMBIA, SC 29203
803-788-0038 PHONE
803-788-0655 FAX

Talliah Shabazz — 23 yrs.

09/12/2013

WINNSBORO, SC 29180

Current Allergies:
NKDA

Current Medications:

Lovaza - 1 gram 3 tabs po daily
riboflavin - 100 mg 4 tabs daily
Topamax - 25 mg 1 tab daily x 1
week then bid thereafter
Mobic - 15 mg QD (# per day:
1.00)
Voltaren - 1 % apply to area of
pain bid

Vitals:

HT: 68 in.
WT: 137 lbs.
BMI: 20.8
R: 18
T: 98.7
P: 89 regular

Previous BP: 110 / 76
BP 1: 113 / 70

Past History:

MEDICAL: Chronic pain
INJURIES: none
HOSPITALIZATIONS:
SURGERIES: none
TREATMENTS: physical
therapy

Family History:

Social History:

single with no children
education given, discussed,
ALCOHOL USE: Patient denies
alcohol use.
DRUG USE: Patient denies
drug use.
CAFFEINE: Patient denies

Problem List:

Code	Description	Onset	Status	Status Date
346.71	CHRONIC MIGRAINE NO	01/10/2014	Chronic	01/10/2014
461.9	ACUTE SINUSITIS, UNS	01/10/2014	Chronic	01/10/2014
719.41	PAIN IN JOINT, SHOUL	01/10/2014	Chronic	01/10/2014
723.0	SPINAL STENOSIS IN C	01/10/2014	Chronic	01/10/2014
724.4	THOR/LUMBOSACRL NURI	01/10/2014	Chronic	01/10/2014
729.1	UNSPECIFIED MYALGIA	01/10/2014	Chronic	01/10/2014
784.0	HEADACHE	01/10/2014	Chronic	01/10/2014
E812.0	OTH MOTR VEH COLL W/	01/10/2014	Chronic	01/10/2014

Primary Care Physician:

Referring Physician:

Dean Floyd, M.D.

Dear Doctor

Thank you very much for the opportunity of seeing this pleasant patient.

Reason for Consultation:

Patient is schedule for a routine follow up visit with for a schedule routine follow up visit with c/o neck and left shoulder blade pain. Patient has history of headaches and lower back pain.

History of Present Illness:

Ms. Shabazz is a 21 year old female who presents today for a schedule routine follow up visit with c/o neck and left shoulder blade pain. Patient has history of headaches and lower back pain. She describes her pain as aching, shooting, sharp and unbearable. Patient pain is constant. Functional level is good with a pain level of 7/10. Notes her pain increase in the morning and evening.

LOCATION: neck and left shoulder blade pain.

QUALITY: aching, shooting, sharp, firing, throbbing, exhausting and unbearable.

SEVERITY: severe.

DURATION: more than a year.

TIMING: constant.

MODIFYING FACTORS: MVA 2012.

ROS:

Positive and pertinent negative responses below. All other areas negative.

Exhibit 5: Neurologist Dr. Ogburu Medical Record page 18

MIDLANDS NEUROLOGY & PAIN ASSOCIATES
ELEANYA OGBURU-OGBONNAYA, MD
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803-788-0038 PHONE
803-788-0655 FAX

Tallah Shabazz — 23 yrs.

09/12/2013

WINNSBORO, SC 29180

caffeine use:
EMPLOYMENT: Unemployed

EYES: vision/glasses, headache, blurry vision.
GASTROINTESTINAL: persistent nausea.
MUSCULOSKELETAL: joint pain any joint, back pain,
PSYCHIATRIC: anxious / nervous, depressed.

Pending Studies:

none

none

Any med/injection given:

none

Exam:

GENERAL: alert and oriented x3, pleasant, well groomed, healthy and in no apparent distress
HEENT: Normocephalic. Pupils are normal. Conjunctivae normal. Mucous membranes normal. No cyanosis or icterus. Trachea central.
RESP: Lungs clear to auscultation, no labored breathing, without wheezes, no rales or rhonchi.
CARDIO: Regular rate & rhythm, no murmurs, ectopy or rubs. No JVD evaluation @45°
ABDOMEN: Soft no masses or organomegaly. No abdominal pulsations or bruits. Femoral pulse intact and equal bilaterally. Normal bowel sounds.
SKIN: No skin rash, subcutaneous nodules, lesions or ulcers observed. Skin is warm and dry with normal turgor.
MUSCULOSKELETAL: tenderness to c-spine with paraspinal spasms, tenderness to the left shoulder
MENTAL STATUS: Recent and remote memory is intact. Attention span, concentration, language and fund of knowledge sufficient.
GAIT / STATION: Normal gait, normal stance and swing phase with no antalgic component.
CERVICAL - Appearance: strain pattern
CERVICAL - Palpation: tender, stiff
CERVICAL - Range of Motion: limited flexion, limited extension
THORACIC - Appearance: within normal limits
THORACIC - Palpation: non tender
LUMBAR - Appearance: within normal limits
LUMBAR - Palpation: non tender
LUMBAR - Range of Motion: within normal limits
UPPER EXTREMITIES - Appearance: limited - left shoulder
UPPER EXTREMITIES - Palpation: tenderness over left shoulder
UPPER EXTREMITIES RANGE OF MOTION - Left: shoulder abduction limited
UPPER EXTREMITIES RANGE OF MOTION - Right: Within normal limits.
LOWER EXTREMITIES - Appearance: within normal limits
LOWER EXTREMITIES - Palpation: non tender
LOWER EXTREMITIES RANGE OF MOTION - Left: Within normal limits.

Exhibit 5: Neurologist Dr. Ogburu Medical Record page 19

No. 0409 P. 20

MIDLANDS NEUROLOGY & PAIN ASSOCIATES
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COLUMBIA, SC 29203
803-788-0038 PHONE
803-788-0655 FAX

Tallah Shabazz — 23 yrs.

09/12/2013

WINNSBORO, SC 29180

LOWER EXTREMITIES RANGE OF MOTION - Right: Within normal limits.
COORDINATION - UPPER: Bilaterally equal, within normal limits.
MOTOR - UPPER: Bilaterally equal, within normal limits. Motor 5 / 5.
REFLEXES - UPPER: Deep tendon reflexes bilaterally equal, within normal limits.
SENSORY - UPPER: Sensation bilaterally intact to touch.
COORDINATION - LOWER: Bilaterally equal, within normal limits.
MOTOR - LOWER: Bilaterally equal, within normal limits. Motor 5 / 5.
REFLEXES - LOWER: Deep tendon reflexes bilaterally equal, within normal limits.
SENSORY - LOWER: Sensory exam normal.

Cranial Nerves:

CN II - NORMAL: CN II-XII grossly intact
CERVICAL SPINE - ABNORMAL: tender
BACK - NORMAL: unremarkable
LOWER BACK - NORMAL: unremarkable

Medical Decision/Time:

>30min spent with pt. mod-complex decision making. pt counseled, labs and PMP reviewed. Based upon evaluation, history and physical examination, and improved and maintained functional improvement goal, it is my medical opinion that the benefits of outpatient tx for this pt for chronic pain outweigh the risk at present. Patient had shoulder strain with healed soft tissue injury with consistent objective finding at mmi suggest class 1, grade b = 2% uei and converts to 1% WPI. (6TH EDITION)

Lab Results:

Diagnosis: OTH MOTR VEH COLL W/MV-DRIVER - E812.0
CHRONIC MIGRAINE NO WINTRACT NO SM - 346.71
UNSPECIFIED MYALGIA AND MYOSITIS - 729.1
HEADACHE - 784.0
ACUTE SINUSITIS, UNSPECIFIED - 461.9
PAIN IN JOINT, SHOULDER REGION - 719.41
SPINAL STENOSIS IN CERVICAL REGION - 723.0
THOR/LUMBOSACRL NURIT/RADICULIT UNS - 724.4

Plan:

RTC in 4 months. Continue current plan of care. UDS, Pharmacy sweep, refer to deep tissue massage therapy. Patient has reached MMI and patient is doing well patient will then be discharged, may need myofascial release pm, good body mechanics and ergonomic posture maintenance, may use baclofen 10mg, Mobic 15mg, and lovaza 3gm, with great care and may need to Mobic during menstrual cycle due anemia and heavy bleeding.

Exhibit 5: Neurologist Dr. Ogburu Medical Record page 20

No. 5984 P. 2

MIDLANDS NEUROLOGY & PAIN ASSOCIATES
ELEANYA OGBURU-OGBOUNNAYA, MD
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COLUMBIA, SC 29203
803-788-0038 PHONE
803-788-0655 FAX

Taliah Shabazz — 22 yrs.

01/10/2014

WINNSBORO, SC 29180

Current Allergies:
NKDA

Current Medications:

Lovaza - 1 gram 3 tabs po daily
riboflavin - 100 mg 4 tabs daily
Topamax - 25 mg 1 tab daily x 1
week then bid thereafter
Mobic - 15 mg QD (# per day:
1.00)
Voltaren - 1 % apply to area of
pain bid

Vitals:

HT: 68 in.
WT: 104 lbs.
BMI: infinity
R: 17
T: 97.2
P: 69

BP 1: 97 / 63

Past History:

MEDICAL: none
INJURIES: none
HOSPITALIZATIONS /
SURGERIES: none
TREATMENTS: physical
therapy

Family History:
diabetes, cancer

Social History:
single with no children
SMOKING STATUS: no

ALCOHOL USE: Patient denies
alcohol use.

DRUG USE: Patient denies
drug use.

CAFFEINE: Patient denies

Problem List:

Code	Description	Onset	Status	Status Date
346.71	CHRONIC MIGRAINE NO	01/10/2014	Chronic	01/10/2014
481.9	ACUTE SINUSITIS, UNS	01/10/2014	Chronic	01/10/2014
719.41	PAIN IN JOINT, SHOUL	01/10/2014	Chronic	01/10/2014
723.0	SPINAL STENOSIS IN C	01/10/2014	Chronic	01/10/2014
724.4	THOR/LUMBOSACRAL NURI	01/10/2014	Chronic	01/10/2014
729.1	UNSPECIFIED MYALGIA	01/10/2014	Chronic	01/10/2014
784.0	HEADACHE	01/10/2014	Chronic	01/10/2014
E812.0	OTH MOTR VEH COLL W/	01/10/2014	Chronic	01/10/2014

Reason for Visit:

Patient is here for a scheduled visit left side pain. pain level is 0/10. functional level is fair. no rashes, side effects or problems with medication. no seizures, hospitalizations or studies done.

History of Present Illness:

Mrs. Shabazz is a 21 year old African American female who has an h/o back and left shoulder pain for 2 years. Patient has a history of Motor Vehicle Accident. Pain gets better when she take muscle relaxers and Tylenol. Pain gets worse when she doesn't stretch her muscles. She noted mild stiffness of the shoulder and crepitation with cervical spasm. Patient c/o popping sound in her right shoulder. Patient is taking 600mg Tylenol bid sometimes for headache relief. Patient has reached maximum medical improvement intermittent follow up. Otherwise no changes.

LOCATION: lower back, left shoulder pain.

QUALITY: aching, uncomfortable.

SEVERITY: moderate, severe.

DURATION: more than a year.

TIMING: comes and goes, constant.

ROS:

Positive and pertinent negative responses below. All other areas negative.

EYES: vision/glasses, headache, blurry vision.

GASTROINTESTINAL: persistent nausea.

MUSCULOSKELETAL: joint pain any joint, back pain.

PSYCHIATRIC: anxious / nervous, depressed.

Pending Studies:

Any med/injection given:

Exhibit 5: Neurologist Dr. Ogburu Medical Record page 21

MIDLANDS NEUROLOGY & PAIN ASSOCIATES
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4801 NORTH MAIN STREET
COLUMBIA, SC 29203
803-788-0038 PHONE
803-788-0855 FAX

Tallah Shabazz — 22 yrs.

01/10/2014

WINNSBORO, SC 29180

caffeine use.
EMPLOYMENT: Unemployed

Exam:

GENERAL: alert and oriented x3; pleasant, well groomed, healthy and in no apparent distress
HEENT: Normocephalic. Pupils are normal. Conjunctivae normal. Mucous membranes normal. No cyanosis or icterus. Trachea central.
RESP: Lungs clear to auscultation, no labored breathing, without wheezes, no rales or rhonchi.
CARDIO: Regular rate & rhythm, no murmurs, ectopy or rubs. No JVD evaluation @45.
ABDOMEN: Soft no masses or organomegaly. No abdominal pulsations or bruits. Femoral pulse intact and equal bilaterally. Normal bowel sounds.
SKIN: No skin rash, subcutaneous nodules, lesions or ulcers observed. Skin is warm and dry with normal turgor.
MUSCULOSKELETAL: tenderness in the shoulder
MENTAL STATUS: Recent and remote memory is intact. Attention span, concentration, language and fund of knowledge sufficient.
GAIT / STATION: Normal gait, normal stance and swing phase with no atalgic component.
UPPER EXTREMITIES - Appearance: limited - left shoulder
UPPER EXTREMITIES - Palpation: tenderness over left shoulder
COORDINATION - UPPER: Bilaterally equal, within normal limits.
MOTOR - UPPER: Bilaterally equal, within normal limits. Motor 5 / 5.
REFLEXES - UPPER: Deep tendon reflexes bilaterally equal, within normal limits.
SENSORY - UPPER: Sensation bilaterally intact to touch.
COORDINATION - LOWER: Bilaterally equal, within normal limits.
MOTOR - LOWER: Bilaterally equal, within normal limits. Motor 5 / 5.
REFLEXES - LOWER: Deep tendon reflexes bilaterally equal, within normal limits.

Cranial Nerves:

CN II - NORMAL: CN II-XII grossly intact

Assessment:

Code	Description	Onset	Status	Status Date
346.71	CHRONIC MIGRAINE NO	01/10/2014	Chronic	01/10/2014
481.9	ACUTE SINUSITIS, UNS	01/10/2014	Chronic	01/10/2014
719.41	PAIN IN JOINT, SHOUL	01/10/2014	Chronic	01/10/2014
723.0	SPINAL STENOSIS IN C	01/10/2014	Chronic	01/10/2014
724.4	THOR/LUMBOSACRL NURI	01/10/2014	Chronic	01/10/2014
729.1	UNSPECIFIED MYALGIA	01/10/2014	Chronic	01/10/2014
784.0	HEADACHE	01/10/2014	Chronic	01/10/2014
E812.0	OTH MOTR VEH COLL W/	01/10/2014	Chronic	01/10/2014

Exhibit 5: Neurologist Dr. Ogburu Medical Record page 22

MIDLANDS NEUROLOGY & PAIN ASSOCIATES
ELEANYA OGBURU-OGBONNAYA, MD
4801 NORTH MAIN STREET
COLUMBIA, SC 29203
803-788-0038 PHONE
803-788-0655 FAX

Tallah Shabazz — 22 yrs.

01/10/2014

WINNSBORO, SC 29180

Lab Results:

No lab results were found.

Diagnosis: Code	Description	Onset	Status	Status Date
348.71	CHRONIC MIGRAINE NO	01/10/2014	Chronic	01/10/2014
481.9	ACUTE SINUSITIS, UNS	01/10/2014	Chronic	01/10/2014
719.41	PAIN IN JOINT, SHOUL	01/10/2014	Chronic	01/10/2014
723.0	SPINAL STENOSIS IN C	01/10/2014	Chronic	01/10/2014
724.4	THOR/LUMBOSACRL NURI	01/10/2014	Chronic	01/10/2014
728.1	UNSPECIFIED MYALGIA	01/10/2014	Chronic	01/10/2014
784.0	HEADACHE	01/10/2014	Chronic	01/10/2014
E812.0	OTH MOTR VEH COLL W/	01/10/2014	Chronic	01/10/2014

Plan:

RTC in 3 months. Continue current plan of care. UDS, Pharmacy sweep, refer to deep tissue massage therapy

BMI Follow-up Plan: discussed, education given, reviewed

Nutrition Counseling: discussed, education given, reviewed

Physical Activity Counseling: discussed, education given, reviewed

Exhibit 5: Neurologist Dr. Ogburu Medical Record page 23

MIDLANDS NEUROLOGY & PAIN ASSOCIATES
ELEANYA OGBURU-OGBONNAYA, MD
4801 NORTH MAIN STREET
COLUMBIA, SC 29203
803-788-0038 PHONE
803-788-0655 FAX

Taliah Shabazz — 22 yrs.

04/11/2014

WINNSBORO, SC 29180

Current Allergies:
NKDA

Current Medications:

Lovaza - 1 gram 3 tabs po daily
Riboflavin - 100 mg 4 tabs daily
Topamax - 25 mg 1tab daily x 1
week then bid thereafter
Mobic - 15 mg QD (# per day:
1.00)
Voltaren - 1 % apply to area of
pain bid

Vitals:

HT: 68 in.
WT: 138 lbs.
BMI: 21.0
R: 17
T: 97.5
P: 66 regular

Previous BP: 97 / 83
BP 1: 97 / 65

Past History:

MEDICAL: Chronic pain
INJURIES: none
HOSPITALIZATIONS:
SURGERIES: none
TREATMENTS: physical
therapy

Family History:
diabetes, cancer

Social History:

single with no children
SMOKING STATUS: no
SMOKING CESSATION:
education given, discussed

ALCOHOL USE: Patient denies
alcohol use.

Problem List:

Code	Description	Onset	Status	Status Date
346.71	CHRONIC MIGRAINE NO	01/10/2014	Chronic	01/10/2014
461.9	ACUTE SINUSITIS, UNS	01/10/2014	Chronic	01/10/2014
719.41	PAIN IN JOINT, SHOUL	01/10/2014	Chronic	01/10/2014
723.0	SPINAL STENOSIS IN C	01/10/2014	Chronic	01/10/2014
724.4	THOR/LUMBOSACRL NURI	01/10/2014	Chronic	01/10/2014
729.1	UNSPECIFIED MYALGIA	01/10/2014	Chronic	01/10/2014
784.0	HEADACHE	01/10/2014	Chronic	01/10/2014
E812.0	OTH MOTR-VEH COLL W/	01/10/2014	Chronic	01/10/2014

Reason for Visit:

Patient is here for a scheduled visit with c/o left shoulder pain. pain level is 5/10. functional level is fair. no rashes, side effects or problems with medication. no seizures, hospitalizations or studies done.

History of Present Illness:

Mrs. Shabazz is a 21 year old African American female who has a lvo back and left shoulder pain for 2 years. Also with chronic migraines Pt went to see PCP today. Was notified she was highly anemic with Hgb of just 6. Tells me she has very heavy menses. Wears 3 pads at a time and still saturates through this. Menses last >1 week. Has 2 menses per month. Her mother is not ready to let her start on birth control. She is not sexually active. Was placed on Ferrous sulfate 325mg BID. She is lo flu on May 23, 2014. Her headaches are usually to rt side and around the eyes. Takes Ibuprofen with headaches. Headache worse with lack of sleep, described as tense and lack of food. Accompanied by nausea and lightheaded feeling. Patient has a history of Motor Vehicle Accident. Pain gets better when she take muscle relaxers and Tylenol. Pain gets worse when she doesn't stretch her muscles. She noted mild stiffness of the shoulder and crepitation with cervical spasm. Patient c/o popping sound in her right shoulder. Patient is taking 500mg Tylenol bid sometimes for headache relief. Patient has reached maximum medical improvement intermittent follow up. Otherwise no changes.

ROS:

Positive and pertinent negative responses below. All other areas negative.
EYES: vision/glasses, headache, blurry vision.
GASTROINTESTINAL: persistent nausea.
MUSCULOSKELETAL: joint pain any joint, back pain.
PSYCHIATRIC: anxious / nervous, depressed.

Pending Studies:

nonenone

Exhibit 5: Neurologist Dr. Ogburu Medical Record page 24

MIDLANDS NEUROLOGY & PAIN ASSOCIATES
ELEANYA OGBURU-OGBOUNNAYA, MD
4801 NORTH MAIN STREET
COLUMBIA, SC 29203
803-788-0038 PHONE
803-788-0655 FAX

Taliah Shabazz — 22 yrs.

04/11/2014

WINNSBORO, SC 29180

DRUG USE: Patient denies
drug use.
CAFFEINE: Patient denies
caffeine use.
EMPLOYMENT: Unemployed

none
Any med/Injection given:

Exam:
GENERAL: alert and oriented x3, pleasant, well groomed, healthy and in no
apparent distress
HEENT: Normocephalic. Pupils are normal. Conjunctivae normal. Mucous
membranes normal. No cyanosis or icterus. Trachea central.
RESP: Lungs clear to auscultation, no labored breathing, without wheezes, no rales
or rhonchi.
CARDIO: Regular rate & rhythm, no murmurs, ectopy or rubs. No JVD evaluation
@45.
ABDOMEN: Soft no masses or organomegaly. No abdominal pulsations or bruits.
Femoral pulse intact and equal bilaterally. Normal bowel sounds.
SKIN: No skin rash, subcutaneous nodules, lesions or ulcers observed. Skin is
warm and dry with normal turgor.
MUSCULOSKELETAL: tenderness in the shoulder
MENTAL STATUS: Recent and remote memory is intact. Attention span,
concentration, language and fund of knowledge sufficient.
GAIT / STATION: Normal gait, normal stance and swing phase with no antalgic
component.
CERVICAL - Appearance: within normal limits
CERVICAL - Palpation: non tender
CERVICAL - Range of Motion: within normal limits
LUMBAR - Palpation: tender - bilateral
LUMBAR - Range of Motion: painful, limited
UPPER EXTREMITIES - Appearance: limited - left shoulder
UPPER EXTREMITIES - Palpation: tenderness over left shoulder
UPPER EXTREMITIES RANGE OF MOTION - Left: limited
UPPER EXTREMITIES RANGE OF MOTION - Right: Within normal limits.
LOWER EXTREMITIES - Appearance: within normal limits
LOWER EXTREMITIES - Palpation: non tender
LOWER EXTREMITIES RANGE OF MOTION - Left: Within normal limits.
LOWER EXTREMITIES RANGE OF MOTION - Right: Within normal limits.
COORDINATION - UPPER: Bilaterally equal, within normal limits.
MOTOR - UPPER: Bilaterally equal, within normal limits. Motor 5 / 5.
REFLEXES - UPPER: Deep tendon reflexes bilaterally equal, within normal limits.
SENSORY - UPPER: Sensation bilaterally intact to touch.
COORDINATION - LOWER: Bilaterally equal, within normal limits.
MOTOR - LOWER: Bilaterally equal, within normal limits. Motor 5 / 5.
REFLEXES - LOWER: Deep tendon reflexes bilaterally equal, within normal limits.
SENSORY - LOWER: Sensory exam normal.

Exhibit 5: Neurologist Dr. Ogburu Medical Record page 25

MIDLANDS NEUROLOGY & PAIN ASSOCIATES
ELEANYA OGBURU-OGBONNAYA, MD
4801 NORTH MAIN STREET
COLUMBIA, SC 29203
803-788-0038 PHONE
803-788-0655 FAX

Taliah Shabazz — 22 yrs.

04/11/2014

WINNSBORO, SC 29180

Cranial Nerves:
CN II - NORMAL: CN II-XII grossly intact

Assessment:

Code	Description	Onset	Status	Status Date
346.71	CHRONIC MIGRAINE NO	01/10/2014	Chronic	01/10/2014
461.9	ACUTE SINUSITIS, UNS	01/10/2014	Chronic	01/10/2014
719.41	PAIN IN JOINT, SHOUL	01/10/2014	Chronic	01/10/2014
723.0	SPINAL STENOSIS IN C	01/10/2014	Chronic	01/10/2014
724.4	THOR/LUMBOSACRL NURI	01/10/2014	Chronic	01/10/2014
729.1	UNSPECIFIED MYALGIA	01/10/2014	Chronic	01/10/2014
784.0	HEADACHE	01/10/2014	Chronic	01/10/2014
E812.0	OTH MOTR VEH COLL W/	01/10/2014	Chronic	01/10/2014

Lab Results:

No lab results were found.

Diagnosis: Code	Description	Onset	Status	Status Date
346.71	CHRONIC MIGRAINE NO	01/10/2014	Chronic	01/10/2014
461.9	ACUTE SINUSITIS, UNS	01/10/2014	Chronic	01/10/2014
719.41	PAIN IN JOINT, SHOUL	01/10/2014	Chronic	01/10/2014
723.0	SPINAL STENOSIS IN C	01/10/2014	Chronic	01/10/2014
724.4	THOR/LUMBOSACRL NURI	01/10/2014	Chronic	01/10/2014
729.1	UNSPECIFIED MYALGIA	01/10/2014	Chronic	01/10/2014
784.0	HEADACHE	01/10/2014	Chronic	01/10/2014
E812.0	OTH MOTR VEH COLL W/	01/10/2014	Chronic	01/10/2014

Plan:

RTC in 3 months, Continue current plan of care, UDS, Pharmacy sweep, refer to deep tissue massage therapy.

BMI Follow-up Plan: discussed, education given, reviewed

Nutrition Counseling: discussed, education given, reviewed

Physical Activity Counseling: discussed, education given, reviewed

Exhibit 5: Neurologist Dr. Ogburu Medical Record page 26

MIDLANDS NEUROLOGY & PAIN ASSOCIATES
ELEANYA OGBURU-OGBONNAYA, MD
4801 NORTH MAIN STREET
COLUMBIA, SC 29203
803-788-0038 PHONE
803-788-0655 FAX

Tallah Shabazz — 22 yrs.

05/09/2014

WINNSBORO, SC 29180

Current Allergies:
NKDA

Current Medications:

Lovaza - 1 gram 3 tabs po daily
riboflavin - 100 mg 4 tabs daily
Topamax - 25 mg 1tab daily x 1
week then bld thereafter
Mobic - 15 mg QD (# per day:
1.00)
Voltaren - 1 % apply to area of
pain bld

Vitals:

HT: 68 in.
WT: 139 lbs.
BMI: 21.1
R: 17
T: 97.9
P: 70 regular

Previous BP: 97/65
BP 1: 109/68

Past History:

MEDICAL: Chronic pain
INJURIES: none
HOSPITALIZATIONS /
SURGERIES: none
TREATMENTS: physical
therapy

Family History:

diabetes, cancer

Social History:

single with no children
SMOKING STATUS: no
SMOKING CESSATION:
education given, discussed,

ALCOHOL USE: Patient denies
alcohol use.

Problem List:

Code	Description	Onset	Status	Status Date
346.71	CHRONIC MIGRAINE NO	01/10/2014	Chronic	01/10/2014
481.9	ACUTE SINUSITIS, UNS	01/10/2014	Chronic	01/10/2014
719.41	PAIN IN JOINT, SHOUL	01/10/2014	Chronic	01/10/2014
723.0	SPINAL STENOSIS IN C	01/10/2014	Chronic	01/10/2014
724.4	THOR/LUMBOSACRL NURI	01/10/2014	Chronic	01/10/2014
729.1	UNSPECIFIED MYALGIA	01/10/2014	Chronic	01/10/2014
784.0	HEADACHE	01/10/2014	Chronic	01/10/2014
E812.0	OTH MOTR VEH COLL W/	01/10/2014	Chronic	01/10/2014

Reason for Visit:

Patient is here for a scheduled visit in bilateral shoulder. pain level is 8/10. functional level is fair. no rashes, side effects or problems with medication. no seizures, hospitalizations or studies done.

History of Present Illness:

Mrs. Shabazz is a 21 year old African American female who has a lvo back and left shoulder pain for 2 years. Also with chronic migraines Patient states she has been experiencing knots and tightness in between her shoulder blades for the last 2 days. Pain is described as aching. Pain is constant. Pain is better than last visit. Patient has not gotten the Topamax but is doing well on current regimen.

ROS:

Positive and pertinent negative responses below. All other areas negative.
EYES: vision/glasses, headache, blurry vision.
GASTROINTESTINAL: persistent nausea.
MUSCULOSKELETAL: joint pain any joint, back pain.
PSYCHIATRIC: anxious / nervous, depressed.

Pending Studies:

none/none

none

Any med/injection given:

Exam:

GENERAL: alert and oriented x3, pleasant, well groomed, healthy and in no apparent distress
HEENT: Normocephalic. Pupils are normal. Conjunctivae normal. Mucous membranes normal. No cyanosis or icterus. Trachea central.

Exhibit 5: Neurologist Dr. Ogburu Medical Record page 27

MIDLANDS NEUROLOGY & PAIN ASSOCIATES
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803-788-0655 FAX

Tallah Shabazz — 22 yrs.

05/09/2014

WINNSBORO, SC 29180

DRUG USE: Patient denies
drug use.
CAFFEINE: Patient denies
caffeine use.
EMPLOYMENT: Unemployed

RESP: Lungs clear to auscultation, no labored breathing, without wheezes, no rales
or rhonchi.
CARDIO: Regular rate & rhythm, no murmurs, ectopy or rubs. No JVD evaluation
@45'.
ABDOMEN: Soft no masses or organomegaly. No abdominal pulsations or bruits.
Femoral pulse intact and equal bilaterally. Normal bowel sounds.
SKIN: No skin rash, subcutaneous nodules, lesions or ulcers observed. Skin is
warm and dry with normal turgor.
MUSCULOSKELETAL: tenderness in the shoulder
MENTAL STATUS: Recent and remote memory is intact. Attention span,
concentration, language and fund of knowledge sufficient.
GAIT / STATION: Normal gait, normal stance and swing phase with no ataxic
component.
CERVICAL - Appearance: within normal limits
CERVICAL - Palpation: non tender
CERVICAL - Range of Motion: within normal limits
LUMBAR - Palpation: tender - bilateral
LUMBAR - Range of Motion: painful, limited
UPPER EXTREMITIES - Appearance: limited - left shoulder
UPPER EXTREMITIES - Palpation: tenderness over left shoulder
UPPER EXTREMITIES RANGE OF MOTION - Right: Within normal limits.
LOWER EXTREMITIES - Appearance: within normal limits
LOWER EXTREMITIES - Palpation: non tender
LOWER EXTREMITIES RANGE OF MOTION - Left: Within normal limits.
LOWER EXTREMITIES RANGE OF MOTION - Right: Within normal limits.
COORDINATION - UPPER: Bilaterally equal, within normal limits.
MOTOR - UPPER: Bilaterally equal, within normal limits. Motor 5 / 5.
REFLEXES - UPPER: Deep tendon reflexes bilaterally equal, within normal limits.
SENSORY - UPPER: Sensation bilaterally intact to touch.
COORDINATION - LOWER: Bilaterally equal, within normal limits.
MOTOR - LOWER: Bilaterally equal, within normal limits. Motor 5 / 5.
REFLEXES - LOWER: Deep tendon reflexes bilaterally equal, within normal limits.
SENSORY - LOWER: Sensory exam normal.

Cranial Nerves:
CN II - NORMAL. CN II-XII grossly intact

Assessment:

Code	Description	Onset	Status	Status Date
346.71	CHRONIC MIGRAINE NO			01/10/2014 Chronic 01/10/2014
461.9	ACUTE SINUSITIS, UNS			01/10/2014 Chronic 01/10/2014
719.41	PAIN IN JOINT, SHOUL	01/10/2014		Chronic 01/10/2014
723.0	SPINAL STENOSIS IN C			01/10/2014 Chronic 01/10/2014
724.4	THOR/LUMBOSACRL NURI			01/10/2014 Chronic 01/10/2014
729.1	UNSPECIFIED MYALGIA			01/10/2014 Chronic 01/10/2014

Exhibit 5: Neurologist Dr. Ogburu Medical Record page 28

MIDLANDS NEUROLOGY & PAIN ASSOCIATES
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803-788-0038 PHONE
803-788-0655 FAX

Tallah Shabazz — 22 yrs.

05/09/2014

WINNSBORO, SC 29180

784.0 HEADACHE 01/10/2014 Chronic 01/10/2014
E812.0 OTH MOTR VEH COLL W/ 01/10/2014 Chronic 01/10/2014

Lab Results:

No lab results were found.

Diagnosis:	Code	Description	Onset	Status	Status Date
348.71	CHRONIC MIGRAINE NO		01/10/2014	Chronic	01/10/2014
461.9	ACUTE SINUSITIS, UNS		01/10/2014	Chronic	01/10/2014
719.41	PAIN IN JOINT, SHOUL		01/10/2014	Chronic	01/10/2014
723.0	SPINAL STENOSIS IN C		01/10/2014	Chronic	01/10/2014
724.4	THOR/LUMBOSACRL NURI		01/10/2014	Chronic	01/10/2014
729.1	UNSPECIFIED MYALGIA		01/10/2014	Chronic	01/10/2014
784.0	HEADACHE		01/10/2014	Chronic	01/10/2014
E812.0	OTH MOTR VEH COLL W/		01/10/2014	Chronic	01/10/2014

Plan:

RTC in 4 months. Continue current plan of care, UDS, Pharmacy sweep, refer to deep tissue massage therapy. Patient has reached MMI and pt will come back in 4 months. If patient is doing well patient will then be discharged.

BMI Follow-up Plan: discussed, education given, reviewed

Nutrition Counseling: discussed, education given, reviewed

Physical Activity Counseling: discussed, education given, reviewed

Exhibit 5: Neurologist Dr. Ogburu Medical Record page 29

MIDLANDS NEUROLOGY & PAIN ASSOCIATES
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COLUMBIA, SC 29203
803-788-0038 PHONE
803-788-0855 FAX

Taliah Shabazz — 22 yrs.

01/08/2015

WINNSBORO, SC 29180

Current Allergies:
NKDA

Current Medications:
Lovaza - 1 gram 3 tabs po daily
riboflavin - 100 mg 4 tabs daily
Topamax - 25 mg 1tab daily x 1
week then bid thereafter
Mobic - 15 mg QD (# per day:
1.00)
Voltaren - 1 % apply to area of
pain bid

Vitals:
HT: 68 in.
WT: 150 lbs.
BMI: 22.8
R: 17
T: 97.0
P: 77 regular

Previous BP: 117 / 76
BP 1: 110 / 76

Past History:
MEDICAL: Chronic pain
INJURIES: none
HOSPITALIZATIONS /
SURGERIES: none
TREATMENTS: physical
therapy

Family History:
diabetes, cancer

Social History:
single with no children
SMOKING STATUS: no
SMOKING CESSATION:
education given, discussed,

ALCOHOL USE: Patient denies
alcohol use.

Problem List:

Code	Description	Onset	Status	Status Date
346.71	CHRONIC MIGRAINE NO	01/10/2014	Chronic	01/10/2014
481.9	ACUTE SINUSITIS, UNS	01/10/2014	Chronic	01/10/2014
719.41	PAIN IN JOINT, SHOUL	01/10/2014	Chronic	01/10/2014
723.0	SPINAL STENOSIS IN C	01/10/2014	Chronic	01/10/2014
724.4	THOR/LUMBOSACRL NURI	01/10/2014	Chronic	01/10/2014
729.1	UNSPECIFIED MYALGIA	01/10/2014	Chronic	01/10/2014
784.0	HEADACHE	01/10/2014	Chronic	01/10/2014
E812.0	OTH MOTR VEH COLL W/	01/10/2014	Chronic	01/10/2014

Primary Care Physician:

Referring Physician:
PCP

Dear Doctor

Thank you very much for the opportunity of seeing this pleasant patient.

Reason for Consultation:

Patient is here today for follow up visit with c/o left side, lower back, and neck pain
occ headache

History of Present Illness:

Mrs. Shabazz is a 22 year old female who presents today for follow up visit with c/o
left side, neck, and lower back pain. Hx of MVA. Pain is constant. Pain level is 7.
Functional level is fair. Notes pain is constant. Pain is described as sharp and
throbbing. Notes she has no trouble maintaining sleeping at night. Notes no side
effects with medications. Notes she needs no refills today. Otherwise no changes.
She is not taking the medication due to concern for side effect...
LOCATION: neck and left shoulder blade pain.

ROS:

Positive and pertinent negative responses below. All other areas negative.
EYES: vision/glasses, headache, blurry vision.
GASTROINTESTINAL: persistent nausea.
MUSCULOSKELETAL: joint pain any joint, back pain.
PSYCHIATRIC: anxious / nervous, depressed.

Page 1 of 1

MIDLANDS NEUROLOGY & PAIN ASSOCIATES
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803-788-0038 PHONE
803-788-0655 FAX

Taliah Shabazz — 22 yrs.

01/08/2015

WINNSBORO, SC 29180

DRUG USE: Patient denies
drug use.
CAFFEINE: Patient denies
caffeine use.
EMPLOYMENT: Unemployed

Pending Studies:
none

Any med/injection given:

Exam:

GENERAL: alert and oriented x3, pleasant, well groomed, healthy and in no
apparent distress

HEENT: Normocephalic. Pupils are normal. Conjunctivae normal. Mucous
membranes normal. No cyanosis or icterus. Trachea central.

RESP: Lungs clear to auscultation, no labored breathing, without wheezes, no rales
or rhonchi.

CARDIO: Regular rate & rhythm, no murmurs, ectopy or rubs. No JVD evaluation
@45°.

ABDOMEN: Soft no masses or organomegaly. No abdominal pulsations or bruits.
Femoral pulse intact and equal bilaterally. Normal bowel sounds.

SKIN: No skin rash, subcutaneous nodules, lesions or ulcers observed. Skin is
warm and dry with normal turgor.

MUSCULOSKELETAL: tenderness in the shoulder

MENTAL STATUS: Recent and remote memory is intact. Attention span,
concentration, language and fund of knowledge sufficient.

GAIT / STATION: Normal gait, normal stance and swing phase with no ataxic
component.

CERVICAL - Appearance: within normal limits

CERVICAL - Palpation: non tender

CERVICAL - Range of Motion: within normal limits

LUMBAR - Appearance: within normal limits

UPPER EXTREMITIES - Appearance: limited - left shoulder

UPPER EXTREMITIES - Palpation: tenderness over left shoulder

UPPER EXTREMITIES RANGE OF MOTION - Left: Within normal limits.

UPPER EXTREMITIES RANGE OF MOTION - Right: Within normal limits.

LOWER EXTREMITIES - Appearance: within normal limits

LOWER EXTREMITIES - Palpation: non tender

LOWER EXTREMITIES RANGE OF MOTION - Left: Within normal limits.

LOWER EXTREMITIES RANGE OF MOTION - Right: Within normal limits.

COORDINATION - UPPER: Bilaterally equal, within normal limits.

MOTOR - UPPER: Bilaterally equal, within normal limits. Motor 5 / 5.

REFLEXES - UPPER: Deep tendon reflexes bilaterally equal, within normal limits.

SENSORY - UPPER: Sensation bilaterally intact to touch.

COORDINATION - LOWER: Bilaterally equal, within normal limits.

MOTOR - LOWER: Bilaterally equal, within normal limits. Motor 5 / 5.

REFLEXES - LOWER: Deep tendon reflexes bilaterally equal, within normal limits.

SENSORY - LOWER: Sensory exam normal.

Exhibit 5: Neurologist Dr. Ogburu Medical Record page 31

MIDLANDS NEUROLOGY & PAIN ASSOCIATES
ELEANYA OGBURU-OGBONNAYA, MD
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803-788-0038 PHONE
803-788-0655 FAX

Tallah Shabazz — 22 yrs.

01/08/2016

WINNSBORO, SC 29180

Cranial Nerves:
CN II - NORMAL: CN II-XII grossly intact

Medical Decision/Time:

Code	Description	Onset	Status	Status Date
346.71	CHRONIC MIGRAINE NO	01/10/2014	Chronic	01/10/2014
461.9	ACUTE SINUSITIS, UNS	01/10/2014	Chronic	01/10/2014
719.41	PAIN IN JOINT, SHOUL	01/10/2014	Chronic	01/10/2014
723.0	SPINAL STENOSIS IN C	01/10/2014	Chronic	01/10/2014
724.4	THOR/LUMBOSACRL NURI	01/10/2014	Chronic	01/10/2014
729.1	UNSPECIFIED MYALGIA	01/10/2014	Chronic	01/10/2014
784.0	HEADACHE	01/10/2014	Chronic	01/10/2014
E812.0	OTH MOTR VEH COLL W/	01/10/2014	Chronic	01/10/2014

Lab Results:

Diagnosis: Code	Description	Onset	Status	Status Date
346.71	CHRONIC MIGRAINE NO	01/10/2014	Chronic	01/10/2014
461.9	ACUTE SINUSITIS, UNS	01/10/2014	Chronic	01/10/2014
719.41	PAIN IN JOINT, SHOUL	01/10/2014	Chronic	01/10/2014
723.0	SPINAL STENOSIS IN C	01/10/2014	Chronic	01/10/2014
724.4	THOR/LUMBOSACRL NURI	01/10/2014	Chronic	01/10/2014
729.1	UNSPECIFIED MYALGIA	01/10/2014	Chronic	01/10/2014
784.0	HEADACHE	01/10/2014	Chronic	01/10/2014
E812.0	OTH MOTR VEH COLL W/	01/10/2014	Chronic	01/10/2014

Plan:

RTC in 4 months. Continue current plan of care, UDS, Pharmacy sweep, refer to deep tissue massage therapy. Patient has reached MMI and patient is doing well patient will then be discharged, may need myofascial release pm, good body mechanics and ergonomic posture maintenance, may use baclofen 10mg, Mobic 15mg, and lovasa 3gm, with great care and may need to Mobic during menstrual cycle due anemia and heavy bleeding. Patient had shoulder strain with healed soft tissue injury with consistent objective finding at mmi suggest class 1, grade b = 2%uel and converts to 1% WPI. (6TH EDITION)

BMI Follow-up: Plan: discussed, education given, reviewed

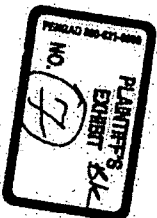
Nutrition Counseling: discussed, education given, reviewed

Physical Activity Counseling: discussed, education given, reviewed

414

General Adult-24 Rev. 10/07 Page 2 of 2

☒ Examples Completed ☐ As Test



8532967956
 PALMETTO MEDICAL
 2 RICHLAND MEDICAL PARK PO BOX 407001
 COLUMBIA SC 292016000
 8032555098

164215 US-03-2013
 R1231231153
 003300114

STATEMENT COVERS PERIOD
 FROM 50812 THROUGH 050812

PATIENT NAME: SHARZZ, TALIAH, KAREEMAH
 PATIENT ADDRESS: W. 1111111111

REF: 12 DATE: 050812

DESCRIPTION	DEBIT AMT	CREDIT AMT	BALANCE
MED/SUR SUPPLIES	050812		4400
CR CERVICAL SPINE 2-3V	050812		39300
CR CLAVICLE LEFT	050812		34600
CR SHOULDER LEFT 2+V	050812		44300
LEVEL 4	050812		09600
SELF ADMINISTERED DRUGS	050812		3200
ORTHO. TECH FEE	050812		21000
TOTALS			246400

000 PAGE 1 OF 1 CREATION DATE 052112 TOTALS 246400

8032967910
PALMETTO HEALTH RICHLAND
5 RICHLAND MEDICAL PARK PO BOX 402121
COLUMBIA SC 292036837 ATLANTA
8032965098 US GA 3038

16:42:55 05-03-2013 6/6
X1-13802090
005807114

STATEMENT COVERED FROM 060612 THROUGH 060612

PATIENT NAME SHABBAZZ, TALIAH, KAREENAH PATIENT ADDRESS WINNSBORO SC 29180

MR. EXT JT LY UP W/O CON

DESCRIPTION	REF DATE	REF QTY	TOTAL CHARGE	REF CHARGE
MR. EXT JT LY UP W/O CON	060612		275500	

0001 PAGE 1 OF 1 CREATION DATE 062912 1011/15 275500

Plaintiff Medical Expenses

EXPENSES

An accounting of Ms. Shabazz's monetary losses is as follows:

<u>PROVIDER</u>	<u>AMOUNT</u>
Richland County EMS (5-8-12)	\$620.00
Palmetto Health Richland (5-8-12)	\$2,464.00
ER Physician (5-8-12)	\$308.14
Pitts Radiology (5-8-12)	\$92.00
Waverly Family Practice (5-16-12 to 5-31-12)	\$125.00
Carolina Shoulder & Knee (6-19-12 to 5-6-13)	\$601.00
Excel Physical Therapy (6-20-12 to 1-9-13)	\$1,666.00
Palmetto Health Richland - MRI (6-6-12)	\$2,755.00
Midlands Neurology (5-24-13 to 1-8-15)	\$5,107.00
In Med Diagnostic (6-27-13)	\$2,310.00
Prescriptions	\$182.30
TOTAL MEDICAL EXPENSES:	\$16,230.44

Plaintiff Medical Expenses: Active Life Medical Record

Active Life Chiropractic

18036997525

p.3

Active Life Chiropractic & Wellness, LLC
921 Longtown Road, Suite F
Columbia SC 29229
(803) 665-4445

1449 04/11/16

Plaintiff Medical Expenses: Active Life Medical Record/ Expenses

12/10/15	New Incident (Taliah Shabazz)	
12/10/15	Exam - Expanded New	27.00
12/10/15	CMT 3-4 Regions	20.00
12/16/15	CMT 3-4 Regions	40.00
12/23/15	CMT 3-4 Regions	40.00
12/28/15	CMT 3-4 Regions	40.00
01/04/16	CMT 3-4 Regions	40.00

Plaintiff Medical Expenses: Massage Therapy Medical Record/ Expense

01/06/2016 15:33 8836357715



Help Yourself Massage Studio

119 North Congress Street
Winnsboro, SC 29180

Phone: 803-712-3322

Web: www.helpyourself.massagetherapy.com

E-mail: helpyourselfmassagestudio@gmail.com

DATE	MASSAGE DESCRIPTION	SESSION	AMOUNT
11/24/2015	Integrated Massage w/ New Client Discount	60 Minutes	\$45.0
12/1/2015	Massage Package—3 Integrated Sessions	60 Minutes	\$120.0
12/23/2015	Massage Package—3 Integrated Sessions	60 Minutes	\$120.0
TOTAL			\$285.0

Service Provider: M. E. Russell LMT

Signature: M. E. Russell LMT

Date: 1-6-16

RECEIVED

DEC 01 2017

SC Court of Appeals

Certificate of Counsel

The undersigned hereby certifies that the Record on Appeal contains all material proposed to be included by any of the parties and not any other material.

November 28, 2017

Taliah K. Shabazz
6289 U.S Highway 321 S
Winnsboro, South Carolina 29180
(803) 718-6786
Pro Se Appellant