

THE STATE OF SOUTH CAROLINA
In The Supreme Court

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

The Hon. Roger M. Young, Sr.
Circuit Court Judge

Opinion No. 5621
Heard November 8, 2018 – Filed January 30, 2019
Petition for Rehearing Denied March 29, 2019

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S.C. SUPREME COURT

Gary Nestler and Julie Nestler.....*Petitioners,*

v.

Joseph E. Fields.....*Respondent.*

App. Case No. *2019-000707*

APPENDIX VOLUME II

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1 the intention. It's not anything. Please don't take my
2 words anything out of context. And that's what I feel is
3 happening. And I would urge you not to do that because
4 that's not fair. What I'm saying is if there was a clinical
5 modality that's out there that somebody can give me, a
6 reasonable, not even a hundred percent certainty, but more
7 than a reasonable idea that it was solve my pain, yeah, then
8 I would consider it. Would I go for it? I don't know. I'd
9 have to see what that is and I would investigate it and
10 continue investigating and continue investigating until I
11 get an answer that works for me.

12 Q. Four recommendations wouldn't have given you a
13 reasonable expectation?

14 A. Four recommendations wouldn't give me a reasonable -- a
15 reasonable expectation.

16 MR. SLOTCHIVER: Your Honor, this has been asked and
17 answered by, you know -- he's testified at length about why
18 he didn't take it.

19 THE COURT: All right.

20 MR. SLOTCHIVER: Four recommendations or 12, it doesn't
21 make a difference. It doesn't change it.

22 MR. TRAINOR: I can wrap up ---

23 THE COURT: Finish up.

24 MR. TRAINOR: Sure.

25 THE COURT: And then move on to a new area if you have

1 another one.

2 A. And because it was torture. I mean, I don't think you
3 would do that if the doctor said to you, "Take this test.
4 It's going to be really bad and it's going to hurt you and
5 potentially cause more damage. It's medieval torture."
6 Would you?

7 THE COURT: All right. Mr. Nestler ---

8 THE WITNESS: I'm sorry, sir.

9 THE COURT: I'll let you finish ---

10 THE WITNESS: I apologize.

11 THE COURT: So move to the next question.

12 BY MR. TRAINOR: (continuing)

13 Q. I want to talk about your last visit, which was, I
14 guess, five months ago about. Do you recall that visit with
15 Dr. Schoderbek?

16 A. Again, if I had the record in front of me ---

17 Q. December 11th of 2015?

18 A. I've heard that referenced.

19 Q. It's about six or seven weeks after I took your
20 deposition, correct? Does that sound right to you?

21 A. Yes it does, sir.

22 Q. Okay. You hadn't received any treatment at that point
23 since -- I guess your last visit would have been August 11th
24 of 2014. So 16 months, correct?

25 A. Okay.

1 Q. Why did you go back?

2 A. Well, it was stated yesterday I believe. And please
3 don't quote me on the exact terminology. I wanted a final
4 disposition done; nothing else to be done.

5 Q. You wanted to ---

6 A. Why am I going back -- excuse me?

7 Q. You wanted to resolve this process?

8 A. I want to resolve my pain. And if Dr. Schoderbek 16
9 months later has come back and said, "Ah, we have a cure.
10 We found something that potentially is going to help you.
11 Go take a look at the data. Go take a look at this." Just
12 like they do in oncology medicine, clinical studies. The
13 patient's on it. Some unfortunately get placebo. So if he
14 came up with something, I would consider it a
15 recommendation. So that's why I went back and I said,
16 "Okay, are we where we are, there's nothing more to do?"

17 Q. So you went back for an impairment rating?

18 A. If that's the terminology, then that's the terminology.
19 I'm not fighting it.

20 Q. That's what your doctor said yesterday.

21 A. That's his terminology. It's an impairment rating.

22 Q. Yeah. Okay. That was at your request.

23 A. My request was to close this out as I just said. I
24 wanted to just finish it. Right.

25 Q. This litigation?

1 A. I want to finish the litigation, absolutely.

2 Q. You had already received a permanent impairment rating
3 16 months prior.

4 A. Right.

5 Q. That wasn't good enough?

6 A. Mr. Trainor, I'm sorry, it was not that it wasn't good
7 enough because I'm not the one to evaluate good or bad,
8 okay. But I can tell you since 16 months have gone by,
9 every single moment of the day including now I am sitting
10 here listening and I'm in pain that I wouldn't wish on my
11 worst enemy because it's unresolvable. I'm 55 years old. I
12 have a life to live; I have a daughter to bring up. This
13 pain sometimes is unbearable. And to sit here and listen, I
14 have no choice. Yes, I want this litigation over and done
15 so I can live my life. This will affect me for the rest of
16 my life. And who knows how much pain I'm going to be in a
17 year, 16 months, two years, five years. Who knows if I lose
18 -- nerve pain is horrible. Just don't know where it goes.
19 Going to a neurologist, they can't tell you. The
20 orthopedist, they can't tell you. Your spine surgeon can't
21 tell you. All they can tell you is, "I'm sorry." And the
22 hard part is they have to say, "I'm sorry, Dr. Nestler," one
23 of our peers, "there's nothing we can do for you." So 16
24 months have gone by; yeah, I went back and I said I want
25 this over. And he said, "Well, I'll have to give you the

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1 impairment rating." Permanent, permanent impairment rating.

2 Okay. What does that mean? Okay.

3 Q. After he had already given you one. Is that correct?

4 A. Sixteen months had gone by. My pain 16 months has
5 gotten worse. Is it a fair assessment to say, "Well, 16
6 months ago, you know, I wish it was over." I wish this
7 whole incident would've been over 60 months ago. We would
8 never be sitting here with these people in the room. But we
9 didn't. But we didn't. And I apologize. I just don't
10 think it's funny. I just don't.

11 Q. Sir, do you know as we sit here what is causing your
12 pain?

13 A. A nerve.

14 Q. Do you have any idea what nerve?

15 A. A nerve.

16 Q. Do you know whether it's a nerve?

17 A. According to Dr. Schoderbek potentially it could be the
18 median -- the medial or the ulnar nerve.

19 Q. When we assume it would be the medial or ---

20 A. Then I assumed that -- I apologize.

21 Q. One second. (Brief pause.)

22 MR. TRAINOR: Dr. Nestler, I don't have any further
23 questions. Please answer anything Mr. Slotchiver may have.

24 THE COURT: Redirect?

25 MR. SLOTCHIVER: Very, very briefly, Your Honor.

REDIRECT EXAMINATION

BY MR. SLOTCHIVER:

Q. I think there's been some mention about degenerative issues to your neck that came out at Southeastern Spine that came out on the examination of Mr. Trainor, correct?

A. Excuse me. Are you leave me with these?

Q. No.

A. Okay. I'm sorry; reask that.

Q. Sure. There was some discussion about degenerative issues to your neck, correct?

A. Yes.

Q. And there was talk about the fact that you don't remember. It went back to 2003, there was claim filed about neck problems?

A. Yes.

Q. The injuries that you testified, the injuries that you are experiencing now, where are they?

A. In my elbow.

Q. The doctor testified it runs, shoulder, elbow, and to your hand. It makes your hand cold.

A. The upper bicep to the lower part of the wrist to the actually lateral side, the outside of the wrist and down to the pinky.

Q. You saw the testimony. You read the notes about the permanent impairment the doctor has prescribed to you, the

1 53 percent upper extremity, the 32 percent whole person.

2 That's your left ---

3 A. That's my left.

4 Q. Shoulder, elbow, and hand?

5 A. From the bicep on down, yes.

6 MR. SLOCHIVER: I've got nothing further. Thank you.

7 THE COURT: Recross?

8 MR. TRAINOR: Nothing further, Your Honor.

9 THE COURT: Okay. You can step down.

10 (Witness complies.)

11 THE COURT: Any further witnesses from the plaintiff?

12 MR. SLOCHIVER: None, Your Honor. The plaintiff
13 rests.

14 THE COURT: Is the defense going to call any?

15 MR. TRAINOR: No witnesses for the defendant, Your
16 Honor.

17 THE COURT: Okay. Well, folks you've heard all of the
18 evidence in the trial now. The next phase of the trial is
19 to have the closing arguments and then we'll charge.

20 Yeah, you can go ahead and have a seat (to the
21 witness). Is lunch here?

22 THE CLERK: Yes, sir.

23 THE COURT: Okay. So your lunch is here. I want to
24 give you the opportunity to go have your lunch before we do
25 the closing arguments and that.

1 Now, you have not had the closing arguments. But most
2 importantly, I haven't charged you on what the law is yet.
3 So it is improper for you to begin your deliberations or
4 discussions about the verdict while you are at lunch. So
5 please don't talk about the case yet, witness demeanor or
6 anything at all about the case. You can talk about anything
7 else on the planet except this case while you're in there.
8 Simply because you haven't had the charge on the law yet nor
9 have you heard the closing arguments. So your lunch is back
10 there. Let's do this, it's 12:30; why don't we meet back at
11 1:30. That will give you time to eat your sandwiches and if
12 you want to step out and get some fresh air, you can do
13 that. You're welcome to, you know, eat in the jury room or
14 you can take it out. There's a beautiful park next door
15 across Meeting Street called Washington Park. Take your
16 lunch much over there and have a picnic if you want to.
17 It's totally up to you. But if you would, just be back in
18 the jury room by 1:30 and then we'll finish up. Thank you
19 for your patience.

20 (The jury exits the courtroom at 12:34 p.m. and the
21 following is held on the record.)

22 THE COURT: Any there any motions before we break?

23 MR. SLOTCHIVER: None for the plaintiff, Your Honor.
24 We wanted to redress the verdict form, the charges as it
25 relates to the mitigation. But that's it.

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1 THE COURT: All right. Do you have any motions you
2 want to make?

3 MR. TRAINOR: None, Your Honor.

4 THE COURT: All right. What are your jury charge
5 issues?

6 MR. SLOCHIVER: We had addressed earlier, Your Honor,
7 that one of the charges deals with failure to mitigate. The
8 testimony -- the only testimony that's been presented is
9 from Dr. Schoderbek. He says that there's nothing he can
10 do, that he's got this permanent condition. There's no
11 testimony introduced by anybody that says that the failure
12 to get go to a neurologist would have made a difference.
13 There's no testimony from anybody that says the failure to
14 get to more physical therapy would have made a difference.
15 The testimony is that people stop if it's not working. And
16 that's what Dr. Schoderbek -- that's what Dr. Nestler
17 testified to. The injections -- excuse me. The injection
18 that he did not take, there's no testimony to show that it
19 made a difference. In fact, the doctor testified that there
20 is nothing that they can do. It's permanent nerve damage.
21 He could've gotten an ENG, would not have made a difference.
22 So there's no testimony that he failed to mitigate. He may
23 not have done everything the doctor told him to do. But
24 there's no testimony that it would have made a difference.
25 And I think it's misleading to a jury on these issues that

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1 they would discuss about what his failures are when there's
2 no testimony to support that there are any failures. I think
3 they can argue his credibility. They can argue the fact
4 that he didn't do these things. And the jury can value it
5 as they wish. But I don't believe it goes to a failure to
6 mitigate that would've changed the injuries that he
7 sustained.

8 THE COURT: Mr. Trainor?

9 MR. TRAINOR: Mr. Slotchiver says there's no evidence,
10 I guess, that any additional treatment would've been helpful
11 and I think that's not entirely true. I think Dr.
12 Schoderbek said the only reason I recommend people to do
13 things is for their benefit and it's their choice whether or
14 not to do them. You heard Dr. Schoderbek say Dr. Nestler
15 did not do these things. You heard Dr. Nestler say I didn't
16 do these things. I think when a doctor says I recommended
17 them solely for the purpose of somebody getting better and
18 they didn't do that, that's the definition of a failure to
19 mitigate.

20 MR. SLOTCHIVER: It's not exactly what he said. He
21 said the ENG doesn't that make you better. He said you can
22 check with a neurologist. He's says try the therapy, but if
23 it doesn't work, stop. He never said it would've made a
24 difference. He never gave an opinion it would've made a
25 difference. They have the right, Your Honor, to do an IME

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1 if they wish to. They have the right to bring an expert to
2 testify that it would've made a difference; they did not.
3 Instead what they're doing is it's no different that when
4 Dr. Nestler testified. He said I could have done
5 acupuncture; I could have taken opiates to relieve the pain.
6 There's a lot of things I could have done. The problem is
7 that none of those things would have made a difference. So
8 there wasn't a failure to mitigate. It was a failure to
9 follow all of the instructions. They may use that as a
10 credibility argument. They can attack him for the fact that
11 he's making this thing up. It's not really, you could tell
12 because he didn't do all the things he was offered. But
13 it's not a failure to mitigate. Because there's no
14 testimony, there's no proof that it would've made a
15 difference. We have the proof that it's just the opposite.
16 So I would ask you to take that portion of the jury
17 instruction out.

18 THE COURT: Well, the doctors all recommended a course
19 of treatment and he gave good reasons why he didn't feel
20 like he needed to do it. But under the circumstances, I
21 think that a failure to mitigate charge is appropriate and
22 you'll get to argue that he made a reasonable choice and
23 they can argue otherwise. So we'll leave it in there.

24 MR. TRAINOR: Your Honor, I also, if I may, I would to
25 strike the plaintiff's complaint on that discovery abuse not

1 disclosing prior injury, prior accident, or prior claim. We
2 had no opportunity to discover what was alleged as a
3 permanent injury to his neck. We had no medical providers,
4 no physicians, no hospitals. We weren't able to depose
5 anybody. We weren't able to investigate that claim at all.
6 And I mean that is intentional omission. It prejudices
7 unbelievably.

8 THE COURT: Mr. Slotchiver?

9 MR. SLOCHIVER: Your Honor, I will tell you as an ---

10 THE COURT: Were you the lawyer?

11 MR. SLOCHIVER: --- officer of the Court that I have
12 no recollection that.

13 THE COURT: Were you the lawyer?

14 MR. SLOCHIVER: I was, apparently. I just saw it ---

15 THE COURT: And you don't remember?

16 MR. SLOCHIVER: I saw it when you put it on the
17 pleadings. We keep our files for six years. This is a
18 filing from 2003. I have no recollection. Dr. Nestler
19 testified he had no recollection of it, but he says, now you
20 show it to me; I guess I recall it but I don't know who the
21 doctors are. The injury was to the neck. The injuries he
22 is complaining are to the shoulder, from the shoulder down
23 to the wrist and down to the hand. There is no prejudice.
24 It's a different angle. There's no recollection of it and
25 discovery is that of what you can remember, what can you

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1 recall. It's not a -- you've got to answer them honestly.
2 But it doesn't mean that you can't answer something honestly
3 and just be mistaken. I had no idea until I saw it. They
4 didn't bring it up to me before and I ask me about it before
5 they presented it to you. I had no idea until I saw on the
6 screen that my name was going to be on it to begin with. It
7 was 2003. That's 13 years ago. And he testified under
8 oath, he had no recollection of it; doesn't remember it at
9 all. They can impeach him on it, which is what they argued
10 and what they I'm sure will do. It's what they've done so
11 far. But to strike a pleading when you've got somebody
12 who's been injured in a significant wreck, because of that,
13 would be improper.

14 We're not moving to strike the pleading because the
15 defendant came in and testified different than the affidavit
16 he gave a month ago was issues we get to argue about; we get
17 to challenge people on. I don't think the right course is
18 to strike the pleading. You've got a guy -- you sat here,
19 Your Honor. You got to witness him; you got to see what he
20 testified to; you got the judge's credibility to some
21 extent. And they can attack him if they want to. But I
22 won't believe that anybody can make an assertion this was an
23 intentional act. I still don't recall it. I'm still
24 curious to see it and I won't have it in my files because we
25 don't go back that far. We go the six years; we probably go

1 a little longer because we have a basement in the office and
2 we keep our files a little bit longer. But they generally
3 don't make more than seven to eight years if that far. So I
4 don't have an answer to it because I don't recall it. He
5 testified he didn't recall it either. But I think it's -- I
6 think it would be improper to strike the pleadings at that
7 point. They could have brought it up earlier. They could
8 have told me about it. They could have given me a chance to
9 see if I do have anything or find anything; but they didn't.

10 MR. TRAINOR: If I may, Your Honor?

11 THE COURT: Uh-huh.

12 MR. TRAINOR: Two things. As far as the causation just
13 like you're saying, separate injury. Well, there's a CT
14 scan, there's an MRI, there's examinations on his neck, the
15 imaging is on his neck to examine for foraminal stenosis or
16 narrowing of the disc to determine some nerve impingement
17 that radiates down into his arm. So there is a connection
18 and a correlation. And when you have a complaint that says
19 you suffer permanent injuries to your neck, back, and other
20 areas, I feel like we're entitled to that information. The
21 other thing is it's not a matter of forgetting; it's a
22 nondisclosure issue. It was not disclosed to us. I mean,
23 that is -- we didn't have the opportunity to investigate
24 prior doctors. It was never, never mentioned to us.

25 THE COURT: Well ---

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1 MR. TRAINOR: I guess -- go ahead, Your Honor. I'm
2 sorry.

3 THE COURT: It is -- never had this come up where the
4 same lawyer who is representing the person in this case says
5 he doesn't remember that he represented this person in a
6 previous case. I'm not happy about that at all. However,
7 you're an officer of the Court and you say you don't
8 remember even now. I'm not going to strike it. I'm not
9 going to grant a mistrial at this point. I'm just going --
10 we'll see where this jury goes with this. If later on after
11 this case is over with you get a hold of these medical
12 records and you find something that is worth pursuing, you
13 know, you can file a post-trial motion and I'll deal with
14 that at that time. That's the way I'm going to do it at
15 this time.

16 MR. TRAINOR: May I request an adverse inference in
17 regards to the nondisclosure?

18 THE COURT: Yeah, I think that is probably fair that
19 you get that.

20 MR. SLOICHIVER: Would that not be the same adverse
21 inference for the purpose to the credibility of the
22 defendant?

23 THE COURT: For what?

24 MR. SLOICHIVER: When it came to the affidavit and his
25 testimony about the accident? Your Honor, just by way of

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1 background, it may be important for you to know just to
2 judge this a case where we couldn't serve the defendant. We
3 had to go through publication to serve him. Ultimately, Mr.
4 Trainor decided to hire an investigator in order to track
5 down the defendant. That was just recently. And just
6 recently we learned about his whereabouts. That's why the
7 affidavit came so late in time. The affidavit was just
8 taken a few weeks ago and he testified inconsistently to it
9 today. I think that certainly you can argue to the
10 credibility of the defendant. But at this point to give an
11 adverse inference against my client and at the same time to
12 have charges about failure to mitigate against my client and
13 at the same time to put up the defendant as someone who
14 works at Walmart and works at Wild Dunes and has no money,
15 but therefore, you're claiming money against him, I just --
16 I think it's not fair. And I would ask you to consider
17 those things.

18 THE COURT: Well, I don't think your argument convinces
19 me that you're entitled to an adverse inference charge. But
20 I still think that in fairness they are. So find me
21 something and give it to me at lunch to look at. All right.
22 I'll meet you back here in 45 minutes.

23 MR. TRAINOR: Thank you, Your Honor.

24 (The proceeding recessed for lunch at 12:45 p.m.)

25 (The proceeding resumed at 1:38 pm)

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1 THE COURT: All right. How long you think you're going
2 to need, Mr. Slotchiver?

3 MR. SLOTCHIVER: Twenty minutes, maybe.

4 THE COURT: All right.

5 MR. SLOTCHIVER: Maybe less.

6 THE COURT: I'll give you that. You get five on
7 rebuttal. Twenty, 25 work for you?

8 MR. TRAINOR: Twenty, 25 works for me, Your Honor.

9 THE COURT: Okay. All right.

10 MR. SLOTCHIVER: Can I just have one moment. I just
11 read the charges and wanted to put a note. I was looking --
12 I was looking at the numbers. Like I discussed, I was using
13 24.68 and he used 25. I just want to make one adjustment to
14 my closing if I can have a moment?

15 THE COURT: You can.

16 (Brief pause.)

17 MR. SLOTCHIVER: I'm ready.

18 THE COURT: Okay. Let's bring the jury in.

19 (The jury enters the courtroom at 1:39 p.m. and the
20 following is held on the record.)

21 BAILIFF: All jurors present, Your Honor.

22 THE COURT: All right. Welcome back, folks. I hope
23 you enjoyed your lunch. We're going to now go into the
24 final phase of the trial in which you will hear closing
25 arguments from the lawyers in which they will attempt to

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1 review the evidence that you heard, try to convince you to
2 render a verdict on their client's behalf. Then I will
3 charge you on the law, go over the verdict form with you,
4 and you will retire to considering your verdict. Let me
5 remind you that what the lawyers are now saying is not to be
6 considered by you as evidence. They are simply reviewing
7 the evidence that you heard or that you saw. And I will
8 also tell you that because the plaintiff has the burden of
9 proof, the plaintiff gets to open and close. So you will
10 hear first from Mr. Slotchiver then from Mr. Trainor and
11 then briefly a rebuttal by Mr. Slotchiver. All right. Mr.
12 Slotchiver, if you are ready, you may begin.

13 CLOSING ARGUMENTS

14 MR. SLOTCHIVER: Thank you, Your Honor. Ladies and
15 gentlemen, at the beginning of the trial I told you it would
16 be probably brief. I think it was. It was a little boring
17 at times, but it was relatively brief. Sitting through a
18 deposition of a doctor for an hour and a half on the
19 television wasn't what any of us want to do, but it
20 accomplishes getting the evidence to you. And that's what
21 we had to do. So I apologize. It wasn't exciting. It's
22 not like on TV, but it's a process and it's how the process
23 works.

24 This case is about a wreck. And unlike some scenarios,
25 in this case the defendant admits liability. And the Judge

1 will tell you that when he gives you a charge. And the
2 charge is where -- in a little while when I'm done, Mr.
3 Trainor is going to -- he'll tell you what the law is.
4 He'll tell you what to consider and what to use and how to
5 make decisions. And then you use your own good common sense
6 to apply that. But let's go back and review what happened
7 briefly because we just did it today and yesterday.

8 March 8, 2014, Dr. Nestler, Gary Nestler, and his
9 daughter were traveling and they were going to Boone Hall
10 Plantation to do a mud run, an outside obstacle course. You
11 might've seen it before. It's muddy; you go through the
12 water; you climb up obstacles; and it's fun. And at that
13 point, his daughter was 11 years old and it was a
14 dad-daughter thing to do while Mom was off doing something
15 else. She was doing the spinning with the Pattison Academy.
16 The wreck was big; it was significant. I don't anybody can
17 dispute that. He was driving an extra long Ford Expedition
18 and the frame bent.

19 These photographs -- and a lot of times you'll see them
20 in trial. We've talked about documents, we've introduced
21 them, and we've shown you different things. I will tell you
22 that when you go back to deliberate, you'll actually have
23 these in the back of the room. So you can actually spend
24 some time looking at the documents that are in evidence.
25 And it helps, those docs, it's helps you to get a full

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1 picture of what happened. It helps you to look. But I
2 think that what everybody can agree with, what we will agree
3 with, is that it's a significant wreck. It didn't need to
4 happen. It bent the frame of this vehicle. It tore up the
5 back of the car. And it left Gary Nestler in an unfortunate
6 position of being transported to the hospital and having
7 permanent problems to deal with.

8 Staying with the accident just one more moment.
9 Mr. Fields testified about it as did Dr. Nestler. I don't
10 think the facts are disputed. In fact, Dr. Nestler said he
11 agrees. Mr. Fields was driving; he was speeding. He
12 testified to it. He submitted an affidavit. You'll have
13 his affidavit back with you when you go back to the
14 boardroom. You'll have this document; you can look at it.
15 And in it he talks about the fact that he was speeding and
16 the fact that he took his eyes off the road for several
17 seconds while traveling somewhere between 45 to 50 miles an
18 hour. We'll talk about the fact that it's somewhere around
19 70, 75 feet per second. You take your eyes off four
20 seconds, you've gone quite some distance without looking.
21 He knew he made a decision. He decided to watch the runs on
22 the side of the road instead of watching the road. We take
23 the position he was reckless. He, himself, acknowledges he
24 was reckless in the affidavit. He denied it when he came to
25 court. When we showed him the affidavit, he remembered

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1 signing it. And he doesn't dispute it. He ran into the
2 back of the vehicle. And then everything started from
3 there.

4 Now, you heard Julie Nestler talk to you about what
5 life was like with Gary and life was like with Aspen. A
6 pretty good life. Everybody has their own way of doing
7 things whether you like it at the beach or whether you like
8 it at a theater. Whatever it is you do, it has it's own
9 passion and hopefully you find a partner in life that shares
10 that passion. And that is what happened with Julie and Gary
11 Nestler. And they have a child that shares their passions.
12 The problem is that those passions deal with activity. It
13 deals with biking and being outside. They're very active
14 people; more active than most people I know. And you've
15 heard it. She's involved in health and fitness, and he is
16 involved in many, many, many things that require him to be
17 healthy in fitness. And those are the work part of it and
18 that's the civic part of it. My compliment. There's not
19 many people that do as much as they've done. And we'll talk
20 about it a little more in a moment.

21 But then you get to the point of the child; and that's
22 the other factor. I've got a young child. I've got a
23 13-year-old child. I've got a child the same age as their
24 child. And everybody here has interacted with children and
25 you know that how your child interacts with you in what they

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1 do -- they don't understand things as well at that tender
2 age. So you've got an 11-year-old child who can't do the
3 same things with her dad. And this isn't her case; it's his
4 case. But he can't do those things with his daughter. And
5 do they understand? Do they appreciate it? I think the
6 phrase we used earlier was, "we've gone from a participant
7 to a bystander." You know, it's whether you like to go jump
8 in the pool or now Dad can't throw you around in the pool.
9 Or whether you want to go play tennis; whatever your own
10 thing is that you like to do. I think we can all think
11 about it in our own personal lives how that affects us. In
12 their world, it was being active and doing the things they
13 like to do together, which they can't do anymore.

14 The testimony from Dr. Schoderbek was clear. It was
15 long, but it was clear. And lawyers do what lawyers do
16 which is try to take things apart and cut them up and slice
17 them and, you know, beat a dead horse. They just go over
18 and over until they get it. But at the end of the day when
19 you listen to what Dr. Schoderbek said, he was clear. This
20 injury, the nerve damage, came from this wreck. This nerve
21 damage cannot be fixed. There's four things that have been
22 talked about. They were talked about -- obviously, they
23 were talked about by defense counsel with Dr. Schoderbek and
24 they were addressed, and they have been clarified. EMG
25 study, while talking of the EMG -- not the EMG. The ENG

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1 study. Excuse me. The ENG study, which Dr. Schoderbek
2 testified to, is medieval torture. He said he himself would
3 not do it. He has to offer it. I asked him at his
4 deposition, "Are the things that you have to offer because
5 you're required? Yes, I do." Doesn't mean you have to do,
6 but I have to offer it. What does it do? Well, it hurts.
7 It puts these needles in your arm and shoots electricity and
8 it hurts really bad. And it tells you which nerves are
9 damaged so you'll know. You'll have information. Like a
10 lot of medicine, you will have the information of what
11 happened. But it doesn't tell you how to fix it. In fact,
12 he said you don't do surgery on this. You don't do surgery
13 unless you want make it worse. You can't fix it. If the
14 idea is to have knowledge, go have it done. And you'll
15 know, you can say, these are the ones for sure. But if you
16 want to fix it, it doesn't fix it. It does nothing. It
17 just gives information.

18 We talked about seeing a neurologist. You can see
19 neurologist. I recommend you go see a neurologist. Well,
20 we know Dr. Nestler is not the normal person, not the normal
21 patient. Dr. Schoderbek testified to it. I think you can
22 judge that and listen to him and his background. But he did
23 go out to research; he wanted to understand. He talked to
24 Dr. Schoderbek about it. He talked to Dr. Don Johnson about
25 it. He studied himself to see: Does it make any sense?

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1 Does it do anything? Or instead, as he testified to: What
2 does it really do? It just gives more information, but it
3 doesn't solve your problem. Nobody here today, nobody here
4 yesterday, has given any perspective on how to solve his
5 problem because there is no solution. If there was, you
6 would have a doctor up there to testify to it and not by us.
7 He would have got the treatment, number one. They would
8 have brought a doctor to testify to it.

9 We talked about the injection. Well, he had an
10 injection before and it worked. Well, he did have an
11 injection before. Had an injection for a completely
12 different injury. He had tendinitis, not nerve damage.
13 It's a different injury. And the problem with doing the
14 injection when you have a nerve injury is it can cause
15 series problems. You heard his testimony; you heard what he
16 said. That's why he wasn't going to do it. Everything you
17 do in medicine -- we all know in life as we get older, is
18 you weigh the pros and the cons, the risks, and the
19 benefits: Does it make sense? Do I want to do it? Will I
20 get enough to take those risks? And you make a decision.
21 You saw him. You've seen him testify. You've seen how he
22 can move his arm. And you've seen how active a lifestyle he
23 has. For that to be right, you have to believe that he's
24 going to suffer the consequences rather than do something
25 that he knows he can't do. He's made reasonable efforts.

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1 One of things the Judge will tell you in the charges is
2 that you can consider whether or not a plaintiff has failed
3 to mitigate. Is there something that a plaintiff did, not
4 do, that he could've done, that would have made it better?
5 And I would suggest to you there's no evidence of any thing.
6 The doctor says it's a permanent injury; it's not going to
7 get better. The ENG is not going to make it better. No
8 evidence that neurology is going to make it better. It's
9 just another place to learn more information. No
10 information, but giving him that injection it's going to
11 make him better. And the therapy he's done, the physical
12 therapy he's gone to, didn't work. He tried it. And he
13 talked to Dr. Schoderbek about it. The fact that they know
14 each other doesn't -- isn't a bad thing. You don't
15 disbelieve somebody because they happen to know each other.
16 Dr. Schoderbek says, "Yes, I know him. I know him casually.
17 I see him at the rec center. I see him playing football
18 with his wife and his child, or I used to." And then he
19 said the problem is that he's lost the joy in his life.
20 He's lost the fun. He can't do what he does. He's a very
21 active person.

22 You'll recall the doctor talked about what is called a
23 permanent impairment. A lot of discussion about what's a
24 permanent impairment. And it's a rating based on the AMA
25 guidelines with where they go in and do certain measurements

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1 to get an objective findings as to what's wrong with you.
2 They try to categorize it and they try to put it together in
3 a way that it's the same test for him as it would be for her
4 as it would be for everybody else. The doctor says this is
5 really hard. You can judge Dr. Schoderbek. You saw him.
6 It's really hard. This isn't a normal range test. This
7 deals with nerve problems. It's difficult. He says he did
8 it once. And I don't see doctors going this way that often.
9 And he said, "Look, I wasn't as thorough. I just wasn't. I
10 wasn't as thorough as I needed to be and I realize that. I
11 wanted to go back and make sure that I had everything and I
12 studied it." Mr. Trainor tried to attack him on some
13 calculation; you're supposed to add them and divide them.
14 The doctor said, "No. That's not how it works." He
15 explained exactly what he did. He said this is the way you
16 do it and this is how I came up with my calculation. And
17 the calculation sounds rather severe: 53 percent permanent
18 impairment to the left upper extremity; 32 percent to the
19 whole person as a result of this. It affects his life.
20 This part of the body. The defense is making a deal talking
21 about his neck. You keep on hearing about degenerative
22 changes to his neck. Heard about it repeatedly. What you
23 haven't heard of, what you haven't heard today, and you
24 haven't heard and you won't hear, is Dr. Nestler complaining
25 that's that what his permanent injury is. Yes, things all

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1 connect to the body. But Dr. Schoderbek said this is not a
2 neck problem; this is a left extremity. Primarily elbow and
3 it radiates down to his hand and it makes his hand cold and
4 it makes it painful and it limits what he can do. That's
5 what the injury is.

6 You'll have evidence; you'll have documents back there.
7 You'll have this document here from the file that talks
8 about the ENG. It clarifies any issues. Look at this. It
9 talks about, "Yes, I recommend it. But it's not going to
10 solve anything. It's not going resolve it." It's written.
11 If you don't remember what he said, I can show you. You can
12 read it. It's right here. It's in the paper. You'll also
13 have a full packet of his entire records. You may recall in
14 the deposition, I moved this into evidence. Mr. Trainor
15 said why don't we move the whole file. I said fine. This
16 might be a little more complicated to go through. This one
17 quite easy to go through. You can read it; you can see it.
18 It addresses it right there.

19 I want to make one comment also about this prior claim
20 from back in 2003 that was made. I want you to judge his
21 credibility. We'll talk about it in a second. I don't
22 recall it. I saw my name on the screen. I had no idea. I
23 don't recall it now. He sat there; he had no recollection.
24 He didn't deny it when it came up. Truth is all these
25 things are filed; when they're filed, they're kept in a

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1 database at the courthouse. You can find it. It's not a
2 secret. He doesn't recall it. It's unfortunate people's
3 memories aren't always perfect. And I ask you to judge the
4 credibility based on who you saw, what you hear, what he
5 does. The fact that there was a lapse of memory doesn't
6 mean that he's not credible. And in fact, the interesting
7 thing was that complaint talked about a neck problem. This
8 isn't a neck problem.

9 I want to remind you of some of the things that we
10 heard about Dr. Nestler. His involvement in IBM. He's the
11 global public safety and security segment leader. He's
12 board-certified in acupuncture. He was an associate
13 professor of medicine at MUSC; dual appointment in
14 anesthesia and perioperative medicine, obstetrics,
15 gynecology; director of the CAM program that he brought down
16 here that had never been here before and he set it up. He
17 was the chairman for the last two years of the Charleston
18 Police Fund. He's a captain of the Isle Of Palms Fire
19 Department. These are volunteer jobs at MUSC, the fire
20 department, the police department. He works on the command
21 staff at the Charleston Police Department SWAT team as a
22 volunteer. He works for FEMA. Firefighter of the year from
23 the Isle of Palms; accommodations from the Charleston
24 Police; accommodation from the White House. Works with
25 Mayor Riley; he works with Mayor Tecklenburg. Was called

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1 into the most serious events we've had in recent -- in
2 recent times to assist with his leadership. This is a guy
3 who doesn't sit around and do nothing. This is a guy who is
4 active. This is a guy who has people all over the country,
5 all over the city and all over the world relying on him. He
6 talked about his global jobs; things that he did. The
7 reliance and help with the government; the abilities that he
8 has; the leadership that he has.

9 So we talked about the accident. We talked about the
10 witnesses. What the Judge will charge you is you got the
11 injury that -- you got the negligence that occurred. Their
12 fault. Question then is: Was he hurt? So one thing I
13 would suggest you look at is the neck, is it for injury?
14 Look at the vehicle. Listen to the facts. Listen to the
15 fact that he went to the EMS, to the hospital, and had all
16 these treatments and all these MRIs and all these CT scans,
17 and all these different tests. Was he hurt? I believe the
18 evidence supports that he strongly was. The next thing is
19 to determine: What are his damages? Now, as you know,
20 there is no way we can reverse time. If we could, it would
21 be a perfect world. You put somebody in a machine and they
22 come back in before they were ever hurt. But it doesn't
23 happen. It can't happen.

24 There's two main things that have two main categories
25 that have affected Gary Nestler as a result of this wreck.

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1 One, pain. He's got pain. He lives with pain everyday. He
2 lives with pain every moment. The more active he is, the
3 more pain he has. That's what he testified to. He's limited
4 range of motion; that's the physical part. The pain is
5 another part of it. He travels quite frequently. How are
6 you going to put your bags up in the plane? He can't. Is
7 it easy to get dressed? No. Is it easy to go to the
8 bathroom? He's testified to it; it's a little humiliating.
9 No, it's not. He lives with the pain, but it's always
10 there. Does he quit his volunteer work? No. He
11 perseveres. He's adjusted. He doesn't go into the fires
12 anymore. He doesn't do what he used to do in the same way,
13 but he still does. He still does it. Does he go to work?
14 He goes to work. He goes like most other people; he needs
15 to make a living. That's how he provides for his family.
16 He goes to work. His work doesn't require him to be
17 physical. It requires him to move luggage to travel quite
18 frequently. It requires him to sit at the desk and type as
19 you heard him say. Now what he does when typing is he
20 writes like he's never written before. He showed you how he
21 puts on a jacket; he's got to turn at an angle. It affects
22 everything he does. And the sad thing about it is it's
23 going to continue to affect everything he does.

24 The Court will tell you that in South Carolina in order
25 to have consistency, and there's a charge on this, South

1 Carolina has created a life expectancy table. Pretty scary
2 stuff. They determine how long you're going to live for
3 purposes of litigation. Doesn't matter that his
4 grandmother's 104 years old. Doesn't matter. It's how long
5 is he going to live? The Court will tell you. You can
6 determine that at 55 years old, he's going to live 25 years.
7 That's going to be the jury charge; he'll live 25 years.
8 That's what you're supposed to consider. A lot of things
9 the Court will tell you that they're just facts that you've
10 got to consider. He will live 25 years. Over the next 25
11 years, he will get older. Over the next 25 years, that
12 little girl who is 13 years old will get married. Over the
13 next 25 years, that little girl will have children. And
14 he'll go pick up his grandchild one day except for this one
15 problem, he can't. He wants to play with her in a pool, he
16 can't. He wants to play with his daughter now or dance with
17 his daughter like he'd like to dance at her wedding, he
18 can't. These are all real things that happen to real people
19 when you have limitations. And granted, people have
20 limitations throughout their lifetime. It happens. The
21 difference here is it didn't happen because of anything he
22 did. He was just innocently sitting in a car on a great
23 day, looking forward to a wonderful event with his daughter.
24 It was Mr. Fields who did it. Mr. Fields made a choice.
25 His choice was to drive fast. His choice was to take his

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1 eyes off the road. And as a result of that, these are
2 damages that he had.

3 So two issues: pain and joy. How do you live your
4 life? You start restricting. How do you live with pain?
5 You start dealing with it. How do you as a juror try to
6 figure out how to compensate somebody for that? It's not
7 easy. Because you can't put him back in a time machine.
8 You can't bring him back. And as the defense will tell you,
9 as they've already told you, they want money. Well, that's
10 the only remedy that our country recognizes. But it's not
11 that we want money; it's that they don't want to pay what
12 they owe for these injuries. So what I'm going to ask you
13 to do when it comes to the charge of actual damages, not the
14 punitives; punitive deals with recklessness. It's a
15 different standard. The Judge will talk to you about that.
16 Because there's evidence of reckless damages, he talk to you
17 about the fact you can award punitive damages to send a
18 message to punish. You deal with that as you see fit. But
19 on the issue of actual damages, I'm going to ask you to
20 consider what the actual damages are and not to be swayed by
21 issues such as when they're going to be paid, how we're
22 going to pay it. Those things, it's not relevant. Figure
23 out what they're worth. If the Mona Lisa was worth ten
24 million dollars and someone destroyed the Mona Lisa, we're
25 not going to discount it. It's worth ten million dollars.

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1 Come up with a figure that represents what the actual cost
2 is, what the actual value is; what seems to be fair. And
3 I'll give you a suggestion.

4 What Gary lives with is pain and issues for the rest of
5 his life for the next 25 years on a daily basis. The
6 average person is awake 16 hours a day. The average person
7 sleeps 8 hours a day. So I would suggest to you consider
8 the 16 hours he's awake, not the other eight. He'll sleep;
9 he may not. I think he testified he slept less. But
10 consider the 16 that he's awake by way of example. And we
11 can look at professions; we can look at hourly; we can look
12 at what people make on minimum wage. But this is something
13 he's going to live with forever. But if you came up, for
14 example, with a number and you said, "You know what? I'm
15 going to give him a dollar twenty-five an hour while he's
16 awake for pain, and I'm going to give him a dollar
17 twenty-five an hour while he's awake for how it's affected
18 his life." That's two-fifty an hour. And if you say I'm
19 going to multiply that two-fifty an hour times 16 hours a
20 day; and I'm going to multiply that 16 hours a day by a
21 year. And if you do that you'll come up with \$14,600 to
22 have from the pain, to have permanent disabilities to do what
23 he used to be able to do and the frustration with living
24 your life, the impact that you have. If you multiply -- and
25 this is where the number seems to jump. And it's gets very

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1 large. But it's because we're talking about 25 years. If
2 you multiply the \$14,600 a year, and you multiply it by the
3 25 years, your number jumps to \$365,000. But that's not
4 \$365,000; it's 14,600 a year. And it's really a dollar
5 twenty-five an hour to walk around in pain, or a dollar
6 twenty-five an hour to walk around not being able to do what
7 you want to be able to do. Make it \$5 an hour. Maybe
8 that's a better number. But if it's \$5 an hour, it's
9 \$29,000 a year; \$730,000 over a lifetime. You can do the
10 math. Whether it's two-fifty, whether it's 500 -- or \$5,
11 whether it's ten; whatever the number is you decide, an
12 argument could be made that the present-day value is
13 different but then you have inflation. It pretty much
14 offsets itself.

15 What we're asking you to do is to come back with a
16 determination that number one, he caused the accident. The
17 Judge will tell you that. But you'll have a jury form and
18 what's he going to ask you is to determine what amount of
19 actual damages there are. And he's going to ask you to
20 determine what amount of punitive damages there are. Those
21 are blanks for you to fill out. Just fill out the number.
22 Fill out what you believe the value to be. We'll deal with
23 the rest of it over time. We'll work it out. But I'm
24 asking for a true value. The judge will also tell you about
25 punitive damages. He will instruct you to talk about that,

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1 about the failure to mitigate charge. You can consider
2 whether or not there's a failure to mitigate. And if there
3 is, what difference does it make? We don't believe there
4 is. We think it's a charge that comes up. We don't believe
5 there's any evidence whatsoever to support that anything
6 else could have been done. In fact, the evidence is quite
7 the contrary. You heard Dr. Schoderbek testify and you
8 heard Dr. Nestler testify.

9 You'll hear you can judge the credibility of the
10 witnesses. I ask you to do that. Think about who you saw;
11 think about how they acted; think about what they said.
12 Think about how it's substantiated by the medical testimony
13 and the medical records. You'll have the records with you.
14 You're allowed to consider circumstantial evidence. You can
15 consider deposition testimony. The testimony of the judge
16 [sic] is actually trial testimony via deposition. Consider
17 that. You can consider expert witnesses. They're at a
18 different level and the Judge will instruct you what to do
19 when it's an expert witness.

20 Proximate cause: Did this wreck cause these injuries?
21 Are there actual damages? And are there punitive damages?
22 He'll charge you on what's called pain and suffering. And
23 he'll tell you that if you find that he has pain and
24 suffering, we talked about the pain, the hurt, that he is
25 entitled to an award for having to deal with pain and

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1 suffering forever. If you find -- you'll be charged on
2 what's called loss of enjoyment of life. We talked a little
3 while ago about the fact that everybody does things
4 differently. What's important to you may not be important
5 to him. But everybody has their own thing that's important.
6 For him, his enjoyment of life isn't there right now. He's
7 lucky, he still has a family. He has a wife, he has a child
8 to stick with him. But it's not the way it was and it's not
9 his fault.

10 The issue came up as to medical bills. And it's not an
11 issue that we were throwing around or pushing around because
12 I don't believe that they're representative of anything.
13 The fact that he got \$7100 in medical bills, what does that
14 really have to do with the fact that for the rest of your
15 life your going to be in pain? And what does it really have
16 to do with the fact that for the rest your life your ability
17 to do what you've always done has been taken away? Is there
18 some measuring stone? If you got \$7,000 in bills then
19 everything else is worth X. But if you got \$200,000 worth
20 of bills then it's worth Y. There's no correlation between
21 it. It's why we weren't putting it out there. It's why we
22 weren't issuing it. But it came up and it's fine that it
23 came up. So, you know, \$7100 of bills. You've got that
24 information. Do with it as you may. I don't think it means
25 much. I don't think it's indicative of much because it's

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1 nothing they can do. People do have hundreds of thousands
2 of dollars; some has millions of dollars of bills. But
3 there's things they can do. Well, if there's nothing you
4 can do, there's nothing you can do.

5 THE COURT: Time to start winding it up.

6 MR. SLOTCHIVER: I'm sorry?

7 THE COURT: Time to start winding it up.

8 MR. SLOTCHIVER: I am, Judge.

9 I think when I sit down in a moment you'll hear from
10 the defense counsel. My guess is he's going to talk about
11 those four things we talked about over and over again. I'll
12 have a brief moment to chat with you after he's done. But I
13 do want to thank you. You all paid great attention
14 throughout the trial. I've seen you all; you watched, you
15 noticed, you stayed awake. I've had trials where it doesn't
16 always work that way. On behalf of my clients and on behalf
17 of the whole court, everybody here, I want to thank you.
18 Because it does make a difference when you pay attention.
19 And it's a short trial, thank goodness. But we do
20 appreciate it. And I'll speak to you guys in a few moments.

21 THE COURT: Mr. Trainor?

22 MR. TRAINOR: Yes, Your Honor.

23 Ladies and gentlemen, when I spoke to you yesterday,
24 talked about -- you heard a lot of numbers. Talked about
25 objective complaints or objective findings or subjective

1 complaints. That's evidence. That's a lot of the evidence
2 you've heard. It's documents that you'll have. It's
3 testimony that you've viewed. The Judge will instruct you,
4 Mr. Slotchiver has alluded to it, nothing that he says --
5 it's nothing that he just said is evidence in this case.
6 The evidences is those documents, the testimony. And we're
7 talking facts. We're not talking emotion; we're not talking
8 sympathy. The Court requires decisions to be made on facts.
9 And you are the finders of the facts. It's not about the
10 sympathy and feelings and emotions. That's maybe the best
11 part about this system is that it is based on facts.

12 I want to recap what the facts that you heard were.
13 Mr. Slotchiver said lawyers have a tendency to massage what
14 they heard or they didn't hear. So I'm going to offer you
15 as many quotes as I can from deposition testimony, from the
16 records that you will have in your possession. Because I
17 think that will help you figure out what was actually said,
18 what the actual facts are rather than us explaining to you
19 what we think it was.

20 You heard Mr. Fields testify. He said this is my
21 fault. There is no question about that. He ran into the
22 back of the someone. He looked off the road, you know, for
23 a second, a couple of seconds. He came back; he said I'm
24 sorry. And Mr. Slotchiver came up and wanted to beat him up
25 on an affidavit. Negligent and reckless. You've heard from

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1 Mr. Fields that a private investigator showed up at his
2 work, asked him what happened, left, came back with a
3 written document and said, "Hey, if you sign this, you don't
4 have to go to court." And we're still here. I can assure
5 you that was not a private investigator. You also heard him
6 say, "I didn't use the words negligent and reckless." And
7 he didn't know what those words mean to him. They have very
8 legal meaning. I don't think it surprises you that those
9 words might have come out of his mouth.

10 You heard from Dr. Nestler's wife, Julie. As Mr.
11 Slotchiver said, you know, we're here to evaluate; evaluate
12 credibility based on motives, biases. I don't think it's a
13 surprise that his wife is going to testify in his favor. I
14 don't. But I will tell you though that part of the lawsuit
15 -- and I'll talk about it in more detail here. The prior
16 lawsuit, we didn't find out about it until last night. And
17 I can guarantee you if I had known, I would have asked her
18 about that, his condition prior to this accident. I didn't
19 get that opportunity. You didn't get the opportunity to
20 hear that. You heard it from Dr. Schoderbek. His doctor,
21 he said I didn't bring a doctor. I brought his doctor
22 because that's the one that really matters. Someone didn't
23 examine him; didn't do any type of treatment with him. I
24 mean, that's -- you've got a doctor, his doctor, one he
25 trusts. One he says he follows his recommendations. What

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1 did Dr. Schoderbek say? He said I refer my patients to
2 other providers solely to get better. It's the only reason
3 I sent him to another provider. He said it's detrimental if
4 a patient doesn't follow a physicians advice. He told you
5 he makes recommendations and it's up to the patient to do
6 what they want with that, with that information. And I know
7 there's been a lot of discussion on recommendations,
8 conversations that happened outside of this courtroom,
9 outside of anyone's presence. And we've talked about that.

10 You also heard Dr. Schoderbek say, "I'm an orthopedist.
11 I do bones. I do muscles. I do joints." He doesn't do
12 nerves. Neurologists do nerves. The reason I think he said
13 that, and he clarified later, he said when we, you know,
14 when an orthopedist may be presented with a nerve problem,
15 we refer them to a spine specialist or a neurologist.
16 That's completely reasonable. And what he said was, and
17 it's minute six in the deposition, "Most orthopedists with a
18 bad nerve injury, something with the spine or otherwise, we
19 kind of send it on to a spine specialist or neurologist."
20 Those are his words from his deposition. What he told you
21 was, "I think there may have been a fracture. I don't know.
22 A small fracture. It's not visible on an X-ray." He said,
23 "I can't say there was a definitively a fracture." What he
24 did say is, "I can assess him with lateral epicondylitis,"
25 tennis elbow, tendinitis. Pain in his elbow.

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1 I think there was some impression that Dr. Schoderbek
2 was 100 percent positive that there's nerve damage. Mr.
3 Slotchiver said, you know, that's the case. Dr. Nestler
4 said I know I have nerve damage. They massaged it to say
5 that Dr. Schoderbek had said that there's never damage. At
6 the very end of his deposition, I said, "As we sit here, can
7 you tell me what is wrong?" And he said, "I assume that it
8 is nerve damage." I assume. That's not a very ringing
9 endorsement. That's why I referred him to Dr. Johnson, the
10 spine specialist. The spine guy. He said he knows better.
11 That's why we refer them to those people. And what did Dr.
12 Johnson say? He said, "I don't see any significant nerve
13 impingement. I don't see any disc herniation." Dr. Johnson
14 assessed Dr. Nestler with a cervical strain. A neck strain.
15 He goes to physical therapy for one day at the request of
16 Dr. Schoderbek. He goes a few times and getting better.
17 And I think as Dr. Schoderbek said, at that point we
18 switched him over to -- switched Dr. Nester over to Coastal
19 Therapeutics. And what did Dr. Schoderbek say about Coastal
20 Therapeutics? His quote was, "They do a very good job with
21 these type of injuries." Two to three times a week, six
22 weeks, five visits. There's testimony from Dr. Nestler that
23 I had these conversation with the physical therapist. I had
24 these conversations with Dr. Schoderbek about if you're not
25 getting better, you don't need to go or we reach alternative

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1 arrangements. Well, you'll have the records. Those are
2 conversations that happened outside that are not in records.
3 Those are conversations with physical therapists that aren't
4 here. We're relying on a statement from Dr. Nestler about
5 conversations that are no where to be found.

6 We talked a lot about nerve conduction studies and the
7 purpose of them, why they are beneficial. Generally, when a
8 doctor orders me to do something, that's high on the list of
9 things to do. And professionals are held to a very high
10 standard and rightfully so. And when they offer their
11 opinions and their advice, I think it's worth listening to.
12 Four times he was recommended. And there's this talk of,
13 "Well, you know, it would've provided more information. It
14 would've given clarity. But, no, it wouldn't have done
15 anything to help him." That opinion was formulated
16 December 11, 2015. The last visit with Dr. Schoderbek and
17 Dr. Isner (ph).

18 You'll have the opportunity to go look at the bills.
19 I'm going to read you the recommendations that were given.
20 May 2nd, "He may also need to get an ENG nerve conduction
21 study to evaluate for a certain entrapment if the symptoms
22 continue." May 30th, "At some point we may need to get a
23 ENG nerve conduction study to evaluate if these symptoms do
24 not improve." July 11th, "These have normal sensory
25 symptoms that he's getting with -- as evaluated with ENG

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1 nerve conduction study to assess the cause of them
2 potentially which he is not interested in doing." August
3 22nd, the last visit before that 16-month gap, before Dr.
4 Nestler goes back, "We've talked previously about getting an
5 ENG nerve conduction study which I think is a good option to
6 evaluate for neurological injury." At that time, Dr.
7 Schoderbek does not know that there's a nerve issue. Does
8 not know. Said it, it is clear that he does not know
9 whether there's a nerve issue at that point. It's clear
10 that he doesn't know there's a nerve issue ever. That's why
11 he referred him to a neurologist. That's why he referred
12 him to Dr. Johnson. You know, you may say, "Well, what
13 about the last visit? Maybe there is some reference of
14 nerve damage."

15 You have the document that Mr. Slotchiver held up and
16 said, you know, "You don't have to go through the records.
17 You can look at this very last page. The very last visit."
18 You can look at that. And go look at the diagnosis and the
19 assessments on that document. You've got pain in left upper
20 extremity, bicep tendinitis, lateral epicondylitis, which is
21 the tennis elbow, and left shoulder pain." There's not a
22 single mention of neurological issues, nerve damage. And
23 we're supposed to believe that that's a certainty. No one
24 has been able to say that with any certainty.

25 Talked about his permanent impairment. And I know

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1 you've probably been beaten to death with that information.
2 There's two permanent impairment ratings. In attempt to
3 explain the second one, Dr. Schoderbek says, you know, "I
4 wasn't thorough. Very difficult to do. There's a learning
5 curve. There are some things in my records that I a
6 probably should have put in and I didn't." But he did his
7 best with that number. Clearly, subject to some sort of
8 interpretation. He also said, and this is in relation to
9 Dr. Nestler's prior injury before this accident about the
10 shoulder, he said, Dr. Schoderbek said, "If he had continued
11 issues, I would've seen him back in." There hasn't been any
12 treatment since June 20th of 2014. The only time he went
13 back to Dr. Schoderbek was to get a second permanent
14 impairment rating. There's no testimony right now, there's
15 no evidence, there's no neurologist here to tell you that
16 there's an actual nerve damage. I don't know what, if
17 anything, is going on. And, obviously, the question, "Why
18 would a doctor do that? Why would a doctor say something
19 that he doesn't believe it?" I'm not saying that he doesn't
20 believe it. Doctors like lawyers are advocates for their
21 patients. We stick up for them. And Dr. Schoderbek was
22 presented with a situation and said I need assistance to
23 resolve litigation. And I don't blame Dr. Schoderbek for
24 saying I'll do what I can to help you out. They are
25 advocates for their patients just like we're advocates for

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1 our clients. You get to consider that when you evaluate the
2 testimony, when you consider what the weight of that
3 testimony is. It doesn't mean that it's any more valuable
4 than anyone else's because he's a doctor.

5 I talked in my opening a little bit about -- and I
6 talked again today about subjective complaints and objective
7 findings. Subjective complaints of pain which Dr.
8 Schoderbek said can't be measured. We talked about
9 objective findings: X-rays are normal; CT scans,
10 degenerative issues; MRI, degenerative issues. There hasn't
11 been a single person other than Dr. Nestler, who is not a
12 neurologist or an orthopedist, that told you that there is
13 nerve damage. And I would submit to you that they haven't
14 met the burden of proof to say that there is nerve damage.
15 I mean, an assumption by doctor does not make it so.
16 Diagnoses from that same doctor not saying there is nerve
17 would be conclusive evidence to me. A cervical strain
18 assessed by a spine specialist who that's his job, cervical
19 strain. He didn't mention neural impingement. He said no
20 significant neural impingement. He didn't say nerve damage.

21 And we heard from Dr. Nestler. And as Mr. Slotchiver
22 eluded to, he's an active guy. He traveled all over the
23 world. He works 18-hour days. He travels on a weekly
24 basis. It's odd I introduced in cross-examination the
25 medical bills. I don't think I ever had do that in a case.

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1 ever. I want you to think about why, why I want you to know
2 that number, \$7,117.50. It's because it's a really low
3 number. Because there's not a lot of treatment. And the
4 base to their response to that is, "Well, there's no
5 treatment to be done." Everyone said, just threw their
6 hands up and said, "We're done here." I don't think that's
7 true. That's not what Dr. Schoderbek records indicate.
8 It's not what Dr. Johnson said. He said continue with
9 physical therapy and chiropractic care.

10 Mr. Slotchiver said and Mr. Nestler said he's been
11 relegated to a bystander as a participant. Maybe; he was,
12 you know -- that may be the case. But the problem I have is
13 that he was a bystander during his treatment when he
14 should've been participating in it; when he should've been
15 going out and doing everything that he said he would do,
16 getting that neurologist's opinion. Because again, we don't
17 have that opinion to say that there is nerve damage. There
18 is no definitive evidence that there is nerve damage. You
19 can look at the records. You're going to see that there is
20 not an assessment for nerve damage by Dr. Schoderbek who
21 testified and said, "I assume that there is nerve damage."
22 And not by Dr. Johnson who is the spine specialist.

23 Now, there's reference to his prior lawsuit. And I
24 brought up that that was not disclosed to us in discovery.
25 And I found that out last night. And you saw in discovery,

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1 he says, "No, never had any damage; never had any injuries
2 from an accident." In fact, he filed a lawsuit claiming
3 permanent injuries to his neck, back, and other areas. Mr.
4 Slotchiver says this is a completely different injury. You
5 know, it's not his neck; it's his arm. Well, why did the
6 doctors then do a CT scan on his neck? Why did these
7 doctors do an MRI on his neck? It's because the nerves
8 related up here run down your arm. That's why. You're
9 going to hear the Judge charge you with an instruction that
10 the failure to disclose information in discovery, those
11 questions we asked, you can draw an adverse inference from
12 that. As a matter of law, you can assume that was damaging
13 to their case. We don't know what providers. We don't know
14 injuries. All I can see is what was on that page when that
15 prior lawsuit, permanent injuries to his neck, back.

16 Obviously, we're here to talk about numbers. We've
17 heard a number. What they're asking is for you to render a
18 verdict against the defendant for \$365,000, I think. That
19 is a ton of money. That is unfathomable money to me. You
20 know, we see this occasionally, you know, in trials.
21 Plaintiff's lawyers put up numbers and they say, well, it's
22 high enough. Juries will sit and say, well, we got to
23 factor that in somehow. I mean, surely there's a reason
24 that number exists. That number has no bearing on your
25 decision today. That number has no relevance. It's not

1 evidence. The break down is not evidence. It's a decision
2 and a calculation by Mr. Slotchiver's clients. You're going
3 to see on this verdict form, it says, "We find for the
4 plaintiff in the amount of," blank. And then it says, "We
5 find punitive damages in the amount of," blank. The reason
6 it doesn't say we find for the defendant is because Mr.
7 Fields has admitted that he caused the accident. He was
8 negligent. That doesn't mean that you can't award whatever
9 you want to award. If it's something nominal? Sure.
10 Medical bills, maybe? I don't know. Is it less than that?
11 That's a decision you all have to make. \$365,000 is a tough
12 pill to swallow.

13 As Mr. Slotchiver said, I really do appreciate y'all's
14 time. I now it's been a long two days. But this is a very
15 important process for everyone here. And I appreciate your
16 time. Unfortunately, I don't get another chance to speak to
17 you. But you'll hear from Mr. Slotchiver briefly. And
18 thank you.

19 THE COURT: All right. Brief reply, Mr. Slotchiver?

20 MR. SLOTCHIVER: Yes, sir. Thank you.

21 By no way am I suggesting that \$365,000 is sufficient
22 to pay to somebody for what Gary Nestler is going to go
23 through for the rest of his life. That's not a floor. It's
24 just going to show you happens if you minimize it down to a
25 dollar twenty-five an hour for pain, and a dollar

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1 twenty-five an hour for having to deal.

2 So the doctor is an advocate to the patients. And
3 advocate, but the doctor is going to say whatever he needs
4 to say. I haven't heard that phrase before that a doctor
5 was an advocate to do whatever he could do to help out his
6 patient to get not medical treatment, but something else; to
7 say whatever I need to have said. Mr. Trainor said he is
8 now -- Gary Nestler is now -- that he may now be a
9 bystander. He doesn't dispute it. He didn't deny it just a
10 few minutes ago. He said, well, he might be. But also
11 maybe he could have been more active. I want to make a
12 couple of comments and I'll be very, very brief. The issue
13 is was there ever any evidence about nerve damage. Instead
14 I want to read some quotes; I'll read you some quotes from
15 the doctor's testimony. Talked about the moderate issue
16 that he had before a year earlier. "The moderate issue that
17 he had pre-accident, that was nothing like the nerve damage
18 he had as a result of the accident, was it? Response, "No.
19 It's just on top of this; it's a very complicated situation
20 with a lot of motor sensory nerve involvement, joint
21 involvement as well." Another quote, Dr. Schoderbek, "You
22 don't go operating on nerves unless you want them to stop
23 working even worse than they already are." Another quote,
24 "There's no surgery to help this."

25 A comment was made that nobody has testified to it.

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1 And Dr. Schoderbek said I do deal with injuries that he has
2 now and the limitations that he has now -- we're talking
3 about the nerve damage -- are due to the car accident that
4 happened on that date. Question, "And is that opinion? Do
5 you state that opinion to a reasonable degree of medical
6 certainty?" And the responses is, "Yes, sir". He said it
7 on the screen yesterday. The doctor said if he does any
8 excessive activities, lifting, anything as I understand, it
9 causes him pretty intense pain that is not just going --
10 that is not just pain and goes away. It's something, that
11 pain, and then it lasts the majority of the day after that
12 as well and affects his ability to play sports and lift and
13 do a lot of things and activities and stuff that he has
14 enjoyed his whole life. Doctor, "Is it your opinion to a
15 reasonable degree of medical certainty that the impairment
16 rating you have just discussed is in fact attributable to
17 the wreck that he was involved in March of 2014? Yes, I
18 believe it is." To suggest today that this a doctor being
19 an advocate, to suggest that there is no evidence whatsoever
20 to support the position, the testimony from the doctor, the
21 testimony from Gary Nestler, the testimony from Julie
22 Nestler, doesn't make sense. I don't believe it's
23 unfathomable. Instead, I would ask that you consider what
24 the amount of damages really are without setting a floor.
25 I'll say one last thing and I'll sit down. A comment

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1 was made about the medical bills. Why wouldn't we show the
2 medical bills? The medical bills as we discussed earlier,
3 they don't play a role in determining what happened to his
4 life. The \$100,000 in medical bills, \$500,000 in medical
5 bills or \$500 in medical bills, they don't equate to how
6 this affected him. They don't affect to the damages that
7 he's had as a result of this wreck. They don't play a role.
8 If they wanted to have somebody testify inconsistent with
9 what Gary Nestler has said, they could have brought somebody
10 in to do an IME (ph). They could have brought their own
11 doctor to discredit it. But they haven't because they
12 can't. Thank you once again for your time.

13 JURY CHARGE

14 THE COURT: All right. Well, folks, you have now heard
15 the closing arguments. And you recall I told you at the
16 beginning of the trial that you and I have different duties
17 to perform. And one of my jobs is as the trial judge is to
18 preside over the trial, make sure both sides get a fair
19 trial, and rule on things like admissibility of evidence,
20 that sort of thing. You as the judges are the judges of the
21 facts and you decide the case based only on the evidence
22 before you. And evidence is testimony given from the
23 witness stand, photographs or documents that were admitted.
24 I also now, though, have the additional duty of charging you
25 on the law that applies to the facts of this case as you

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1 find them. And so if you have some idea of what you think
2 the law is or what the law ought to be and it does not agree
3 with what I now charge you, you're under the oath that you
4 took at the beginning of the trial to accept and apply the
5 law exactly as I state it to you.

6 Now, I told you, you are the judges of the facts and
7 you're the sole judges of the facts. I as a judge cannot
8 comment on or make any kind of statement, comment, or tell
9 you anything about what I think about the facts of the
10 trial. The law doesn't allow me to have an opinion about
11 the facts of the case. That's solely a matter for you the
12 jury to determine. It is your job as jurors to determine
13 the effect, the value, the weight and the truth of the
14 evidence that was presented to you during this trial. You
15 judge such things as the credibility of witnesses. And
16 credibility simply means believability. It becomes your job
17 as jurors to analyze and evaluate the evidence and determine
18 what evidence convinces you of its truth. In determining
19 the believability of witnesses who testified in this case,
20 you can believe one witness over several witnesses or
21 several witnesses over one witness; you can believe the
22 witness -- testimony of a witness in its entirety or you can
23 reject the testimony of a witness in its entirety. You can
24 believe part of the testimony of a witness and you can
25 reject the remaining part of the testimony of that same

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1 witness. If you reject part, you can still accept the
2 remainder.

3 You determine whether or not a witness has exhibited
4 any sort of an interest or bias or prejudice or other motive
5 in a case like this. You can determine or consider such
6 things as their appearance and demeanor of a witness while
7 on the witness stand. You are not bound to decide this case
8 based solely on the number of witnesses that a side
9 produces. And the fact that a testimony is not contradicted
10 directly does not necessarily mean that it's undisputed.
11 You can consider the inherent probability of testimony and
12 credibility of witnesses. Uncontradicted testimony is not
13 binding upon you, and have the right consider it in light of
14 all the circumstances and give it such weight, if any, that
15 you think it deserves.

16 I also talked to you about at the beginning of the
17 trial the burden of proof. And this is a civil case. And I
18 told you the plaintiff has the burden of proof in a civil
19 case. And the burden of proof in a civil case is what we
20 call a preponderance of the evidence which simply means the
21 greater weight of the evidence. Or stated another way, when
22 viewed as a whole, is the evidence sought to prove, to show
23 the facts that -- or it is evidence which when viewed as a
24 whole shows that the facts sought to be proved is more
25 likely true than not true. A preponderance of the evidence

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1 is not determined by the number of witnesses. Instead it's
2 determined by the greater weight of all of the evidence.

3 Now, we usually have two types of evidence in trial.
4 And one is called direct evidence and the other is called
5 circumstantial evidence. And direct evidence usually proves
6 the existence of a fact and does not require deduction.
7 Circumstantial evidence is proof of a chain of facts and
8 circumstances that indicate the existence of a fact. You
9 also heard some testimony in this trial in the form of a
10 deposition. And a deposition is I told you at the time is
11 testimony that was given under oath before the trial began
12 and is preserved in writing or electronic means such as a
13 video recording. And you are to consider that testimony as
14 if it were given by the witness in court. We also, I told
15 you, don't ordinarily let people give us their opinions
16 about the evidence in a case. But we make an exception for
17 expert witnesses and these are people who are experts
18 because of their education or experience or specialized
19 training in a field. They can give their opinion and they
20 can state the reasons for their opinion. You can give an
21 expert's opinion as much or as little weight as you think it
22 deserves. And if you don't think it's based upon sufficient
23 education or experience or you conclude the experts opinion
24 is not sound or that it's outweighed by other evidence, you
25 can disregard the opinion entirely. You are not compelled

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1 to blindly accept an expert's opinion. And you have the
2 right to consider that testimony in light of all the
3 circumstances and give it such weight, if any, that you
4 think it's entitled to.

5 Now, this case was brought under a theory of what we
6 call negligence, which means that the plaintiff claims that
7 the defendant was negligent and should compensate the
8 plaintiff for the injuries that he suffered as a result of
9 the defendant's negligence. In order to prove that the
10 plaintiff [sic] was negligent, the plaintiff must prove by a
11 preponderance or the greater weight of the evidence the
12 following things. Negligence is normally proven by showing
13 one party owed another a duty and that there was a breach of
14 that duty and that the party suffered injuries as a
15 proximate cause of the breach of that duty. The defendant
16 has admitted that he was at fault for the accident that
17 occurred between himself and the plaintiff. And therefore
18 the plaintiff does not have to prove that the defendant owed
19 him a duty and that he breached that duty. However, the
20 defendant contest the amount of damages the plaintiff claims
21 that he has suffered. Therefore, the plaintiff must prove
22 by a preponderance of the evidence that he suffered damages
23 as a result of the breach of the duty and the amount of
24 those damages.

25 Finally, the plaintiff must prove by a preponderance or

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1 the greater weight of the evidence that the damages were
2 proximately caused by the defendant's breach of duty. The
3 proximate cause is something that produces a natural chain
4 of events which in the end brings about the injury. It's
5 the direct cause of the injury. To prove that a defendant's
6 negligence proximately caused the plaintiff's injury, the
7 plaintiff must first prove causation and fact. And this is
8 proven by showing that the injury would not have occurred
9 but for the defendant's negligence. And then the plaintiff
10 must also prove legal cause. And legal cause is proven by
11 showing that the injury was foreseeable. And this simply
12 means that the injury occurred as a natural and probable
13 consequence of the defendant's negligence. Plaintiff must
14 prove that some injury from the defendant's negligence was
15 foreseeable but does not have to prove that the particular
16 injury that occurred was foreseeable. However, the
17 defendant cannot be held responsible for things that could
18 not be expected to happen. Proximate cause does not mean
19 the only cause. The defendant's act can be a proximate
20 cause of the plaintiff's injury if at least one of direct --
21 if it is at least one of the direct concurring causes of the
22 injury.

23 So if you decide that the plaintiff is entitled to a
24 verdict, your next step would be to decide how much money
25 the defendant should be required pay. Actual damages are to

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1 compensate a plaintiff for the plaintiff's loss or injuries
2 and to put the plaintiff as near as possible in the same
3 position that the plaintiff was in before the incident
4 occurred. In other words, actual damages would be the
5 actual losses and expenses which the plaintiff suffered
6 because of the defendant's negligence. The plaintiff must
7 prove that the expenses caused by the injury were necessary
8 and reasonable. Actual damages by a plaintiff -- or for a
9 plaintiff who has been physically injured include pain and
10 suffering, both past and future, as well as mental anguish,
11 impairment of health or physical conditions, and
12 disfigurement. In determining the amount of compensation
13 for personal injuries, it's proper to consider past and
14 present aspects of the injury. This would include physical
15 and mental pain and suffering, expenses incurred for
16 necessary medical treatment, the loss of enjoyment of life
17 suffered as a result of the injury, and any other losses
18 which are reflected by the character of the injury. Pain
19 and suffering compensates a plaintiff for physical
20 discomfort and emotional response to the sensation of pain
21 caused by the injury itself. There is no definite standard
22 by which to compensate a plaintiff for pain and suffering.
23 You have the authority to determine the amount, if any, to
24 be allowed for pain and suffering using calm and reasonable
25 judgment to ensure that the plaintiffs are just and

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1 reasonable in light of the testimony and evidence presented
2 in this case.

3 Loss of the capacity to enjoy life is also a proper
4 element of damages provided you find it results from the
5 defendant's negligence. You can award damages to the
6 plaintiff to compensate him for any limitations he may
7 suffer from his inability to participate in and derive
8 pleasure from the normal activities of daily life. You may
9 consider his inability to pursue his talents, recreational
10 interests, hobbies, or avocations. Loss of enjoyment of
11 life compensates the plaintiff not only for the subjective
12 knowledge that he can no longer enjoy all of life's
13 pursuits, but also for the objective loss of his ability to
14 engage in those activities.

15 Injured party may recover for future damages that are
16 reasonably sure to result from the injury. The principle
17 underlying compensation for future damages is that only one
18 action can be brought and therefore only one recovery had.
19 It's proper to include in the estimate of future damages
20 compensation for attention to the plaintiff's ordinary
21 business, future medical expenses, and pain and suffering
22 with reasonable certainty result. Plaintiff is never
23 entitled to recover for conjectural or speculative damages.
24 But if you find that the plaintiff is entitled to a verdict
25 for actual damages, your verdict should include an amount to

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1 cover any past, present, and future damages which were
2 proximately caused by the defendant. Any future damages must
3 be reasonably certain to incur in the future as a result of
4 the defendant's acts. Actual damages need not be proven to
5 a mathematical certainty or be based on the evidence -- or
6 based on evidence of the precise amount of damages plaintiff
7 has suffered. Instead, plaintiff must allow you to
8 determine what amount of damages is fair, just, and
9 reasonable. Any future damages must be reasonably
10 calculated to have resulted from the alleged injury or
11 damage sustained in this case. Future damages must be
12 reduced to their present cash value.

13 If you find the plaintiff was permanently injured as a
14 result of the defendant's actions, you must decide how, if
15 at all, that injury will affect the rest of the plaintiff's
16 life. A person's life expectancy is determined by a life
17 expectancy table which is the part of the laws of the State.
18 The life expectancy table is only an estimate of the
19 probable average remaining length of the life of all persons
20 in our state of any given age. The plaintiff is a
21 55-year-old male with a life expectancy, according to the
22 life expectancy table, of 25 years. This fact is to be
23 consider by you along with any other facts and circumstances
24 and evidence bearing on the plaintiff's life expectancy
25 including habits and health at the time of the jury in

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1 deciding the amount of damages to be awarded to the
2 plaintiff.

3 Now, when a plaintiff is injured or damaged by the
4 wrongful act of another person, it's the duty of the
5 plaintiff to reasonably try to avoid and lessen the damages.
6 And these damages which may be avoided by use of reasonable
7 efforts, care, and prudence by the plaintiff cannot be the
8 proximate result of the defendant's actions or wrongful act.
9 Therefore, the plaintiff cannot recover for damages which
10 reasonably might had been avoided. The efforts required by
11 the plaintiff must be determined by the rules of common
12 sense in fair dealing, and what person of ordinary reason
13 and prudence would do under the same circumstances. The
14 plaintiff is not required to use unreasonable efforts or
15 great expense to avoid and lessen the damages. The
16 plaintiff has the burden of proving a failure to lessen
17 damages -- or the defendant has the burden of proving a
18 failure to lessen damages on the part of the plaintiff by a
19 preponderance or greater weight of the evidence. The
20 plaintiff is required to use reasonable care and diligence
21 to reduce the seriousness of the injuries caused by the
22 defendant. This duty includes making a reasonable attempt
23 to see a doctor and to take part in a physical therapy
24 program. If you find the plaintiff failed to do this, the
25 plaintiff may recover damages for the injury themselves but

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1 not damages for the aggravation of the injuries.

2 I also charge you that when a party fails to disclose
3 evidence during the discovery process, you may infer that
4 the evidence which was not provided by that party would have
5 been adverse to that party. Then if you find or reward
6 actual damages, you may also consider an award of punitive
7 damages. Punitive damages are designed to punish the to
8 defendant for extraordinary and outrageous misconduct and to
9 prevent the defendant and others from committing similar
10 acts in the future. Punitive damages can only be awarded
11 when conduct of the defendant has been something more than
12 mere negligence. The evidence must establish that
13 defendant's acts were reckless, willful, and wanton meaning
14 there was a conscious failure to exercise due care or
15 conscious, indifference to the rights and safety of others
16 or a reckless disregard thereof. Recklessness means a
17 conscious failure to use reasonable care. A person who is
18 negligent acts carelessly. However, a person who acts
19 recklessly, willfully, and wantonly is not only careless but
20 also aware that he is being careless. If you find that the
21 defendant's conduct was willful, wanton, and reckless, you
22 may award the plaintiff punitive damages.

23 To support an award of punitive damages, the plaintiff
24 must prove by clear and convincing evidence that the conduct
25 complained of included a consciousness of wrongdoing at the

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1 time of the conduct. Preponderance or greater weight of the
2 evidence which requires only proof which persuades you that
3 a party's claim is more likely true than not true. On the
4 other hand, clear and convincing proof is not as high a
5 standard as the burden of proof in criminal cases which is
6 proof beyond a reasonable doubt. Clear and convincing proof
7 leaves no substantial doubt in your mind. It means that the
8 evidence is not ambiguous, doubtful, equivocal or
9 contradictory. Convincing means persuading by proof or
10 argument causing one to believe in the truth of what is
11 asserted. Clear and convincing proof establishes in your
12 mind not only that the fact is probable, but that is highly
13 probable. Before awarding punitive damages, you must
14 consider and weigh four elements which may be pertinent to
15 the facts of this case. You must first consider the
16 relationship between any punitive damage award and the harm
17 caused. Any penalty imposed should take into account the
18 reprehensibility of the conduct, the harm caused, the
19 defendant's awareness of the conduct's wrongfulness, the
20 duration of the conduct, and any concealment. That's any
21 penalty imposed should bear a relationship to the nature and
22 extent of the conduct and the harm caused including the
23 compensatory damage award made by you.

24 Secondly, any penalty imposed should take into account
25 as a mitigating factor any other penalty that may have been

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1 imposed or which may be imposed for the conduct involved
2 including any criminal or civil penalty or any other
3 punitive damages award arising out of the same conduct.
4 Next you should consider whether the award of and the amount
5 of any punitive damages award may deprive the defendant of
6 any profits derived from the improper conduct, and whether
7 the yield-gotten profits should be properly awarded to the
8 plaintiff. Finally, any award of punitive damages must be
9 limited to punishment and thus may not affect economic
10 bankruptcy. To this end, the defendant's ability to pay any
11 punitive damage award should be considered. However, the
12 economic bankruptcy factor is not an absolute bar to an
13 award of punitive damages.

14 Finally, your verdict must be unanimous. Now, Mr.
15 Foreman, there is a verdict form that I'm going to send back
16 with you. There are two verdicts that you are to consider.
17 One is for actual damages and one is for punitive damages.
18 The first one is listed is as actual damages. And it simply
19 says, "We the jury find for the plaintiff against the
20 defendant in the amount of," blank, "actual damages." You
21 write whatever dollar amount for actual damages is the jury
22 considers there; sign it and date it. If you put in an
23 award for actual damages, then you may consider an award for
24 punitive damages. And if you do, you simply go down to the
25 next box where it says, "We the jury find for the plaintiff

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1 against the defendant in the amount of," blank, "punitive
2 damages." You would write that dollar amount and sign it
3 and date it.

4 All right. I'm going to send you back to the jury room
5 now. Don't begin your deliberations just yet. I have to
6 give the lawyers the opportunity to tell me if I misspoke in
7 any way. And then we'll send the evidence back with the
8 bailiffs along with the verdict form. And they will tell
9 you that the Judge said it's okay to begin your
10 deliberations. This just takes a couple minutes, all right.
11 Thank you for your patience.

12 (The jury exits the courtroom at 2:53 p.m. and the
13 following is held on the record.)

14 THE COURT: Any from the plaintiff?

15 MR. SLOTCHIVER: Nothing from the plaintiff.

16 THE COURT: From the defense?

17 MR. TRAINOR: No, Your Honor.

18 THE COURT: Do y'all have any objection to me sending a
19 copy of the instructions back?

20 MR. SLOTCHIVER: Of the jury charges?

21 THE COURT: Yes.

22 MR. TRAINOR: The ones you have handed us?

23 THE COURT: Yes.

24 MR. SLOTCHIVER: No.

25 THE COURT: Okay. All right. Do we have everything

1 down here that goes back?

2 MR. SLOCHIVER: I have two. I'm not sure if these are
3 in or not.

4 (Court reporter confirmed those were marked for
5 identification.)

6 MR. SLOCHIVER: Can we -- okay. Are we at ease? I
7 think we're good.

8 THE COURT: Okay. Do you want to take this back to
9 them.

10 BAILIFF: Yes, sir.

11 THE COURT: Tell them they can begin deliberations and
12 then bring me the alternate. I'll discharge her.

13 BAILIFF: Yes, sir.

14 (The jury begins deliberations at 2:55 p.m. The
15 alternate juror is released)

16 (The proceeding resumed at 4:10 p.m. and the following
17 was held on the record.)

18 THE COURT: All right. Everybody here? I understand
19 they reached a verdict. Is the defendant gone?

20 MR. TRAINOR: We dismissed him. Yes, Your Honor.

21 THE COURT: Okay. Bring the jury on in.

22 (The jury enters the courtroom at 4:12 p.m.)

23 BAILIFF: All jurors present, Your Honor.

24 VERDICT OF THE JURY

25 THE COURT: All right. Mr. Foreman, I understand the

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1 jury has reached a verdict. Is that right?

2 FOREMAN: That is, Your Honor.

3 THE COURT: All right. Is it unanimous?

4 FOREMAN: It is.

5 THE COURT: All right. Would you hand it to the
6 bailiff.

7 (Juror complies.)

8 THE COURT: All right. Well, the verdict is we the
9 jury find for the plaintiff in the -- or for the plaintiff
10 against the defendant in the amount of \$7,117.50 actual
11 damages and no award for punitive damages. Is that correct,
12 Mr. Foreman?

13 FOREMAN: It is, sir.

14 THE COURT: All right. If this is in fact your verdict
15 would you please indicate that by raising your right hand?

16 (Jurors comply.)

17 THE COURT: Let the record reflect all the jurors have
18 raised their right hand. You may put your hands down.
19 Well, thank you ladies and gentlemen, for helping us resolve
20 this case this week. You know, some cases take up long
21 weeks. In fact, we just had a verdict this morning on one
22 that started a week ago. And then some only take a day or
23 two. But they're all important to these folks and it is
24 their day in court. And what they wanted was for 12 people
25 to listen and help them decide it, and you've done that. So

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1 we can't ask for anything more than what you've done and
2 that your assistance as citizens of the United States. As I
3 spoke to you yesterday, I guess it was, you know, I hope
4 that you'll look back on this and realize what an important
5 thing it is that you've done this week to participate in the
6 government and help us have a peaceful means of resolving
7 differences between people. So on behalf of the people of
8 Charleston County, I want to thank you for your service this
9 week. You're free to go not only for the rest of the day
10 but for the rest of the week. We've settled everything else
11 or it has worked itself out. And you may get a chance to
12 serve again one day, hopefully. If you get picked again
13 this year, you're disqualified. But you might remember that
14 if you get picked in the next three years, you'll have the
15 opportunity to be excused, but it doesn't mean you have to
16 exercise it. And if you enjoyed it, maybe you'll want to do
17 it again. So we hope that you did enjoy your service
18 because we need people to show up and we need people to go
19 back out say that, you know, they were glad they did it.
20 And most people do feel that way. When it's over with they
21 think well, I didn't want to do it when I first got there,
22 but after I got there, I understood hopefully what was going
23 on and you got to participate. And that's all we can ask.
24 So thank you very much for your service and you are free to
25 go. They'll give you some papers for your work if you need

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1 them. If not, they'll be mailing you a check here soon.

2 (The jury is excused at 4:15 p.m. and exits the
3 courtroom.)

4 THE COURT: All right. I'll give you ten days for any
5 post-trial motions. Thank y'all for your services, getting
6 it done so quickly and efficiently. All right. Good luck.
7 Thanks.

8 MR. TRAINOR: Your Honor, do you want us to make any
9 motions at this point or . . .

10 THE COURT: Yeah, you got ten days if you want to make
11 any.

12 (The trial concluded at 4:16 p.m.)
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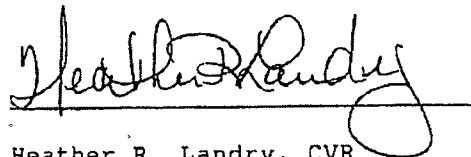
STATE OF SOUTH CAROLINA
COUNTY OF CHARLESTON

CERTIFICATE OF REPORTER

I, HEATHER R. LANDRY, Official Court Reporter for the Judicial Department of the State of South Carolina, do hereby certify that the foregoing is a true, accurate and complete Transcript of Record of the proceedings had in the trial of the captioned case, in the Court of Common Pleas for Charleston County, South Carolina, on the 25th-26th day(s) of April 2016.

I do further certify that I am neither of kin, counsel, nor interest to any party herto.

October 16, 2016

A handwritten signature in dark ink, appearing to read "Heather R. Landry", is written over a horizontal line.

Heather R. Landry, CVR
Official Court Reporter

Original Transcript of Record - Nestler v. Fields, April 25-26, 2016

**State of South Carolina
County of Charleston**

**In the Court of Common Pleas
for the Ninth Judicial Circuit**

Affidavit of Joseph Eugene Fields

My name is Joseph Eugene Fields. I am 33 years of age and I am currently employed by Allied Barton Security Services at the Wild Dunes Community at the Isle of Palms, S.C. I am providing this affidavit to Robert L. Minter, a licensed private investigator freely and voluntarily concerning an automobile accident I caused on March 8, 2014 at approximately 08:36am on Highway 17 North in Mt. Pleasant, S.C.

On March 8, 2014 at approximately 08:00am, I left the Wild Dunes resort after working the midnight shift as security for the resort. I worked 12 midnight until 08:00am that particular day. I left Isle of Palms and drove to Highway 17 where I headed North on Highway 17 toward Highway 41 which is the route I take to get home in Huger, S.C.

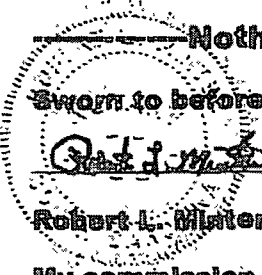
As I was headed North on Highway 17, I could see some people running in the annual mud race at Boone Hall plantation. I negligently and recklessly took my eyes off the roadway for several seconds while watching the participants at the event at Boone Hall. When I returned my eyes to the roadway in front of me, I realized the traffic ahead of me was stopped and I slammed on my brakes but was not able to avoid hitting the vehicle that I now know was being occupied by Gary Nestler and his minor daughter.

To the best of my recollection, I was travelling 45 to 50mph prior to the collision.

I didn't speak to anyone at the accident scene because I had to be transported also due to my injuries.

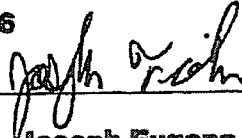
Nothing Follows

Sworn to before me this 6th Day of April 2016

 Robert L. Minter

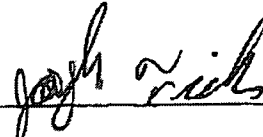
Robert L. Minter, Notary Public

My commission expires: 10/12/2025



Joseph Eugene Fields

I have received a copy of the above affidavit



Joseph Eugene Fields

In the Matter Of:

Nestler, Gary, et al v
Fields, Joseph E.

Robert Schoderbek, MD

April 05, 2016

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R. 268

1 STATE OF SOUTH CAROLINA
2 COUNTY OF CHARLESTON COURT OF COMMON PLEAS
3 FOR THE NINTH JUDICIAL
4 GARY NESTLER and JULIE NESTLER,
5 Plaintiffs,
6 vs. CASE NO. 2015-CP-10-00330
7 JOSEPH E. FIELDS,
8 Defendant.
9
10 VIDEOTAPED
11 DEPOSITION OF: ROBERT SCHODERBEK, M.D.
12 DATE: April 5, 2016
13 TIME: 8:42 AM
14 LOCATION: Offices of Robert Schoderbek,
15 M.D.
16 2093 Henry Tecklenburg Drive
17 Charleston, SC
18 TAKEN BY: Counsel for the Plaintiffs
19 REPORTED BY: JANE MESSINEO, Registered
20 Professional Reporter, CSR-NJ
21 A. WILLIAM ROBERTS, JR., & ASSOCIATES
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1 APPEARANCES OF COUNSEL:

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10 ATTORNEYS FOR THE DEFENDANT
11 JOSEPH E. FIELDS:

12 HALL BOOTH SMITH, PC
13 BY: PAUL TRAINOR
14 40 Calhoun Street, Suite 550
15 Charleston, SC 29401
16 (843) 720-3460
17 ptrainor@hallboothsmith.com

18 ALSO PRESENT:

19 Ed Lighthart, Videographer
20 Gary Nestler

21 (INDEX AT REAR OF TRANSCRIPT)
22
23
24
25

1 THE VIDEOGRAPHER: We are now on the
2 record. Today's date is April 5, 2016. The time
3 is approximately 8:42 a.m. This is the video
4 deposition of Robert Schoderbek, M.D. The location
5 is 2093 Henry Tecklenburg Drive, Charleston, South
6 Carolina. My name is Edward Lighthart, legal
7 videographer representing A. William Roberts, Jr. &
8 Associates. This deposition is taken in the
9 matter of Gary Nestler, et al verse Joseph E.
10 Fields. Case No. 2015-CP-10-00330.

11 Counsel, please introduce yourselves
12 for the record.

13 MR. SLOTCHIVER: Dan Slotchiver for the
14 plaintiff.

15 MR. TRAINOR: Paul Trainor on behalf of
16 the defendant.

17 THE VIDEOGRAPHER: Would the court
18 reporter please swear in the witness.

19 ROBERT SCHODERBEK, M.D.
20 being first duly sworn, testified as follows:

21 EXAMINATION

22 BY MR. SLOTCHIVER:

23 Q. Dr. Schoderbek, my name is Dan
24 Slotchiver and we are here today for your trial
25 testimony in the case of Gary Nestler and Julie



1 Nestler versus Joseph E. Fields. We are going to
2 move quickly. I know you've got clinic starting
3 in a few minutes.

4 A. Yeah.

5 Q. So I apologize for that. We'll move as
6 quickly as we possibly can.

7 A. Okay.

8 Q. I am going to start by asking you some
9 background questions.

10 A. Okay.

11 Q. Are you a physician licensed to
12 practice medicine in the state of South Carolina?

13 A. Yes, sir, I am.

14 Q. And when were you licensed?

15 A. I finished my fellowship in 2009. I
16 have been practicing since then and I have been
17 board eligible at that point and then I have been
18 board certified for about four years.

19 Q. Can you briefly describe your
20 educational background?

21 A. I went to NC State University for
22 undergrad. Came down here, down to Charleston,
23 and went to Medical University of South Carolina
24 for medical school. I did my orthopaedic
25 residency training at University of Virginia. And



1 then I did a sports medicine fellowship at the
2 American Sports Medicine Institute in Burmingham,
3 Alabama. I have been in practice here for six
4 years.

5 Q. And you said you are board certified;
6 correct?

7 A. Yes, sir.

8 Q. In orthopaedics?

9 A. Yes.

10 Q. What is orthopaedics?

11 A. Taking care of broken bones and nerve
12 and -- muscle injuries and ligament injuries,
13 musculoskeletal issues that people deal with.
14 That's what we do.

15 Q. Do you have any additional
16 certifications?

17 A. No, sir.

18 Q. And what specific experience do you
19 have in dealing with and treating injuries such as
20 nerve damage? I think we are going to talk about
21 nerve damage today with reference to Dr. Nestler
22 but --

23 A. No, evaluate it, you know, and try to
24 determine cause, effect and -- the -- the effect of
25 the body with it in relation to further evaluation

1 using, you know, most orthopaedists if it's a bad
2 nerve injury, something with the spine or
3 otherwise, we kind of send it on to a spine
4 specialist or neurologist.

5 Q. What is the name of your practice?

6 A. Orthopaedic Specialist of Charleston.

7 Q. And where is it located?

8 A. Multiple offices, but right now we are
9 at St. Francis Hospital in West Ashley.

10 Q. Okay.

11 MR. SLOCHIVER: Your Honor, at this
12 point I would like to offer Dr. Schoderbek as an
13 expert in the field of orthopaedic medicine.

14 MR. TRAINOR: I have no objection.

15 BY MR. SLOCHIVER:

16 Q. Doctor, I'd like to call your attention
17 to your patient Dr. Gary Nestler.

18 A. Yes, sir.

19 Q. Can you tell me how it is that you came
20 to treat Dr. Nestler for the injuries he sustained
21 in March of 2014?

22 A. So Mr. Nestler was injured in a car
23 accident. He was rear ended on Highway 17 on
24 March 8, 2014. He actually -- we are
25 acquaintances, friends, we have played flag --

1 touch football together at IOP and stuff like that.
2 So he actually called me after the accident and
3 said he was in a car accident and would like to
4 come in and get checked out, and make sure
5 everything is okay. So he contacted me and we -- I
6 don't think I was available the day he came in. I
7 think I was in the operating room I believe so he
8 saw my PA -- one of our physician assistants here
9 at Orthopaedic Specialists on 3/11/14. And then I
10 saw him the -- about a week, week-and-a-half later
11 after that.

12 Q. What was your initial diagnosis when
13 you saw him? Can you -- and -- and maybe better,
14 can you walk us through your treatment of him and
15 your findings?

16 A. Sure. So when he came in on that
17 first day, basically explained to me that he was
18 rear ended on Highway 17.

19 He was holding really hard on the
20 steering wheel and felt immediate discomfort in his
21 left upper extremity being elbow and shoulder. He
22 was transferred to East Cooper emergency department
23 where they did some x-rays where everything showed
24 up no obvious fractures and then later on went to
25 Nason Medical Center, I believe the next day, and

1 got a C-T -- examination of the cervical spine
2 which again, showed no obvious fractures. They
3 sent him -- put him on some antiinflammatories and
4 kind of sent him to see me -- see us here at
5 Orthopaedic Specialists. On examination he had a
6 lot of diffuse kind of tingling, myofascial/muscle
7 fascial-type symptoms with his left upper
8 extremity, shoulder, elbow, and hand.

9 Q. Can -- and I'm sorry to interrupt you.
10 But can you explain what that means to the jury?

11 A. Muscle fascia -- myofascial issues are
12 basically pain that is associated with muscle
13 involvements within your upper extremity for --
14 specifically for his left upper extremity, so which
15 could be either just muscle related or it could be
16 nerve sensitivity, could be a variety of things.

17 Q. Okay.

18 A. And so when I saw him on that first day
19 I did examination -- examined his shoulder and
20 elbow and whole left upper extremity which
21 basically showed a lot of pain, discomfort in the
22 shoulder girdle, some weakness associated with, you
23 know, with rotator cuff muscles and strengthening
24 -- strength testing of his upper extremity.

25 Elbow -- elbow and arm were probably

1 what -- the area of his body that was more
2 sensitive. A lot of discomfort around the elbow
3 itself and some weakness with muscle testing with
4 his elbow due to the pain response.

5 At that point we -- he had an MRI which
6 didn't show any obvious fractures, but at that
7 point had showed what we call -- what's called a
8 fat pad sign. Sometimes when you have potential
9 fractures that aren't actually visible on the
10 x-ray, it will show up as -- you'll get swelling
11 within the joint and on elbow x-rays you get a fat
12 pad sign which is kind like a little pad of fat
13 both the inside -- anterior and posterior aspect of
14 his elbow around the humerus that can get -- give
15 an indication there's some type of joint injury,
16 either occult-type fracture -- occult fracture is a
17 fracture that isn't really able to be visualized
18 that well by x-rays, but with the -- the component
19 you either assume there's some type of capsule or
20 joint injury or maybe occult fracture that you
21 can't exactly see.

22 So that first time I saw him I assumed
23 that. We kind of limited his activities with the
24 arm, having a sling, limit -- limited his lifting
25 activities. And because also the nerve-type

1 symptoms that he was getting, the whole upper
2 extremity, we ordered a C-T -- sorry, MRI of his
3 neck to evaluate it further.

4 Q. Yes, sir.

5 A. And then let's see. So he -- went and
6 had his MRI done of his neck and showed some
7 basically degenerative findings, some -- some
8 foraminal narrowing at certain levels within the
9 cervical spine.

10 Conclusion from the MRI showed moderate
11 severe bilateral neuroforaminal narrowing at C3-4;
12 some, again, neural -- bilateral neuroforaminal
13 narrowing at C5-6 and also at C6-7. More on the --
14 on the left side there.

15 Q. And what does that mean?

16 A. Basically, there's some -- there's
17 narrowing -- the nerves -- nerves in your neck come
18 out of what we call little foramens; so there's
19 seven cervical vertebrae and nerves come out above
20 and below the vertebrae. And what happens over
21 time as we get older or injury-related or anything
22 to that extent, you can have either disc
23 herniations or you can have extra bone formation
24 due to arthritic changes and it squeezes down those
25 holes and makes it tighter around the nerve itself



1 and you can -- that's -- can be a potential source
2 of having nerve-type symptoms and pain and
3 discomfort.

4 Q. Okay.

5 A. So he got the -- had the MRI, saw those
6 findings. Again, we were reeval -- continued to
7 evaluate the -- the elbow which continued -- elbow
8 and forearm and arm itself which continued to be
9 symptomatic.

10 Again, as I stated before, felt that he
11 may have -- may have either a small occult fracture
12 or just some joint injury which we still limit his
13 activities with his elbow and left upper extremity
14 due to concern that if there was a fracture and he
15 did too much he could displace. And then we also
16 referred him over Dr. Don Johnson to Southeast
17 Spine for evaluation of the cervical spine.

18 Q. Okay.

19 A. And let's see. I saw him about a month
20 later. At that point, I felt if there, you know,
21 was a fracture at that point, it should have been
22 fairly healed, but he continued to have a lot of
23 elbow pain, arm pain, forearm pain. I thought
24 some of the symptoms -- at that point things had
25 calmed down in certain areas, we were able to kind

1 of -- after an injury people tend to have global
2 discomfort in a joint and at that point it seemed
3 to be more focused around kind of the lateral side
4 of the elbow. We thought it was some tendonitis
5 or lateral condylitis and also a lot of his
6 symptoms seemed to be consistent, as I stated, with
7 some type of nerve response, either some nerve
8 compression either from the cervical spine or other
9 areas within the upper extremity because there's
10 multiple nerves that allow you to function your
11 hand and move your hand that come from your
12 cervical spine so they can also get compressed in
13 the neck, like I talked about with the MRI, but
14 they also can have multiple areas within the upper
15 extremity where you can get compression of the
16 nerves from inflammation, scar tissue from possible
17 injury from the car accident or anything to that
18 extent, which can cause you to have these symptoms
19 so I thought he had some epicondylitis, some nerve
20 compression; and we had talked about doing an
21 injection in the elbow to calm down some of the
22 tendonitis from the lateral condylitis and we also
23 talked about doing an EMG nerve conduction study to
24 evaluate if there was any signs of nerve entrapment
25 in the upper extremity.

1 Q. At that point had you heard back from
2 Dr. -- Southeastern Spine?

3 A. I don't have anything in here in my
4 notes. I -- I -- I do -- I do -- I mean this was
5 a year-and-a-half ago or two years ago.

6 Q. Sure.

7 A. So I don't -- I don't have -- I
8 remember us discussing it, but basically from what
9 I can recollect was that, is more degenerative kind
10 of findings, nothing acutely -- occurring, but
11 could have -- give us a little bit of an
12 explanation of his -- some of his symptoms.

13 Q. I am going to hand you a note from
14 Southeastern Spine and see if -- if maybe that --
15 have you seen that before?

16 A. I have not seen this before. It is
17 more conversation.

18 Q. It appeared to me that he was
19 referring --

20 A. Back to me.

21 Q. -- the patient back to you.

22 A. Didn't see any significant disc
23 herniations or neural impingement. Suggest
24 continued nonoperative treatment with therapy and
25 chiropractic intervention.

1 Q. So that's consistent with the way you
2 have been treating him?

3 A. Yes, exactly.

4 Q. Thank you. Okay. And I interrupted
5 you, Doctor. If you'll --

6 A. It's okay. So at that point we talked
7 about we needed to get things feeling better, try
8 see if we can get some of the inflammatory process
9 calmed down, the tendonitis, inflammation around
10 the elbow. We talked about injections.
11 Injections especially around the condyle are quite
12 uncomfortable and he still had a lot of -- a good
13 amount of discomfort and didn't want to put himself
14 through that injection. We talked about doing an
15 EMG study as well. What an EMG nerve conduction
16 study is that they basically take little needles
17 and put them up and down your arm in many different
18 positions and send little -- they -- they assess
19 the nerve -- the -- the kind of wiring -- or not
20 wiring, but when they put the needle in, they get
21 different types of information -- in response to
22 nerve -- excitement, nerve involvement, nerve
23 innervation.

24 And I don't know many people that would
25 like to have needles stuck up and down their arm,

1 but sometimes it -- it's a thing that gives more --
2 a little more information, but doesn't really give
3 us a complete direction of, you know --

4 Q. Yeah, I was going to ask you, is the
5 result of the nerve study, does that tell you how
6 to treat them or does that just give you more
7 information?

8 A. Just gives you more information.

9 Q. Okay.

10 A. And from the discomfort that he has and
11 we discussed about that, he wasn't interested in
12 being tortured more with that test which I don't
13 fully blame him.

14 Q. All right. That was a medically sound
15 position to take?

16 A. Yes.

17 Q. Okay. Okay.

18 A. And so got him into physical therapy,
19 occupational -- occupational therapy with
20 Charleston Hand Group or -- let's see. Here,
21 sorry. Coastal Therapeutics, it's just -- and
22 they started working on his elbow, nerve entrapment
23 with some nerve glide test, modalities, and a lot
24 of condylitis and tendonitis within the elbow
25 itself.

1 And so, let's see where that was.
2 Okay, so at that point the next time I saw him was
3 back in July of 2011. States basically continued
4 to have nerve-type pain in his arm, tendonitis-type
5 symptoms, nerve entrapment-type symptoms.

6 Q. I'm sorry, you said July of --

7 A. 11, 2014.

8 Q. Okay.

9 A. Sorry. Did I say the wrong date.

10 Q. You said 2011. That's why I wanted to
11 clarify.

12 A. Sorry. July 11, 2014. He did have
13 an episode about two weeks prior to this where he
14 went to go grab something with the elbow or kind of
15 push forward like open a door and felt a pop in his
16 elbow which caused pretty intense pain but it also
17 -- and some swelling afterwards, but actually
18 noticed that he had some slight improvements in his
19 range of motion at that point so with the -- with
20 the discomfort that he has in his elbow which is
21 basically with all activities, grasping things,
22 lifting things, moving things, holding his arm in
23 certain positions would always cause intense pain
24 that would start in certain areas and shoot down to
25 his hand.

1 And so what happens with that when you
2 -- when you have pain most people don't want to
3 move your joint as much so you get a little tight
4 of tightness with the joint which we call adhesive
5 capsulitis. I think that popping sensation he got
6 --

7 THE REPORTER: Which we call --

8 THE WITNESS: Adhesive capsulitis.

9 That popping sensation was is probably breaking up
10 some scar tissue in his elbow that had developed so
11 that actually was probably a good thing that helped
12 him gain a little bit more range of motion.
13 Still had a good amount of discomfort at extreme --
14 extreme ranges of motion, supination, pronation,
15 flexion and extension of his elbow and still having
16 a lot of this kind of abnormal nerve response up
17 and down his arm. And so we were continuing
18 pushing physical therapy and just conservative
19 intervention. We still talked again about EMG
20 studies, but again he didn't feel like -- as you
21 stated, it would give us some more information but
22 no complete direction in treatment and he didn't
23 feel like getting stuck with a bunch of needles and
24 shocked to determine that, to do that, have that
25 test done.

1 Q. Okay. Any further treatment?

2 A. Yeah. So I saw him back again in
3 August of -- 22 of 2014, which is basically same
4 process. We were still working with therapy. He
5 was trying to do his best to get his strength --
6 strength and function back within the elbow itself
7 as best he could and try to diminish the nerve
8 pain. We also had discussion throughout this time
9 about starting some nerve protective-type
10 medications which different kinds of those are like
11 Neurontin or Lyrica; and with him being a physician
12 and having to be, you know, mentally sound to make
13 decisions, we -- concerned that that may affect his
14 ability to make appropriate decisions as a
15 physician so we decided against that.

16 Q. Is that one of the side effects of
17 Neurontin --

18 A. Yes --

19 Q. -- and medicines like that?

20 A. It's kind of a nerve pain, nerve
21 protective type medication. Anything that causes
22 nerve -- affects nerves is going to affect
23 mentation as well.

24 Q. And you understand that he travels
25 quite significantly?



1 A. Yes.

2 Q. As consultants?

3 A. Yes, I do.

4 Q. So those are issues that could affect
5 his ability to perform?

6 A. Absolutely. So.

7 Q. So the trade off is your ability to
8 perform mentally versus your ability --

9 A. Maybe decreases your pain a little bit,
10 but then mentally functionality with his job-wise,
11 that would affect his ability to do his job, so he
12 decided to just keep toughing it out and do the
13 best he could.

14 Q. Okay. Is that a reasonably sound
15 position to take?

16 A. I probably wouldn't take Neurontin
17 because I have to be on all the time.

18 Q. Yes, sir. Okay. Could you walk us
19 through more of your treatment, please?

20 A. And then I saw him again in December
21 11, 2015 as kind of a final evaluation. Basically
22 he's done -- had done at this point excessive
23 amount of therapy, felt that he was -- had gotten
24 about as good as he was able to get, still
25 continues to have nerve pain in certain positions,

1 certain things that he does, holds his arm in
2 certain positions. I think on a daily basis he's
3 okay but lives with a certain amount of pain, but
4 if he does more with that left upper extremity, it
5 causes pretty intense pain down in the arm, affects
6 the shoulder function, causes headaches at times as
7 well when it gets more intense. So that the
8 functionality of his upper -- of his left arm is
9 significantly diminished.

10 Q. Doctor, have you have an opinion or did
11 you have an opportunity to form an opinion to a
12 reasonable degree of medical certainty as to
13 whether or not the injuries that you have described
14 today are a result of the motor vehicle accident
15 that Dr. Nestler was involved in in March of 2014?

16 A. I do feel that the injuries that he has
17 now and the limitations that he has now are due to
18 the car accident that happened on that date.

19 Q. And is that opinion -- do you state
20 that opinion to a reasonable degree of medical
21 certainty?

22 A. Yes, sir.

23 Q. Okay.

24 A. And prior to that he was -- I had seen
25 him about a year or so before that for little



1 shoulder issues, little bicep tendonitis --

2 Q. That was a different shoulder; correct?

3 A. I believe it was still -- it was his
4 left I believe from what my notes show, but he was
5 completely healed and had no problems with that.
6 More of a tendonitis-type thing that cleared up
7 with antiinflammatories and some modalities.

8 Q. Okay. Completely separate event.

9 A. Yeah, completely separate event.

10 Q. Okay. And can you tell us please, are
11 you familiar with the term impairment rating?

12 A. Yes, I am.

13 Q. What is an impairment rating?

14 A. Impairment rating is an assessment of
15 functionality. Somebody's arm or somebody's limb
16 in relation to the normal, so it's based off of you
17 look at motor and sensory and pain levels and
18 functionality of an extremity compared to the
19 normal.

20 Q. Okay. And how is it -- how do you
21 create the rating? Is there a guideline that you
22 follow?

23 A. It's -- can be -- sometimes it's
24 extremely straightforward. Sometimes it's not,
25 you know, in relation to evaluating let's say just

1 a shoulder injury or an elbow injury. Generally
2 it's based off of -- I look at strength and range
3 of motion and function of the joint itself.

4 Where Dr. Nestler's is a bit more
5 complicated because there's a lot of nerve
6 response, nerve pain in relation to that. You
7 know. When you are -- when I am doing impairment
8 -- impairment ratings, I basically -- I -- I
9 generally look at what's a range of motion and
10 what's their strength like. And so this is a bit
11 more complicated to try to figure out what his
12 rating would be.

13 Q. Did you have an opportunity to do an
14 impairment rating on him?

15 A. I did my best. As I said, it's a bit
16 of a complicated situation because there's more
17 than just a joint involved.

18 Q. Yes, sir.

19 A. Muscle and also nerve involvement and
20 pain involvement as well. And those books don't
21 really give you any straightforward direction on
22 what -- it's exactly this or not. But at this
23 point you kind of got to look at the many different
24 aspects of the impairment and see what is the best
25 for a patient.

1 So looking at impairment rating for Dr.
2 Nestler, I looked at, one, the function of his
3 shoulder because his shoulder is also affected by
4 this in relation to his range of motion and his
5 strength. And then also although range of motion
6 is limited, but most of the stuff I looked were --
7 at dealt with more muscle and nerve pain. So you
8 can either choose motion or strength or nerve
9 involvement and so for more the upper extremity
10 relation below the elbow I looked more at muscle
11 involvement.

12 Q. And what was the impairment?

13 A. So the impairment rating that I did on
14 2/11/2015 showed median nerve combined involvement
15 which includes both sensory and motor function of
16 29 percent. Ulnar nerve combined involvement as
17 -- as again, motor and sensory involvement of 13
18 percent. And then 11 percent disability rating
19 for the shoulder itself because the median and
20 ulnar nerve involvement is more distal to the elbow
21 or away from the elbow -- away from the shoulder
22 itself and so the shoulder is also affected with
23 this as well.

24 Q. Okay. So that was a total of a --

25 A. 53 percent.



1 Q. -- 53 percent upper extremity?

2 A. Yes.

3 Q. Did you have a chance to convert that
4 to a whole person impairment?

5 A. I didn't do that. I'm sorry. I
6 could go get the book and tell you what it is.

7 Q. Let me show you the record I have. I
8 know this is a long time ago. And I know you've
9 got -- let's see. Let me show you a record and
10 see if this refreshes your recollection. This is
11 from your notes.

12 A. Oh, 32 percent. I'm sorry. I should
13 have looked at the page before that. Yes, 32
14 percent for the entire person. Sorry about that.

15 Q. So -- and this is based on the AMA
16 guidelines?

17 A. Based off of AMA guidelines. I used
18 the fifth edition for disability ratings because I
19 find the sixth edition even more confusing than the
20 fifth edition.

21 Q. Okay. And this is the accepted -- this
22 is an accepted form that you used in order to make
23 the impairment rating?

24 A. Yes, sir.

25 Q. Okay. And is it your opinion to a

1 reasonable degree of medical certainty that the
2 impairment rating that you have just discussed is
3 in fact attributable to the wreck that he was
4 involved in in March of 2014?

5 A. Yes, I believe it is.

6 Q. Okay. And one last thing, Doctor.
7 Sometimes it's hard to understand what the
8 impairment rating really means. I understand there
9 is a rating. We have talked about 32 percent of
10 the whole person. In real terms how does it
11 affect him on a daily basis?

12 A. And as I stated before, I've played
13 touch football with -- with Dr. Nestler and, you
14 know, know him outside of just being in the office.
15 But --

16 Q. That's a rec league get together?

17 A. I wouldn't call it the rec league. I
18 think it's the old man league, I believe. Just to
19 go out and have fun with -- also our kids play and
20 all that stuff as well.

21 Q. Right, families and kids?

22 A. Families and kids. And so question
23 again?

24 Q. I was asking how -- I understand
25 there's an impairment rating, but in -- in -- in

1 real terms how does it affect him? How is his life
2 different?

3 A. Reason I brought that up before is
4 prior to this I had played football and basketball
5 with him as well within these little groups of guys
6 that kind of do this. And very active, always,
7 you know, in the center of the mix and having fun,
8 enjoying himself with, you know, with minimal --
9 with no issues. And then at this point, this --
10 issue with his arm is -- affects him on a daily
11 basis. He's here in the -- in the room and I can
12 see him over there shaking his hand, you know -- I
13 think to kind of shake off the nerve-type pain that
14 he gets on a daily basis. Affects his -- if he
15 does any excessive activities, lifting, anything to
16 that extent, it causes his pretty intense pain that
17 is not just pain and goes away. It's something
18 that -- pain and then it lasts the majority of the
19 day after that as well and affects his ability to
20 play sports and to lift and to do a lot of the
21 activities and stuff that he's enjoyed doing all of
22 his life.

23 Q. Okay. And is this an impairment -- we
24 discussed it being a permanent impairment. That
25 means it will be an impairment that he will have

1 for the rest of his life?

2 A. I believe it will, yes.

3 Q. Okay. I've got no further questions.

4 Thank you.

5 EXAMINATION

6 BY MR. TRAINOR:

7 Q. Dr. Schoderbek --

8 A. Yes.

9 Q. -- we met briefly. My name is Paul
10 Trainor. I'm here on behalf of the Fields.

11 Prior to starting your deposition who
12 did you speak to in regards to your testimony
13 today?

14 A. I spoke with Dan for about five minutes
15 prior to the deposition.

16 Q. Did you talk to Gary at all?

17 A. I have not spoken with him since this
18 visit on December. Maybe saw him in the grocery
19 store once, but nothing involved with his upper
20 extremity.

21 Q. Okay. Did you talk to him on the phone
22 at all?

23 A. I don't recollect that to be honest
24 with you.

25 Q. What documents did you look over? I



1 know you've got -- it looks like all of the visits.
2 Did you review any other documents in preparation
3 for today's deposition?

4 A. Just all the things that are here in
5 front of me, documents from the -- his visits, MRI
6 evaluations and the therapy notes as well.

7 Q. I know there's some discussion about
8 permanent impairments and you were using the AMA
9 guides for permanent impairment fifth edition;
10 correct?

11 A. Yes.

12 Q. Okay. How long have you known
13 Mr. Nestler?

14 A. About five years.

15 Q. Okay. And you have a personal and
16 professional relationship with him?

17 A. Profession -- yeah. Yes, I would say
18 so.

19 Q. It's my understanding, and I think you
20 had alluded to it earlier, Mr. Nestler came to
21 visit you sometime in 2013 for a left shoulder
22 injury. Do you recall that?

23 A. Shoulder and wrist. It was more
24 tendonitis-type symptoms diagnosed at that point
25 with bicep tendonitis and we did some conservative

1 treatment; and I think the next time I saw him in
2 passing after that he said everything was totally
3 normal. It's back to regular activities, had no
4 problems with the shoulder at all.

5 Q. You had indicated that that was I think
6 earlier a minor -- minor issue?

7 A. Yes.

8 Q. Okay. That minor issue prompted a
9 corticosteroid injection; is that correct?

10 A. Yes, I do believe we injected the
11 shoulder at that point which helped calm down the
12 tendonitis and the bicep tendon.

13 Q. You also referred Mr. Nestler to
14 physical therapy at that time. Do you recall
15 that?

16 A. I believe we did. Did a little
17 therapy for him; injected the shoulder with
18 antiinflammatories. And as I said, he didn't have
19 any problems with that shoulder prior to this car
20 accident. Everything had calmed down and he was
21 back doing his regular activities.

22 Q. Are you aware that Mr. Nestler
23 discontinued his physical therapy prior to
24 completing that treatment in regards to that left
25 shoulder injury?



1 A. That he discontinued it?

2 Q. Yes.

3 A. Yes, because I believe he was feeling
4 better.

5 Q. Okay. Talk about permanent impairment
6 and it's my understanding the AMA guidelines try to
7 limit your evaluation to objective findings as much
8 as possible; is that a fair -- fair assessment?

9 A. Yes.

10 Q. Pain is not an objective finding; is
11 that a fair statement?

12 A. I would agree, yes.

13 Q. Okay. That's a subjective complaint?

14 A. Right.

15 Q. Okay. There's no real way for you to
16 measure that; is that right?

17 A. No, there's no way to truly measure
18 pain levels.

19 Q. How often do you refer patients to
20 physical therapy or occupational therapy or outside
21 treatment?

22 A. Daily basis.

23 Q. Okay. What's the purpose for you doing
24 that?

25 A. Try to get people feeling better so



1 they can go back and do all the fun things they
2 want to do.

3 Q. Okay. Is that really the only reason
4 that you do that?

5 A. I mean not -- people come to me because
6 they are hurting in different ways to do that first
7 is conservative. Second -- second is surgical if
8 it needs to be done. So majority of conservative
9 intervention includes antiinflammatories,
10 injections if you need to and physical therapy.

11 Q. Okay. And so the most important reason
12 you refer anyone to another provider is to make
13 them better?

14 A. Yes, it is.

15 Q. Okay. How do you choose the providers
16 or facilities that you refer your patients to?

17 A. Proximity to the patient for ease, make
18 it easy for the patient, but I also have certain
19 places that I send them to because I think --
20 certain therapists are better than others.

21 Q. Okay. Competency is --

22 A. Yes.

23 Q. -- a factor? Is -- is -- do you factor
24 in the complaints or issues that they are having
25 when you refer someone to another provider?

1 A. No. I mean I refer them to physical
2 therapists that I trust.

3 Q. Okay. Do you say it's detrimental if a
4 patient does not follow a physician's
5 recommendation?

6 A. Yes, I believe it is detrimental. In
7 relation to therapy, too, as well and I can see the
8 way you are going with this is that certain
9 situations you send them into physical therapy to
10 try to get improvement and then you rely on the
11 therapist and the patient to try to make a decision
12 how they are doing. You know, so it's either hey,
13 I am doing pretty well. Give me some home
14 exercises. I can do this at home. If I have
15 problems, I'll give you a call back and I'll get
16 back in or it continues to hurt and they come back
17 and see me and things aren't getting better and we
18 then do diagnostic testing to kind of evaluate
19 things are not improving with the conservative
20 treatment. Then we get more involved with the
21 more diagnostic evaluation to see if surgery is
22 something that is needed to help improve them.

23 So when you say as you stated before
24 you discontinued his therapy, there was probably
25 some type of interaction, again, I saw him one time

1 and then after that didn't see him back because he
2 got better with the intervention that we did. And
3 so a lot of those times there's some type of
4 communications sometimes that I don't see through
5 the therapists. And you know, as you see for this
6 paperwork this is just one case. You should see
7 the stacks and stacks of therapy stuff so -- that
8 we get or other paperwork that we get in relation
9 to patient care.

10 And so there was probably -- at some
11 point some type of interaction between him and the
12 therapist dealing with the shoulder, the tendonitis
13 that we treated prior to this injury that they said
14 hey, I am doing pretty well. Give me some home
15 stuff. I will work on it at home. If I get
16 worse, I will come back and see you or get back and
17 see Dr. Schoderbek.

18 Q. When you see a patient, do you perform
19 a physical examination on every visit?

20 A. Yes, that's --

21 Q. And that's reflected in your records,
22 each visit has a physical examination and your
23 findings; correct?

24 A. Yes.

25 Q. I think on the first visit, you were

1 not -- it looks like it was your PA that saw
2 Mr. Nestler that day?

3 A. One of the PAs because I was -- I
4 was -- I think I was in the operating room.

5 Q. Okay. At that time, and I will go
6 through the records with you, I believe Mr. Nestler
7 had some complaints of left clavicle, neck, and
8 elbow pain; correct?

9 A. Yes. I believe so.

10 Q. At that time, during your physical
11 inspection, you noted that Mr. Nestler's elbow
12 strength was within normal -- normal limits; is
13 that correct?

14 A. That was not me that evaluated. That
15 was Erin Watrobski --

16 THE REPORTER: That was?

17 THE WITNESS: The PA. Is that what
18 you are talking about?

19 BY MR. TRAINOR:

20 Q. Yes.

21 A. Yeah.

22 Q. Did you have a chance to review the C-T
23 scan of Mr. Nestler's neck?

24 A. Yes, I did.

25 Q. So we are not just relying on Erin



1 Watrobski on that?

2 A. No. No, I mean I -- C-T was ordered
3 and, you know, showed some -- some
4 mild degenerative -- some degenerative findings
5 within the neck which were consistent as we
6 discussed before that most of them were -- there
7 was nothing emergent involved with that or acute
8 involvement with that which was what Dr. Don
9 Johnson had mentioned in his notes.

10 Q. Degenerative issues.

11 A. Yes.

12 Q. Okay. On the second page of that
13 entry, who wrote this entry?

14 A. Whose entry?

15 Q. On the first visit, March 11, 2014,
16 page 2 under Cervical Strength, who wrote that
17 entry?

18 A. That would be Erin Watrobski because
19 that's her note that you are asking about.

20 Q. Okay. Looks like she says most likely
21 this was aggravated from his motor vehicle
22 collision.

23 Do you disagree with that?

24 A. No. I would agree with that.

25 Q. That it's an aggravation of a

1 degenerative issue that had previously been there?

2 A. From his cervical spine?

3 Q. Correct.

4 A. Yes. I mean he -- these findings that
5 by -- that were seen on the C-T scan of his neck
6 did not happen at the time of the car accident.
7 These likely had been there for a while which is
8 most of the time -- which is what happens with
9 degenerative-type findings. And I do likely
10 believe that something -- you know, he does have
11 these degenerative findings within his neck that --
12 that's definitely going to be aggravated in a car
13 accident like -- that he was involved in.

14 Q. Okay. At that time there was also an
15 x-ray of Mr. Nestler's left elbow; correct?

16 A. Yes.

17 Q. And that showed, let's see. No
18 evidence of elbow joint effusion or fracture. Can
19 you explain what joint effusion is?

20 A. Fluid within the joint and I believe
21 that's somewhat disagree with that because I
22 thought he had a fat pad sign so my evaluation is
23 that he some fat -- as I stated before, fat pad
24 signs, an indication that maybe some type of injury
25 within the elbow and I was concerned at least in



1 the first few -- few visits that there may be an
2 occult-type injury within the elbow, occult-type
3 fracture, something you can't see. So although I
4 guess I did put it in my notes, I somewhat
5 disagreed with her findings.

6 Q. Okay. What -- what did you believe may
7 have been fractured?

8 A. In those situations, as I said before,
9 you don't know. If you don't see an obvious
10 fracture line, it's hard to say exactly where the
11 fracture is. If there is one, as I stated, the
12 fat pad sign is an indication of an injury to the
13 joint, either capsule or bone related. And once
14 that happens you get fluid within the joint and
15 gives you those type of findings.

16 Q. You are not sure whether or not there
17 was a fracture?

18 A. No, I don't. I -- I was not sure, no.
19 Correct.

20 Q. Had there been a fracture, we'll just
21 assume in the event there were a fracture, is it
22 fair assessment those generally heal on their own?

23 A. Yeah. I mean absolutely. Usually
24 you just continue to treat it conservatively.

25 Q. Okay. At that time it looks like Erin,



1 your PA, indicated Mr. Nestler benefit from a
2 course of physical therapy. Would you have agreed
3 with that, that finding at that time?

4 A. Yes.

5 Q. Okay. And at that time, either you or
6 your PA referred Mr. Nestler to Olympic Physical
7 Therapy. Do you recall that?

8 A. I believe so. I remember seeing a
9 note in here about it.

10 Q. I think it's on the third page of that
11 entry.

12 A. Yeah, he went and saw March 14.

13 Q. On the third page of your March 11
14 entry, or your PA's entry, it says physical
15 therapy. Eval and treat. Two to three times a
16 week for four weeks.

17 Would you agree with that decision at
18 that time?

19 A. Yes. I would agree with that
20 decision.

21 Q. You think that was medically warranted?

22 A. Yes, sir.

23 Q. Okay. I believe it's after that first
24 visit is the time at which you ordered an MRI of
25 Mr. Nestler's neck; correct?



1 A. Yes, I did.

2 Q. And that was -- why -- why did you do
3 that?

4 A. Because he had a lot of
5 neurological-type findings involved with this as
6 well. He had degenerative changes within his
7 neck. His C-T scan shows bone. But it doesn't
8 show soft tissue. With a lot of the
9 neurological-type findings he had in his whole left
10 upper extremity I wanted to make sure there was
11 nothing soft tissue oriented like a herniated disc
12 or something to that extent that could be causing
13 his symptoms.

14 Q. I believe on your -- third visit which
15 would have been April 4, you reviewed those
16 findings with Mr. Nestler; correct?

17 A. Yes.

18 Q. I believe you were presented with a
19 document from Southeastern Spine and Dr. Don
20 Johnson. It said no significant disc herniation
21 or neural impingement. Do you agree with that?

22 A. He's the spine expert so he would be
23 the one to make those decisions. I mean if you
24 look at the MRI read, it does show there's some
25 neuroforaminal narrowing which could be causing

1 some impingement -- some -- some process of
2 impingement, but as I said, Dr. Johnson -- I am not
3 a spine specialist. So that's why I sent him over
4 there for -- to get evaluated and treated for the
5 issues with his neck.

6 Q. You also stated from Nestler to
7 continue with nonoperative treatment, physical
8 therapy and chiro.

9 A. Yes.

10 Q. Do you agree with that?

11 A. Yes.

12 Q. I believe on the fourth visit, May 2,
13 it looks like you took another x-ray of
14 Mr. Nestler's left elbow.

15 A. Yes, I did. Everything at that point
16 looked -- looked -- looked good. There were no
17 obvious signs of fracture and whatever effusion I
18 had seen before had calmed down so that's usually
19 either an indication that without the fat pad sign
20 or effusion, then you -- you assume things are
21 healing within the joint itself.

22 Q. Okay. At that point, you had assessed
23 Mr. Nestler with lateral epicondylitis; is that
24 correct?

25 A. Yes, sir.



1 Q. Is that what we generally call tennis
2 elbow?

3 A. Yes, sir, it is.

4 Q. There's a lot of notes in here about
5 Carolina Hand Therapy.

6 A. Uh-huh.

7 Q. Is that one of the providers that you
8 referred Mr. Nestler to?

9 A. Yes, sir.

10 Q. And I believe during that fourth visit,
11 you got Coastal Therapeutics -- which is it?
12 There's Carolina Hand Therapy there. It says --

13 A. I just see -- I see Coastal
14 Therapeutics. I believe that's where he was
15 going.

16 Q. I am trying to clarify because your
17 records have Carolina Hand Therapy in several of
18 these visits. So did you send him to Carolina
19 Hand Therapy or did you send him to Coastal
20 Therapeutics?

21 A. I am not sure exactly. I see notes
22 from Carolina Therapeutic so it's -- I believe he
23 went there. They both do a very good job with
24 treatment of -- of -- of these types of injuries.

25 Q. Okay. During that fourth visit you had

1 also suggested that if -- if Mr. Nestler remained
2 symptomatic you would try injection to see if that
3 would help.

4 A. We had discussed about that, yes.

5 Q. And you also discussed EMG nerve
6 conduction study to evaluate for nerve entrapment
7 if his symptoms continued; correct?

8 A. Yes.

9 Q. Fifth visit on May 30, we've got in
10 your HPI, History of Present Illness, it says
11 patient has been working with the Occupational
12 Therapist of Charleston and Therapy which I assume
13 to be just a typographical error from dictation.

14 A. Yeah. I guess I should have looked at
15 the note better and realized he was going to
16 Coastal Therapeutics, but he was getting
17 therapeutic intervention at that point.

18 Q. At that time, on this fifth visit, you
19 again said at some point we may need to get an EMG
20 nerve conduction study to evalu and if his symptoms
21 do not improve, I also discussed doing an injection
22 today for lateral epicondylitis which he wants to
23 hold off on because he is showing some mild
24 improvements in his symptoms and function with the
25 therapy that he is doing.

1 A. Yes.

2 Q. That was the second time you discussed
3 an EMG nerve conduction study.

4 A. Yeah. As I stated before, that's not
5 a very fun test. I actually explain it to most
6 people that it's a medieval torture test. They
7 take needles and put it up and down your arm and
8 shock you to see what type of nerve innervation you
9 are getting and with somebody that already has a
10 good amount of discomfort I can under -- and also
11 what medical background he understands the effect
12 that that would be on him. Yes, it would give us
13 a little more information if we do have a nerve
14 entrapment but it wouldn't -- it would not give us
15 any surgical direction to go with. It just gives
16 us another piece of the puzzle.

17 Q. So -- so it would provide you more
18 information, but that information would be useless?

19 A. I wouldn't say useless. It would give
20 us a little more information, but it wouldn't
21 change our therapeutic direction.

22 Q. Okay. What was -- what was the point
23 in discussing it now for the second time during
24 this May 30 visit?

25 A. I was just stating that we had

1 discussed about it.

2 Q. Okay. Those needles that you talked
3 about, are they actually needles? I mean are they
4 gauge needles? Do they -- I mean --

5 A. They have needles with some type of
6 electrical -- kind of wiring connected to it and it
7 gives you muscle response when the needle goes in,
8 muscle response when you send electrical current
9 from one place to the other.

10 Q. Measuring neural impulses between parts
11 of the body; is that correct?

12 A. Yes.

13 Q. On July 11, 2014, looks like it's a
14 four-page entry. You've got these abnormal
15 sensory symptoms that he is getting would best be
16 evaluated with an EMG nerve conduction study to
17 assess the cause of them potentially which he is
18 not interested in doing.

19 A. Yes.

20 Q. So at this point you were -- you were
21 saying -- what are you saying by that?

22 A. That he's not -- he wasn't interested
23 in doing the EMG study.

24 Q. I know what he's saying. I am asking
25 what you are saying with that note. If you say

1 these abnormal sensory symptoms that he is getting
2 would best be evaluated with EMG nerve conduction
3 study --

4 A. That would it give us some -- it would
5 give us a little indication of why he continues to
6 have nerve-type pain.

7 Q. Okay. But again, your -- your
8 statement is that that would have provided no
9 benefit to you or Mr. Nestler --

10 A. It would give us a little bit more
11 information, but it wouldn't give us -- it wouldn't
12 give us any more -- we know we have some type of
13 nerve-type symptoms going on. It would just maybe
14 hone down to exactly where that is, but it
15 wouldn't -- it wouldn't give us an indication if we
16 are going to operate on anything.

17 Q. Do you know where that is?

18 A. No, sir. I don't.

19 Q. Okay. You also at that point again
20 said we could also inject the elbow as well to see
21 if that will help with his range of motion.
22 Patient is not interested in doing those
23 interventions at this point.

24 A. Yes.

25 Q. You had given Mr. Nestler a



1 corticosteroid injection in his shoulder prior to
2 this accident; correct?

3 A. Yes.

4 Q. That was for what you -- what you
5 characterize as a minor issue; correct?

6 A. Yes.

7 Q. And he found relief from that; correct?

8 A. Right.

9 Q. Okay. August 22, 2014 which I think is
10 the eighth -- seventh visit, I apologize.

11 A. Yes.

12 Q. We have previously talked about getting
13 an EMG nerve conduction study which I think is a
14 good option to evaluate for neurological injury in
15 the patient's upper left -- upper left extremity.

16 Are you having these conversations with
17 Mr. Nestler about your opinions of an EMG nerve
18 conduction study?

19 A. Yes. That's why I put it in the note,
20 that we had discussed it.

21 Q. Okay. This is the fourth time you had
22 had that discussion.

23 A. Yeah.

24 Q. And he continued to not want to do
25 that.

1 A. Yes.

2 Q. Okay. And despite these four
3 discussions and four entries, you are now telling
4 me you didn't believe it would be of any benefit?

5 A. Well, I can offer recommendations on
6 patients and it's their decision if they want to
7 have that evaluation or not.

8 Q. I am asking -- I am asking what your
9 opinion is given the four --

10 A. I think it would give us some more
11 information of the nerve-type pain that we were
12 dealing with.

13 Q. Okay. At that time, you formulated an
14 impairment rating; is that correct?

15 A. Yeah. I looked at that. And
16 obviously that differs from the impairment rating
17 we did at the -- this last visit December 11, 2015.
18 And I felt that that first one I did in August was
19 not thorough enough which is why --

20 Q. Why didn't you think that?

21 A. Because I don't -- I did not put in --
22 I didn't evaluate the shoulder. And to be honest,
23 I don't have a complete explanation of what -- of
24 differing -- the difference is that I wasn't -- I
25 don't think I thoroughly kind of looked at the

1 disability -- disability ratings in relation to the
2 full aspect of nerve involvement, shoulder
3 involvement, elbow involvement. As I said, this
4 is a very complicated evaluation with a lot of
5 players involved.

6 Q. Sure.

7 A. I didn't look at it thorough enough.

8 Q. You were aware of all those issues at
9 that time when you made that impairment rating?

10 A. Yes.

11 Q. And you just didn't --

12 A. I wasn't thorough enough.

13 Q. You had mentioned you didn't consider
14 the shoulder at that time, but you did subsequently
15 in your December 11, 2015 impairment rating;
16 correct?

17 A. And I think --

18 Q. I believe you assessed functional
19 impairment?

20 A. Yes, because if you look -- if you look
21 at the evaluation of the shoulder on that physical
22 examination you can see there are physical
23 limitations with the shoulder, but I did not put
24 that into the --

25 Q. Which visit are you referring to?

1 A. 8/22/14. But I didn't -- I didn't --
2 I didn't -- I didn't assess that into the
3 disability rating. Again, I was not thorough
4 enough in exactly why -- working through as many
5 people as we see and trying to figure different
6 things out, I just -- I realize looking at that
7 visit and this last visit that I was not thorough
8 enough in looking at the full aspect of the --
9 whole aspect of his whole left upper extremity
10 involving shoulder, elbow, muscles, motor and
11 sensory function.

12 Q. On the first visit, while we are
13 talking about the shoulder and, March 11, 2014,
14 there's an assessment. It says shoulder pain.
15 And I don't know -- I don't know if you need to
16 look at it to believe me. I am -- I am looking at
17 it right now.

18 I notice that there is -- that
19 assessment was -- was removed after that first
20 visit for the next six visits until December 11 of
21 2015 when you included it in your impairment. Do
22 you have an explanation for that?

23 A. My explanation is that I was focused on
24 the part of his body that was most symptomatic
25 being his arm -- being nerve involvement, muscle

1 involvement of the humerus, elbow, forearm and
2 hand.

3 Q. You assessed Mr. Nestler with a
4 functional shoulder impairment of 11 percent on
5 your -- on your 2015 -- your December 2015; is that
6 correct?

7 A. Sorry. What was the question again?

8 Q. During your December 11, 2015 visit --
9 well, I guess let me rephrase.
10 That -- that's about 16 months after
11 his prior visit; correct?

12 A. Yes.

13 Q. You hadn't seen him in those 16 months.

14 A. Yeah, from August 22, 2014 until
15 December, yes.

16 Q. Okay. And to your knowledge, did he
17 receive any treatment during that time?

18 A. I believe he was doing home exercise
19 activities that were taught to him through the
20 multiple therapeutic interventions that he
21 received.

22 Q. You don't know if he was doing those,
23 though?

24 A. I do not. No. But that's -- but I
25 would assume and obviously when I asked him -- when

1 I see them for follow-up, I say what have you been
2 doing? Have you been doing therapy. A lot of
3 them, if they stop doing therapy, some of them,
4 majority of people; if they are doing some type of
5 intervention, they will mention that to me. But I
6 do believe he was doing some home activities,
7 exercises.

8 Q. On this -- on this shoulder
9 impairment --

10 A. Yes?

11 Q. -- you have a functional impairment of
12 11 percent; is that correct?

13 A. Yes, which is -- comes from evaluation
14 due to limitations and range of motion and
15 decreased -- decreased range of motion and also
16 strength deficit with the shoulder.

17 Q. Okay. Do you have the -- the records
18 from Mr. Nestler's visit on October 1, 2013? That
19 would have been before the accident that we are
20 here about today. I think that was the point at
21 which you gave him an injection in his shoulder.

22 A. Yes, I do.

23 Q. I just want to run down. Let's see
24 here, if we can get the right page. You conducted
25 a physical examination of Mr. Nestler's left

1 shoulder; correct?

2 A. Yes.

3 Q. And under that you have range of motion
4 and those are various movements that you measure;
5 correct?

6 A. Yes.

7 Q. Flexion of 160. Left abduction of
8 150. External rotation at -- at -- at 90 degrees,
9 measurement was 80. And internal rotation was 50;
10 is that correct?

11 A. Yes.

12 Q. You didn't take an extension
13 measurement?

14 A. No, I did not.

15 Q. You didn't take an induction
16 measurement?

17 A. No, I did not.

18 Q. And you didn't -- you didn't observe
19 any impingement at that time?

20 A. No, he did not show any signs of
21 impingement.

22 Q. Based on that information, are you
23 aware of what the functional impairment would have
24 been based on those measurements?

25 A. I haven't looked that up. So at that

1 point, I wasn't looking for an impairment rating.
2 It was more -- those limitations are due to
3 response of symptoms at that time.

4 Q. Okay. Let's flip to December 11, 2015.
5 You again conducted a physical examination of
6 Mr. Nestler's left shoulder; correct?

7 A. Yes.

8 Q. At the bottom of what appears, I guess,
9 to be page 2 of that entry, range of motion.
10 Flexion 150.

11 A. Yes.

12 Q. Extension 60. Abduction 150.
13 Adduction, 160. External rotation, 80. Internal
14 rotation, 60.

15 A. Yes.

16 Q. Why did you take not the extension and
17 adduction measurements when Mr. Nestler's shoulder
18 was hurting before?

19 A. I'm sure I assessed it. I just didn't
20 put it in the note.

21 Q. You didn't put it in the note. Okay.

22 How -- how different are these numbers
23 from, now we are talking two years pre-accident and
24 post accident, flexion before the accident was 160.
25 It's 150 now. We don't have an extension reading.

1 Abduction was 150 pre-accident. It's 150 nearly
2 two years -- over two years -- sorry. About a
3 year and nine months after. We have no adduction
4 rating pre because you didn't put it in the notes.
5 Your external rotation was 80 pre-accident and 80
6 after. Internal rotation was 50 pre-accident and
7 internal was 60 after.

8 What is the -- what is the
9 impairment -- what is the difference that prompted
10 you to assess an 11 percent impairment?

11 A. If you look at the disability book from
12 -- fifth edition, if you look at the numbers within
13 that indicating impairment in relation to range of
14 motion, that's the -- the -- the numbers, the
15 impairment rating you get from that.

16 Q. Is 11 percent.

17 A. I believe so. 2 percent for --

18 Q. 2 percent for flexion.

19 A. 1 percent for abduction.

20 Q. 2 percent for internal rotation?

21 A. And also he has some limitations in his
22 strength as well so I added that in there as well,
23 for plus for a reduction --

24 Q. Can you agree with me those
25 measurements are almost identical to the ones in

1 2013?

2 A. Yeah, I agree with you.

3 Q. So that impairment is not the result of
4 this accident, then.

5 A. I wasn't look -- he had -- he had
6 limitation of motion because he was hurting at that
7 point. So I didn't see him afterwards so I don't
8 have a note to tell you that he had full motion and
9 function that had no limitations. So it's hard to
10 compare that because that was different treatment
11 time, different situation.

12 Q. I thought you said that he was
13 completely better at that point.

14 A. Yeah. After -- no. I saw him for the
15 tendonitis, on == when was it, 2000 -- October
16 2013, and that's -- he had those limitations,
17 motion, at that point due to treating him for bicep
18 tendonitis.

19 Q. So sometime between October of that
20 year and then March when this accident occurred he
21 regained complete motion in his shoulder.

22 A. That would be my assumption because I
23 didn't see him back.

24 Q. I want to talk about -- you've got --
25 and I don't know if you have it on you, I don't

1 know what I did with it, you've got a handwritten
2 note in your records. And it looks like this.

3 A. Yeah.

4 Q. Do you have that in your possession?

5 A. Yes, I do.

6 Q. Can you tell me the date on which you
7 put this together?

8 A. That was that visit 8/22/14 I believe.

9 Q. That's when you did your initial
10 impairment.

11 A. Yes.

12 Q. And from what I can tell, you've got
13 this top portion is the left elbow range of motion
14 measurements; correct?

15 A. Yes.

16 Q. And then you also have the radial and
17 ulnar nerves.

18 A. Radial and ulnar, .

19 Yes.

20 Q. It appears you've included the sensory
21 and the motor impairment into this analysis.

22 A. Yes.

23 Q. You told me earlier that you weren't
24 thorough and you didn't consider the neurolog --
25 the neurological aspect. What is this -- what is

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1 this right here?

2 A. That's -- I mean it's looking at motor
3 and neurological involvement.

4 Q. Two nerves in the arm?

5 A. Yeah.

6 Q. And the range of motion which would be
7 the functional impairment?

8 A. Yeah.

9 Q. In the left elbow; correct?

10 A. Yeah, yes.

11 Q. Okay. You've got a 4 percent
12 impairment for the functional --

13 A. Elbow, yes.

14 Q. And then you have 7 and a half for the
15 radial nerve.

16 A. And 8 for the ulnar.

17 Q. 1.5 for the ulnar it would appear.

18 A. Okay. Yeah.

19 Q. Those add up to 13, which then becomes
20 an 8 percent whole body which I believe is what you
21 discussed earlier.

22 A. Yeah, I believe so.

23 Q. After that, that's -- that's August 22,
24 2014. Sixteen months later you then have a new
25 impairment rating of, what was it, 53 percent?

1 A. Yes, I believe so.

2 Q. And at that time it's no longer the
3 radial and ulnar nerves. It's the ulnar and
4 medial nerves; is that correct?

5 A. Yes. That's what I wrote.

6 Q. You didn't mention the radial nerve at
7 that time?

8 A. No, I did not.

9 Q. You didn't mention the medial nerve in
10 your August 22nd entry, did you?

11 A. No, I did not.

12 Q. When you -- when you put this -- these
13 numbers together for this permanent impairment on
14 your -- was it December 11, 2015 visit, you just
15 added all three of those impairments; is that
16 correct?

17 A. Yes, I did.

18 Q. Are you familiar with the Combined
19 Values Chart?

20 A. Somewhat. As I said, I am not -- when
21 it comes to ratings I do ratings and evaluations
22 for specific, you know, joints, elbows; so part of
23 this is a little bit of a learning curve in
24 relation to nerve involvement and full motor nerve
25 sensory involvement as well.

1 Q. So are you -- are you casting doubt on
2 your ability to assess a permanent impairment,
3 then?

4 A. No, I am not casting doubt. It's just
5 on top of this is a very complicated situation with
6 a lot of motor sensory nerve involvement, joint
7 involvement as well. And I guess looking back at
8 that, I felt that I -- maybe had a better
9 understanding when I did the assessment in December
10 of -- of rating him appropriately.

11 Q. You were more thorough that second
12 time?

13 A. I believe I was, yes.

14 Q. Even though you were fairly thorough
15 that first time?

16 A. I believe I was more thorough the
17 second time, yes.

18 Q. Because it's a higher number.

19 A. Well, I think I had -- I was more
20 thorough because I looked at the full aspects of --
21 of all the involvement and realized it was much
22 more involved than what I had done the assessment
23 prior to that.

24 Q. Does this -- does this look familiar to
25 you at all?

1 A. Yes, it does.

2 Q. You have seen that?

3 A. Yes.

4 Q. That's a Combined Values Chart?

5 A. Yes.

6 Q. Do you know how to use that?

7 A. To an extent, yes.

8 Q. Okay. It's my understanding that when
9 you have multiple impairments in, say, the upper --
10 upper left extremity; you do not add them total.

11 You -- there is a method to figure out what the
12 actual impairment is because --

13 A. It's also for each nerve involvement
14 too or -- or involvement as well, because if you
15 look at sensory and motor for different things, you
16 get, you know, meaning for the sensory it comes out
17 with 50 for sensory or 25 for motor, I guess what I
18 wrote here. And you look at those combined
19 numbers and find it, whatever the number is for
20 that portion.

21 Q. Right. So if you have these three
22 numbers, are you -- is it your testimony that you
23 just add these up and that's -- that's how you get
24 it?

25 A. Yes.

1 Q. Okay. Can you read -- let's see: I
2 will find the paragraph. What I have starred
3 there which is the third paragraph on the Combined
4 Values Chart, can you just read that to me?

5 A. Three or four impairment values are to
6 be combined, select any two and find their combined
7 values as above. Then use the value in the third
8 value to locate the combined value of all. This
9 process can be repeated indefinitely. The final
10 value in each instance being the combination of all
11 the previous values. Each step of this process,
12 the larger impairment value, you must identify the
13 side of the chart.

14 Q. You didn't -- you didn't use that chart
15 to do this impairment rating, did you?

16 A. I did look at that chart, yes.

17 Q. Okay. Well, let's -- let's -- let's --
18 do it, then. If you look through it, you take the
19 larger number and you put that on the left side.
20 Is that -- is that what that says?

21 A. Yes.

22 Q. So the largest number there is 29 and
23 then you can take any one of the other two numbers;
24 right? So you take 29 and you can go over 13 on
25 the bottom and that comes to a number.

1 A. Nine and 13. Says 38, I believe.

2 Q. Okay. And then if you take 38, is it
3 38?

4 A. That's what it says here, yes.

5 Q. Thirty-eight and 11 so 38 on the side
6 and 11 on the bottom. What does that come to?

7 A. That is 37. But this is also looking
8 at motor and nerve function here as well. Okay?
9 So in evaluating the shoulder, shoulder is 11
10 percent in relation to his range of motion so
11 that's more motor -- this is motor and sensory
12 involvement when the other one is looking at
13 strength and range of motion and isn't involved in
14 this because this combined value chart I believe
15 looks at motor and nerve involvement which is all
16 distal to the shoulder.

17 Q. And you say you believe. You don't
18 know.

19 A. I'm sorry?

20 Q. Do you know whether what you are saying
21 is accurate in regards to that chart?

22 A. I believe it is from my knowledge of
23 doing these things.

24 Q. You assess Mr. Nestler with a permanent
25 impairment, not a disability rating; correct?

1 A. Yeah. I mean -- that's -- when I --
2 disability ratings to me look more like when I am
3 giving disability ratings it's dealing more with
4 workers' comp situations. Impairment rating is
5 just giving a rating of what the limitations and
6 function are at that point.

7 Q. Does that impairment rating give you
8 any guidance --

9 A. I think -- I think they are both about
10 the same. Impairment rating, disability rating.
11 It's the same kind of number I look for.

12 Q. The AMA distinguishes those two;
13 correct?

14 A. I believe so.

15 Q. What prompted Mr. Nestler to come back
16 in after 16 months of not seeing you?

17 A. I think he was ready to be done with
18 this process.

19 Q. This process being what?

20 A. The car accident --

21 Q. The litigation?

22 A. -- litigation, all that aspect of it.

23 Q. I see. So he came -- he came back to
24 you for a revised permanent impairment in hopes of
25 resolving this litigation?

1 A. That's my understanding.

2 Q. So I guess you are then aware that we
3 attempted to settle and -- this case in mediation
4 about a month prior to that?

5 A. I don't really discuss that with
6 patients.

7 MR. SLOTCHIVER: Objection.

8 BY MR. TRAINOR:

9 Q. Are you aware that that last visit was
10 approximately six weeks after Mr. -- Mr. Nestler's
11 deposition?

12 A. No, I did not.

13 Q. But as far as you know, that -- that
14 visit was -- was an attempt to resolve this
15 litigation?

16 A. If that's what -- I mean --

17 Q. That's what you just said. I am
18 asking you if that's what you are saying?

19 A. That would be -- I think my
20 understanding was I am ready to be done with this
21 process so can we kind of have a final valuation
22 assessment and then go on from there.

23 Q. Is that what he told you?

24 A. I think that was in our conversation,
25 like --

1 Q. Your write-up -- well, I guess -- I
2 guess I can say if that was your understanding, is
3 that why your write-up on November -- or December
4 11 of 2015 is so much more detailed than all the
5 other ones?

6 A. I don't know exactly why it would be
7 different.

8 Q. Well, I think it's the first time you
9 ever took a full range of motion test on his left
10 shoulder.

11 A. That's -- that's probably why that was.
12 Because it's kind of finalizing the situation.
13 Obviously, you know, you learn from all these
14 situations that sometimes you realize you are not
15 being as thorough in situations as you need to.
16 And I realized this was being a final situation
17 dealing with sitting in front of you nice gentlemen
18 here, I'd need to be thorough enough to evaluate
19 all aspects of his upper extremity.

20 Q. So we have -- we have no idea what you
21 left out of your records prior to this visit.

22 A. What do you mean left out?

23 Q. Well, you are saying you weren't as
24 thorough or --

25 A. Well --



1 Q. -- conducted a more thorough exam?

2 A. I am always thorough with my
3 examinations. Sometimes when you are seeing
4 multiple patients, in situation where we know this
5 is likely coming to some type of litigation and
6 looking back at my previous notes it makes me
7 realize I didn't put in information that would be
8 pertinent enough to give you guys information that
9 I thought would be helpful.

10 Q. That last entry, December 11, 2015, you
11 again mention the nerve conduction study. It says
12 we have previously discussed -- discussed
13 previously about doing EMG nerve conduction study
14 to evaluate for the exact area where he has nerve
15 injury. We could do this test, but it would not
16 give us any more direction on any type of surgical
17 intervention that would be needed for this patient.

18 A. Yes.

19 Q. There was never any discussion of
20 surgical intervention, was there?

21 A. I think we had discussed, you know, off
22 and on with him, but I didn't put it in the notes.
23 But there's no -- you don't go operate on nerves
24 unless you want them to stop working even worse
25 than they already are. So sometimes when you have

1 bad compressions like let's say cubital tunnel
2 syndrome or carpal tunnel syndrome, that sometimes
3 can help improve some of the nerve symptoms. His
4 were a little bit outside of the ordinary in
5 relation to where his symptoms were coming from.
6 It was also not coming just from the elbow and
7 forearm, also from the upper arm as well. So
8 there could be some area of compression. But you
9 know, I can as I stated before, I can provide my
10 recommendations as best I can. It's the patient's
11 decision if they want to go through that route of
12 evaluation.

13 Q. Are you telling the jury that you had a
14 discussion with Mr. Nestler about surgical
15 intervention and did not put it in your records?

16 A. No. Likely what my -- not likely.
17 My conversation with -- with him was there's no
18 surgery to help this. That would be my
19 conversation with him.

20 Q. We discussed --

21 A. There was no discussion saying well,
22 let's do an EMG so we can find out what surgery we
23 can do. That -- was -- that did not happen.
24 It's more like we can get an EMG like I stated
25 before, to give us a little more information, but

1 there's no surgical intervention for any of this.
2 And him being a physician realized that as well
3 which is probably the reason why he didn't want to
4 have the EMG done on top of the pain that it could
5 already elicit to him that he already has in that
6 upper extremity as well.

7 Q. Dr. Johnson didn't recommend -- didn't
8 see surgery as a necessity?

9 A. No, sir.

10 Q. And you said he's -- he's a spine guy.

11 A. Yeah. Yes, sir.

12 Q. You had three discussions with
13 Mr. Nestler about having an injection in his elbow;
14 correct?

15 A. Yes.

16 Q. And he never wanted to do that.

17 A. He was not interested in doing that is
18 my understanding.

19 Q. Okay. He received treatment -- he
20 received relief from the injection he received
21 prior to this accident; correct?

22 A. Yes, I believe he did.

23 Q. At some point you recommended
24 Mr. Nestler see a neurologist as well; correct?

25 A. Yeah. That would be more along the



1 line of EMG evaluation as well.

2 Q. That doesn't require an EMG; correct?

3 A. No, no, it does not.

4 Q. He didn't want to do that either?

5 A. I believe not.

6 Q. Other than your -- your records, have
7 you reviewed any of Mr. Nestler's medical record --
8 other medical record from other providers?

9 A. Only thing I have reviewed are -- are
10 my notes in front of me and then that note that Dan
11 showed me earlier about his -- evaluation by Dr.
12 Johnson.

13 Q. From Southeastern Spine; correct?

14 A. Yes, sir.

15 Q. I believe you or your PA referred
16 Mr. Nestler on his first visit to Olympic Physical
17 Therapy; correct?

18 A. Yes, sir.

19 Q. At that time, it seems like your
20 indication was treatment for two to three times a
21 week for four weeks. Does that sound correct to
22 you?

23 A. Yes.

24 Q. You haven't seen the records from
25 Olympic Physical Therapy?

1 A. That one note that I have. I didn't
2 see -- I'm sure at some point I have seen previous
3 notes from them, but I have this one visit here
4 from Olympic. I guess his first assessment.

5 Q. Perfect. Is that dated March 14,
6 2014?

7 A. Yes, it is.

8 Q. And that's a letter addressed to you;
9 correct?

10 A. Let's see. Yes, it is.

11 Q. All right. Let's see. That time, I
12 believe that was his first -- that was initial
13 consultation; correct?

14 A. Yes, it was.

15 Q. At that time, the plan from Olympic
16 Physical Therapy at the bottom there says
17 treatments here at Olympic Physical Therapy two to
18 three times a week for six to eight weeks in order
19 to achieve above listed short- and long-term goals;
20 correct?

21 A. Yes.

22 Q. It also says about right in the middle
23 of the page, under those itemized -- that itemized
24 list, last sentence of that says patient has
25 excellent rehab prognosis as long as he is

1 compliant with his PT program; correct?

2 A. Yes, it does.

3 Q. Do you have any reason to disagree with
4 that?

5 A. No, that's why we try conservative
6 treatment.

7 Q. That's why you referred him to physical
8 therapy?

9 A. That's why -- yeah, that's why we do
10 physical therapy, to see if we can get an
11 improvement to try to avoid any -- get things
12 feeling better.

13 Q. Okay. Are you aware that Mr. Nestler
14 went to three sessions of physical therapy?

15 A. I was not aware of how many visits he
16 went to.

17 Q. Are you aware that in those three
18 visits combined --

19 A. With Olympic or with the other one?

20 Q. With Olympic.

21 A. At that point he had come to see me so
22 -- so based on the March 14, that's after he saw
23 the -- our PA, Erin Watrobski, and then after that
24 visit, after -- after that time he had come in to
25 see me. At that point we kind of honed down a

1 little bit more. I don't know -- I don't know
2 if -- I don't know exactly where Coastal
3 Therapeutics, but they do a little bit more -- I
4 find they are a little bit better with kind of
5 nerve hand type issues, some of the hand therapy
6 groups. So I think he went to some visits with
7 that afterwards.

8 Q. Sure, we'll talk about that. I am
9 just trying to understand. In these three visits
10 Mr. Nestler got an hour and 35 minutes of treatment
11 when it was your recommendation he go two to three
12 times a week for four weeks and Olympic Physical
13 Therapy's recommendations was two to three times a
14 week for six to eight weeks.

15 A. I think we switched therapy places
16 after that point as well. I believe -- didn't we
17 switch him over to the Coastal Therapeutics? I
18 just have two visits here, but one is 5/27/14. So
19 I think he went to a few visits with Olympic.
20 Then we switched him over to Coastal Therapeutics,
21 I believe. I don't have all the visits in front of
22 me when he went to Coastal Therapeutics, so.

23 Q. So at some point you know that he did
24 go to Coastal Therapeutics?

25 A. Yes.



1 Q. And that is not Carolina Hand Therapy
2 or Charleston Hand Therapy; correct?

3 A. Coastal Therapeutics, I believe, is
4 where he went to.

5 Q. Have you ever seen the records from
6 that provider?

7 A. I see the -- the notes here and I'm
8 sure I have seen multiple notes that come through
9 our office, but it's been a year or so since --
10 little bit more than a year so I don't recollect
11 all the notes that I have seen.

12 Q. Again, I believe your recommendation
13 for Coastal Therapeutics was two to three times a
14 week for six weeks; correct?

15 A. I believe something to that extent I am
16 sure.

17 Q. Are you aware that Mr. Nestler showed
18 up five times for therapy?

19 A. I wasn't aware of how many visits he
20 actually went to. If -- and as I stated, yeah,
21 therapy is always a good thing to keep doing if the
22 patient and therapist feel that -- we provide
23 recommendations and a lot of times I have a good
24 relationship with these therapy places. And some
25 patients that, you know, if they feel they can do

1 -- progress to do home interventions or
2 interventions on their own, then they can progress
3 from that as they feel comfortable doing.

4 Q. Have you ever seen the discharge
5 summary from Coastal Therapeutics?

6 A. I don't have it on me; no, sir.

7 Q. I am going to show you a discharge
8 summary. And if there's a reason for discharge
9 there, I believe --

10 A. Failure to return.

11 Q. -- there's also -- if you wouldn't mind
12 sharing, it looks like I didn't make an extra copy.

13 Let's see here. Activities of daily
14 living, they have independent there. What is --
15 do you have any idea of what that means?

16 A. I do not.

17 Q. Okay. What does that sheet tell --

18 A. Probably like feeding yourself,
19 dressing yourself is my under -- my guess, what
20 independent --

21 Q. What would limited mean?

22 A. That you have to have somebody to help
23 you to do that.

24 Q. Okay. Other than that note saying
25 discharge for failure to return, you don't know

1 anything about his treatment there, do you?

2 A. Well, I mean -- I -- I know that they
3 worked on motor and function and getting his
4 shoulder and elbow and the hand improvement, but
5 exactly all the exact interventions they do, I am
6 not sure as I am not a physical therapist.

7 Q. You said that the most important reason
8 you refer people to outside providers is to get
9 them better.

10 A. Yeah.

11 Q. And you agree that it may be
12 detrimental if a patient does not follow a medical
13 provider or physician's recommendations.

14 A. It could be, yes.

15 Q. It could be. And your recommendation
16 was two to three times a week for six weeks. And
17 he went for five visits and you don't see a problem
18 with that?

19 A. Obviously you wish patients to go as
20 much as will help them. I don't always have
21 control of patients' lives and their direction and
22 thought process there. But you know, we would
23 like them to go as much as we would recommend.
24 But other things get in the way of people's
25 situations that prevent that from occurring or,



1 again, why he stopped. That's, you know, I
2 provide recommendations and I rely on the patients
3 to either make the decision if they want to
4 continue that route or if they are getting better
5 and interact with the therapist and think that they
6 are improving, then discontinue on their own. But
7 that's --

8 Q. So a patient at their -- at their
9 leisure can -- you would -- you would say that
10 that's an acceptable course of action?

11 A. I wouldn't say it's always acceptable,
12 but it happens.

13 Q. Is it advised that that happens?

14 A. Not all the time, no. I mean we --
15 provide recommendations and hope that the patient
16 or therapist kind of work through what they think
17 is best for them and then patients make their own
18 decisions on direction they'd like to, you know --
19 what they want to be doing or can be doing in
20 relation to life activities as well.

21 Q. That last note, December 11, 2015, you
22 use the word, I think or the phrase, extensive
23 physical therapy; is that right?

24 A. Yes, I did.

25 Q. From what I can tell Mr. Nestler went



1 to nine visits of physical therapy. Is that
2 extensive in your mind?

3 A. I wouldn't say extensive. I'd say he
4 went to -- he went to some therapy, but I wouldn't
5 say extensive. I guess I -- I guess I didn't
6 fully realize he had only gone to nine visits.

7 Q. Did he mislead you on that?

8 A. No, he said he was doing therapy and --
9 he had done some therapy, but it's also doing a lot
10 of stuff on his own as well.

11 Q. So the word extensive is an
12 exaggeration?

13 A. No, it's not -- yes, extensive is an
14 exaggeration.

15 Q. I don't think I have any further
16 questions right now. Dan?

17 EXAMINATION

18 BY MR. SLOCHIVER:

19 Q. Very briefly. Doctor, there was
20 discussion a few moments ago about prior injection
21 that Dr. Nestler had which you related to a minor
22 ailment. This -- that moderate issue that he had
23 pre-accident, that was nothing like the nerve
24 damage he had as a result of the accident, was it?

25 A. No, it's not.

1 Q. And it is your understanding that the
2 pre-accident issues had resolved; correct?

3 A. Yes. In fact I think I even said that
4 in one of the visits --

5 Q. Mr. Trainer --

6 A. -- says all the issues with his left
7 shoulder that were treated previously had
8 completely resolved.

9 Q. And the symptoms and the symptomology
10 that presented himself with now were quite
11 different than he presented before?

12 A. Yes, sir.

13 Q. Is it normally your practice to give
14 impairment ratings on people who have resolve --
15 whose issues have resolved?

16 A. No, because I don't see them in clinic
17 anymore.

18 Q. And there's no permanent impairment
19 with which to do an impairment rating I take it?

20 A. No.

21 Q. Mr. Trainor --

22 A. Generally people don't ask for
23 impairment ratings just for regular injury.
24 Either comes with the disabil -- workers' comp
25 related or something to this extent.

1 Q. Yes, sir. Mr. Trainor used some
2 references to range of motions that he found in
3 your notes related to the pre-accident, but would
4 it be fair that those -- that those measurements
5 that you had taken at that point were done when the
6 injury was still fresh, not the injury -- when
7 that -- when that complaint was still fresh as
8 opposed to after it healed?

9 A. I believe so.

10 Q. So it would be an unfair comparison to
11 look at injuries that had peaked before the
12 accident and compare them to permanent injuries.

13 A. Yes. I mean so that assessment came
14 in for shoulder pain prior to that is just an
15 assessment at that point. I'm sure if he -- if he
16 had continued issues I would have seen him back in.
17 You know, or most people don't come in if they get
18 better. So I don't have ability to know what his
19 range of motion would be after that.

20 Q. Is it fair to say that in the treatment
21 of patients that -- it's a growing process, you
22 learn as you go? In other words, people that come
23 in for an evaluation, the reason they come back
24 again and again and again is because their
25 symptoms --



1 A. Continue.

2 Q. -- improve, get worse, or --

3 A. Plateau.

4 Q. Yeah.

5 A. Yes, sir.

6 Q. Is that fair? And was it your
7 understanding when Gary Nestler, Dr. Nestler, came
8 in and said he was done with -- with the process,
9 that he had gotten as good as he, in his opinion,
10 as good as he could get and he just wanted you to
11 give him a final analysis?

12 A. I believe -- I believe that is kind of
13 the reasoning for that last visit; yes, sir.

14 Q. Dr. Nestler is more in tuned with
15 physiological complaints than your average patient,
16 would that be fair to say?

17 A. He's a physician, so yes, he is.

18 Q. And last thing, I want to -- this is a
19 document I had shown you before, part of your notes
20 that talked about the impairment rating.

21 A. Yes, sir.

22 MR. SLOCHIVER: I'd like to mark that
23 as an exhibit and introduce it into evidence. Any
24 objection?

25 MR. TRAINOR: I was actually going to

1 mark the entire record if you want.

2 MR. SLOTCHIVER: That's fine.

3 MR. TRAINOR: Okay.

4 MR. SLOTCHIVER: Let me mark this,
5 though, as plaintiff's exhibit.

6 MR. TRAINOR: Sure, okay.

7 MR. SLOTCHIVER: I've got nothing
8 further.

9 MR. TRAINOR: Nothing more.

10 THE VIDEOGRAPHER: This concludes the
11 video --

12 MR. TRAINOR: No. I am going to go
13 back on.

14 EXAMINATION

15 BY MR. TRAINOR:

16 Q. You had indicated permanent impairment.
17 Mr. Nestler came in and wanted to be done with this
18 process and wanted his permanent impairment rating;
19 is that -- is that right?

20 A. Yes, sir.

21 Q. Does that permanent impairment rating
22 assist in any way in making him better?

23 A. No. The impairment rating is because
24 you guys want that kind of stuff to give us
25 information on what to do for -- in relation to

1 litigation.

2 Q. Right. It serves -- serves no purpose
3 outside of litigation.

4 A. Or workers' comp evaluations, yes.

5 Q. It does nothing to assist in -- in
6 benefiting Mr. Nestler.

7 A. No. It's just -- gives us information
8 of what type of impairment he has with whatever
9 extremity -- for him his left upper extremity.

10 Q. Which would have been more beneficial
11 to Mr. Nestler, an EMG nerve conduction study or
12 that permanent impairment rating?

13 A. I think an EMG would give us a little
14 more information. I don't think it would have
15 changed our direction of treatment. As I said,
16 it's kind of like another piece of the puzzle, you
17 know.

18 Q. As we sit here today do you know what
19 is causing Mr. Nestler's pain?

20 A. I think he has a lot of nerve
21 irritation.

22 Q. What nerves?

23 A. My assumption would be from what I
24 said, median and ulnar nerve. The problem is
25 it's -- his -- where some of his symptoms are, he's

1 also getting symptoms in not only ulnar but median
2 nerve. And some people's nerves actually cross to
3 be honest with you. There's some abnormalities
4 and innervations so I think it's a combination of
5 those is what we are dealing with.

6 Q. When you say your assumption is, I mean
7 do you not know?

8 A. That's what my assumption is, is that
9 it's a combination of the two nerve involvements.

10 Q. Would an EMG nerve conduction study
11 have offered some clarity or --

12 A. Yes.

13 Q. -- insight into that?

14 A. It would give us some clarity, yes.

15 Q. And I'll -- I'll mark -- I am going to
16 mark the entire, which I believe is your entire
17 file, and we can redact it as needed.

18 MR. SLOCHIVER: Okay.

19 MR. TRAINOR: If that works for you.

20 MR. SLOCHIVER: I have one follow-up
21 question.

22 MR. TRAINOR: Sure.

23 EXAMINATION

24 BY MR. SLOCHIVER:

25 Q. Doctor, the -- a lot of discussion has



1 been made about the EMG studies. Is it fair to say
2 that as a practicing physician there are certain
3 things that you are required medically to recommend
4 that aren't == that are not necessarily medically
5 prudent? Is that why the reference to the EMG was
6 made?

7 A. I think the reason I kept going at that
8 and recommending is because he had nerve-type
9 symptoms so it would give us a little more clarity,
10 but it's not going to change our treatment
11 direction.

12 Q. And is -- is anything that we have
13 discussed today via the examination that I have
14 taken of you or the examination that Mr. Trainor
15 has taken from you altered or affected or changed
16 any of the opinions you have given as to the
17 relationship of the symptoms that Dr. Nestler
18 currently has and its connection to the car
19 accident?

20 A. No. It hasn't changed. It made me
21 realize I need to be more thorough at times.

22 Q. Thank you, sir.

23 MR. TRAINOR: I think we are all good.
24 Thank you, Doctor.

25 THE VIDEOGRAPHER: This completes the

1 video deposition of Robert Schoderbek, M.D. The
2 time is approximately 10:10 a.m. We are now off
3 the record.

4 (The witness, after having been advised
5 of his right to read and sign this transcript,
6 waives that right.)

7 (PLF. EXH. 1, Copy of two pages of
8 notes, labeled Page 5 and 6 of 47, no Bates stamps,
9 was marked for identification.

10 (DFT. EXH. 1, Copy of file of Dr.
11 Schoderbek, was marked for identification.)

12 (The deposition was adjourned at 10:10
13 A.M.)

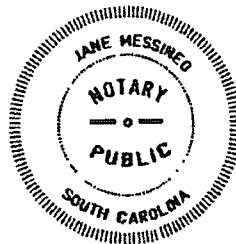
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CERTIFICATE OF REPORTER

I, Jane Messineo, Court Reporter and
Notary Public for the State of South Carolina at
Large, do hereby certify that the foregoing
transcript is a true, accurate, and complete
record.

I further certify that I am neither
related to nor counsel for any party to the cause
pending or interested in the events thereof.

Witness my hand, I have hereunto
affixed my official seal this 5th day of April,
2016 at Charleston, Charleston County, South
Carolina.



Jane Messineo, RPR, CSR-NJ
My Commission expires
February 18, 2025



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Nestler, Gary, et al v
Fields, Joseph E.

Robert Schoderbek, MD
April 05, 2016

Y

year

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year-and-a-half
13:5

years

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R. 367

Carpal Tunnel
Pressure Test *Negative*
Phalens *Negative*
Tinnels *Negative*

Range of Motion
Radial Deviation *20*
Ulnar Deviation *20*
Flexion *80*
Extension *80*

Strength
Grip Strength *Decreased*
Extension *5*
Flexion *5*

Sensation
Left Wrist *Intact to light touch distally*

Radial Pulse
Left *2+*

RADIOGRAPHS:
Interpretation _____

Assessments

1. Pain of left upper extremity - M79.602 (Primary)
2. Biceps tendinitis, left - M75.22
3. Lateral epicondylitis of left elbow - M77.12
4. Left shoulder pain - M25.512

Treatment

1. Pain of left upper extremity

Notes: Patient seems to have a lot of issues associated with nerve pain which therefore seems to affect the function of the entire left arm including shoulder, elbow and hand. The hypersensitivity issues with nerve pain in his arm causes decreased functionality of both his shoulder, elbow and the entire arm. We have discussed previously about doing an EMG nerve conduction study to evaluate for the exact area where he has nerve injury. We could do this test but it would not give us any more direction on any type of surgical intervention that would be needed for the patient. Patient has done an extensive amount of conservative treatment with both physical therapy and chiropractic intervention. I will continue surgical intervention that I can do to help improve the patient's symptoms and functionality. We've also discussed about using some neurotrophic type drugs including either Lyrica or Neurontin but he feels that would affect the ability to do his work. This patient's arm will likely never be the same and will always be affected due to the injury that occurred in the car accident that he was involved in.

It is hard to determine a disability rating associated with the injury that has affected this patient's functionality of his arm because of the complexity of determining the affect.

Disability rating for the patient affect the left upper extremity is 53% for the upper extremity which corresponds to 32% for the entire



Patient: NESTLER, GARY S - DOB: _____

Progress Note: Robert J Schneiderbek MD 12/11/2015

Note for printed by eClinicalWorks EMR/PM Software P. www.eClinicalWorks.com

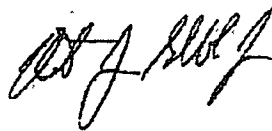
person. These number are drived from the 5th addition disability book. Medium Nerve combined involvement-29%, Ulnar nerve combined involvement of 13% and decreased functionality of the shoulder of 11% for a total combined disability rating for the left upper extremity of 53%.

2. Others

Continue Medications reported as directed by the ordering provider, --, as directed

Follow Up

pm



Electronically signed by ROBERT SCHODERBEK MD on
12/31/2015 at 10:15 AM EST

Sign off status: Completed

OSC Mt Pleasant
594 LONE TREE DR
MT PLEASANT, SC 29464-8170
Tel: 843-958-2500
Fax: 843-606-8058

Patient: NESTLER, GARY S DOB:

Progress Note: Robert J Schoderbek MD 12/11/2015

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

No H/P
No P/MS

H/B/S HALL BOOTH SMITH, PC.

Paul Trainor | 40 Calhoun Street, Suite 550
P: (843) 720-3466 | Charleston, SC 29401
E: ptrainor@hallboothsmith.com | W: www.hallboothsmith.com
P: (843) 720-3460 F: (843) 720-3475

November 18, 2015

VIA CERTIFIED U.S. MAIL

Robert J. Schoderbek, M.D.
c/o Records Custodian
594 Lone Tree Drive
Mount Pleasant, South Carolina 29464

RE: *Nestler v. Fields*
Civil Action No.: 2015-CP-10-330

Complete chart
all records and bills
JMS CC 12-31-15

To Whom It May Concern:

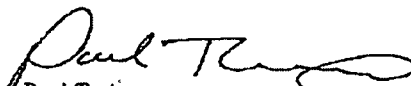
Enclosed please find a Subpoena requesting the production of a complete copy of your file for **Gary Nestler** (DOB: , SSN:). Please note we are requesting the production of a complete copy of your file, including all medical, radiology/imaging, billing records. We ask that you remit documents to my attention at the above address within fourteen (14) days of service, or by December 4, 2015. Please provide a Certification of Authenticity and enclose with the records you are providing.

We will gladly reimburse your reasonable costs incurred for the copying of these documents; however, please notify our office before copying if the costs exceed \$100.00. Please include your Federal tax identification number on your invoice so that we can issue prompt payment.

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, 45 CFR § 164.512(c), we have provided the above-named Plaintiff, through her counsel of record, with notice of our intent to Subpoena these records. By copy of this correspondence to Plaintiff's counsel we are advising of this request for records. If they should require copies of the same, we ask that they contact our office to make arrangements to have copies made at their expense or to inspect the copies at our office at a mutually convenient time.

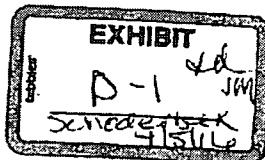
Thank you for your attention to this matter. Should you have any questions or concerns, please do not hesitate to contact our office.

Very truly yours,


Paul Trainor

PT/sb

CHARLESTON



INLAW

R. 370

STATE OF SOUTH CAROLINA

ISSUED BY THE COMMON PLEAS COURT

IN THE COUNTY OF CHARLESTON

Gary Nestler and Julie Nestler,

Plaintiffs,

SUBPOENA IN A CIVIL CASE

v.

Case Number: 2015-CP-10-330

Joseph E. Fields,

Defendant.

Pending in CHARLESTON County

TO: Robert J. Schoderbeck, M.D.
c/o Records Custodian
594 Lone Tree Drive
Mount Pleasant, South Carolina 29464

☐ YOU ARE COMMANDED to appear in the above named court at the place, and time specified below to testify in the above case.

PLACE OF TESTIMONY:

COURTROOM:

DATE AND TIME:

☐ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify at the taking of a deposition in the above case.

PLACE OF DEPOSITION:

DATE AND TIME:

☒ YOU ARE COMMANDED to produce and permit inspection and copying of the following documents or objects in your possession, custody or control at the place, date and time specified below: See attached Exhibit A

PLACE: Hall Booth Smith, P.C.
40 Calhoun Street, Suite 550
Charleston, South Carolina 29401

DATE AND TIME: December 4, 2015

☐ YOU ARE COMMANDED to permit inspection of the following premises at the date and time specified below.

PREMISES:

DATE AND TIME:

ANY SUBPOENAED ORGANIZATION NOT A PARTY TO THIS IS HEREBY DIRECTED TO RULE 35(b)(6), SOUTH CAROLINA RULES OF CIVIL PROCEDURE, TO FILE A DESIGNATION WITH THE COURT SPECIFYING ONE OR MORE OFFICERS, DIRECTORS, OR MANAGING AGENTS, OR OTHER PERSONS WHO CONSENT TO TESTIFY ON ITS BEHALF SHALL SET FORTH, FOR EACH PERSON DESIGNATED, THE MATTERS ON WHICH HE WILL TESTIFY OR PRODUCE DOCUMENTS OR THINGS. THE PERSON SO DESIGNATED TESTIFY AS TO MATTERS KNOWN OR REASONABLY AVAILABLE TO THE ORGANIZATION

I CERTIFY THAT THE SUBPOENA IS ISSUED IN COMPLIANCE WITH RULE 45(c)(1), AND THAT NOTICE AS REQUIRED BY RULE 45(b)(1) HAS BEEN GIVEN TO ALL PARTIES.


Attorney/Issuing Officer's Signature

11/18/2015

Date

Paul B. Trainor, Esq., Attorney for UIM
Carrier QBE Insurance Company

Print Name

Attorney's Address and Telephone Number: Hall Booth Smith, PC, 40 Calhoun St., Suite 550, Charleston, SC 29401
(843) 720-3460

Exhibit "A"

A certified copy of ANY and ALL documents in your possession related to Gary Nestler (DOB: , SSN:). The term "documents" as used herein shall include, but is not limited to, any and all forms completed with regard to medical, imaging, and billing records, such as:

- medical records;
- bills/invoices;
- reports;
- correspondence;
- consent forms;
- laboratory and/or test reports and results;
- radiology/radiographic reports including CT Scans and MRI Images;
- x-rays or other radiographic images;
- photographs;
- copies of all films or other images;
- charts;
- diagrams;
- nurses' and/or physicians' notes;
- health care questionnaires; and
- any other documentary evidence pertaining to patient Gary Nestler.

In short, we are seeking your entire file relating to Gary Nestler in whatever form it may be stored, without exception or omission.

ACCOUNT CHARGE ACTIVITY SUMMARY
01/03/2016

CLINIC:
NAME ROPER SAINT FRANCIS PHYSICIANS
ADDRESS PO BOX 751649
CHARLOTTE, NC 282751649
843-789-1520

GUARANTOR:
0210-7993 PC: S
NAME UNCTED ADV C
ADDRESS

DATA SELECTION CRITERIA:
CUSTOMER: 10414
FIN CLASS:
PHYSICIAN:
SITE:
AGC: 81410SC
DEPARTMENT:
LOCATION:
PRINT: Summary
DATE SELECTION: Date of service
DATE FROM:
DATE TO:
PROC CODE FROM:
PROC CODE TO:
RESPONSIBLE: All
CHARGE STATUS: Both

PATIENT RESPONSIBLE: 64.78-
INSURANCE RESPONSIBLE: 124.21-
PREPAYMENTS: 0.00
INSURANCE UNAPPLIED PAYMENTS: 0.00
PERSONAL UNAPPLIED PAYMENTS: 64.78-
LINKED PAYMENTS: 0.00

SORT BY:
PRIMARY: Date of service
SECONDARY:
TERTIARY:

PAGE: 1

OPERATOR: shalje01

GUARANTOR: 0210-7993 NESTLER, GARY S
 PATIENT:

ACCOUNT CHARGE ACTIVITY SUMMARY

DOB	CODE	DESCRIPTION	PATIENT	PHYSICIAN	PAT PAID	PAT ADJ	OPEN BAL
	BILL AMOUNT	INS RESP	INS PAID	INS ADJ	PAT RESP		
03/29/2013	73030	X-RAY EXAM OF SHOULDER	GARY NESTLER	SCHODERBEK, ROBERT J	11.02	11.02	0.00
03/29/2013	73100	X-RAY EXAM OF WRIST	GARY NESTLER	SCHODERBEK, ROBERT J	9.56	9.56	0.00
10/01/2013	99214	OFFICE/OUTPATIENT VISIT EST	GARY NESTLER	SCHODERBEK, ROBERT J	31.69	31.69	0.00
10/01/2013	20550	INJ TENDON SHEATH/LIGAMENT	GARY NESTLER	SCHODERBEK, ROBERT J	23.34	23.34	0.00
10/01/2013	J1030	METHYLPREDNISOLONE 40 MG INJ	GARY NESTLER	SCHODERBEK, ROBERT J	1.08	1.08	0.00
03/11/2014	99214	OFFICE/OUTPATIENT VISIT EST	GARY NESTLER	WATROBSKI, ERIN N	32.39	32.39	0.00
03/11/2014	73000	X-RAY EXAM OF COLLAR BONE	GARY NESTLER	WATROBSKI, ERIN N	0.00	0.00	0.00
03/11/2014	73070	X-RAY EXAM OF ELBOW	GARY NESTLER	WATROBSKI, ERIN N	0.00	0.00	0.00
03/21/2014	99214	OFFICE/OUTPATIENT VISIT EST	GARY NESTLER	SCHODERBEK, ROBERT J	32.39	32.39	0.00
04/04/2014	99214	OFFICE/OUTPATIENT VISIT EST	GARY NESTLER	SCHODERBEK, ROBERT J	32.39	32.39	0.00
05/02/2014	99214	OFFICE/OUTPATIENT VISIT EST	GARY NESTLER	SCHODERBEK, ROBERT J	32.39	32.39	0.00
05/02/2014	73080	X-RAY EXAM OF ELBOW	GARY NESTLER	SCHODERBEK, ROBERT J	0.00	0.00	0.00
05/30/2014	99214	OFFICE/OUTPATIENT VISIT EST	GARY NESTLER	SCHODERBEK, ROBERT J	32.39	32.39	0.00
07/11/2014	99214	OFFICE/OUTPATIENT VISIT EST	GARY NESTLER	SCHODERBEK, ROBERT J	32.39	32.39	0.00
08/22/2014	99214	OFFICE/OUTPATIENT VISIT EST	GARY NESTLER	SCHODERBEK, ROBERT J	32.39	32.39	0.00
12/11/2015	99214	OFFICE/OUTPATIENT VISIT EST	GARY NESTLER	SCHODERBEK, ROBERT J	0.00	0.00	132.41
	2,320.00	2,016.58	1,034.71	849.46	303.42	303.42	0.00
							132.41
							0.00
							132.41
							0.00

PAGE: 2

OPERATOR: shblje01

Last Name: NESTLER Mr. Mrs. Miss. Other _____ Sex: Male
First Name: GARY Date of birth: _____ Age: 54 Y SSN: _____
Middle Name: S Preferred Name: _____
Address: _____ County: _____
Email Address: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
May we leave a message about appointments and/or normal test results on the phone numbers you provided? Yes _____ No _____
Marital Status: Married
Ethnicity: Hispanic or Latino Not Hispanic or Latino
Primary Language: English Spanish French Other: _____
Race: Caucasian African American Asia Native Hawaiian or Pacific Islander Other: _____
Student Status: Not a Student Full Part
Employment Status: Full Part N/A:
Pharmacy Name: CVS/pharmacy #4263 Address: _____ Phone: 843-884-8281
Emergency Contact: Name: JULIE NESTLER Relationship: _____ Phone: _____
Alternate Contact: If you want this Practice to contact you at an alternate address or telephone number, please complete:
Alt Address: _____ City: _____ State: _____ Zip: _____ Phone: () _____
Referred by: _____ Primary Care Physician: _____

Last Name: NESTLER Mr. Mrs. Miss Other _____ Sex: Male Female _____
First Name: GARY Date of Birth: ____/____/____ Age: ____ SSN: ____-____-____
Middle: S Relationship to Patient: _____
Address: _____
Home Phone: () _____ Cell Phone: () _____ Work Phone: () _____
Guarantor/Financially Responsible Person's Email Address: _____

<u>Primary Insurance</u>	<u>Secondary Insurance</u>
Insurance Company: <u>BCBS OUT OF STATE W PPO</u>	Insurance Company: _____
Policyholder Name: <u>NESTLER, GARY S</u>	Policyholder Name: _____
Member or Policyholder ID: <u>IEDAN3872707</u>	Member or Policyholder ID: _____
Policy Date of Birth: <u>01/20/1961</u>	Policy Date of Birth: _____
Insurance Co. Phone #: _____	Insurance Co. Phone #: _____
Group #: <u>003330081</u>	Group #: _____
Relationship to Patient: _____	Relationship to Patient: _____

Ongoing Communication Regarding Your Healthcare

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? (Please provide the information below.)

For ongoing communication regarding your healthcare and for your privacy, you must complete this section to authorize this Practice to release and/or discuss your health information with the following people or organizations for the following specific dates of service. Any revocation or modification to your authorization with regard to a family member or other individual must be submitted in writing.

From date of service: _____ To date of service: _____

Name of person	Address	Phone/Fax	Relationship to you
<i>Example: John Doe</i>	<i>3 Main Street, ABC City, SC 29401</i>	<i>843-555-1212</i>	<i>Husband</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

A separate Authorization to Release Information Form must be completed for other releases and disclosures not listed in the section below.

To request restrictions of the use of your information, you must complete a separate Request For Restrictions Form.

I consent to treatment and allow this Practice and their affiliates to use and release my protected health information for treatment, payment, and healthcare operations as allowed by HIPAA and as described in the Roper St. Francis Healthcare Notice of Information Practices, which a copy has been made available to me.

I understand that my medical information including complete medical records, test results, and billing information may be released to my insurance company and to other medical professionals and/or medical care institutions for treatment and payment purposes.

I allow payment to be made directly to Roper St. Francis Healthcare for all medical or surgical benefits otherwise payable to me under terms of my insurance.

I understand that I am financially responsible for paying all co-payments, co-insurance, deductibles, and non-covered services.

A photocopy of this form shall be considered as effective and as valid as the original.

To the best of my knowledge the information I have given on this form is accurate and true. I know it is my or my legal guardian's responsibility to keep this Practice and my Physician informed of changes to my contact information; a failure to do so may interfere with the ability to contact me concerning my healthcare.

Print Patient's Name: *Dr. Gary West*

Patient's Signature: *[Signature]*

Date: *12/11/15*

Print Legal Guardian's Name: _____

Legal Guardian's Signature: _____

Date: / /

Office Use Only:

Revised 01/2014

CHART#: 221310 #50
DATE: 3/11/14

PATIENT INFORMATION

Name: Neatter, Gary DOB: _____ Sex: (M) F
Race: W Age: 53 Family MD: Lieberman
Involved body part: HN (Dorsum of Neck) Referring MD: Schoenberger / Ed Keenan
Date of injury / onset: 3/8/14 Work related: YES (NO)
Last full-time work date: _____ Do you need a form to return to work/school: YES (NO)
How injury occurred?: MVA Hit from Rear
Where injury occurred?: Hit Plaintiff's
Dominant Hand? (circle one): LEFT-HANDED RIGHT-HANDED

CHIEF COMPLAINT / HPI: (the reason for today's visit):

Location (Example bottom of foot, left hand, etc): (C) Sacrum, wrist, collarbone, neck, head.
Quality (Example: throbbing, numb, etc): _____
Severity (Example: intolerable, dull, sharp, etc): Sharp at times
Duration (Example: all day, few minutes, all night, etc): dull throughout day
Timing (Example: upon rising, at end of day, etc): _____
Context (Example: while typing, after exercising, etc): rotating, lifting
Modifying Factors (Example: what improves or worsens symptoms, etc): bold exercises
Associated Signs & Symptoms (Example: tingling, stiffness, etc): stiffness

KNOWN SIGNIFICANT MEDICAL DIAGNOSES AND CONDITIONS:

Height: 6'1" Weight: 195

Medical Illnesses (Please check below all that apply):

☐ Weight Changes
☐ Allergies/Hay Fever/Latex
☐ Change in Vision
☐ Ringing in Ears
☐ Temperature Intolerance
☐ Excessive Thirst
☐ Cold Extremities
☐ Fatigue
☐ Edema

☐ Shortness of Breath
☐ Wheezing
☐ Chest Pain
☐ Dizziness
☐ Heartburn
☐ Abnormal Bleeding
☐ Circulatory Problems
☐ Poor Wound Healing
☐ Sleep Apnea

DNA
☐ Instability/Balance Issues
☐ Swelling
☐ Redness
☐ Muscle Aches
☐ Painful / Stiff Joints
☐ Skin Rash
☐ Weakness
☐ Limited Range of Motion
☐ Blood Clots

☐ Sciatica
☐ Tingling/Numbness
☐ Depression
☐ Anxiety
☐ Headache
☐ Change in Activity Level
☐ Pain/Cramping after Exertion
On blood thinner? Y or N
Take Insulin? Y or N

Other health complications not listed above: _____

PAST MEDICAL HISTORY:

Known significant medical operative and invasive procedures (type of surgery and date):

N/A

Family Medical History (list family illnesses):

N/A

SOCIAL HISTORY:

Do you work outside the home? ☒ YES ☐ NO If yes, occupation? contractor

What physical activities do you do on a regular basis? : athletic, all sports

Do you smoke? YES ☒ NO If yes, how much and how long? _____

Do you consume alcohol? YES ☒ NO If yes, how much and how long? _____

ADVERSE AND ALLERGIC DRUG REACTIONS (list all):

Cumin

MEDICATIONS CURRENTLY TAKING (list all):

N/A

OTHER: Are there other questions or concerns that you have for your Doctor/ provider today?
If so, please list them below:

Are you a resident of a skilled nursing facility?

YES

☒ NO

If yes, name of facility? _____

Address _____

Effective Dates From: _____

TO: _____

PATIENT/GUARDIAN SIGNATURE

DATE

R. 378

Patient's HPP Guarantor #: _____

Patient's HPP Acct#: 2213130



Orthopaedic Specialists of Charleston
Patient Information – Injury and/or Pain Form

This information is required by most insurance carriers when medical services are related to any Accident/Injury/Incident.

To Be Filled Out by Patient: Injury/Accident/Incident Information

Patient's Name: GARY NGREN Date of Birth: 1/20/61
Date of Accident: 3/18/14

OR the Approx. Date Symptom(s)/Pain first began: 3/18/14

Where Accident Occurred: (Please check one) At Home Work Other

- ☐ Work Related (Give Employment Information Below)
☒ Auto Accident State: SC Note: If auto accident, the State in which the accident occurred is required
☐ Home
☐ Other, Please Specify: _____

Brief description of how accident/incident or onset of symptoms occurred and the affected body part:
Example: Twisted ankle/foot after stepping in hole in yard at home yesterday at approx. 5pm

RVA hit by pickup truck from back.

If not work related, please skip to signature section.

Employment Information for Work Related Injury:

This information is required for all work related injuries when a Worker's Compensation Insurance Carrier should be billed. Please give the staff any paperwork you received from your employment and/or their worker's compensation insurance, so we may file your services properly. Without the correct billing information, for a work related injury, you may be held responsible for payment.

Name of Employer: _____ Contact Phone: (____) _____
Name of Employer Contact: _____
Work Comp Policy/Claim #: _____
Name and address of Work Comp Carrier: _____
If Dept of Labor*, Diagnosis Code(s): _____

*Provide letter from DOL. The DOL should have sent you a letter approving your claim and assigned a diagnosis.

Name of Adjuster: _____ Phone # (____) _____

Name of person providing information: _____ Relationship to Patient: _____

To the best of my knowledge, the information provided above is correct.

Patient's Signature: [Signature] Date: 3/18/14

Created 3/24/2011
S:\physio\lab\ac\audit\forms\Accident Information Sheet

NESTLER, GARY S

DOB: Age: 54 Y Sex: male
Home:
Work:
Cell:
Email: NESTLERG@GMAIL.COM

Primary Insurance: BCBS OUT OF STATE W PPO
PCP: Allan D Lieberman, MD
Account Number: 00002213130

Allergies: cumin

Medical History**Active Problem List**

Code	Name	Specify	Notes	Added On	Modified On	Modified By
727.05	Wrist tendonitis			03/29/2013	03/29/2013	SCHODERBEK, ROBERT J
726.12	Bicipital tenosynovitis			10/01/2013	10/01/2013	SCHODERBEK, ROBERT J
726.0	Adhesive capsulitis			10/01/2013	10/01/2013	SCHODERBEK, ROBERT J
847.0	Cervical strain		DOI: 3/8/14	03/11/2014	03/11/2014	WATROBSKI, ERIN N
923.00	Shoulder contusion		DOI: 3/8/14, Left shoulder	03/11/2014	03/11/2014	WATROBSKI, ERIN N
923.11	Elbow contusion		DOI: 3/8/14, Left elbow	03/11/2014	03/11/2014	WATROBSKI, ERIN N
719.42	Elbow pain			03/21/2014	03/21/2014	SCHODERBEK, ROBERT J
812.40	Elbow fracture			03/21/2014	03/21/2014	SCHODERBEK, ROBERT J
722.91	Cervical disc disease			04/04/2014	04/04/2014	SCHODERBEK, ROBERT J
722.0	Cervical HNP			04/04/2014	04/04/2014	SCHODERBEK, ROBERT J
726.32	Lateral Epicondylitis			05/02/2014	05/02/2014	SCHODERBEK, ROBERT J
354.3	Posterior Interosseous nerve syndrome			05/30/2014	05/30/2014	SCHODERBEK, ROBERT J
M75.22	Biceps tendinitis, left			12/11/2015	12/31/2015	SCHODERBEK, ROBERT J
M77.12	Lateral epicondylitis of left elbow			12/11/2015	12/31/2015	SCHODERBEK, ROBERT J
M25.512	Left shoulder pain			12/31/2015	12/31/2015	SCHODERBEK, ROBERT J
M79.602	Pain of left upper extremity			12/31/2015	12/31/2015	SCHODERBEK, ROBERT J

Medications

Name strength formulation, Sig: take route frequency

Medications reported as directed by the ordering provider -- , Sig: as directed Start Date: 05/02/2014

Surgical History

Date	Reason
------	--------

Hospitalization

NESTLER, GARY S

DOB: **Age:** 54 Y **Sex:** male
Home:
Work:
Cell:
Email:

Primary Insurance: BCBS OUT OF STATE W PPO
PCP: Allan D Lieberman, MD
Account Number: 00002213130

Allergies : cumin

Date	Reason
------	--------

Social History

Name	Value
Drugs	Denies
Alcohol Screen	Denies Did you have a drink containing alcohol in the past year?: No, Points: 0
Tobacco Use/Smoking:	Are you a: nonsmoker

Vitals

Name	Date	Value
Ht	12/11/2015	6 ft 1 in
Wt	12/11/2015	195
BMI	12/11/2015	25.72



NESTLER, GARY S

54 Y old Male, DOB:
Account Number: 0000012130

Home:

Guarantor: NESTLER, GARY S Insurance: BCBS OUT OF
STATE W PPO Payer ID: PAPER
PCP: Allan D Lieberman, MD
Appointment Facility: OSC Mt Pleasant

12/11/2015

Progress Notes: Robert J Schoderbek MD

Current Medications

Taking

- Medications reported as directed by the ordering provider — as directed

Past Medical History

No Medical History.

Surgical History

No Surgical History documented.

Family History

Denies cardiac, respiratory, gastrointestinal, genitourinary, and other musculoskeletal issues in the patient's family.

Social History

Tobacco Use

Tobacco Use/Smoking: Are you a:

nonsmoker.

Drugs/Alcohol:

Drugs: Denies.

Alcohol Screen: Denies

Did you have a drink containing alcohol in the past year? No
Points 0

Allergies

cumin

Hospitalization/Major

Diagnostic Procedure

No Hospitalization History.

Review of Systems

General/Constitutional:

Fatigue denies. Weakness denies.

Weight change denies

Musculoskeletal:

... See HPI for details.

Reason for Appointment

1. F/u elbow

History of Present Illness

Symptom(s):

Patient presents today with complaints of neck, LEFT clavicle/shoulder, and LEFT elbow pain. Patient was involved in a MVA on 3/8/14 where he was rear-ended while stopped on Highway 17 N. He was driving the car and was restrained. He then had a gradual onset of headache associated with neck pain. He continues to have pain diffusely about his cervical spine as well as anterior LEFT shoulder and LEFT elbow. He has a diffuse sense of tingling sensation about the entire LEFT hand.

Patient states that he continues to have left lateral elbow, forearm, and arm pain. Some tingling sensation down into the fingers at times. Patient has been working with the occupational therapist at Charleston and therapy. He does report some mild improvement in some of the symptoms in his forearm and elbow. Although he does indicate some atrophy of his muscles some tingling-type sensations consistent with PIN nerve compression and issues also associated with lateral epicondylitis

7/11/14-patient contacted me a week or 2 ago and states that he went to rotate his elbow and felt a pop. He had immediate swelling afterwards but surprisingly his motion had improved. Swelling went down after a few hours. Patient still gets a tingling-type sensations down to his hand that extended into the ulnar nerve distribution but surprising the pain radiates from more of the lateral aspect of his elbow. He still reports pain at the extremes of range of motion within his elbow with supination and pronation flexion and extension

Current treatment- patient presents to returns today for evaluation of issues with the left upper extremity. Patient has done extensive amount of physical therapy with Charleston Hamburg. He's been working with a chiropractor that does active release therapy. Patient states that issues with his left upper extremity has affected every aspect of his life. Patient was an extremely active individual prior to this injury occurring, playing many different types of sports. He had none of these issues with his left upper extremity prior to this injury occurring. Patient states that he has a constant.

Vital Signs

Patient: NESTLER, GARY S DOB:

Progress Note: Robert J Schoderbek MD 12/11/2015

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Ht 6 ft 1 in, Wt 195 lbs, BMI 25.72 Index.

Examination

General Examination:

GENERAL APPEARANCE: Well-developed, well-nourished, well nourished, in no acute distress.

Mini Mental Status Exam:

ORIENTATION: patient is alert and oriented to person, place and time.

Cardiology Exam:

Peripheral Pulses: normal.

Psychiatry:

ATTITUDE: cooperative.

Gait and Station:

Gait normal.

Station normal.

Cervical Spine:

INSPECTION: normal contour.

PALPATION: paraspinal tenderness right and left, left trapezial tenderness.

RANGE OF MOTION: limitation in range of motion along with left lateral bending and turning.

SENSORY EXAM UPPER EXTREMITIES: abnormal tingling sensation noted extending down the left arm.

TESTS: positive Spurling's, positive direct compression post triangle.

Right shoulder:

ROM: full ROM.

STRENGTH TESTING (OUT OF 5): 5/5 all RTC groups.

PALPATION: no tenderness.

STABILITY TESTS: all stability tests are negative.

UPPER EXTREMITY EXAM: no motor or sensory deficits, sensation intact to light touch distally with 2-3 second capillary refill.

Left Shoulder Structured:

General

Wound None noted

Inspection No muscle asymmetry, No scapular winging, No atrophy

Cervical Spine

Left Spurlings Positive

Left Axial Compression Positive

Inspection Normal Contour

Palpation Paraspinal Tenderness

Range of Motion limited lateral bending and rotation

Range of Motion

Left Forward Flexion 150

Left Extension 60

Left Abduction 150

Left Adduction 60

Left ER at 90 80

Left IR at 90 60

Patient: NESTLER, GARY S DOB:

Progress Note: Robert J Schoderbek MD 12/11/2015

Not appropriate for eDocumentation - CA/PT/PT/2000.com (www.eClinical.com)

Rotator Cuff Strength
Left Abduction 4+
Left Position of Jobc 4+
Left ER 5-
Left IR 5-
Left Belly Press 5

Impingement
Left Neer *Negative*
Left Hawkins *Mildly Positive*

SLAP
Left OBriens *Mildly Positive*
Left Mimori *Negative*

Bicep
Left Speeds *Negative*
Left Yergasons *Negative*

Instability
Left Apprehension *Negative*
Left Relocation *Negative*
Left Jerk Test *Negative*
Left Anterior Translation *Stable*
Left Posterior Translation *Stable*
Left Anterior Drawer *Good Endpoint*

Tenderness
Left AC Joint *Negative*
Left Bicipital Groove *Negative*

AC Joint
Left Cross Arm Adduction *Negative*

Radial Pulse
Left 2+

Right elbow:

INSPECTION: no ecchymosis, no swelling.
WOUNDS: no wounds noted.
PALPATION: non-tender.
RANGE OF MOTION: full range of motion.
STRENGTH: 5/5 all groups.
STABILITY: no instability.
SENSATION: light touch intact.
VASCULAR: radial pulse 2+.

Left Elbow:

General

Wound *None noted*
Inspection *No ecchymosis, Swelling noted*

Tenderness
Global Tenderness *Positive*

Patient: NESTLER, GARY S DOB:

Progress Note: Robert J Schoderchek MD 12/11/2015

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Lateral Epicondyle *Positive*
Medial Epicondyle *Positive*
Olecranon *Positive*
Extensor Mass *Positive*
Flexor Mass *Positive*
Ulnar Collateral Ligament *Negative*
Milking Maneuver *Negative*
Cubital Fossa *mild tenderness*
Bicep Tendon *Negative*

Range of Motion

Extension *5 painful at the extremes of motion*
Flexion *130 painful at the extremes of motion*
Supination *80 painful at the extremes of motion*
Pronation *80 painful at the extremes of motion*

Strength

Extension *4*
Flexion *4*
Supination *4*
Pronation *4*

Stability

Varus Stress at 0 degrees *Stable*
Valgus Stress at 0 degrees *Stable*

Sensation

Left *Diminished Tingling sensation to ulna and median nerve distribution*

Radial Pulse

Left *2+*

Right wrist:

WOUND: none noted.
PALPATION (BONE): no tenderness.
RANGE OF MOTION: full range of motion.
STRENGTH: full grip strength.
STABILITY: no gross instability noted.
TESTS: negative grind first carpometacarpal (CMC).
SENSATION: sensation intact all fingers distally.
VASCULAR: good capillary refill < 3 seconds.

Left Wrist:

General

Swelling *None*
Wound *None noted*

Tenderness

Modified Watson Test *Negative*
Volar *Negative*
Dorsal *Negative*
Scaphoid Tubercle *Negative*
Snuff Box *Negative*

Carpal Tunnel
Pressure Test *Negative*
Phalens *Negative*
Tinnels *Negative*

Range of Motion
Radial Deviation *20*
Ulnar Deviation *20*
Flexion *80*
Extension *80*

Strength
Grip Strength *Decreased*
Extension *5*
Flexion *5*

Sensation
Left Wrist *Intact to light touch distally*

Radial Pulse
Left *2+*

RADIOGRAPHS:
Interpretation _____

Assessments

1. Pain of left upper extremity - M79.602 (Primary)
2. Biceps tendinitis, left - M75.22
3. Lateral epicondylitis of left elbow - M77.12
4. Left shoulder pain - M25.512

Treatment

1. Pain of left upper extremity

Notes: Patient seems to have a lot of issues associated with nerve pain which therefore seems to affect the function of the entire left arm including shoulder, elbow and hand. The hypersensitivity issues with nerve pain in his arm causes decreased functionality of both his shoulder, elbow and the entire arm. We have discussed previously about doing an EMG nerve conduction study to evaluate for the exact area where he has nerve injury. We could do this test but it would not give us any more direction on any type of surgical intervention that would be needed for the patient. Patient has done an extensive amount of conservative treatment with both physical therapy and chiropractic intervention. I will continue surgical intervention that I can do to help improve the patient's symptoms and functionality. We've also discussed about using some neurotrophic type drugs including either Lyrica or Neurontin but he feels that would affect the ability to do his work. This patient's arm will likely never be the same and will always be affected due to the injury that occurred in the car accident that he was involved in.

It is hard to determine a disability rating associated with the injury that has affected this patient's functionality of his arm because of the complexity of determining the affect.

Disability rating for the patient affect the left upper extremity is 53% for the upper extremity which corresponds to 32% for the entire

Patient: NESTLER, GARY S DOB:

Progress Note: Robert J Schoderbek MD 12/11/2015

body generated by eClinicalWorks eCMTM Software for the ClinicVision.com

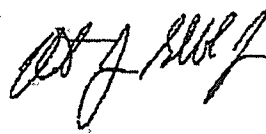
person. These number are dreived from the 5th addition disability book. Medium Nerve combined involvement-29%, Ulnar nerve combined involvement of 13% and decreased functionality of the shoulder of 11% for a total combined disability rating for the left upper extremity of 53%.

2. Others

Continue Medications reported as directed by the ordering provider, --, as directed

Follow Up

pm



Electronically signed by ROBERT SCHODERBEK MD on
12/31/2015 at 10:15 AM EST

Sign off status: Completed

OSC Mt Pleasant
594 LONE TREE DR
MT PLEASANT, SC 29464-8170
Tel: 843-958-2500
Fax: 843-606-8058

Patient: NESTLER, GARY S DOB:

Progress Note: Robert J Schoderbek MD 12/11/2015

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



NESTLER, GARY S

53 Y old Male, DOB:
Account Number: 00002214140

Home:

Guarantor: NESTLER, GARY S Insurance: BCBS OUT OF
STATE W PPO Payer ID: PAPER
PCP: Allan D Lieberman, MD
Appointment Facility: OSC Mt Pleasant

08/22/2014

Progress Notes: Robert J Schoderbek MD

Current Medications

Taking Medications reported as directed by the ordering provider -- as directed
Medication List reviewed and reconciled with the patient

Past Medical History

No Medical History.

Surgical History

No Surgical History documented.

Family History

Denies cardiac, respiratory, gastrointestinal, genitourinary, and other musculoskeletal issues in the patient's family.

Social History

Tobacco Use:

Tobacco Use/Smoking: Are you a:
nonsmoker.

Drugs/Alcohol:

Drugs: Denies

Alcohol Screen: Denies.

Allergies

cumin

Hospitalization/Major

Diagnostic Procedure

No Hospitalization History.

Review of Systems

General/Constitutional:

Fatigue denies. Weakness denies.

Weight change denies.

Musculoskeletal:

... See HPI for details.

Reason for Appointment

1. Left elbow

History of Present Illness

Symptom(s):

Patient presents today with complaints of neck, LEFT clavicle/shoulder, and LEFT elbow pain. Patient was involved in a MVA on 3/8/14 where he was rear-ended while stopped on Highway 17 N. He was driving the car and was restrained. He then had a gradual onset of headache associated with neck pain. He continues to have pain diffusely about his cervical spine as well as anterior LEFT shoulder and LEFT elbow. He has a diffuse sense of tingling sensation about the entire LEFT hand.

Patient states that he continues to have left lateral elbow, forearm, and arm pain. Some tingling sensation down into the fingers at times. Patient has been working with the occupational therapist at Charleston and therapy. He does report some mild improvement in some of the symptoms in his forearm and elbow. Although he does indicate some atrophy of his muscles some tingling-type sensations consistent with PIN nerve compression and issues also associated with lateral epicondylitis

7/11/14-patient contacted me a week or 2 ago and states that he went to rotate his elbow and felt a pop. He had immediate swelling afterwards but surprisingly his motion had improved. Swelling went down after a few hours. Patient still gets a tingling-type sensations down to his hand that extended into the ulnar nerve distribution but surprising the pain radiates from more of the lateral aspect of his elbow. He still reports pain at the extremes of range of motion within his elbow with supination and pronation flexion and extension.

Vital Signs

Ht 6 ft 1 in, Wt 195 lbs, BMI 25.72.

Examination

General Examination:

GENERAL APPEARANCE: Well-developed, well-nourished, well nourished, in no acute distress.

Mini Mental Status Exam:

ORIENTATION: patient is alert and oriented to person, place and time.

Patient: NESTLER, GARY S DOB:

Progress Note: Robert J Schoderbek MD 08/22/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Cardiology Exam:

Peripheral Pulses: normal.

Psychiatry:

ATTITUDE: cooperative.

Gait and Station:

Gait normal. Station normal.

Cervical Spine:

INSPECTION: normal contour. PALPATION: paraspinal tenderness right and left, left trapezial tenderness. RANGE OF MOTION: limitation in range of motion along with left lateral bending and turning. SENSORY EXAM UPPER EXTREMITIES: abnormal tingling sensation noted extending down the left arm. TESTS: positive Spurling's, positive direct compression post triangle.

Right shoulder:

ROM: full ROM. STRENGTH TESTING (OUT OF 5): 5/5 all RTC groups. PALPATION: no tenderness. STABILITY TESTS: all stability tests are negative. UPPER EXTREMITY EXAM: no motor or sensory deficits, sensation intact to light touch distally with 2-3 second capillary refill.

Left Shoulder Structured:

General

Wound None noted

Inspection No muscle asymmetry, No scapulary winging, No atrophy

Range of Motion

Left Forward Flexion 150

Left Abduction 140

Left ER at 90 80

Left IR at 90 50

Rotator Cuff Strength

Left Abduction 4+

Left Postition of Jobe 4+

Left ER 4+

Left IR 4+

Left Belly Press 4+

Impingement

Left Neer Negative

Left Hawkins Negative

SLAP

Left OBriens Negative

Left Mimori Negative

Bicep

Left Speeds Negative

Left Yergasons Negative

Instability

Left Apprehension Negative

Left Relocation Negative

Left Jerk Test Negative

Left Anterior Translation Stable

Left Posterior Translation Stable

Left Anterior Drawer Good Endpoint

Tenderness

Left AC Joint Negative

Patient: NESTLER, GARY S DOB:

Progress Note: Robert J Schneider MD 08/22/2013

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Left Ricipital Groove *Negative*
 AC Joint
 Left Cross Arm Adduction *Negative*
 Sensation
 Left *Intact to light touch distally*
 Radial Pulse
 Left *2+*
Right elbow:
 INSPECTION: no ecchymosis, no swelling. WOUNDS, no
 wounds noted. PALPATION: non-tender. RANGE OF
 MOTION: full range of motion STRENGTH: 5/5 all groups.
 STABILITY: no instability. SENSATION: light touch intact.
 VASCULAR: radial pulse 2+.
Left Elbow:
 General
 Wound *None noted*
 Inspection *No ecchymosis, Swelling noted*
 Tenderness
 Lateral Epicondyle *Positive*
 Medial Epicondyle *Positive*
 Olecranon *Positive*
 Resisted Wrist Extension *Pain with maneuver*
 Resisted Finger Extension *Negative*
 Range of Motion
 Extension *120*
 Flexion *100*
 Supination *70*
 Pronation *70*
 Strength
 Extension *4*
 Flexion *4*
 Supination *4*
 Pronation *4*
 Stability
 Varus Stress *Stable*
 Valgus Stress *Stable*
 Sensation
 Left *Diminished Tingling senastion to ulnar nerve distribution*
 Radial Pulse
 Left *2+*
Right wrist:
 WOUND: none noted. PALPATION (BONE): no tenderness.
 RANGE OF MOTION: full range of motion. STRENGTH: full
 grip strength. STABILITY: no gross instability noted.
 TESTS: negative grind first carpometacarpal (CMC).
 SENSATION: sensation intact all fingers distally.
 VASCULAR: good capillary refill < 3 seconds.
Left Wrist:
 General
 Wound *None noted*
 Swelling *None*
 Tenderness
 Snuff Box *Negative*

Patient: NESTLER, GARY S DOB:

Progress Note: Robert J Schoderbek MD 08/22/2014

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Scaphoid Tubercle *Negative*
 Dorsal *Negative*
 Volar *Negative*
 Modified Watson Test *Negative*
 Carpal Tunnel
 Tinnels *Negative*
 Phalens *Negative*
 Pressure Test *Negative*
 Range of Motion
 Extension 80
 Flexion 80
 Ulnar Deviation 20
 Radial Deviation 20
 Strength
 Flexion 5
 Extension 5
 Grip Strength *Decreased*
 Sensation
 Left Wrist *Intact to light touch distally*
 Radial Pulse
 Left 2+

RADIOGRAPHS:
 Interpretation _____

Assessments

1. Lateral Epicondylitis - 726.32 (Primary)
2. Cervical disc disease - 722.91
3. Posterior interosseous nerve syndrome - 354.3

Treatment

1. Lateral Epicondylitis

Notes: Patient continues to have issues with left elbow pain, hypersensitivity and neurological type symptoms that it extended from his elbow to his hand and proximally as well. We have talked previously about getting an EMG nerve conduction study which I think is a good option to evaluate for neurological injury and the patient's left upper extremity. Impairment rating for the patient would include 13% for his left upper extremity which corresponds to 8% for the whole person. I would even recommend him going to see a neurologist at this point due to his continued elbow pain. We discussed starting some neuroprotective-type medication being either Neurontin or Lyrica at some point but he's not interested in starting any medications at this point. We provided the patient with a Heelbo pad to provide some cushioning to his arm is if they'll help as well.

2. Others

Continue Medications reported as directed by the ordering provider, --, as directed

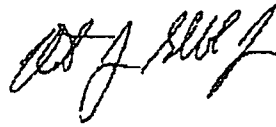
Follow Up

prn

Patient: NESTLER, GARY S DOB:

Progress Note: Robert J Schoderbek MD 08/21/2014

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Electronically signed by ROBERT SCHODERBEK MD on
08/29/2014 at 08:53 AM EDT
Sign off status: Completed

OSC Mt Pleasant
594 LONE TREE DR
MT PLEASANT, SC 29464-8170
Tel: 843-958-2500
Fax: 843-606-8058

Patient: NESTLER, GARYS DOB:

Progress Note: Robert J Schoderbek MD 08/22/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



NESTLER, GARY S

54 Y old Male,
Account Number: 0000220130

Home
Guarantor: NESTLER, GARY S Insurance: BCBS OUT OF
STATE W PPO Payer ID: PAPER
PCP: Allan D Lieberman, MD
Appointment Facility: OSC Mt Pleasant

07/11/2014

Robert J Schoderbek MD

Current Medications

Taking Medications reported as directed by
the ordering provider -- as directed
Medication List reviewed and reconciled with
the patient

Past Medical History

No Medical History.

Surgical History

No Surgical History documented.

Family History

Denies cardiac, respiratory, gastrointestinal,
genitourinary, and other musculoskeletal
issues in the patient's family.

Social History

Tobacco Use:
Tobacco Use/Smoking: Are you a:
nonsmoker.
Drugs/Alcohol:
Drugs: Denies.
Alcohol Screen: Denies.

Allergies

cumin

Hospitalization/Major

Diagnostic Procedure

No Hospitalization History.

Review of Systems

General/Constitutional:

Fatigue denies. Weakness denies.

Weight change denies.

Musculoskeletal:

... See HPI for details.

Reason for Appointment

1. OFFICE VISIT 15

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SIAP

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Left Yergasons *Negative*

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Left AC Joint *Negative*

Patient: NESTLER, GARY S DOR:

Progress Note: Robert J Schoderbek MD 07/11/2014

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