THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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SC Court of Appeals

APPEAL FROM SOUTH CAROLINA
SC Workers' Compensation Commission
Appellate Panel

Appellate Case No.: 2018-001237

Kenneth L. Barr, Claimant, ... Appellant,

v.

Darlington County School District, Employer,
and SC School Boards Insurance Trust,
Carrier, ...Respondents.

RECORD ON APPEAL
VOLUME II OF IV

Preston F. McDaniel
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Counsel for Respondents

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RE: Kenneth L. Barr
DOB:

Dear Dr. Healy:

I would appreciate it if you would provide answers and opinions to the following questions concerning your patient Kenneth L. Barr:

1. Is the history that you have at this point as recorded initially by you on 3/31/16 that Mr. Barr became a commercial painter and began being exposed to commercial paints with the School District over six (6) years ago and that approximately six (6) years ago he developed and sought medical care for chronic headaches and fatigue; that thereafter he has been treated for chronic headaches and that in May of 2015 he was taken out of work as a commercial painter due to severe chronic headaches and fatigue; and that the paints to which he was exposed were commercial paints which contain a high level of Volatile Organic Compounds. Does that accurately reflect the history and your understanding of exposure by Mr. Barr at this point in time?

X
Yes

No

RJH
RJH (initials)

2. Is it your working diagnosis at this time that he is suffering from chronic, daily headaches and fatigue that require medications and other treatment to control?

X
Yes

No

RJH
RJH (initials)

3. Is it your opinion as this point in time that he is not at maximum medical improvement in reference to his chronic headaches and fatigue and is in need of additional evaluation and treatment for those problems?

X
Yes

No

RJH
RJH (initials)

4. Have you had and treated other patients that have been exposed to commercial paints and have suffered problems related to that exposure to the Volatile Organic Compounds in the paints?

X
Yes

No

RJH
RJH (initials)

5. Based on the history that you have available to you at this time and based upon your evaluation and treatment of Mr. Barr at this time, is it your opinion at this point in time that his chronic headaches and fatigue are causally related to his exposure to the Volatile Organic Compounds in the commercial paints he was using between 2009 and 2015?

X
Yes

No

RJH
RJH (initials)

The above referenced opinions expressed by me concerning by patient, Kenneth L. Barr, constitute my opinions to a reasonable degree of medical certainty.

R. Joseph Healy, M.D.

8/16/16
Date:

OFFICE NOTE
R. JOSEPH HEALY, MD

DATE: 7/21/16

PATIENT: Kenneth Barr DOB

7/21/16	OOA	24 hr ECG (-) Still smoking
		carotid US (-)
5'10"		still having "spells"
134		Hx poor memory (immediate)
109/73		hx bilateral retinal hemorrhages
		cholesterol OK no diabetes
		homocysteine borderline 15
		hx osa → using c-PAP
		still hx daily headache
		will give trial of VPA 250/250

OFFICE NOTE
R. JOSEPH HEALY, MD

DATE: 6/28/16

PATIENT: Kenneth Barr DOB

6/28/16 using C-PAP poor memory
PLMS - ferritin 47 → supplement Fe
134 having episodes of headache →
124/83 chest pain → stutters and disoriented x4
2 episodes yesterday
heavy snoker
palpitations → fatigue

- AMS - episodic → needs long EEG
- ? CAD
- PLMS - dedicated qst Requip

OFFICE NOTE
R. JOSEPH HEALY, MD

DATE: 5/4/16

PATIENT: Kenneth Barr DOB

5/4/16 PSG shows severe OSA
emergency C-PAP started → 10 cm H_2O
5'10" PMS – ↓ fertility
140 Trial Regimen 142 g M q 4 hrs
123/87 ABG on RA – mildly abnormal
PFT
go see eye doctor

R. Joseph Healy, M.D., P.A.
P.O. Box 3408
805 Pamplico Hwy, Suite a130
Florence, South Carolina 29505
(843) 664 9200
(843) 664-9202 (FAX)

Polysomnograph Interpretation

95811

Name: Kenneth Barr
Date of Birth:
Weight: 138
Height: 5' 11"

Date of Study: 4/27/2016

Referring Physician: Healy

Reason for Study: Sleep apnea and hypersomnia

Epworth Sleepiness Scale: 11/24

Sleep Statistics: Sleep latency was 10.5 minutes. Total sleep time of 323.0 minutes with a sleep efficiency of 86.5%. Slow wave sleep accounted for 13.9% of sleep time. REM sleep occurred with a latency of 307.0 minutes and accounted for 11.8% of total sleep time.

Respiratory Data: There were a total of 2 obstructive apneas and 125 hypopneas which resulted in an overall AHI of 23.6. AHI prior to CPAP was 54.9. AHI @ 8cm was 0.0.

Oximetry Data: Mean oxygen saturation level was 96%. A total of 127 desaturations were seen with a minimum desaturation of 84%.

Myoclonus Data: 175 limb movements were reported with 102 of these movements occurring in sequence. This equates to a PLM index of 18.9.

Cardiac Data: The patient's mean heart rate was 49 beats per minute. Sinus bradycardia was noted.

Impression: NPSG portion was abnormal due to the presence of severe obstructive sleep apnea syndrome with associated desaturations and secondarily disordered sleep architecture. Emergency CPAP was initiated and successfully titrated to an optimal pressure of 8cm of H2O. CPAP therapy at home is recommended with compliance monitoring. Moderate nocturnal myoclonus was also reported. Treatment for myoclonus is recommended if clinically indicated. Emphasis on proper sleep hygiene and proper sleep environment is also recommended. Clinical correlation is warranted.

R. Joseph Healy, M.D.

CAROLINAS HOSPITAL SYSTEM
BARR KENNETH L HSV:8LP
Admit: 04/27/16 MedRec:0003 89092
Att Dr.: HEALY R JOSEPH JR
DOB: Age: Y
Sex:M Pat #:3968770

OFFICE NOTE
R. JOSEPH HEALY, MD

DATE: 4/19/16

PATIENT: Kennetta L. Barr DOB [redacted]

MRN [illegible]

4/19/16 Persistent headache
Takes headache medication daily
5'10" ? Rebound headache
171 Still a smoker - no pulmonary complaints
12/4/16 has confusional episodes

- COPD
- Chronic headache
- ? rebound
- Sleep disorder
  await PSG

MRI OF THE BRAIN

DATE: April 11, 2016

PATIENT: Kenneth Barr

DOB:

Diagnosis: Memory loss and Chronic HA

Routine pulse sequences utilize image of the head and intracranial contents. Sagittal, axial and coronal images are obtained. No contrast given.

Brain volume normal. There are no extracerebral collections. The flow voids are normal. Sinus and orbits unremarkable. Ventricular system normal. Posterior fossa normal. There is no abnormal signal or abnormal enhancement.

R. JOSEPH HEALY, MD
RJH/nb

PATIENT NAME Bass, Kenneth DATE 4/11/16

30/30 DOB

MINI-MENTAL STATE EXAM

Instructions: Ask all questions in the order listed and score immediately. Record total number of points.

Maximum Score	Score	
5	(5)	1. Ask the patient to name the year, season, date, day and month. (1 point each).
5	(5)	2. Ask the patient to give his/her whereabouts: state, county, town, street, floor. (1 point each).
3	(3)	3. Ask the patient to repeat three unrelated objects that you name. Repeat them and continue to repeat them until all three are learned. (1 point each). Bird, Clock, Shoe
5	(5)	4. Ask the patient to subtract 7 from 100, stopping after five subtractions, or to spell the word "world" backwards. (1 point for each correct calculation or letter.)
3	(3)	5. Ask the patient to repeat the three objects previously named. (1 point each)
2	(2)	6. Display a wrist watch and ask the patient to name it. Repeat this for a pencil. (1 point each).

Maximum Score	Score	
1	(1)	7. Ask the patient to repeat this phrase: "No ifs, ands, or buts!" (1 point)
3	(3)	8. Have the patient follow a three-point command such as, "Take a paper in your right hand, fold it in half, and put it on the floor!" (1 point each)
1	(1)	9. On a blank piece of paper write, "Close your eyes!" Ask the patient to read it and do what it says. (1 point)
1	(1)	10. Ask the patient to write a sentence on a blank piece of paper. It must be written spontaneously. Score correctly if it contains a subject and a verb and is sensible. (Correct grammar and punctuation are not necessary.) (1 point)
1	(1)	11. Ask the patient to copy a design you have drawn on a piece of paper (two intersecting pentagons with sides about one inch). (1 point)

Total Score: 30

(Maximum score = 30)

SCORING[1]: Scores of 23 or less: a high likelihood of dementia.
Scores of 25-30: normal aging or borderline.

[1] Adapted from Folstein et al.[14]

R. Joseph Healy MD, PA

new patient / consult / admission

Date 3/31/16
Name Kenneth Barr
MR#
Age / Sex
Ref. MD
LMD
Height 5'10"
Weight 134
Vision
OD - 20/20
OS - 20/20
Glasses
11/7/85

Chief Complaint:

PMHx:
Cardiac
Diabetes
Hyperlipidemia
Hypertension
Smoker
Alcohol
Drugs
Pulmonary - some dyspnea
GI
GU
Surgery - hypothyroid
Transfusion
HEENT
STD
Endocrine
Rheumatologic
Musculoskeletal
Infections Disease
Neoplastic
Vaccinations

painter x 12 year
6 years c sides (systems)
Taken out of work
last 5/15 due to
chronic HA, fatigue
paint @ school has
high VOC

HA x 4 years - generalized
NSAID worked in beginning
con awaken

memory ↓ x 18 months
immediate recall

3/15 episode of
confusion
lost while
driving

Allergies
Drug
Contrast
Food

Medications
Depakote ER
Levothyroxine 100
Hydrocodone

Neurologic Hx and Risk Factors: bad memory ↓

CVA
Seizure
CHI
Psychiatric
Headache
Infectious Disease
Vascular
Neoplastic
Surgery
ROS

anxiety
depression

Family Med Hx:
Maternal
Paternal
Children

no disease
F 72 ✓ cancer
M 75 SLE

Social Hx:
M / S / D
Education / Occupation
Children
Exercise
Sexual Orientation

married
out of work

ROS
General Health
Fever
Rash
Wt. Loss / Gain
Arthralgia
Myalgia
Weakness
Dysuria
Cardiac
Pulmonary
ABD / GI
HEENT
Musculoskeletal
Skin
Allergy
GU
Sleep - poor
Psychiatric
Dementia

Chronic ↓ memory
Memory loss
Sleep disorder
MS

CAROLINAS
HOSPITAL SYSTEM

ELECTRONEURODIAGNOSTIC
EEG Monitoring Interpretation

Patient: Barr, Kenneth L.
Medical Record: 389092
Dates: 7/5-7/6/16
Referring Physician: Healy
Room#: 816
Interpreting Physician: Healy
Account # 4000778

Digital Analysis done on 7/6/16

EEG Monitoring with Video X 18 hours

Normal awake & asleep EEG + 2 seizures

Date of Interpretation 7/7/16

CAROLINAS HOSPITAL SYSTEM
BARR KENNETH L HSV:OBS
Admit: 07/05/16 MedRec:000389092
Att D[illegible] R JOSE[illegible] TR
DOB: Age: Y
Sex:M Pat #:4000778

Patient Name: BARR, KENNETH L
MRN: 389092 FIN: 4000778 DOB:
Admission Date: 07/06/16 11:49:00

History and Physical

Facility:
Carolinas Hospital System
805 Pamplico Highway
Florence SC 29505

* Final Report *

Chief Complaint
episodic confusion

History of Present Illness
year-old right handed white male who had been seeing for several months. Patient has been a pain or for 12 years. Last 6 years have been with the school system. Patient was taken out of work about a year ago due to chronic headache and fatigue. the patient said he uses at school were high in volitile organic compounds. he would use a resplrator. Patient has had a 4 year history of headaches which seem to occur without aura and can awaken him from sleep. these are generalized and initially relieved with nonsteroidals. Since then nothing has really been beneficial. Pt does take medication for headache daily. patient also has been having episodes of confusion. On one occasion he got lost while driving. Typically has no memory for the events. No frank, partial or focal seizure activity has been noted. there has been no tongue bite or incontinence.he complains of tremor which is low amplitude and high frequency and occurs with action. patient doesn't believe alcohol helps the tremor. No known family history for tremor. patient has had neuropsychological testing which showed cognitive impairment

Review of Systems
sleep is fragmented but he does use CPAP. He does snore. PSG was remarkable for OSA. Weight has been stable. Appetite is fair. he does experience palpitations. on several occasions he has had chest pain. He complains of poor memory which typically his recent or immediate memory. Patient is a heavy smoker and continues. Fatigue is a major complaint. no nausea or vomiting. no melena or hematochezia. he does have increasing dyspnea with exertion. he does suffer from PLMS and ferritin was borderline low and has been supplemented.

Physical Exam

Vitals & Measurements
T: 54 °F (Intravascular) **T:** 97.9 °F (Oral) **TMIN:** 54 °F (Intravascular) **TMAX:** 97.9 °F (Oral) **HR:** 54 (Monitored) **RR:** 21 **BP:** 102/64 **SpO2:** 98% **WT:** 60.3 kg
General: thin appearing, no acute distress
HEENT: atraumatic, PERRLA, moist mucosa, normal pharynx, normal tonsils and adenoids, normal tongue, no fluid in sinuses
Neck: Trachea midline, no carotid bruit, no masses. decreased extension of the cervical spine

Problem List/Past Medical History
Ongoing
No qualifying data
Historical
No qualifying data
Chronic headache
Hypothyroid
Depression
Anxiety

Procedure/Surgical History

Medications
Inpatient
Aspirin Low Dose, 81 mg, 1 tab(s), Oral, Daily
lisinopril, 20 mg, 2 tab(s), Oral, Daily
methimazole, 5 mg, 1 tab(s), Oral, Daily
Protonix, 20 mg, Oral, Daily
PROzac, 40 mg, 4 cap(s), Oral, Daily
Valium, 10 mg, 1 tab(s), Oral, TID, PRN
Home
Aspirin Low Dose, 81 mg, Oral, Daily
lisinopril 20 mg oral tablet, 20 mg, 1 tab(s), Oral, Daily
Lorcet HD 10 mg-325 mg oral tablet, 1 tab(s), Oral, BID
methimazole, 5 mg, Oral, Daily
NexIUM 40 mg oral delayed release capsule, 40 mg, 1 cap(s), Oral, Daily
PROzac 40 mg oral capsule, 40 mg, 1 cap(s), Oral, Daily
Valium, 10 mg, Oral, TID, PRN

Allergies
No Known Medication Allergies

Result type:	History and Physical
Result date:	July 05, 2016 18:59 EDT
Result status:	Auth (Verified)
Result title:	Admission H & P
Performed by:	HEALY JR, R JOSEPH MD on July 05, 2016 19:00 EDT
Verified by:	HEALY JR, R JOSEPH MD on July 06, 2016 10:57 EDT
Encounter info:	4000778, SC Carolinas, Inpatient, 7/6/2016 - 7/7/2016

Printed by: Thomy, Mary Healy Office
Printed on: 08/16/2016 11:51 EDT

Respiratory: normal chest wall expansion, CTA B, no r/r/w, no rubs
Cardiovascular: RRR, no m/r/g, Normal S1 and S2
Abdomen: Soft, non-tender, non-distended, normal bowel sounds in all quadrants, no hepatosplenomegaly, no tympany
Genitourinary: deferred
Rectal: deferred
Musculoskeletal: normal ROM in upper and lower extremities
Integumentary: warm, dry, and pink, with no rash, purpura, or petechia
Heme/Lymph: no lymphadenopathy, no bruises
Neurological: 2+ patellar reflexes, Cranial Nerves II-XII grossly intact, no tics, normal sensation to pressure and light touch. no lateralized motor weakness
Psychiatric: cooperative with normal mood, affect, and cognition

Assessment/Plan
Ordered:
aspirin, 81 mg, Tab-DR, Oral, Daily, Routine, First Dose: 07/06/16 9:00:00 EDT
diazepam, 10 mg, Tab, Oral, TID PRN for agitation or anxiety, Routine, First Dose: 07/05/16 18:58:00 EDT
FLUoxetine, 40 mg, Cap, Oral, Daily, Routine, First Dose: 07/06/16 9:00:00 EDT
lisinopril, 20 mg, Tab, Oral, Daily, Routine, First Dose: 07/06/16 9:00:00 EDT
methimazole, 5 mg, Tab, Oral, Daily, Routine, First Dose: 07/06/16 9:00:00 EDT
pantoprazole, 20 mg, Tab-DR, Oral, Daily, Routine, First Dose: 07/06/16 7:00:00 EDT
Basic Metabolic Profile w/Total Calcium
Complete Blood Count w/o Diff
Place in Observation
Telemetry Monitoring
episodic confusion- patient being admitted for 24-hour EEG.

sleep disordered breathing- patient will use his CPAP in the hospital and will check oximetry overnight to see if it is adequate.

anemia- we will check stool Hemoccult and iron studies along with a B12 level

Chronic cephalalgia- we will give her a dose of DHE 45 to see if this is compatible with chronic daily headache

chest pain- we will monitor his cardiac rhythm. EKG will be obtained along with echo. Will ask cardiology to see since he has significant risk for coronary artery disease.

Social History
Alcohol
Past, Beer, Wine, Liquor
Employment/School
disable
Exercise
Exercise duration: 0.
Home/Environment/Abuse
Lives with Spouse. Living situation: Home/Independent. Home equipment: CPAP/BiPAP. Alcohol abuse in household: No. Substance abuse in household: No. Smoker in household: No. Feels unsafe at home: No. Safe place to go: Yes. Family/Friends available for support: Yes. Concern for family members at home: No.
Marijuana Recreational Use
Former smoker, Household Marijuana Concerns: No.
Nutrition/Health
Regular
Sexual
Sexually active: Yes.
Substance Abuse
Never
Tobacco
5 or more cigarettes avg volume per day (=>1/4 pack), Current every day smoker, Cigarettes

Family History
father died at 72 of cancer
Mother is 75 and has SLE
no family history for tremor

Immunizations
current

Lab Results
Labs (Last four charted values)

Result type:	History and Physical
Result date:	July 05, 2016 18:59 EDT
Result status:	Auth (Verified)
Result title:	Admission H & P
Performed by:	HEALY JR, R JOSEPH MD on July 05, 2016 19:00 EDT
Verified by:	HEALY JR, R JOSEPH MD on July 06, 2016 10:57 EDT
Encounter info:	4000778, SC Carolinas, Inpatient, 7/6/2016 - 7/7/2016

Printed by: Thomy, Mary Healy Office
Printed on: 08/16/2016 11:51 EDT

Patient Name: **BARR, KENNETH I**
MRN: 389092 FIN: 4000778 DOB:
Admission Date: **07/06/16 11:49:00**

History and Physical

Facility:
Carolinas Hospital System
806 Pamplico Highway
Florence SC 29505

Further recommendations will await completion of the database.

WBC	7.4	(JUL 05)
Hgb	L 11.5	(JUL 05)
Hct	L 35.0	(JUL 05)
Plt	276	(JUL 05)
Na	142	(JUL 05)
K	3.9	(JUL 05)
CO2	29	(JUL 05)
Cl	102	(JUL 05)
Cr	L 0.8	(JUL 05)
BUN	9	(JUL 05)
Ca	9.4	(JUL 05)

Diagnostic Results
MRI of the head was unremarkable.
Routine EEG was normal

Signature Line
Electronically Signed on 07/06/2016 10:57 AM EDT

HEALY JR, R JOSEPH MD

Completed Action List:
* Perform by HEALY JR, R JOSEPH MD on July 05, 2016 19:00 EDT
* Sign by HEALY JR, R JOSEPH MD on July 06, 2016 10:57 EDT Requested by HEALY JR, R JOSEPH MD on July 05, 2016 19:00 EDT
* VERIFY by HEALY JR, R JOSEPH MD on July 06, 2016 10:57 EDT

Result type:	History and Physical
Result date:	July 05, 2016 18:59 EDT
Result status:	Auth (Verified)
Result title:	Admission H & P
Performed by:	HEALY JR, R JOSEPH MD on July 05, 2016 19:00 EDT
Verified by:	HEALY JR, R JOSEPH MD on July 06, 2016 10:57 EDT
Encounter info:	4000778, SC Carolinas, Inpatient, 7/6/2016 - 7/7/2016

Printed by: Thomy, Mary Healy Office
Printed on: 08/16/2016 11:51 EDT

NI Echo TTE 2D Complete w Color Doppler

Patient Name: BARR, KENNETH L
MRN: 389092FIN: 4000778 DOB:
Admission Date: 07/06/16 11:49:00

Facility:
Carolinas Hospital System
805 Pamplico Highway
Florence SC 29505

* Final Report *

Reason For Exam
bradycardia;Other (please specify)

RADRPT
FLORENCE, SOUTH CAROLINA
ECHOCARDIOGRAM REPORT

Pt. Name:	KENNETH L BARR	MRN #:	389092		
Exam Date:	7/6/2016	Pt DOB:			
Date of Report:	7/6/2016	Ht.:	70 in	AGE	years
Referring Phys:	HEALY	Wt:	140 lb		
ROOM #:	816	BSA:	1.79		
Indication:	AMS HTN SOB	Sonographer:	Karla Ard RDCS		

Study Details: Complete Echocardiogram-93306. Adequate echocardiogram. The patient was awake.

******Impression******
1. LV ejection fraction is estimated to be 55 to 60%.
2. Mild aortic valve sclerosis without stenosis.
3. Mild mitral valve regurgitation.
4. Mild tricuspid regurgitation.

Rate and Rhythm: Sinus bradycardia.

Left Ventricle: Overall left ventricular ejection fraction is estimated to be 55 to 60%. Normal left ventricular size. Spectral Doppler shows normal pattern of LV diastolic filling. The left ventricular ejection fraction is normal.

Right Ventricle: The right vetricle is normal in size. The right ventricular systolic function appears normal.

Result type:	NI Echo TTE 2D Complete w Color Doppler
Result date:	July 06, 2016 12:42 EDT
Result status:	Auth (Verified)
Result title:	NI Echo TTE 2D Complete w Color Doppler
Performed by:	Ard, Karla Reg Vascular Techno Lead on July 06, 2016 12:42 EDT
Verified by:	HEALY JR, R JOSEPH MD on July 06, 2016 15:39 EDT
Encounter info:	4000778, SC Carolinas, Inpatient, 7/6/2016 - 7/7/2016

Printed by: Thorny, Mary Healy Office
Printed on: 08/16/2016 11:50 EDT

NI Echo TTE 2D Complete w Color Doppler

Patient Name: BARR, KENNETH L
MRN: 389092FIN: 4000778 DOB:
Admission Date: 07/06/16 11:49:00

Facility:
Carolinas Hospital System
805 Pamplico Highway
Florence SC 29505

Atria: The left atrium is mildly dilated. The left atrial A/P dimension is 4.00 cm. The right atrium is mildly dilated.
Pericardium/Pleural: No pericardial effusion is seen.
Great vessels: Aortic root is normal in size.
Pulmonary Artery: The pulmonary artery is not well visualized.
Venous: The inferior vena cava was not well seen.
Mitral Valve: The mitral valve is thickened. Mild mitral valve regurgitation is seen.
Tricuspid Valve: The tricuspid valve is normal in structure. Mild tricuspid regurgitation is visualized. The tricuspid regurgitant velocity is 2.22 m/s, and with an assumed right atrial pressure of 10 mmHg, the estimated right ventricular pressure is normal at 29.7 mmHg.
Aortic Valve: The aortic valve is trileaflet. Mild aortic valve sclerosis is present, with no evidence of aortic valve stenosis. No aortic valve regurgitation is seen.
Pulmonic Valve:The pulmonic valve was not well visualized. Trace pulmonic valve regurgitation.

Electronically signed by: Greg A May Dr. on:7/6/2016 at: 3:43:37 PM

2D AND M-MODE MEASUREMENTS :

Left Ventricle:

		Normal
IVSd (2D):	0.9 cm	(0.7-1.1)
LVPWd (2D):	1.0 cm	(0.7-1.1)
LVIDd (2D):	5.0 cm	(3.4-5.7)
LVIDs (2D):	3.6 cm	
LV FS (2D):	28.7 %	(>25%)
LV EF (2D):	55 %	(>50%)

Aorta/Left Atrium:

		Normal
Aortic Root:	3.4 cm	(2.4-3.7)
AoV Cusp Separation:	2.6 cm	(1.5-2.6)
Left Atrium (Mmode):	4.0 cm	(1.9-4.0)

Right Ventricle:
RVd (2D): 2.8 cm

Result type:	NI Echo TTE 2D Complete w Color Doppler
Result date:	July 06, 2016 12:42 EDT
Result status:	Auth (Verified)
Result title:	NI Echo TTE 2D Complete w Color Doppler
Performed by:	Ard, Karla Reg Vascular Techno Lead on July 06, 2016 12:42 EDT
Verified by:	HEALY JR, R JOSEPH MD on July 06, 2016 15:39 EDT
Encounter info:	4000778, SC Carolinas, Inpatient, 7/6/2016 - 7/7/2016

Printed by: Thomy, Mary Healy Office
Printed on: 08/16/2016 11:50 EDT

NI Echo TTE 2D Complete w Color Doppler

Patient Name: BARR, KENNETH L
MRN: 389092FIN: 4000778 DOB:
Admission Date: 07/06/16 11:49:00

Facility:
Carolinas Hospital System
805 Pamplico Highway
Florence SC 29505

Atria: The left atrium is mildly dilated. The left atrial A/P dimension is 4.00 cm. The right atrium is mildly dilated.
Pericardium/Pleural: No pericardial effusion is seen.
Great vessels: Aortic root is normal in size.
Pulmonary Artery: The pulmonary artery is not well visualized.
Venous: The inferior vena cava was not well seen.
Mitral Valve: The mitral valve is thickened. Mild mitral valve regurgitation is seen.
Tricuspid Valve: The tricuspid valve is normal in structure. Mild tricuspid regurgitation is visualized. The tricuspid regurgitant velocity is 2.22 m/s, and with an assumed right atrial pressure of 10 mmHg, the estimated right ventricular pressure is normal at 29.7 mmHg.
Aortic Valve: The aortic valve is trileaflet. Mild aortic valve sclerosis is present, with no evidence of aortic valve stenosis. No aortic valve regurgitation is seen.
Pulmonic Valve:The pulmonic valve was not well visualized. Trace pulmonic valve regurgitation.

Electronically signed by: Greg A May Dr. on:7/6/2016 at: 3:43:37 PM

2D AND M-MODE MEASUREMENTS :

Left Ventricle:

		Normal
IVSd (2D):	0.9 cm	(0.7-1.1)
LVPWd (2D):	1.0 cm	(0.7-1.1)
LVIDd (2D):	5.0 cm	(3.4-5.7)
LVIDs (2D):	3.6 cm	
LV FS (2D):	28.7 %	(>25%)
LV EF (2D):	55 %	(>50%)

Aorta/Left Atrium:

		Normal
Aortic Root:	3.4 cm	(2.4-3.7)
AoV Cusp Separation:	2.6 cm	(1.5-2.6)
Left Atrium (Mmode):	4.0 cm	(1.9-4.0)

Right Ventricle:
RVd (2D): 2.8 cm

Result type:	NI Echo TTE 2D Complete w Color Doppler
Result date:	July 06, 2016 12:42 EDT
Result status:	Auth (Verified)
Result title:	NI Echo TTE 2D Complete w Color Doppler
Performed by:	Ard, Karla Reg Vascular Techno Lead on July 06, 2016 12:42 EDT
Verified by:	HEALY JR, R JOSEPH MD on July 06, 2016 15:39 EDT
Encounter Info:	4000778, SC Carolinas, Inpatient, 7/6/2016 - 7/7/2016

Printed by: Thomy, Mary Healy Office
Printed on: 08/16/2016 11:50 EDT

NI Echo TTE 2D Complete w Color Doppler

Patient Name: BARR, KENNETH L
MRN: 389092FIN: 4000778 DOB:
Admission Date: 07/06/16 11:49:00

Facility:
Carolinas Hospital System
805 Pamplico Highway
Florence SC 29505

Doppler Data:

Mitral Valve:
MV Peak E: 1.0 m/s
MV Peak A: 0.7 m/s
E/A Ratio: 1.4

E/e' Ratio: 7.1
Decel Time: 254.0 msec

MV p1/2 T: 73.7 msec
MV Area PHT: 3.0 cmï¿½

LVOT Vmax: LVOT VTI: LVOT Diameter: 2.0 cm

Tricuspid Valve: PA/RV Systolic Pressure:
RA pressure: 10 mmHg TR VMax: 224.0 cm/s RVSP/PASP: 29.7 mmHg

*** Final ***

CAROLINAS HOSPITAL SYSTEM

Signature Line
***** Final *****

Signed by: HEALY JR, R JOSEPH MD
Signed (Electronic Signature): 07/06/2016 03:39 pm EDT

Completed Action List:

Result type:	NI Echo TTE 2D Complete w Color Doppler
Result date:	July 06, 2016 12:42 EDT
Result status:	Auth (Verified)
Result title:	NI Echo TTE 2D Complete w Color Doppler
Performed by:	Ard, Karla Reg Vascular Techno Lead on July 06, 2016 12:42 EDT
Verified by:	HEALY JR, R JOSEPH MD on July 06, 2016 15:39 EDT
Encounter info:	4000778, SC Carolinas, Inpatient, 7/6/2016 - 7/7/2016

Printed by: Thomy, Mary Healy Office
Printed on: 08/16/2016 11:50 EDT

NI Echo TTE 2D Complete w Color Doppler

Patient Name: BARR, KENNETH L
MRN: 389092FIN: 4000778 DOB:
Admission Date: 07/06/16 11:49:00

Facility:
Carolinas Hospital System
805 Pamplico Highway
Florence SC 29505

* Order by HEALY JR, R JOSEPH MD on July 06, 2016 10:58 EDT
* Perform by Ard, Karla Reg Vascular Techno Lead on July 06, 2016 12:42 EDT
* VERIFY by HEALY JR, R JOSEPH MD on July 06, 2016 15:39 EDT

Result type:	NI Echo TTE 2D Complete w Color Doppler
Result date:	July 06, 2016 12:42 EDT
Result status:	Auth (Verified)
Result title:	NI Echo TTE 2D Complete w Color Doppler
Performed by:	Ard, Karla Reg Vascular Techno Lead on July 06, 2016 12:42 EDT
Verified by:	HEALY JR, R JOSEPH MD on July 06, 2016 15:39 EDT
Encounter info:	4000778, SC Carolinas, Inpatient, 7/6/2016 - 7/7/2016

Printed by: Thomy, Mary Healy Office
Printed on: 08/16/2016 11:50 EDT

EKG Report

Patient Name: BARR, KENNETH L
MRN: 389092FIN: 4000778 DOB:
Admission Date: 07/06/16 11:49:00

Facility:
Carolinas Hospital System
805 Pamplico Highway
Florence SC 29505

* Final Report *

Electrocardiogram 12 Lead
This document has an image

Electrocardiogram 12 Lead

Stationary ECG Study
Carolinas Hospital System

Pat Name:	KENNETH BARR	Test Date:	7/6/2016 2:44:04 PM
Patient ID:	389092	Department:	
Gender:	Male	Room:	816 1
DOB:		Technician:	MJ
Order Number:	975154213	Requested by:	R Healy
		Reading MD:	Thomas Stoughton, M. D.

Intervals		Axis	
Rate:	52	P:	74
PR:	150	QRS:	59
QRSD:	88	T:	59
QT:	434		
QTc:	403		

Interpretive Statements
Sinus bradycardia

Electronically Signed On 7-7-2016 18:47:00 by Thomas Stoughton, M. D.

Result type:	EKG Report
Result date:	July 06, 2016 14:44 EDT
Result status:	Auth (Verified)
Result title:	Electrocardiogram 12 Lead
Performed by:	STOUGHTON, THOMAS L MD on July 06, 2016 14:44 EDT
Verified by:	STOUGHTON, THOMAS L MD on July 07, 2016 18:47 EDT
Encounter info:	4000778, SC Carolinas, Inpatient, 7/6/2016 - 7/7/2016
Contributor system:	SCC_EPIPHANY

Printed by: Thorny, Mary Healy Office
Printed on: 08/16/2016 11:50 EDT

EKG Report

Patient Name: BARR, KENNETH L
MRN: 389092FIN: 4000778 DOB:
Admission Date: 07/06/16 11:49:00

Facility:
Carolinas Hospital System
805 Pamplico Highway
Florence SC 29505

Completed Action List:
* Perform by STOUGHTON, THOMAS L MD on July 06, 2016 14:44 EDT
* Assist by on July 06, 2016 14:44 EDT
* VERIFY by STOUGHTON, THOMAS L MD on July 07, 2016 18:47 EDT
* Assist by STOUGHTON, THOMAS L MD on July 07, 2016 18:47 EDT

Result type:	EKG Report
Result date:	July 06, 2016 14:44 EDT
Result status:	Auth (Verified)
Result title:	Electrocardiogram 12 Lead
Performed by:	STOUGHTON, THOMAS L MD on July 06, 2016 14:44 EDT
Verified by:	STOUGHTON, THOMAS L MD on July 07, 2016 18:47 EDT
Encounter info:	4000778, SC Carolinas, Inpatient, 7/6/2016 - 7/7/2016
Contributor system:	SCC_EPIPHANY

Printed by: Thomy, Mary Healy Office
Printed on: 08/16/2016 11:50 EDT

Stress Test

Patient Name: BARR, KENNETH L
MRN: 389092FIN: 4000778 DOB:
Admission Date: 07/06/16 11:49:00

Facility:
Carolinas Hospital System
805 Pamplico Highway
Florence SC 29505

* Final Report *

STRESS TEST
DATE OF SERVICE: 07/07/2016

PERSANTINE MYOVIEW STRESS TEST

INDICATION: The patient is a -year-old male with risk factors for coronary artery disease including hypertension and tobacco use, who gives a history of atypical chest pain and palpitations. The patient is undergoing a Persantine Myoview stress test to exclude myocardial ischemia. The patient has poor exercise tolerance and is disabled from his job.

PROCEDURE: Baseline blood pressure 140/89, baseline heart rate 47. Baseline EKG shows sinus bradycardia. There were nonspecific T-wave abnormalities noted in the inferior leads.

The patient received intravenous Persantine by standard protocol. During the Persantine infusion, ECG showed no diagnostic ischemic changes. There was no significant atrial or ventricular ectopy noted. During the Persantine infusion, the patient complained of headache, but had no chest pain or shortness of breath. The patient received 75 mg of intravenous aminophylline at the conclusion of the procedure. During the Persantine infusion, heart rate increased from 47 at baseline to a peak of 76. Blood pressure fell from 140/89 to a low of 121/77.

The patient received 10.5 mCi of intravenous technetium-99 Myoview at rest and 25.5 mCi of intravenous technetium-99 Myoview following Persantine infusion. Nuclear images were obtained in standard views.

Myocardial perfusion images show an inferior defect, which is more prominent on the resting image compared to the stress image, suggesting that this is a diaphragm attenuation artifact. There is no clear-cut evidence of myocardial ischemia noted.

Gated images show normal wall motion in all segments with an ejection fraction of 63%.

Result type:	Stress Test
Result date:	July 07, 2016 11:43 EDT
Result status:	Auth (Verified)
Result title:	ST
Performed by:	MAY, GREGORY ARTHUR MD on July 07, 2016 11:43 EDT
Verified by:	MAY, GREGORY ARTHUR MD on July 18, 2016 16:28 EDT
Encounter info:	4000778, SC Carolinas, Inpatient, 7/6/2016 - 7/7/2016
Contributor system:	SCC_MMODAL

Stress Test

Patient Name: BARR, KENNETH L
MRN: 389092FIN: 4000778 DOB:
Admission Date: 07/06/16 11:49:00

Facility:
Carolinas Hospital System
805 Pamplico Highway
Florence SC 29505

The TID ratio is 0.99, which is within normal limits.

IMPRESSION: This is a negative nuclear stress test for ischemia. Based on these stress test results, there would be a low suspicion for significant obstructive coronary artery disease.

Gregory A May, MD

CC:
Jennifer Lynch, NP
RJoseph . HealyJr, MD

D Date / Time: 07/07/2016 11:43 AM ET
T Date / Time: 07/07/2016 08:18 PM ET
R Date / Time:
S Job #: CARHS83751116
D Job #: 444630
MT: 1202211

Signature Line
Electronically Signed on 07/18/2016 04:28 PM EDT

MAY, GREGORY ARTHUR MD

Completed Action List:
* Perform by MAY, GREGORY ARTHUR MD on July 07, 2016 11:43 EDT
* Transcribe by on July 07, 2016 20:18 EDT
* Sign by MAY, GREGORY ARTHUR MD on July 18, 2016 16:28 EDTRequested on July 07, 2016

Result type:	Stress Test
Result date:	July 07, 2016 11:43 EDT
Result status:	Auth (Verified)
Result title:	ST
Performed by:	MAY, GREGORY ARTHUR MD on July 07, 2016 11:43 EDT
Verified by:	MAY, GREGORY ARTHUR MD on July 18, 2016 16:28 EDT
Encounter info:	4000778, SC Carolinas, Inpatient, 7/6/2016 - 7/7/2016
Contributor system:	SCC_MMODAL

Stress Test

Patient Name: BARR, KENNETH L
MRN: 389092FIN: 4000778 DOB:
Admission Date: 07/06/16 11:49:00

Facility:
Carolinas Hospital System
805 Pamplico Highway
Florence SC 29505

20:23 EDT
* VERIFY by MAY, GREGORY ARTHUR MD on July 18, 2016 16:28 EDT
* Review by HEALY JR, R JOSEPH MD on August 07, 2016 16:24 EDTRequested on July 07, 2016
20:23 EDT

Result type:	Stress Test
Result date:	July 07, 2016 11:43 EDT
Result status:	Auth (Verified)
Result title:	ST
Performed by:	MAY, GREGORY ARTHUR MD on July 07, 2016 11:43 EDT
Verified by:	MAY, GREGORY ARTHUR MD on July 18, 2016 16:28 EDT
Encounter info:	4000778, SC Carolinas, Inpatient, 7/6/2016 - 7/7/2016
Contributor system:	SCC_MMODAL

Printed by: Thorny, Mary Healy Office
Printed on: 08/16/2016 11:52 EDT

Carolinas Hospital System

805 Pamplico Highway
Florence, SC 29505

(843) 674-5000

Patient:	BARR, KENNETH L	Adm Date:	7/6/2016
MRN:	389092	Attending:	HEALY JR,R JOSEPH MD
Account #:	4000778	Primary Care:	LYNCH,JENNIFER NP
Service Code:	MIP MEDICAL INPATIENT	DOB/Sex:	Male
Room #: 816	Bed #: 1	Copy to:	HEALY JR,R JOSEPH MD

Consultation

Result Type:	Consultation
Result Date:	7/6/2016 16:45 EDT
Result Status:	Auth (Verified)
Result Title:	Consult Note-Cardiology
Performed By:	MAY,GREGORY ARTHUR MD (7/6/2016 17:02 EDT)
Verified By:	MAY,GREGORY ARTHUR MD (7/6/2016 17:02 EDT)

Chief Complaint
Headaches/episodic confusion

Reason for Consultation
Chest pain

History of Present Illness
-year-old male with history of hypertension and one pack per day cigarette use admitted by Dr. Healy with complaints of episodic confusion and headaches. Patient has a history of obstructive sleep apnea and gives a history of occasional palpitations and possible chest lightness. Patient denies any clear-cut exertional chest pain or shortness of breath but has a very sedentary lifestyle after being laid off from work last year. Patient denies any prior history of established coronary disease or myocardial infarction. He has never undergone any noninvasive cardiac testing.

Review of Systems
Markable for anxiety/depression/migraine headaches/possible emphysema

Physical Exam

Vitals & Measurements
T: 97.9 °F (Oral) TMIN: 97.3 °F (Oral) TMAX: 98.0 °F (Oral) HR: 48 (Monitored)
RR: 18 BP: 127/75 SpO2: 97%
General: Patient is a well-developed well-nourished white male in no acute distress
HEENT: Unremarkable
Neck: No jugular venous distention, no carotid bruits
Chest: Clear to auscultation bilaterally
Heart: Grade 1-2 systolic ejection murmur at the apex
Abdomen: Soft, nontender, no palpable hepatosplenomegaly, no masses, no bruits
Extremities: No edema. Pulses are 1-2+ throughout the lower extremities
Neurologic: Patient is alert and oriented ×3, nonfocal

Assessment/Plan
Ordered:
Chest pain/palpitations/risk factors for CAD:

Patient has very poor exercise tolerance and will therefore plan a Lexiscan Myoview stress test on 7/7/16 to exclude myocardial ischemia as a possible precipitating cause for chest discomfort and palpitations. Further workup and recommendations will depend on these

Problem List/Past Medical History
Ongoing
No qualifying data
Historical
Carpal tunnel release
Depression
Fatigue
HTN (hypertension)
Hyperthyroidism
Lung collapse
Memory loss
Migraines
Stuttering

Procedure/Surgical History
Appendectomy, Carpal tunnel release, feet, Hand surgery service.

Medications
Inpatient
Aspirin Low Dose, 81 mg, 1 tab(s), Oral, Daily
D.H.E. 45, 0.5 mg, 0.5 mL, IV, q8H, PRN
HYDROcodone-acetaminophen 10 mg-325 mg oral tablet, 1 tab(s), Oral, BID
lisinopril, 20 mg, 2 tab(s), Oral, Daily
methimazole, 5 mg, 1 tab(s), Oral, Daily
Protonix, 40 mg, 1 tab(s), Oral, Daily
PROzac, 40 mg, 4 cap(s), Oral, Daily
Sodium Chloride 0.9% 1,000 mL, 1000 mL, IV
Valium, 10 mg, 2 tab(s), Oral, TID, PRN
Home
Aspirin Low Dose, 81 mg, Oral, Daily
lisinopril 20 mg oral tablet, 20 mg, 1 tab(s), Oral, Daily

Patient: BARR, KENNETH L
MRN: 389092
Account #: 4000778
Service Code: MIP MEDICAL INPATIENT

Adm Date: 7/6/2016
Attending: HEALY JR,R JOSEPH MD
Primary Care: LYNCH,JENNIFER NP
DOB/Sex: Male
Copy to: HEALY JR,R JOSEPH MD

Consultation

results.

Lorcet HD 10 mg-325 mg oral tablet, 1 tab(s), Oral, BID
methimazole, 5 mg, Oral, Daily
NexIUM 40 mg oral delayed release capsule, 40 mg, 1 cap(s), Oral, Daily
PROzac 40 mg oral capsule, 40 mg, 1 cap(s), Oral, Daily
Valium, 10 mg, Oral, TID, PRN

Allergies
No Known Medication Allergies

Social History
Alcohol
Past, Beer, Wine, Liquor
Employment/School
disable
Exercise
Exercise duration: 0.
Home/Environment/Abuse
Lives with Spouse. Living situation: Home/independent. Home equipment: CPAP/BiPAP. Alcohol abuse in household: No. Substance abuse in household: No. Smoker in household: No. Feels unsafe at home: No. Safe place to go: Yes. Family/Friends available for support: Yes. Concern for family members at home: No.
Marijuana Recreational Use
Former smoker, Household Marijuana Concerns: No.
Nutrition/Health
Regular
Sexual
Sexually active: Yes.
Substance Abuse
Never
Tobacco
5 or more cigarettes avg volume per day (=>1/4 pack). Current every day smoker, Cigarettes

Family History
Arthritis: Mother.
Depression: Mother.
Lupus: Mother.
Prostate: Father.
Rheumatoid arthritis: Mother.

Immunizations

Lab Results
Labs (Last four charted values)

Patient: BARR, KENNETH L
MRN: 389092
Account #: 4000778
Service Code: MIP MEDICAL INPATIENT

Adm Date: 7/6/2016
Attending: HEALY JR,R JOSEPH MD
Primary Care: LYNCH,JENNIFER NP
DOB/Sex: Male
Copy to: HEALY JR,R JOSEPH MD

Consultation

WBC 7.4 (JUL 05)
Hgb L 11.5 (JUL 05)
Hct L 35.0 (JUL 05)
Plt 276 (JUL 05)
Na 142 (JUL 05)
K 3.8 (JUL 05)
CO2 29 (JUL 05)
Cl 102 (JUL 05)
Cr L 0.8 (JUL 05)
BUN 9 (JUL 05)
Ca 9.4 (JUL 05)

Diagnostic Results

EKG 7/6/16 shows sinus bradycardia at a rate of 52 with nonspecific T abnormalities in the inferior leads

Echo 7/6/16-1. LV ejection fraction is estimated to be 55 to 60%.
2. Mild aortic valve sclerosis without stenosis.
3. Mild mitral valve regurgitation.
4. Mild tricuspid regurgitation.

Electronically Signed on 07/06/2016 05:02 PM EDT

MAY, GREGORY ARTHUR MD

South Carolina Workers' Compensation Commission
1333 Marion Street, Suite 500
P.O. Box 1715
Columbia, South Carolina 292021715
( ) 7375739

PRE-HEARING BRIEF
WCC FILE NO: 1507304

Kenneth L. Barr Claimant's Name	Darlington County School District Employer's Name
Address	120 East Smith Avenue Address
City State Zip	Darlington, SC 29532 City State Zip
Home Phone Work Phone	SC School Boards Insurance Trust Carrier

Kirsten L. Barr — Preparer's Name
(843) 881-4228 — Phone #

A claim for workers' compensation benefits is made based on the following grounds:

☒ Injury (Alleged ☒ Illness (Alleged) ☒ Repetitive Trauma (Alleged)

1. Compensation Rate: $407.76 2. AWW: $611.61 Date of Injury: May 21, 2015

3. Type of injury and body part(s):

Claimant alleges "Encephalopathy, Brain (headaches, memory, fatigue, confusion), neurological/central nervous system, psychological functioning." Claimant argues that these alleged injuries were either caused by an accident, repetitive trauma, or an occupational disease. Defendants deny Claimant has encephalopathy, any injury to his brain or nervous system, and deny his pre-existing psychological issues are causally-related to his employment. Defendants further deny that Claimant's working conditions were either repetitive or traumatic and deny that the Claimant can satisfy the mandatory elements of the Occupational Disease statute.

4. Facts in controversy:

Claimant claims to have "encephalopathy" as a result of his work as a painter at the Darlington County School District. The Claimant admits that, not only does he always work in a well-ventilated area, and not only does he always paint with a brush and roller (as opposed to sprayers), but that he always wears a respirator, with fume and particulate filters, while painting indoors. There is simply no evidence that any "exposure" he may have had at work was injurious or traumatic.

Perhaps more importantly, there is no objective evidence that Claimant has "severe permanent brain damage" or "encephalopathy," as alleged. While Claimant relies on the vague, speculative opinions of a Dr. White, Dr. White is simply not credible and he, himself, was forced to concede that his opinions are not based on any objective evidence. When asked how he "diagnosed encephalopathy in [Claimant's] case, Dr. White responded: *"It's based on his history of memory deficits. The fact that I've observed him to be forgetful. I've observed him to have slow processing speeds."* (White depo p. 32, lines 12—16). Dr. White admitted that *"neuropsych testing is the best objective measure we have for evaluating patients with encephalopathic conditions."* (White depo p. 54, lines 8—12).

Claimant vehemently objected to Defendants' scheduling him for neuropsychological testing, arguing that neuropsychologists are somehow not "qualified;" however, Claimant's attorney obtained his own neuropsychological testing with Dr. Lind, which showed absolutely no evidence of slowed processing speed and no evidence of memory deficits. In fact, Dr. Lind's testing proved that Claimant's memory was average or above average on all tests, despite Dr. White's speculation to the contrary. According to Dr. Mark Wagner, Claimant's *"memory performance was his major area of cognitive strength and greatly exceeds his IQ. Memory impairment is the most vulnerable domain with chronic toxic solvent exposure. There was no objective evidence of any hint of memory impairment."* (APA p. 380). Dr. Randolph Waid concurred with Dr. Wagner's opinions and further stated that *"there is no evidence to indicated that [Claimant] suffered physical brain injury as a direct result of his employment with the Darlington County School District."* (APA p. 410c).

Dr. Paul Pritchard, a neurologist at MUSC, evaluated Claimant on February 2, 2016. According to Dr. Pritchard, *"the neurological exam today was normal, including normal scores for orientation, memory, calculations, and language function on exam and the Montreal Cognitive Assessment. [Claimant] did not have findings to support a diagnosis of encephalopathy on today's exam."* (APA p. 373) (emphasis added).

With respect to Claimant's complaint of headache, this complaint pre-dates his employment with the School District. He has been treated for many years for what his prior neurologist, Dr. Skinner, described as tension-type headaches, which are aggravated by analgesic rebound

caused by the multiple pain medications Claimant takes for various orthopaedic complaints (neck, low back, knees, right arm, hand, etc...). (APA pp. 172, 183, 186, 187, 1919, 349). At no time did Dr. Skinner ever relate the Claimant's headaches to his employment. In fact, not even the Claimant described his work environment as a factor in his headaches, stating to his family physician "[t]hey occur for no reason." (APA p. 232). Claimant even sought treatment with pain management for "severe headaches" in May 2012 – after he had been completely out of work for 5 months due to a non-work-related hand injury. (APA p. 342). At that time, Claimant complained that his headaches started in 2010 "when awoke with a severe headache and was noted to have mini strokes." (APA p. 232). When asked about aggravating factors, Claimant reported "stress makes headaches worse." (APA p. 343).

Likewise, Claimant's complaints of "fatigue" and psychological issues also predate his employment with the School District. (APA p. 222--227). In fact, Claimant began taking Prozac in 2005 and Celexa in 2009. There is no evidence that these pre-existing conditions were aggravated by his employment with the School District. In fact, neither Dr. White, nor Dr. Lind, even reviewed Claimant's prior medical records.

5. Legal issues involved:

Defendants deny Claimant is entitled to any benefits under S.C. Code Ann. § 42-1-160, as he alleges his injuries were due to cumulative events. Furthermore, his alleged mental injury is unaccompanied by any physical injury and there was nothing extraordinary or unusual about the circumstances of Claimant's employment.

Defendants deny Claimant is entitled to any benefits under S.C. Code Ann. § 42-1-172 because his employment was neither repetitive, nor traumatic. There is no competent evidence of any traumatic or injurious "exposure" at work. Furthermore, Claimant cannot establish a "direct causal connection" between his employment and his exposure to paints and solvents, because Claimant admits that he has been exposed to paints and solvents for many years outside of his employment with the School District with his side business, Kenny's Painting. Not even Claimant's expert, Dr. White, was willing to differentiate Claimant's alleged exposures.

Defendants deny Claimant has or can satisfy his burden of proof under S.C. Code Ann. § 42-9-35, as there is no medical evidence to support a finding that his alleged "exposure" at work

aggravated his documented pre-existing conditions.

Defendants deny Claimant is entitled to any benefits under S.C. Code Ann. § 42-11-10, most obviously because Claimant does not have any disease and certainly does not have any "occupational disease." Neuropsychological testing has confirmed that Claimant does not have memory loss, cognitive dysfunction, or any other brain injury or disease. Headaches, fatigue, and psychological issues are not considered "diseases" and are otherwise "ordinary diseases of life to which the general public is equally exposed." Finally, Claimant has produced no evidence that he was exposed to "hazards in excess of those ordinarily incident to employment" or "peculiar to the occupation" of painter.

Defendants deny Claimant has met his burden of proof under S.C. Code Ann. § 42-15-60, as there is no evidence that he requires any medical care or treatment to lessen the period of alleged disability. While Dr. White vaguely suggested treatment for encephalopathy and dementia, Claimant does not have either encephalopathy or dementia. In addition, Dr. White has not even seen Claimant since July 2015 and; therefore, has no knowledge of Claimant's current condition.

6. Unusual aspects: None at this time.

7. Witnesses (designate if expert*):

Claimant, Larry Stegner, Dr. Marshall White* (via deposition), Dr. Roland Skinner* (via deposition); Dr. Nicholas Lind* (via deposition); Dr. Paul Pritchard* (via deposition); Dr. David Eagerton*, Dr. Joseph Healy* (via deposition).

8. Exhibits:

Please see attached Notice of Submissions; Claimant's personnel file; Claimant's medical records; Claimant's discovery deposition; Toxicology Report.

9. Medical evidence: (Indicate report pursuant to R.67612; deposition or appearance)

Please see attached Notice of Submissions; deposition of Dr. Healy to be submitted upon receipt.

10. Name, address, and specialty, if any, of the treating physician:

N/A

11. Impairment rating(s); body part(s); physician and date of opinion:

Per Dr. Paul Pritchard, neurologist, on February 2, 2016, *"the neurological exam today was normal, including normal scores for orientation, memory, calculations, and language function on exam and the Montreal Cognitive Assessment. [Claimant] did not have findings to support a diagnosis of encephalopathy on today's exam."* (APA p. 373)

12. I am amending my Form 50/51 in the following manner:

N/A

☐ **Mediation**

☐a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B
☐b. Mediation is required pursuant to Reg. 67-1802
☐c. Mediation is requested by consent of the Parties pursuant to Reg. 67-1803
☐d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse

Questions regarding mediation may be submitted to mediation@wcc.sc.gov

I verify the contents of this form are accurate and true to the best of my knowledge.

I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to: Preston F. McDaniel, Esq., 1315 Elmwood Avenue, Columbia, SC 29201 and Gerald Malloy, Esq., 108 Cargill Way, Hartsville, SC [illegible]50.

on the 22nd day of August 2016
by ☒ first class postage ☐ certified mail ☐ personal service.

Signature: Kristen L. Barr Email: kbarr@trask-howell.com

Date of hearing: August 31, 2016 Time needed for hearing: One Hour

File this form and proof of service on the opposing party according to R.67-611 and R.67-212. Do not send medical reports.
* Commissioners reserve the right to admit expert witnesses at hearings.

STATE OF SOUTH CAROLINA	)	
	)	BEFORE THE
COUNTY OF DARLINGTON	)	SOUTH CAROLINA
	)	WORKERS' COMPENSATION COMMISSION
	)	
Kenneth L. Barr,	)	W.C.C. FILE NO. 1507304
	)	
Claimant,	)	
	)	
-vs-	)	
	)	
Darlington County School District,	)	NOTICE OF WITNESSES AND WRITTEN MEDICAL REPORTS TO BE INTRODUCED AS DIRECT EVIDENCE
	)	
Employer,	)	
	)	
-and-	)	
	)	
SC School Boards Insurance Trust,	)	
	)	
Carrier,	)	
	)	
Defendants.	)	
	)	

TO: South Carolina Workers' Compensation Commission and Preston F. McDaniel, Esq. and Gerald Malloy, Esq., attorneys of record for Kenneth L. Barr

YOU ARE HEREBY NOTIFIED THAT Kirsten L. Barr, pursuant to the provisions of the South Carolina Workers' Compensation Act, S. C. Code Ann. § 41-1-160, *et seq.* and the South Carolina Administrative Procedures Act, S. C. Code Ann. § 1-23-330, herewith submits the following evidence on behalf of the Defendants, to wit:

APA #	DESCRIPTION	DATES	PAGES
10	William H. Woodbury, M.D.	4/20/05	247-248
11	Raymond M. Chapman, M.D. The Medical Group	6/29/05—3/6/13	249-264
12	Carolina Pines Radiology	9/15/10—11/1/13	265-266
13	Terrence Hassler, M.D. Hartsville Orthopaedic Sports Medicine	1/26/12—8/29/13	267-297

14	McLeod Health Rehab Services	2/21/12—5/3/12	298-257
15	Joseph Jackson, Jr., M.D. Camden Orthopaedic Associates	5/2/12—6/29/12	258-368
16	Thomas E. Brandt, Jr., D.O. Center for Pain Control	5/9/12—5/24/12	369-395
17	Avie J. Rainwater, III, Ph.D.	5/29/12—4/30/12	396-402
18	Paul B. Pritchard, M.D. MUSC	2/2/16	403-408
19	Mark T. Wagner, Ph.D. MUSC	2/12/16	409-443
20	L. Randolph Waid, Ph.D.	2/12/16	444-446
21	David H Eagerton, Ph.D., F-ABFT, Presbyterian College	2/14/16	447-467

EXHIBITS#	DESCRIPTION	DATES	PAGES
22	Emmanuel Baptist School	9/1975—5/1987	468-490
23	Employer Records re: FMLA	4/8/09—6/4/12	491-498

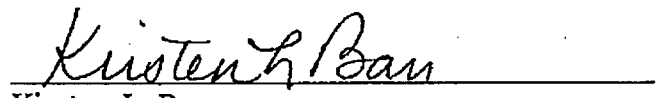
YOU ARE FURTHER HEREBY NOTIFIED that you have the right to cross-examination; and, should you desire to exercise said right, you are to forthwith schedule the depositions of any of the physicians whose reports are submitted, for the purpose of cross-examination.

YOU ARE FURTHER NOTIFIED that the following witnesses may be called on behalf of the Defendants:

Claimant
Larry Stegner
Dr. Marshall White (via deposition)
Dr. Roland Skinner* (via deposition)
Dr. Nicholas Lind (via deposition)
Dr. Paul Pritchard* (via deposition)

Dr. David Eagerton* (via deposition)

Dr. Joseph Healy* (via deposition)



Kirsten L. Barr
Attorney for the Defendants

Date: August 22, 2016

6860\886\notice#3

FOLLOW UP NOTE

NAME: Kenneth Barr **CHART#** 34715-01
DATE: 04/20/05

CHIEF COMPLAINT: Vertigo for 4 years; had a bad attack a couple of days ago. Pulled muscle in the right side. Questionable prostatitis; burns when urinates and when ejaculates.

SUBJECTIVE: Mr. Barr presents today after having been absent for a while. He has had intermittent vertigo for the past four years. He states he recently had an attack this past Sunday that lasted approximately all afternoon. He states that normally something will trigger an attack like this. There will be a strong smell or something along those lines but he really could not think of anything that may have triggered it on Sunday. He states he was out in the park and noted it to occur. He had the sudden onset of dizziness and feeling of imbalance, trouble walking because of that. Nausea was associated with it. He states he took an extra couple of Antivert and laid down and it resolved, and by Monday, he was feeling back to normal again. He states he takes a meclizine every day, one every morning as a cautionary measure but it does make him drowsy. He states that for a couple of months he has been having some "terrible pain" in the right flank area. It may occur at rest. It is not necessarily exertional. He thought initially that it was a pulled muscle, but he did not remember doing anything that would have precipitated a muscular strain. He states that it may last a few minutes but it would surely tend to take his breath away when it occurs. It is intermittent. He states it feels like a pulled muscle but then again, it does not relate any particular movement that seems to make it worse. Over that period of time, he has also noticed some dysuria with some mild discomfort when he has gone to the bathroom at times, again, this being intermittent and not continuous. He has also noticed a couple of episodes where he has had some burning with ejaculation. He has a history of prostatitis in the past, and some of these symptoms feel sort of like that but some of them do not. He also has had some occasional hesitancy with urination that he has noted as well. He noticed no blood in the urine, no change in the color or odor of the urine.

MEDS: Includes the meclizine once a day. Otherwise none.

ROS: GENERAL: Negative. HEENT: Negative. CARDIOVASCULAR: Negative. RESPIRATORY: Negative. GI: Negative. GU: As above. M/S: As above. NEURO: Negative.

OBJECTIVE:
WT: 152 pounds. T: 98.2. P: 80. R: 18. BP: 120/78.
GEN: Well developed, well nourished white male in no acute distress.
HEAD: Normocephalic, atraumatic.
EYES: PERRL. EOMI. Sclerae and conjunctivae nonicteric.
EENT: TMs clear bilaterally. Throat clear.
NECK: Supple with no masses. No JVD or bruits.
LUNGS: Resonant to percussion throughout. Clear to auscultation in all areas.
COR: Regular rate and rhythm. No murmurs. No rubs. No gallops.
ABD: Soft. Nontender. Normal bowel sounds. No masses. No hepatosplenomegaly.
EXT: No edema. Pulses equal bilaterally.
BACK: Some minimal CVA tenderness to percussion on the right side. There is minimal palpation to the paralumbar muscles on the right compared to the left but nothing significant. No appreciable spasm.

GU: The rectal exam shows no masses or other obvious abnormalities on external exam. Examination of the prostate reveals it to be nontender, not enlarged.

IMPRESSION/PLAN:

1. Vertigo. Has been intermittent over time. Has not really changed any of that time although this last episode seems to be actually less intense than previous episodes. I am going to have him just use the Antivert on a p.r.n. basis because I do not think just using one daily prophylactically is really going to give him much benefit. Will observe off, of any medication and see how soon this recurs. It is currently resolved and without any complications.
2. Flank pain, dysuria. Urinalysis today reveals it to be negative for any evidence of infection and no blood is noted. The symptoms have actually resolved, and he has not had any for the past several days. Prostate exam is really unremarkable for significant prostatitis. The history on examination sounds most consistent with what sounds like a renal stone, and, in fact, we are going to proceed with a CT stone study to evaluate for any evidence of stone. He is to strain his urine. He is advised that if he has recurrent symptoms to seek us out and to let us evaluate him on the day that he is having the symptoms so that we can better evaluate what may be going on. For the current moment, I am just going to observe and have him call for recurrent symptoms and proceed with the CT stone study.

RTC: He will return p.r.n. or sooner as needed for problems or worsening symptoms.

WHW

William H. Woodberry, M.D.
WHW/hp/bfm
D: 04/20/05
T: 04/21/05

Patient Name: Kenneth Barr Date: 6/29/05
ALLERGIES: Morphine Age:

Chief Complaint: Works in paints and sanding. Was sanding a wall last Tues c̄ No respirator. C/o cough, congestion

Vitals: T: 97.1 P: 54 R: 20 B/P: 102/64 Wt: 145

General: NAD mild moderate severe distress
HEENT: NC/AT PERRLA TM nl / abl EOMI OP nl / abl
CV: RRR murmurs /6 sys / dys rubs gallops
RESP: lungs clear coarse bs resp. effort NL / distress rales rhonchi + wheezes UAW + congestion + rhinorhea
GI: soft flat / distended bowel sounds NL / ABN tender / non-tender guarding rebound
MS: ROM NL clubbing cyanosis edema
SKIN: warm dry diaphoretic rashes
NEURO: CN 2 12 intact DTRs equal / symmetric
PSYCH: AAO x3 mood / affect NL
OTHER:

Reviewed					
PMH	✓	Current Meds	✓	SH	
		PSH	✓	FH	✓

obtain CXR

LABS:
Duoneb/ Pulmicort neb in office
Deca 8/Depo 40 IM
Durade
Flonase
Allegra D
Tenelon Perles

ASSESSMENT/PLAN:
1) Chemical pneumonitis
2) allergic rhinitis
3) agoraphobia
4)

RTC

Patient Name: Kenneth Barr Date: 11/9/05
ALLERGIES: MSO4 Age:

Chief Complaint: Sinus drainage + pressure, ⊕ chest congestion c̄ productive cough onset monday; ⊕ subj. fever; ⊖ rash

Vitals: T: 97.9 P: 67 R: 18 B/P: 131/81 Wt: 146

General: NAD mild moderate severe distress
HEENT: NC/AT PERRLA TM nl / abl EOMI OP nl / abl
CV: RRR murmurs /6 sys / dys rubs gallops
RESP: lungs clear coarse bs resp. effort NL / distress rales rhonchi wheezes UAW congestion rhinorhea
GI: soft flat / distended bowel sounds NL / ABN tender / non-tender guarding rebound
MS: ROM NL clubbing cyanosis edema
SKIN: warm dry diaphoretic rashes
NEURO: CN 2 12 intact DTRs equal / symmetric
PSYCH: AAO x3 mood / affect NL
OTHER:

Reviewed					
PMH	✓	Current Meds	✓	SH	
Immun		PSH	✓	FH	

LABS:
— Duoneb/pulm neb ~ office
— Deca 8/Depo 40 IM ⊕ glut - ask for LPN
— Ketek x 10 days
— Flonase BID-BID
— Duradex BID

ASSESSMENT/PLAN:
1) sinusitis
2) bronchitis
3)
4)

RTCN

249

Patient Name: Kenneth Barr Date 5/12/06
ALLERGIES: MSO4 Age:

Chief Complaint: epigastric pain x few (2-3) months ; very fatigued
↳ low sternal to epigastric area ; sometimes radiates to back ; (L) arm occ numb ; occ nausea occ SOB
Ø FH CAD
occ heartburn

Vitals: T: 98.3 P: 67 R: 20 B/P: 108/74 Wt: 147

Reviewed					
PMH	✓	Current Meds	✓	SH	✓
		PSH	✓	FH	✓

General: NAD mild moderate severe distress
HEENT: NC/AT PERRLA TM nl / abl EOMI OP nl / abl
CV: RRR murmurs /6 sys / dys rubs gallops
RESP: lungs clear / coarse bs resp. effort NL / distress rales rhonchi wheezes UAW congestion rhinorrhea
GI: soft flat / distended bowel sounds NL / ABN tender / non-tender guarding rebound
MS: ROM NL clubbing cyanosis edema
SKIN: warm dry diaphoretic rashes
NEURO: CN 2 12 intact DTRs equal / symmetric
PSYCH: AAO x3 mood / affect NL
OTHER:

smokes 1 ppd
(+) reproducible CW pain to (L) ant sternal border
LABS:
— consider sleep apnea, costochondritis

ASSESSMENT/PLAN:
1) CP
2) SOB
3) tobacco abuse
4) fatigue

— ✓ PFT
— ✓ CMP, CBC, TSH, free T4, ESR
— Wellbutrin XL 150 g
— to taper cigarette use

EKG: SBOS1
Toradol 60mg/im
(R) flut alexiphan
RTC as directed.
Nathy

Patient Name: Kenneth Barr Date: 2/2/07
ALLERGIES: MSO4 Age:

Chief Complaint: C/O cold symptoms/dry cough ; sore throat ;
(B) ear congestion ; (+) chest congestion ; sx's ~ 2 wks
now ; tried OTC's ∃ relief ; pt ∃ (L) flank pain

Vitals: T: 98.4 P: 70 R: 20 B/P: 101/63 Wt: 158

Reviewed					
PMH	✓	Current Meds	✓	SH	✓
Immun		PSH	✓	FH	✓

General: NAD mild moderate severe distress
HEENT: NC/AT PERRLA TM nl / abl EOMI OP nl / abl
CV: RRR murmurs /6 sys / dys rubs gallops
RESP: lungs clear / coarse bs resp. effort NL / distress rales rhonchi wheezes (+) UAW congestion (+) rhinorrhea
GI: soft flat / distended bowel sounds NL / ABN tender / non-tender guarding rebound
MS: ROM NL clubbing cyanosis edema
SKIN: warm dry diaphoretic rashes
NEURO: CN 2 12 intact DTRs equal / symmetric
PSYCH: AAO x3 mood / affect NL
OTHER:

mild (L) flank pain
LABS:

ASSESSMENT/PLAN:
1) sinusitis
2) pharyngitis
3) (L) flank pain
4) hyperglycemia
fatigue

— Levaquin 750 g QD
— consider sleep study
— ✓ U/A, FSBS = 86
— Voltaren 50 TID pm
— Prozac 20 g QD
— Prednisone taper

RCG

250

Name: ~~Ace~~ Kenneth Barr Date: 5/31/07

Allergies MSO4

Race: W Sex: M Age: —

Chief Complaint/Present Illness: 1) vertigo 2) N/V over weekend; (R)UQ pain, ↓'d urine output

ROS: ER labs/xrs reviewed from 5/28; pt c/o cont pain & tenderness; ∅ CP/SOB/HA or neuro deficits

Vitals: T 96.9 P 60 R 18 B/P 129/68 Weight 149

General Appearance: NAD, Alert, Lucid, Oriented mild distress

HEENT: NCAT, PERRL, TM's clear, Oropharynx benign

Neck: Supple, no LAD, no Bruits

Lungs: CTA, no wheeze, rale, rhonchi (WRR)

Heart: RRR, no MRG

Abd: soft, nt, ND, bowel sounds, no rebound/guard; ↑ generally tender in (R)UQ; ∅HSM noted

Ext: FROM, no edema

Skin: NL, no rash

Neuro: (NL) motor, sensation, reflexes

	Reviewed
PMH	✓
SH	
FH	✓
MEDS	✓
SURGERY	

time in 0930
time out 1150

LABS: ↓ = abnormal ↓ skin turgor

Phenergan 12.5 mg Dosage IM

ASSESSMENT/PLAN:

1) leukocytosis — ✓ CBC
2) (R)UQ abd pain — ✓ GB U/S ⇒ ∅ cholecystitis; ✓ HIDA Scan
3) dehydration — 1 L LR IV
4) N/V s/vertigo — ↑ PO fluids; phenergan pr

RTC as directed

6-13-07 Faxed Chest CT to Dr Hunyet Sr

Name: Kenneth Barr Date: 7-31-07

Race: W Sex: M Age: —

C/o green productive cough last couple of days, ~10 days; ↑ SOB; cont'd cough; ∅ wheeze; ∅ sinus c/o

ROS:

Vitals: T 98.4 P 64 R 20 B/P 114/74 Weight 152

General Appearance: NAD, Alert, Lucid, Oriented mild distress

HEENT: NCAT, PERRL, TM's clear, Oropharynx benign ↑ N/V cough c/o nausea

Neck: Supple, no LAD, no Bruits

Lungs: CTA, no wheeze, rale, rhonchi (WRR)

Heart: RRR, no MRG cont BS (R)

Abd: soft, nt, ND, bowel sounds, no rebound/guard

Ext: FROM, no edema

Skin: NL, no rash

Neuro: NL, motor, sensation, reflexes

	Reviewed
PMH	✓
SH	
FH	
MEDS	✓
SURGERY	

LABS:

- Allegra D
- Levaquin 500
- refer to Dr. Jona, pulm 9-10-07 @ 1:30
- Duoneb/pulm neb ~ office
- Mucinex BID
- ✓ CBC

— Decadron/Depo 4 g IM (L) hip IM pr
— Claritin 10 mg QD
— quit smoking

ASSESSMENT/PLAN:

1) sinusitis
2) bronchitis
3) hilar LAN s/GERD
4) tobacco abuse

RTC

Name: Kenneth Barr Date: 12-21-07

Race: W Sex: M Age: xx

Chief Complaint/Present Illness: Chest congestion, productive cough x several weeks; feels SOB @ times; pain in lower back

ROS: ↑ groin; pt reports hard itching

Vitals: T 98 P 74 R 18 B/P 118/74 Weight 157

General Apperance: NAD, Alert, Lucid, Oriented

HEENT: NCAT, PERRL, TM's clear, Orapharynx benign

Neck: Supple, no LAD, no Bruits

Lungs: CTA, no wheeze, rale, rhonchi (WRR)

Heart: RRR, no MRG coarse BS (B)

Abd: soft, nt, ND, bowel sounds, no rebound/guard

Ext: FROM, no edema

Skin: NT no rash

Neuro: NI, motor, sensation, reflexes

	Reviewed
PMH	✓
SH	✓
FH	✓
MEDS	✓
SURGERY	

LABS

ASSESSMENT/PLAN:

1) COPD — Decadron/Depo 40g IM
— Levaquin 500g QD x 10 days
2) GERD — Nasacort
3) hemorrhoids — Anusol HC 2.5% cream BID
SINUSITIS — Mucinex DM BID c fluids

RTC

Name: Kenneth Barr Date: 2/28/08

Race: W Sex: M Age:

Chief complaint: sinus pressure; frontal HA; (B) eye pressure; congestion; ↳ frontal/maxillary

ROS: mild NP cough; ↓ wheezes; ↓ FC/N/V mild lightheadedness

Vitals: T 97.6 P 69 R 18 B/P 113/72 Weight 154

General Apperance: NAD, Alert, Lucid, Oriented

HEENT: NCAT, PERRL, TM's clear, Orapharynx benign

Neck: Supple, no LAD, no Bruits

Lungs: CTA, no wheeze, rale, rhonchi (WRR)

Heart: RRR, no MRG

Abd: soft, nt, ND, bowel sounds, no rebound/guard

Ext: FROM, no edema

Skin: NI, no rash

Neuro: NI, motor, sensation, reflexes

	Reviewed
PMH	✓
SH	✓
FH	✓
MEDS	✓
SURGERY	

LBP; sciatica

LABS:

ASSESSMENT/PLAN:

1) SINUSITIS — Tylenol #3 c 80 p #90; -1 RF
— Voltaren 75g BID, before/p work
2) GERD — Steroped DS taper x 12 days
3) LBP — Nexium 40g QD
— refer to P.T. for strengthening/mobilization

RTC

252

THE MEDICAL GROUP

Michael Ambrose MD
Abraham Arceephanthu MD
James Bell MD
Robert E. Bullard MD
Shari Carter FNP
R. Mac Chapman MD

William Davis Jr DO
Robert L. Elder MD
Michael Harless MD
William Long MD
M.B. Nickles MD
Praveena Pusang MD

Emmanuel Quaye MD
Susan Reynolds MD
John Ropp III MD
Andrea Trader FNP

CVS-Harts.
CVS-Darl.
Bishopville Drug
Rite-Aid Pharmacy
Hartsville Drug
Harseys

Carolina - Darlington
Medical Arts
Walgreens
Medicine Shoppe-Darl.
Medi-Cap
Sandhills Pharmacy

Super X
Wal-Mart
Price Wise
Chesterfield Drug
Society Hill Pharmacy
Wannamaker

Allergy: [illegible]

Patient: Kenneth Brew

Telephone: Home: 858-2266 Date of Birth: _____

Work: _____ Cell: _____

Refill Rx: Pharm. Req./Pt. Req. _____

[illegible] x5d

Lab Results

MEDS

1. _____

2. _____

3. _____

4. _____

Date: 4-14

Time: 9:15

Initial: [illegible]

The Medical Group

Name: Kenneth Barr Date: 9.19.08

Race: W Sex: M Age:

Chief Complaint/Present Illness: Chest congestion, non productive cough x 2 weeks, ⊖ fever

ROS:

Vitals: T 98.7 P 78 R 18 B/P 120/79 Weight 154

General Apperance: NAD, Alert, Lucid, Oriented
HEENT: NCAT, PERRL, TM's clear, Orapharynx benign
Neck: Supple, no LAD, no Bruits
Lungs: CTA, no wheeze, rale, rhonchi (WRR)
Heart: RRR, no MRG
Abd: soft, nt, ND, bowel sounds, no rebound/guard
Ext: FROM, no edema
Skin: NI, no rash
Neuro: NI, motor, sensation, reflexes

	Reviewed
PMH	✓
SH	✓
FH	
MEDS	✓
SURGERY	

LABS:

ASSESSMENT/PLAN:
1) COPD exac
2)
3)
4)

— Celexa 20g QD
— Prednisone 10g dosepack #48
— Duoneb / pulmicort neb in office
— Avelox 400g QD
— Hydromet ½ tsp

Name: Kenneth Barr Date: 5/15/09

Race: W Sex: M Age:

Chief Complaint/Present Illness: c/o indigestion; ↑ prostate Sx's; ⊖ fever

ROS:

Vitals: T 97.4 P 71 R 16 B/P 126/81 Weight 151

General Apperance: NAD, Alert, Lucid, Oriented
HEENT: NCAT, PERRL, TM's clear, Orapharynx benign
Neck: Supple, no LAD, no Bruits
Lungs: CTA, no wheeze, rale, rhonchi (WRR)
Heart: RRR, no MRG
Abd: soft, nt, ND, bowel sounds, no rebound/guard
Ext: FROM, no edema
Skin: NI, no rash
Neuro: NI, motor, sensation, reflexes

	Reviewed
PMH	✓
SH	✓
FH	
MEDS	✓
SURGERY	

LABS:

ASSESSMENT/PLAN:
1) GERD
2) prostatitis
3)

— Protonix 40g
— Cipro 500g BID x 10d
— Saw Palmetto

RKG

THE MEDICAL GROUP

Michael Ambrose MD
Abraham Aroephantho MD
James Bell MD
Robert E. Bullard MD
Sharl Carter FNP
R. Mac Chapman MD
William Davis Jr DO
Robert L. Elder MD
Michael Harless MD
William Long MD
M.D. Mickles MD
Emmanuel Quaye MD
Susan Reynolds MD
John Ropp III MD
Andrea Trader FNP

Bishopville Drug
Carolina - Darlington
Chesterfield Drug
CVS-Darl.
CVS-Harts.
Harseys
Hartsville Drug
McLeod
Med-Center
Medi-Cap
Medical Arts
Medicine Shoppe-Darl.
Price Wise
Rite-Aid Pharmacy
Sandhills Pharmacy
Society Hill Pharmacy
Super X
Walgreens
Wal-Mart
Wannamaker

Allergy: _____

Patient: Kenneth Barr

Telephone: Home: 858-2266 Date of Birth: _____

Work: _____ Cell: _____

Refill Rx: Pharm. Req. Pt. Req. _____

Lab Results

MEDS

2RF 1. Celexa 20mg ✓ Done Dorial VP

2. _____

3. _____

4. _____

OK

Date: 12-30-08

Time: 3:05

Initial: [illegible]

The Medical Group

THE MEDICAL GROUP

Michael Ambrose' MD
Abraham Aneephanthu MD
James Bell MD
Robert E. Bullard MD
Shari Carter FNP
R. Mac Chapman MD
William Davis Jr DO
Robert L. Elder MD
Michael Harless MD
William Long MD
M.B. Nickles MD
Emmanuel Quaye MD
Susan Reynolds MD
John Ropp III MD
Andrea Trader FNP

Bishopville Drug
Carolina - Darlington
Chesterfield Drug
CVS-Darl.
CVS-Harts.
Harseys
Hartsville Drug
McLeod
Med-Center
Medi-Cap
Medical Arts
Medicine Shoppe-Darl.
Price Wise
Rite-Aid Pharmacy
Sandhills Pharmacy
Society Hill Pharmacy
Super X
Walgreens
Wal-Mart
Wannamaker

Allergy: _____

Patient: Kenneth Barr

Telephone: Home: 858-2266 Date of Birth: _____

Work: _____ Cell: _____

Refill Rx: Pharm. Req. Pt. Req.

Lab Results

MEDS

1. Celexa 20 CS RF

2. _____

3. _____

4. _____

Date: 4-14-09

Time: 11:15

Initial: SKO

The Medical Group

The Medical Group

Name: Kenneth Barr Date: 5/27/09

Race: W Sex: M Age: ____

Chief Complaint/Present Illness: PPD

ROS:

Vitals: T____ P____ R____ B/P____ Weight____

General Apperance: NAD, Alert, Lucid, Oriented
HEENT: NCAT, PERRL, TM's clear, Orapharynx benign
Neck: Supple, no LAD, no Bruits
Lungs: CTA, no wheeze, rale, rhonchi (WRR)
Heart: RRR, no MRG
Abd: soft, nt, ND, bowel sounds, no rebound/guard
Ext: FROM, no edema
Skin: N1, no rash
Neuro: N1, motor, sensation, reflexes

	Reviewed
PMH	
SH	
FH	
MEDS	
SURGERY	

PPD 0.5mL to (L) forearm
Lot 81816
exp. 573010
manufactor: IHP Pharmaceuticals

— Elaphin LPN

LABS:

ASSESSMENT/PLAN:
1)
2)
4)

Name: Kenneth Barr Date: 12-14-09.

Race: W Sex: M Age: ____

Chief Complaint/Present Illness: LBP, ↑ d anxiety

ROS:

Vitals: T 98.7 P 61 R 16 B/P 119/70 Weight 155

General Apperance: NAD, Alert, Lucid, Oriented
HEENT: NCAT, PERRL, TM's clear, Orapharynx benign
Neck: Supple, no LAD, no Bruits
Lungs: CTA, no wheeze, rale, rhonchi (WRR)
Heart: RRR, no MRG
Abd: soft, nt, ND, bowel sounds, no rebound/guard
Ext: FROM, no edema
Skin: N1, no rash
Neuro: N1, motor, sensation, reflexes

	Reviewed
PMH	✓
SH	✓
FH	
MEDS	✓
SURGERY	

OLBP 5 Radiculopathy

LABS:

ASSESSMENT/PLAN:
1) LBP
2) GAD
3)
4)

— Diclofenac 75 g 8/100 ford
— Celexa to 40 g QD
— Klonopin 0.5 g 1/2 - 1 BID, #60, RF

257

For the sinuses, Biaxin 500 mg b.i.d. x10 days, Lodrane 24 hour once-daily #20 with no refills and Veramyst nasal spray 2 sprays each nostril daily with sample vial given and I instructed the patient on its use. Work excuse is given for the rest of this week with a return to work on 09/20/10 unless changes are needed and he is to call us.

As young as this patient is with his abnormal brain MRI, I recommend aspirin 81 mg daily for now in addition to further neurological evaluation. Plavix may be a better option. We will plan followup in a few weeks. Counseling and coordination of care greater than 50% of time with patient. Total time with patient and wife 30 minutes.

Raymond M. Chapman, M.D.

RMC/jg

D: 09/16/10
T: 09/17/10

THE MEDICAL GROUP

CONSULTATION REQUEST

Date: 9-11-10

Patient Name: Lorreth Barr DOB: / /

Phone (H): (C): (W):

Address: City/Zip

Primary Insurance: BCBS State of SC

Secondary Insurance: ZCS036035250

Referred by: Dr. Chapman Phone: (843) 383-5191 Fax: (843) 656-1214

Referred to: Dr. Shirner Phone: 1065-4104 Fax: 1061-0160

Reason/Diagnosis: ischemic episodes

---

* Date of Appointment: Sept 23 Time: 9am Spoke to:

Specialist: Neurologist

Office location: McLeod Medical Plaza Suite 380.

Patient needs to bring: Photo Ins Card

Authorization required? Yes No Authorization #:

Referral dates: until Number of Visits:

Authorized by:

Completed by: Date:

☒ Patient notified ☐ Referral complete ☐ Faxed

PATIENT: Kenneth Barr
CHART:
DATE: 05/02/11

SUBJECTIVE: A -year-old white male who works for the Darlington County Maintenance School System with tension headaches. He is scheduled to see his neurologist Dr. Skinner in about 2 weeks. He comes in today for followup. We recently had weaned his Zoloft. He states he really sees no difference in headache frequency or in his overall wellbeing. I have given him a prescription for Ultram 50 mg t.i.d. for the headaches. He states the headaches have continued. They occur for no reason. There is no aura. They are not usually severe and he goes about his business. He has had a rather extensive neurological evaluation with diagnosis of tension headaches though there were some questions of a very small aneurysm seen and he is to have what sounds like a CTA of the brain under the direction of Dr. Skinner in about 2 weeks.

HABITS: Continues to smoke despite numerous encouragement and conversations and recommendations for aids to assist in this area. No alcohol use.

ALLERGIES: PENICILLIN AND MORPHINE.

CURRENT MEDICATIONS: Listed at left and reviewed.

REVIEW OF SYSTEMS: As above, otherwise noncontributory.

PHYSICAL EXAMINATION:
VITAL SIGNS: Vitals by JA. Afebrile. Respirations 16. Blood pressure 120/80. Pulse 78. Weight 161.
GENERAL: A pleasant white male. He smells of cigarettes and is alert, oriented and responds appropriately.
SKIN: Warm and dry. Good turgor.
HEENT: Atraumatic, normocephalic. Extraocular muscles intact. Visual acuity grossly normal. Oral mucosa moist and pink. Posterior pharynx is clear.
NECK: Supple, nontender. No adenopathy. Trachea midline.
LUNGS: Clear.
CARDIAC: Regular rate and rhythm.
ABDOMEN: Soft, nontender.
EXTREMITIES: Moves all appropriately. No edema. Motor strength 5/5.

ASSESSMENT:
1. Tension headaches.
2. Smoker.

PLAN: Increase Ultram to 100 mg t.i.d. p.r.n. #90 with 2 refills. Keep appointment with Dr. Skinner. We will plan followup in 3 months.

The patient asked about being referred to The Headache Center at MUSC. I have asked him to mention this to Dr. Skinner but will be happy to followup on this.

Raymond M. Chapman, M.D.

RMC/jg

D: 05/02/11
T: 05/04/11

THE MEDICAL GROUP
CONSULTATION REQUEST

Date: 10/8/12

Patient Name: Kenneth Barr DOB:

Phone (H): (C): (W):

Address: City/Zip:

Primary Insurance BC BS state of SC

Secondary Insurance:

Referred by: Dr. Chapman Phone: (843) 383-5191 Fax: (843) 656-1214

Referred to: Dr. White Phone: 803-774-7246 Fax: 803-774-7250

Reason/Diagnosis: DDD, back pain

Date of Appointment: 10/17/12 Time: 12 NOON Spoke to:

Specialist: Neurology

Office location: Hartsville

Patient needs to bring: INS Cards, ID, medicines

Authorization required? Yes (No) Authorization #:

Referral dates: 10-17-12 until Number of Visits: AS Needed

Authorized by:

Completed by: D. Yow Date: 10-16-12

☐ Patient notified ☐ Referral complete ☐ Faxed

10/8
Faxed to Dr. White
for appt. date.
(DY)

PATIENT: BARR, KENNETH
CHART#:
DOB:
DATE: 03/06/2013

SUBJECTIVE: A -year-old white male with a history of generalized anxiety disorder in today with a chief complaint of right knee pain. He states 3 or 4 months ago he felt popping sound in the right knee. Since then he has had increased pain and instability to the point that even walking on a flat surface it will buckle. He is afraid to climb a ladder or has to be very careful maneuvering steps. No redness or swelling. It is just a grinding sound whenever he flexes and extends. He has taken some OTC NSAIDs with minimal improvement. He took meloxicam which he states has "helped a little."

HABITS: Continues to smoke. No alcohol use. No illicit drug use.

ALLERGIES: Intolerant to **PENICILLIN AND MORPHINE.**

CURRENT MEDICATIONS: Listed at left and reviewed.

REVIEW OF SYSTEMS: As above, otherwise noncontributory.

PHYSICAL EXAMINATION:
VITAL SIGNS: Vitals by JA. Afebrile. Respirations 14. Blood pressure 130/72. Pulse 60. Weight 143.
GENERAL: A lean pleasant white male who walks with a slight limp but is alert, oriented and responds appropriately.
SKIN: Leathery, warm and dry.
HEENT: Atraumatic, normocephalic.
NECK: Supple. No adenopathy. Trachea midline.
LUNGS: Clear in all fields though distant.
CARDIAC: Regular rate and rhythm. No murmurs, gallops or rubs.
ABDOMEN: Flat, soft and nontender.
EXTREMITIES: Moves all appropriately. Motor strength 5/5 of the upper extremities. Calves are soft. No peripheral edema. Examination of the right knee: Flexion-extension is normal though there is a grating sensation when he fully extends at the knee. No obvious erythema or edema. He is moderately tender over the medial aspect of the knee. Negative drawer sign. He is unable to squat secondary to pain and unstable sensation involving the right side.

ASSESSMENT: Right knee pain with instability.

PLAN: X-ray of the right knee. Also MRI to evaluate internal soft tissue structures. Would wear knee immobilizer for now.

Excuse for work
Tues thru 3/18/13
Sees ortho on that
date
DR Thompson

PATIENT: BARR, KENNETH
CHART#:
DOB:
DATE: 03/06/2013
PAGE 2

Meloxicam 7.5 mg 1-2 p.o. daily #60 with 3 refills and warned of GI bleed side effects and should take with food.

Raymond M. Chapman, M.D.

RMC/jg

D: 03/06/13
T: 03/07/13

CAROLINA PINES

RADIOLOGY REPORT

EXAM DATE: 20/10/0915

ORDERING PHY: R. MAC CHAPMAN
ATTENDING PHY:
PATIENT NAME: BARR,KENNETH L
ROOM: OP BIRTH DATE:

PT. ACCT. NO.: 2829683
MED REC NUMBER: 14905

HISTORY: HA/ ATAXIA
HEADACHES X 4 WEEKS-ATAXIA-DIZZINESS

MRI BRAIN AND BRAINSTEM WITHOUT CONTRAST:

INDICATION: 69 year old, dizziness, weakness, headaches.

Multiple MR images of the brain and brainstem were obtained without contrast, routine noncontrast protocol. Computed cranial tomography of 08/30/2010 is reviewed.

FINDINGS: The basilar structures and cerebellopontine angles are normal. No mass effect or midline shift is seen. Scattered foci of abnormal signal is seen on FLAIR images representing microvascular ischemic insults. Diffusion-weighted images fail to demonstrate evidence of acute event. No midline shift is seen. We see mucous retention cyst changes in the maxillary antra bilaterally, greater on the right. Left deviated nasal septum is seen. Mild left frontal mucosal disease is seen.

IMPRESSION:
MICROVASCULAR ISCHEMIC CHANGES AS ABOVE. PARANASAL SINUS DISEASE AS ABOVE.

DD: 09/15/2010 00:00 Dictated By: DAVIS, CHARLES
DT: 09/15/2010 09:53 SW Signed By: DAVIS, CHARLES

DD: 09/15/2010 00:00 Dictated By: DAVIS, CHARLES
DT: 09/15/2010 09:53 SW Signed By: DAVIS, CHARLES

ADDENDUM
The indication incorrectly states 69 year old. Actually this is a 41 year old male.

DD: 09/15/2010 00:00 Dictated By: DAVIS, CHARLES
DT: 09/15/2010 19:28 SW Signed By: DAVIS, CHARLES

DATE DICTATED: 9/15/2010
DATE TRANSCRIBED: 9/15/2010
TRANSCRIPTIONIST: SW

CHARLES DAVIS
REVIEWED AND SIGNED

HMA Fax Server 11/1/2013 3:47:15 PM PAGE 2/002 Fax Server

Radiology Results

Carolina Pines Regional Medical Center

Patient Name: BARR, KENNETH L

DOB:		Age:	Y	Patient Status:	O	Patient Type: O	
Visit #:	2926236	Sex:	M	Patient Location:	OP		
Acc.:	4727052			Completed:	11/01/2013		
Exam:	(833) MRBRWW - - MR BRAIN W&WO CONT						

Requesting Provider: CHAPMAN, RAYMOND MAC, MD MRN/Pt Num: 0000014905

Attending Provider: CHAPMAN, RAYMOND, MD
701 MEDICAL PARK DRIVE
HARTSVILLE, SC 29550

Diagnostic Report Text:

BRAIN MRI 11/01/2013
INDICATION: Occipital headache. Headache for several weeks.
COMPARISON: Brain MRI dated 09/15/2010. Head CT dated 08/30/2010.
TECHNIQUE: Multiplanar, multi-sequence T1 and T2 images were obtained through the brain without contrast.
FINDINGS: Nonspecific periventricular and subcortical white matter T2 hyperintensities remain unchanged compared to the study. No diffusion weighted imaging abnormalities to suggest acute infarct or acute abnormality. Some mucosal thickening right greater than left maxillary sinuses. No midline shift or evidence of mass effect. No intracranial hemorrhage. No abnorm post-contrast enhancement visualized. No midline shift or evidence of mass effect.
IMPRESSION: Nonspecific white matter changes as previously seen. This can be seen in the setting of migraine headaches. Otherwise, no acute abnormality or abnormal post-contrast enhancement.
PB 11/1/2013 11:02 AM

End of diagnostic report for accession: 4727052

Dictated By:	ENTERKIN, JACOB, MD	
Transcribed By:	Blais, Pat, 833Trans	11/01/2013 11:02 AM EDT
Edited By:	ENTERKIN, JACOB, MD	11/01/2013 2:17 PM EDT
Signed By:	ENTERKIN, JACOB, MD	11/01/2013 2:17 PM EDT

PATIENT: Barr, Kenneth AGE: years old EXAM DATE: 01/30/12

DOI/DOS: 1/26/12

Referring Provider: CHAPMAN, RAYMOND,

SUBJECTIVE

CC:. None

HPI: Kenneth is here for follow up right hand complex laceration repair of the ECU tendon and side to side anastomosis of the extensor digitorum quinti tendon to the EDC tendon of the ring finger. He also lacerated the abductor digit quinti tendon which was not repaired

SOCIAL HISTORY: Alcohol-Denies
Employment: Fulltime: painter
Martial Status: Married
Tobacco: 1-2 PPD
FAMILY HISTORY: Acid Reflux
Arthritis
Cancer
Hypertension
ILLNESSES: Acid Reflux
anxiety
Arthritis
OPERATIONS: appendectomy
Foot
Lungs: 13 years ago
MEDICATIONS: Albuterol
Aspirin (Dosage: 81mg SIG: 1 daily)
Cymbalta
Neurontin
Relafen
ALLERGIES: NKDA

OBJECTIVE

PHYSICAL EXAM .Wound site is clean and dry, no evidence of infection.
Neurovascular status is intact.

X-RAY:. X-Rays show none taken.

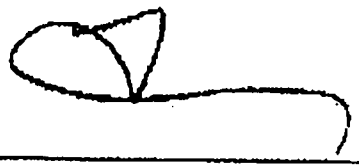
ASSESSMENT

Follow up for repairs as above, doing well.

PLAN

PRESCRIPTION:. No data for Prescription
.Follow up one week for suture removal, the ulnar gutter splint with rest and extension and fingers and

extension



Terence Hassler, M.D.

PATIENT: Barr, Kenneth AGE: years old EXAM DATE: 02/07/12

DOI/DOS: 1/26/12

Referring Provider: CHAPMAN, RAYMOND,

SUBJECTIVE

CC:. Continued pain the patient is out of pain medication is taking to pain pills q4h

HPI: Kenneth is here for follow up right hand complex laceration repair of the ECU tendon and side to side anastomosis of the extensor digitorum quinti tendon to the EDC tendon of the ring finger. He also lacerated the abductor digit quinti tendon which was not repaired

SOCIAL HISTORY: Alcohol-Denies
Employment: Fulltime: painter
Martial Status: Married
Tobacco: 1-2 PPD
FAMILY HISTORY: Acid Reflux
Arthritis
Cancer
Hypertension
ILLNESSES: Acid Reflux
anxiety
Arthritis
OPERATIONS: appendectomy
Foot
Lungs: 13 years ago
MEDICATIONS: Albuterol
Aspirin (Dosage: 81mg SIG: 1 daily)
Cymbalta
Neurontin
Relafen
ALLERGIES: NKDA

OBJECTIVE

PHYSICAL EXAM .Wound site is clean and dry, no evidence of infection.
Neurovascular status is intact.

X-RAY:. X-Rays show none taken.

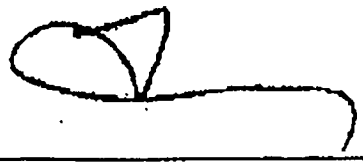
ASSESSMENT

Follow up for repairs as above, doing well.

PLAN

PRESCRIPTION:. Lorcet (Dosage: 10/325 SIG: 1PO q4h PRN Pain Dispense: 60 Refills: 1 Method: Print)
.Follow up one week for suture removal, continue in ulnar gutter splint with wrist in extension and

fingers and extension. I asked him to slow down the pain medication.



Terence Hassler, M.D.

PATIENT: Barr, Kenneth AGE: years old EXAM DATE: 02/13/12

DOI/DOS: 1/26/12

Referring Provider: CHAPMAN, RAYMOND,

SUBJECTIVE

CC:. . Some pain in the right hand.

HPI: Kenneth is here for follow up right hand complex laceration repair of the ECU tendon and side to side anastomosis of the extensor digitorum quinti tendon to the EDC tendon of the ring finger. He also lacerated the abductor digit quinti tendon which was not repaired

SOCIAL HISTORY: Alcohol-Denies
Employment: Fulltime: painter
Martial Status: Married
Tobacco: 1-2 PPD
FAMILY HISTORY: Acid Reflux
Arthritis
Cancer
Hypertension
ILLNESSES: Acid Reflux
anxiety
Arthritis
OPERATIONS: appendectomy
Foot
Lungs: 13 years ago
MEDICATIONS: Albuterol
Aspirin (Dosage: 81mg SIG: 1 daily)
Cymbalta
Lorcet (Dosage: 10/325 SIG: 1PO q4h PRN Pain Dispense: 60 Refills: 1)
Neurontin
Relafen
ALLERGIES: NKDA

OBJECTIVE

PHYSICAL EXAM .Wound site is clean and dry, no evidence of infection. Neurovascular status is intact.

X-RAY:. X-Rays show none taken.

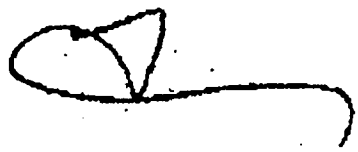
ASSESSMENT

Follow up for repairs as above, doing well.

PLAN

PRESCRIPTION:. No data for Prescription

.Follow up one week, suture removal, continue in ulnar gutter splint with wrist in extension and fingers in extension. Begin therapy after next visit..



Terence Hassler, M.D.

PATIENT: Barr, Kenneth AGE: years old EXAM DATE: 02/20/12

DOI/DOS: 1/26/12

Referring Provider: , CHAPMAN, RAYMOND,

SUBJECTIVE

CC:. . Some pain in the right hand.

HPI: Kenneth is here for follow up right hand complex laceration repair of the ECU tendon and side to side anastomosis of the extensor digitorum quinti tendon to the EDC tendon of the ring finger. He also lacerated the abductor digit quinti tendon which was not repaired

SOCIAL HISTORY: Alcohol-Denies
Employment: Fulltime: painter
Martial Status: Married
Tobacco: 1-2 PPD
FAMILY HISTORY: Acid Reflux
Arthritis
Cancer
Hypertension
ILLNESSES: Acid Reflux
anxiety
Arthritis
OPERATIONS: appendectomy
Foot
Lungs: 13 years ago
MEDICATIONS: Albuterol
Aspirin (Dosage: 81mg SIG: 1 daily)
Cymbalta
Lorcet (Dosage: 10/325 SIG: 1PO q4h PRN Pain Dispense: 60 Refills: 1)
Neurontin
Relafen
ALLERGIES: NKDA

OBJECTIVE

PHYSICAL EXAM .Wound site is clean and dry, no evidence of infection. Neurovascular status is intact.

X-RAY:. X-Rays show none taken.

ASSESSMENT

Follow up for repairs as above, doing well.

PLAN

PRESCRIPTION:. No data for Prescription

.Follow up 2 weeks, suture removal, discontinue ulnar gutter splint. Begin hand therapy.

Terence Hassler, M.D.

PATIENT: Barr, Kenneth AGE: years old EXAM DATE: 03/01/12

DOI/DOS: 1/26/12

Referring Provider: CHAPMAN, RAYMOND,

SUBJECTIVE

CC:. . Some pain in the right hand.

HPI: Kenneth is here for follow up right hand complex laceration repair of the ECU tendon and side to side anastomosis of the extensor digitorum quinti tendon to the EDC tendon of the ring finger. He also lacerated the abductor digit quinti tendon which was not repaired

SOCIAL HISTORY: Alcohol-Denies
Employment: Fulltime: painter
Martial Status: Married
Tobacco: 1-2 PPD
FAMILY HISTORY: Acid Reflux
Arthritis
Cancer
Hypertension
ILLNESSES: Acid Reflux
anxiety
Arthritis
OPERATIONS: appendectomy
Foot
Lungs: 13 years ago
MEDICATIONS: Albuterol
Aspirin (Dosage: 81mg SIG: 1 daily)
Cymbalta
Neurontin
Relafen
ALLERGIES: NKDA

OBJECTIVE

PHYSICAL EXAM .Wound site is clean and dry, no evidence of infection.
Neurovascular status is intact.

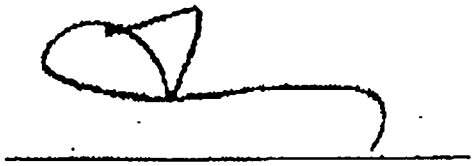
X-RAY:. X-Rays show none taken.

ASSESSMENT

Follow up for repairs as above, doing well.

PLAN

PRESCRIPTION:. Lorcet (Dosage: 10/325 SIG: 1PO q6h PRN Pain Dispense: 90 Refills: 1 Method: Print)
.Follow up 3 weeks, continue hand therapy.



Terence Hassler, M.D.

PATIENT: Barr, Kenneth AGE: years old EXAM DATE: 03/22/12

DOI/DOS: 1/26/12

Referring Provider: CHAPMAN, RAYMOND,

SUBJECTIVE

CC:. . Some pain in the right hand.

HPI: Kenneth is here for follow up right hand complex laceration repair of the ECU tendon and side to side anastomosis of the extensor digitorum quinti tendon to the EDC tendon of the ring finger. He also lacerated the abductor digit quinti tendon which was not repaired

SOCIAL HISTORY: Alcohol-Denies
Employment: Fulltime: painter
Martial Status: Married
Tobacco: 1-2 PPD
FAMILY HISTORY: Acid Reflux
Arthritis
Cancer
Hypertension
ILLNESSES: Acid Reflux
anxiety
Arthritis
OPERATIONS: appendectomy
Foot
Lungs: 13 years ago
MEDICATIONS: Albuterol
Aspirin (Dosage: 81mg SIG: 1 daily)
Cymbalta
Neurontin
Relafen
ALLERGIES: NKDA

OBJECTIVE

PHYSICAL EXAM .Wound site is clean and dry, no evidence of infection. Neurovascular status is intact. He has very poor range of motion he cannot make a fist yet.

X-RAY:. X-Rays show none taken.

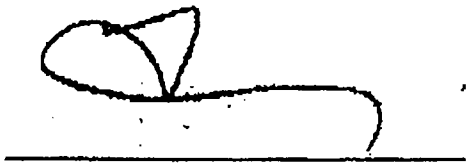
ASSESSMENT

Follow up for repairs as above, progress is very slow

PLAN

PRESCRIPTION:. Lorcet (Dosage: 10/325 SIG: 1PO q6h PRN Pain Dispense: 90 Refills: 1 Method: Print)

.Follow up 3 weeks, continue hand therapy.



Terence Hassler, M.D.

PATIENT: Barr, Kenneth AGE: years old EXAM DATE: 04/12/12

DOI/DOS: 1/26/12

Referring Provider: CHAPMAN, RAYMOND,

SUBJECTIVE

CC:. . Some pain in the right hand.

HPI: Kenneth is here for follow up right hand complex laceration repair of the ECU tendon and side to side anastomosis of the extensor digitorum quinti tendon to the EDC tendon of the ring finger. He also lacerated the abductor digit quinti tendon which was not repaired

SOCIAL HISTORY: Alcohol-Denies
Employment: Fulltime: painter
Martial Status: Married
Tobacco: 1-2 PPD
FAMILY HISTORY: Acid Reflux
Arthritis
Cancer
Hypertension
ILLNESSES: Acid Reflux
anxiety
Arthritis
OPERATIONS: appendectomy
Foot
Lungs: 13 years ago
MEDICATIONS: Albuterol
Aspirin (Dosage: 81mg SIG: 1 daily)
Cymbalta
Lorcet (Dosage: 10/325 SIG: 1PO q6h PRN Pain Dispense: 90 Refills: 1)
Neurontin
Relafen
ALLERGIES: NKDA

OBJECTIVE

PHYSICAL EXAM .Wound site is clean and dry, no evidence of infection. Neurovascular status is intact. He has very poor range of motion he cannot make a fist yet. He has 75° of flexion of the ring finger MP joint and 55° to flexion passively at the MP joint of the small finger. He has no active extension and I feel that he has had lesions of the fifth finger tendon.

X-RAY:. X-Rays show none taken.

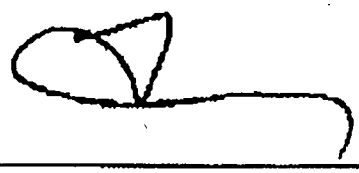
ASSESSMENT

Vitals: P 64 R18 WT 148 Ht 5'9 B 126/85
Follow up for repairs as above, progress is very slow

PLAN

PRESCRIPTION:. **No data for Prescription**

.Follow up 2 weeks, continue hand therapy. We may have tingling and Lasix lesions of the fifth finger.



Terence Hassler, M.D.

PATIENT: Kenneth Barr AGE: years old EXAM DATE: 04/26/12

Home Phone: Work Phone:

Address:

Insurances: No data for Insurances

Dr. Joe Jackson
803 432 9300

He is now Dear Joe:

Thank you for seeing Kenneth Barr for me. Kenneth has had right and complex laceration repair of ECU and EDQ tendon to be of EDC tendon of the fourth finger. He has been going to hand therapy and I believe that he has significant adhesions and may need a lysis of these adhesions. I would appreciate your opinion and recommendations and if surgery/splinting/hand therapy is indicated, I would appreciate your assuming the patient's care. The patient was given all pertinent notes and studies and is hand carrying them to you.

Yours sincerely,

Terence W. Hassler, M.D.
700 Medical Park Drive
Hartsville, SC 29550
Office: (843) 383-3742
Cell: (843) 858-0202
Fax: (843) 332-3745

-PATIENT: Barr, Kenneth AGE: years old EXAM DATE: 04/26/12

DOI/DOS: 1/26/12

Referring Provider: CHAPMAN, RAYMOND,

SUBJECTIVE

CC:. . Some pain in the right hand.

HPI: Kenneth is here for follow up right hand complex laceration repair of the ECU tendon and side to side anastomosis of the extensor digitorum quinti tendon to the EDC tendon of the ring finger. He also lacerated the abductor digit quinti tendon which was not repaired

SOCIAL HISTORY: Alcohol-Denies
Employment: Fulltime: painter
Martial Status: Married
Tobacco: 1-2 PPD
FAMILY HISTORY: Acid Reflux
Arthritis
Cancer
Hypertension
ILLNESSES: Acid Reflux
anxiety
Arthritis
OPERATIONS: appendectomy
Foot
Lungs: 13 years ago
MEDICATIONS: Albuterol
Aspirin (Dosage: 81mg SIG: 1 daily)
Cymbalta
Lorcet (Dosage: 10/325 SIG: 1PO.q6h PRN Pain Dispense: 90 Refills: 1)
Neurontin
Relafen
ALLERGIES: NKDA

OBJECTIVE

PHYSICAL EXAM .Wound site is clean and dry, no evidence of infection. Neurovascular status is intact. He has very poor range of motion he cannot make a fist yet. He has 75° of flexion of the ring finger MP joint and 55° to flexion passively at the MP joint of the small finger. He has no active extension and I feel that he has had lesions of the fifth finger tendon.

X-RAY:. X-Rays show none taken.

ASSESSMENT

Vitals: [illegible] 8 WT 148 Ht 5'9 B 126/85
Follow up for repairs as above, progress is very slow

PLAN

PRESCRIPTION:. No data for Prescription

.Follow up 2 weeks, continue hand therapy. He may need lysis of adhesions. We will send him to Dr. Joe Jackson for a second opinion. One flavor and.

Terence H..ssler M.D.

PATIENT: Barr, Kenneth AGE: years old EXAM DATE: 04/22/13

REFERRING PROVIDER: CHAPMAN, RAYMOND,

DATE OF ONSET:. Approximately December 2012

CHIEF COMPLAINT:. Right knee pain

HISTORY:. The patient has had an injury in December 2012 he thinks where he twisted his knee heard a loud pop and was eventually able to weight bear after several minutes. He continued to have pain and is slowly worsened especially with his activities as he climbs up and down ladders as a painter for the school system. He eventually sought care from Dr. Chapman had an MRI showing a complex tear of the medial meniscus. The pain is located in the medial knee and is of mild-to-moderate severity lasting intermittently. It does come and go and is associated with weightbearing. Rest makes it better. There is no prior history of similar occurence. The patient does recall injury. The patient does not have associated radicular symptoms. The patient presents today for further evaluation and recommendations.

PAST HISTORY:

ILLNESSES: Acid Reflux
anxiety
Arthritis

OPERATIONS: appendectomy
Foot
Lungs: 13 years ago

INJURIES: None noted

HOSPITALIZATIONS: For the aforementioned surgeries

MEDICATIONS: Albuterol
Aspirin (Dosage: 81mg SIG: 1 daily)
Cymbalta
Lorcet (Dosage: 10/325 SIG: 1PO q6h PRN Pain Dispense: 90 Refills: 1)
Neurontin
Relafen

ALLERGIES: NKDA

IMMUNIZATIONS: Are up to date

SOCIAL HISTORY: Alcohol-Denies
Employment: Fulltime: painter
Martial Status: Married
Tobacco: 1-2 PPD

FAMILY HISTORY: Has been reviewed and is non contributory to the patient's disease process.

REVIEW OF SYSTEMS:	Head:	Denies Headaches, or difficulty with vision, taste, smell or swelling.
	Neck:	Denies Difficulty swallowing or masses noted

Heart:	Denies Chest pain, palpitations, orthopnea, edema or syncope.
Lungs:	Denies SOB, cough, sputum production, wheezes or hemoptysis.
GI:	Denies Abdominal pain, dyspepsia, change in bowel habits, blood in stool.
GU:	Denies Dysuria, hematuria, frequency, urgency, or discharge.
Neuro:	Denies focal neurologic deficit, weakness, paresthesias or incoordination.
Psychosocial:	Denies depression, or anxiety, recent stressors or change in lifestyle.
Heme:	Denies bleeding problems, or easy bruising.
Lymph:	Denies swollen glands.

All other systems have been reviewed and are negative.

Implants:. None **Anticoagulant:.** None

EXAMINATION: **VITAL SIGNS: Pulse:No Data for Pulse Blood Pressure:No data for Blood Pressure Weight:No Data for Weight Height:**

Constitutional: Well Developed, well nourished, in no acute distress.
Mental Status: Alert, oriented x 3, cooperative, pleasant.
Neck: No thyromegaly or lymphadenopathy, no masses, FROM.
Cardiovascular: No swelling, pulses full, skin warm, no edema.
Spine: Full range of motion of Neck, Upper and Lower back without tenderness to palpation or percussion.
Extremities: . **Right knee reveals tenderness over the medial joint line with 2+ effusion. Range of motion 0-120°. Positive McMurray sign with negative pivot shift negative anterior draw and negative Lachman's**
Skin: No rashes, good color
Neuro: No focal weakness, loss of sensation or incoordination. DTRs intact and equal bilaterally.

IMAGING:. **MRI as above. I have personally reviewed these studies.**

DIAGNOSIS:. **Right knee medial meniscus complex tear**

MEDICAL DECISION MAKING. **I have discussed diagnostic and therapeutic options with the patient and at present, I recommend arthroscopic debridement of medial meniscus tear. The patient wishes to go ahead with surgery on 4/26/13**

PRESCRIPTION:Lorcet (Dosage: 10/325 SIG: 1PO q4h PRN Pain Dispense: 60 Refills: 1 Method: Print)

TESTS:. **Preoperative evaluation**

FOLLOW UP:. **4/29/13**

Terence Hassler, M.D.

Electronically Signed

Dictated on: 04/22/13

BARR, KENNETH L (id #89639, dob:)

Encounter Summary

Patient

Name	BARR, KENNETH (, M) ID# 89639	Appt. Date/Time	04/25/2013 03:50PM
DOB		Service Dept.	TMG_Hartsville Ortho Sports Med
Provider	TERENCE HASSLER MD		
Insurance	Med Primary: BCBS-SC: STATE HEALTH PLAN Insurance # : ZCS03635250 Policy/Group # : 002132900 PCP : CHAPMAN, RAYMOND M Prescription: MHS - Member is eligible.		

Problems

None recorded.

Past Medical History

Reviewed Past Medical History
Arthritis: Y
GERD/Reflux: Y - Reflux
Other: Y - Anxiety

Family History

Reviewed Family History
Non-contributory.

Social History

Reviewed Social History
Ortho
Smoking Status: Current every day smoker.
Marital status: Married.
Smoker (1 1/2 PPD).
Alcohol intake: None.

Surgical History

Reviewed Surgical History
- Appendectomy
- Orthopaedic Surgery - Both feet
- Other - Right Lung
- Knee Surgery - 04/23/2013 - Right Knee Scope

Allergies

Reviewed Allergies
NKDA

Medications

Reviewed Medications	
Name	Date
ASPIRIN 81 MG TABLET,DELAYED RELEASE Take 1 tablet(s) every day by oral route.	04/25/13 entered
BUSPIRONE 15 MG TABLET 1 po tid	04/22/13 filled
CLONAZEPAM 0.5 MG TABLET	02/27/13 filled

BARR, KENNETH L (id #89639, dob:)

1/2 po tid	
FLUOXETINE 20 MG CAPSULE 1 po q day	04/14/13 filled
HYDROCODONE 10 MG-ACETAMINOPHEN 325 MG TABLET	04/22/13 filled
MELOXICAM 7.5 MG TABLET 2 po qhs	04/22/13 filled
NEXIUM 40 MG CAPSULE,DELAYED RELEASE 1 po q day	03/29/13 filled
TIZANIDINE 4 MG TABLET 1/2 po q hs	02/14/13 filled
TOPIRAMATE 50 MG TABLET	04/22/13 filled

Vitals

Notes: POST OP

Chief Complaint

None recorded.

ROS

None recorded.

Physical Exam

None recorded.

Assessment / Plan

None recorded.

Return to Office

- Terence Hassler, MD for Post op 15 at TMG_Hartsville Ortho Sports Med on 05/02/2013

Encounter Sign-Off

Encounter signed-off by Terence Hassler, MD, 05/02/2013.

Patient's Providers

Primary Care Provider (Primary Insurance): CHAPMAN, RAYMOND M: 701 MEDICAL PARK DRIVE, HARTSVILLE, SC 29550-4778, Ph (843) 383-5191, Fax (843) 656-1214
Other: TERENCE HASSLER MD: 700 MEDICAL PARK DR, HARTSVILLE, SC 29550-4765, Ph (803) 383-3742, Fax (843) 383-3745

Encounter performed and documented by Terence Hassler, MD
Encounter reviewed & signed by Terence Hassler, MD on 05/02/2013 at 1:26pm

REFERRING PROVIDER: CHAPMAN, RAYMOND,

PATIENT: Barr, Kenneth AGE: years old EXAM DATE: 04/25/13

DOS: 4/23/13

SUBJECTIVE

CHIEF COMPLAINT: S/P right Knee arthroscopy. C/O minimal pain.

HPI: Kenneth had findings of: **The medial compartment revealed medial meniscal tear which was resected to a stable rim. The medial femoral condyle revealed no chondromalacia. The medial tibial plateau revealed no chondromalacia. The intercondylar notch revealed intact ACL. The lateral compartment revealed no chondromalacia of the lateral femoral condyle with chondromalacia of the lateral tibial plateau. The retropatellar area revealed no chondromalacia with no chondromalacia of the intercondylar groove.**. The patient is using assistive devices: Crutches.

MEDICATION: **Albuterol**
Aspirin (Dosage: 81mg SIG: 1 daily)
Cymbalta
Lorcet (Dosage: 10/325 SIG: 1PO q6h PRN Pain Dispense: 90 Refills: 1)
Lorcet (Dosage: 10/325 SIG: 1PO q4h PRN Pain Dispense: 60 Refills: 1)
Neurontin
Relafen
ALLERGIES: NKDA
SOCIAL HISTORY: Alcohol-Denies
Employment: Fulltime: painter
Martial Status: Married
Tobacco: 1-2 PPD
FAMILY HISTORY: Acid Reflux
Arthritis
Cancer
Hypertension
ILLNESSES: Acid Reflux
anxiety
Arthritis
OPERATIONS: appendectomy
Foot
Lungs: 13 years ago

OBJECTIVE

PHYSICAL EXAM

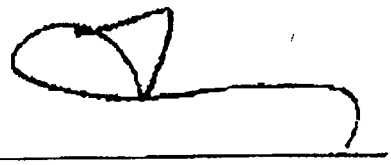
APPEARANCE:	No distress, good color on room air. Alert and cooperative.
CDV:	Pulses are normal, operated extremity.
SKIN:	No skin lesions or rashes. Wounds are clean and dry.
EXTREMITY:	Effusion: 1+. ROM: 0 degrees of extension, 90 degrees of flexion.
NEUOLOGICAL:	No focal weakness, loss of sensation, or incoordination.

ASSESSMENT

S/P right Knee arthroscopy, progressing nicely.

PLAN

PRESCRIPTION:.	No data for Prescription
Activity: Wk/school/sports:.	As tolerated, no work because she has to climb ladders at work.
Physical Therapy:.	None at present.
Return to clinic:.	1 week, may wean from crutches.



Terence Hassler, M.D.

Dictated and Transcribed on: 04/25/13 @ 9:43 AM

BARR, KENNETH L (Id #89639, dob:
Encounter Summary

Patient

Name	BARR, KENNETH , , , M) ID# 89639	Appt. Date/Time	05/02/2013 03:30PM
DOB		Service Dept.	TMG_Hartsville Ortho Sports Med
Provider	TERENCE HASSLER MD		
Insurance	Med Primary: BCBS-SC: STATE HEALTH PLAN Insurance # : ZCS03635250 Policy/Group # : 002132900 PCP : CHAPMAN, RAYMOND M Prescription: MHS - Member is eligible.		

Problems

None recorded.

Past Medical History

Past Medical History not reviewed (last reviewed 04/25/2013)
Arthritis: Y
GERD/Reflux: Y - Reflux
Other: Y - Anxiety

Family History

Family History not reviewed (last reviewed 04/25/2013)
Non-contributory.

Social History

Social History not reviewed (last reviewed 04/25/2013)
Ortho
Smoking Status: Current every day smoker.
Marital status: Married.
Smoker (1 1/2 PPD).
Alcohol Intake: None.

Surgical History

Surgical History not reviewed (last reviewed 04/25/2013)
- Appendectomy
- Orthopaedic Surgery - Both feet
- Other - Right Lung
- Knee Surgery - 04/23/2013 - Right Knee Scope

Allergies

Allergies not reviewed (last reviewed 04/25/2013)
NKDA

Medications

Medications not reviewed (last reviewed 04/25/2013)	
Name	Date
ASPIRIN 81 MG TABLET,DELAYED RELEASE Take 1 tablet(s) every day by oral route.	04/25/13 entered
BUSPIRONE 15 MG TABLET 1 po tid	04/22/13 filled
CLONAZEPAM 0.5 MG TABLET	02/27/13 filled

BARR, KENNETH L (id #89639, dob:)

1/2 po tid	
UOXETINE 20 MG CAPSULE 1 po q day	04/14/13 filled
HYDROCODONE 10 MG-ACETAMINOPHEN 325 MG TABLET	04/22/13 filled
MELOXICAM 7.5 MG TABLET 2 po qhs	04/22/13 filled
NEXIUM 40 MG CAPSULE,DELAYED RELEASE 1 po q day	03/29/13 filled
TIZANIDINE 4 MG TABLET Take 2 tablet(s) by oral route at bedtime PRN.	05/03/13 prescribed
TOPIRAMATE 50 MG TABLET	04/22/13 filled

Vitals

None recorded.

Chief Complaint

None recorded.

ROS

None recorded.

Physical Exam

None recorded.

Assessment / Plan

None recorded.

Return to Office

- Terence Hassler, MD for Post op 15 at TMG_Hartsville Ortho Sports Med on 05/16/2013

Encounter Sign-Off

Encounter signed-off by ATHENA, 05/03/2013.

Patient's Providers

Primary Care Provider: CHAPMAN, RAYMOND M: 701 MEDICAL PARK DRIVE, HARTSVILLE, SC 29550-4778, Ph (843) 383-5191, Fax (843) 656-1214
Other: TERENCE HASSLER MD: 700 MEDICAL PARK DR, HARTSVILLE, SC 29550-4765, Ph (803) 383-3742, Fax (843) 383-3745

Encounter performed and documented by
Encounter reviewed & signed by ATHENA on 05/03/2013 at 3:47pm

REFERRING PROVIDER: CHAPMAN, RAYMOND,

PATIENT: Barr, Kenneth AGE: years old EXAM DATE: 05/02/13

DOS: 4/23/13

SUBJECTIVE

CHIEF COMPLAINT: S/P right Knee arthroscopy. C/O minimal pain until he stepped in a hole 2 days ago and had immediate swelling in his knee..

HPI: Kenneth had findings of: **The medial compartment revealed medial meniscal tear which was resected to a stable rim. The medial femoral condyle revealed no chondromalacia. The medial tibial plateau revealed no chondromalacia. The intercondylar notch revealed intact ACL. The lateral compartment revealed no chondromalacia of the lateral femoral condyle with chondromalacia of the lateral tibial plateau. The retropatellar area revealed no chondromalacia with no chondromalacia of the intercondylar groove..** The patient is using assistive devices: None.

MEDICATION: Albuterol
Aspirin (Dosage: 81mg SIG: 1 daily)
Cymbalta
Lorcet (Dosage: 10/325 SIG: 1PO q6h PRN Pain Dispense: 90 Refills: 1)
Lorcet (Dosage: 10/325 SIG: 1PO q4h PRN Pain Dispense: 60 Refills: 1)
Neurontin
Relafen
ALLERGIES: NKDA
SOCIAL HISTORY: Alcohol-Denies
Employment: Fulltime: painter
Martial Status: Married
Tobacco: 1-2 PPD
FAMILY HISTORY: Acid Reflux
Arthritis
Cancer
Hypertension
ILLNESSES: Acid Reflux
anxiety
Arthritis
OPERATIONS: appendectomy
Foot
Lungs: 13 years ago

OBJECTIVE

PHYSICAL EXAM

APPEARANCE:	No distress, good color on room air. Alert and cooperative.
CDV:	Pulses are normal, operated extremity.
SKIN:	No skin lesions or rashes. Wounds are clean and dry.
EXTREMITY:	Effusion: 1+. ROM: 0 degrees of extension, 110 degrees of flexion.
NEUOLOGICAL:	No focal weakness, loss of sensation, or incoordination.

ASSESSMENT

S/P right Knee arthroscopy, progressing nicely.

PLAN

PRESCRIPTION:.	Mobic (Dosage: 7.5mg SIG: 1 PO BID PRN Pain Dispense: 60 Refills: 0 Method: Print)
Activity: Wk/school/sports:.	As tolerated, no work because she has to climb ladders at work.
Physical Therapy:.	None at present.
Return to clinic:.	2 weeks no work until then

~Object:{54FDCE22-E75A-4356-9670-2F0C47C303

Terence Hassler, M.D.

Dictated and Transcribed on: 05/02/13 @ 9:42 AM

BARR, KENNETH L (id #89639, dob: .....)

Encounter Summary

Patient

Name	BARR, KENNETH (43, M) ID# 89639	Appt. Date/Time	05/16/2013 10:00AM
DOB	.....	Service Dept.	TMG_Hartsville Ortho Sports Med
Provider	TERENCE HASSLER MD		
Insurance	Med Primary: BCBS-SC: STATE HEALTH PLAN Insurance # : ZCS03635250 Policy/Group # : 002132900 PCP : CHAPMAN, RAYMOND M Prescription: MHS - Member is eligible.		

Problems

- Tear of medial cartilage or meniscus of knee, current (836.0)

Past Medical History

Reviewed Past Medical History
Arthritis: Y
GERD/Reflux: Y - Reflux
Other: Y - Anxiety

Family History

Family History not reviewed (last reviewed 04/25/2013)
Non-contributory.

Social History

Reviewed Social History
Ortho
Smoking Status: Current every day smoker.
Marital status: Married.
Smoker (1 1/2 PPD).
Alcohol intake: None.

Surgical History

Reviewed Surgical History
- Appendectomy
- Orthopaedic Surgery - Both feet
- Other - Right Lung
- Knee Surgery - 04/23/2013 - Right Knee Scope

Allergies

Allergies not reviewed (last reviewed 04/25/2013)
NKDA

Medications

Medications not reviewed (last reviewed 04/25/2013)	
Name	Date
ASPIRIN 81 MG TABLET,DELAYED RELEASE Take 1 tablet(s) every day by oral route.	04/25/13 entered
BUSPIRONE 15 MG TABLET 1 po tid	04/22/13 filled
CLONAZEPAM 0.5 MG TABLET	05/14/13 filled

BARR, KENNETH L (id #89639, dob:

1/2 po tid	
UOXETINE 20 MG CAPSULE 1 po q day	05/14/13 filled
HYDROCODONE 10 MG-ACETAMINOPHEN 325 MG TABLET	04/22/13 filled
MELOXICAM 7.5 MG TABLET 2 po qhs	04/22/13 filled
NEXIUM 40 MG CAPSULE,DELAYED RELEASE 1 po q day	05/14/13 filled
TIZANIDINE 4 MG TABLET Take 2 tablet(s) by oral route at bedtime PRN.	05/03/13 prescribed
TOPIRAMATE 50 MG TABLET	04/22/13 filled

Vitals

Ht: 5 ft 8 in **Wt:** 145 lbs **BMI:** 22

Chief Complaint

None recorded.

HPI

the patient is status post right knee arthroscopy on 4/23/13 he is doing quite well with findings of medial meniscus tear which was trimmed back to a stable rim only.

None recorded.

Physical Exam

Patient is a year-old male.

right knee reveals full range of motion and no effusion well-healed surgical scars

Assessment / Plan

Status post right knee arthroscopy with trimming of the medial meniscus doing quite well

1. TEAR OF MEDIAL CARTILAGE OR MENISCUS OF KNEE, CURRENT (836.0)

- MENISCUS TEAR: AFTER YOUR VISIT

Discussion: Follow up again in 2 weeks for reexam.

Return to Office

- Terence Hassler, MD for Post op 15 at TMG_Hartsville Ortho Sports Med on 06/06/2013

Encounter Sign-Off

Encounter signed-off by Terence Hassler, MD, 05/16/2013.

Patient's Providers

Primary Care Provider (Primary Insurance): CHAPMAN, RAYMOND M: 701 MEDICAL PARK DRIVE, HARTSVILLE, SC 29550-4778, Ph (843) 383-5191, Fax (843) 656-1214
Other: TERENCE HASSLER MD: 700 MEDICAL PARK DR, HARTSVILLE, SC 29550-4765, Ph (803) 383-3742, Fax (843) 383-3745

Encounter performed and documented by Terence Hassler, MD
Encounter reviewed & signed by Terence Hassler, MD on 05/16/2013 at 6:18pm

BARR, KENNETH L (id #89639, dob:
ounter Summary

Patient

Name	BARR, KENNETH (M) ID# 89639	Appt. Date/Time	08/29/2013 02:30PM
DOB	08/17/1969	Service Dept.	TMG_Hartsville Ortho Sports Med
Provider	TERENCE HASSLER MD		
Insurance	Med Primary: BCBS-SC: STATE HEALTH PLAN Insurance # : ZCS03635250 Policy/Group # : 002132900 PCP : CHAPMAN, RAYMOND M Prescription: MHS - Member is eligible.		

Problems

Reviewed Problems
- Generalized anxiety disorder (300.02)
- Nondependent abuse of drugs; tobacco use disorder (305.1)
- Osteoarthrosis; unspecified whether generalized or localized; site unspecified (715.90)
- Degeneration of thoracic or lumbar intervertebral disc; lumbar or lumbosacral intervertebral disc (722.52)
- Chest pain; unspecified (786.50)
- Tear of medial cartilage or meniscus of knee; current (836.0)

Past Medical History

Reviewed Past Medical History
Allergies: Y
Arthritis: Y
D/Reflux: Y - Reflux
er: Y - Anxiety

Family History

Reviewed Family History
Father - Cancer (died age: 72)
Mother - lupus

Social History

Reviewed Social History
General IM and Ortho
Marital status: Married.
Smoking Status: Current every day smoker.
Smoker (1 1/2 PPD).
Alcohol Intake: None.

Surgical History

Reviewed Surgical History
- Appendectomy
- Orthopaedic Surgery - Both feet
- Other - Right Lung
- Knee Surgery - 04/23/2013 - Right Knee Scope

Allergies

Reviewed Allergies
MORPHINE
ICILLINS

Medications

Medications not reviewed (last reviewed 07/19/2013)	

BARR, KENNETH L (id #89639, dob:

Name	Date
ASPIRIN 81 MG TABLET,DELAYED RELEASE Take 1 tablet(s) every day by oral route.	04/25/13 entered
BUSPIRONE 15 MG TABLET Take 1 tablet(s) 3 times a day by oral route.	08/05/13 filled
CLONAZEPAM 0.5 MG TABLET Take 1 tablet(s) 3 times a day by oral route for 30 days., CALLED IN	08/09/13 prescribed
FLUOXETINE 20 MG CAPSULE Take 1 capsule(s) every day by oral route.	08/15/13 filled
MELOXICAM 7.5 MG TABLET Take 1 tablet(s) twice a day by oral route with FOOD for 30 days.	08/09/13 prescribed
NEXIUM 40 MG CAPSULE,DELAYED RELEASE Take 1 capsule(s) every day by oral route for 30 days.	08/27/13 filled
TIZANIDINE 4 MG TABLET Take 2 tablet(s) by oral route at bedtime PRN.	05/03/13 prescribed
TOPIRAMATE 50 MG TABLET Take 3 tablet(s) every day by oral route at bedtime for 30 days.	08/12/13 prescribed

Vitals

None recorded.

Chief Complaint

Itch in Rt. hand

HPI

patient had a Prolene suture remaining in his right hand from surgery to repair the tendons in 2012. This is apparently irritating him

ROS

None recorded.

Physical Exam

Patient is a year-old male.

the suture was removed without difficulty

Assessment / Plan

Status post repair the tendons of the right hand extensor. Residual suture irritation, which was removed

Discussion: follow up again has necessary

Return to Office

- as needed

Encounter Sign-Off

Encounter signed-off by Terence Hassler, MD, 08/29/2013.

Patient's Providers

Primary Care Provider (Primary Insurance): CHAPMAN, RAYMOND M: 701 MEDICAL PARK DRIVE, HARTSVILLE, SC 29550-4778, Ph (843) 383-5191, Fax (843) 656-1214

Other: TERENCE HASSLER MD: 700 MEDICAL PARK DR, HARTSVILLE, SC 29550-4765, Ph (803) 383-3742, Fax (843) 383-3745

000121623268

McLeod Health
Rehab Services
555 East Cheves St
Florence, SC 29502
McLeod Health

000121623268

NAME: BARR, KENNETH	Account ID: 000121623268
ROOM: HC	Date of Birth:
ADMIT DATE: 04/24/2012	Med. Record # : 00076499
CHART: cindy	

Date/Time: 2/21/12 10:25 am

Start Time: 8:05 End Time: 9:15
Session Duration: 70

OP HC-Evaluation - UE Hand Revised

Occupational Therapy
Outpatient Upper Extremity/Hand Evaluation - UE Hand

Provider #420051
HCIN: 248219326
Medical Diagnosis: RIGHT HAND COMPLEX LACERA
Demographics:
Age:
Gender: Male
Primary Language: English
Hand Dominance: Right.
Referring Physician: Dr Hassler
Concurrent Services: None.
Previous treatment for this condition: No previous treatment.
Past Medical History: Carpal tunnel release of R hand, smoker and depression
History of Present Illness:
Date of Injury: 01-25-12
Date of Surgery: 01-26-12
Method of injury/illness: hand went through glass door
Surgical procedure: ECU repair and side to side anastomosis of extensor digitorum quinti tendon to EDC tendon of ring finger. Laceration of abductor digit quinti tendon was not repaired
Medications and Allergies: none
Rehabilitation Precautions/Restrictions/Barriers to Treatment: No treatment/activity precautions.

SUBJECTIVE 3
Social History: Marital Status: Married
Children: 3
Employment Status: Painter for Darlington county school district
Recreational Activities/Hobbies: fishing
Premorbid Functional Level: Patient/caregiver reports the following functional limitations: independent
Patient Goals: regain use of his hand
Self-Care Management: Patient reported limitations with the following ADL tasks: needs assistance for fasteners, cutting food
Pain: 8 out of 10

OUTCOME SCORES:

000121623268

McLeod Health
Rehab Services
555 East Cheves St
Florence, SC 29502
McLeod Health

000121623268

NAME: BARR, KENNETH	Account ID: 000121623268
ROOM: HC	Date of Birth:
ADMIT DATE: 04/24/2012	Med. Record # : 00076499
CHART: cindy	

PAIN: 8
MOTION: 9
FUNCTION: 8

OBJECTIVE

Observation: Moderate swelling on dorsum of hand. Steri strips in place over incision on dorsum of hand.
Sensation: sensation is reported to be normal
Range of Motion:
Right hand/Upper Extremity: (extension/flexion in degrees unless otherwise noted)

AROM Index: MP -10 /40 , **PIP** -4 /78 ; **DIP** 0 /42 ; **TAM** 146

AROM Middle: MP -28 /54 ; **PIP** -10 /50 ; **DIP** 0 /24 ; **TAM** 90

AROM Ring: MP -14 /20 ; **PIP** -24 /44 ; **DIP** 0 /10 ; **TAM** 36

AROM Small: MP -18 /-18 , **PIP** -26 /34 ; **DIP** 0 /0 ; **TAM** -28

AROM Thumb: MCP -14 /40 ; **IP** 0 /54

R wrist AROM:
extension.45
flexion:0
UD:5
RD: 10

Pain Interventions: massage
Pain Reassessment: 8 out of 10

Treatment: Retrograde massage was completed for ring/small fingers up through dorsum of hand. PROM completed to all digits with emphasis placed on ring and small fingers. Each joint was ranged followed by hook and composite fisting. Pt was issued compression glove to assist with reducing edema.

Education: Pt was provided handouts for PROM for fingers and active tendon gliding. Pt was educated on retrograde massage and scar massage as well. Pt verbalized understanding.

ASSESSMENT

Necessity: Patient requires therapy plan in order to return to work. Patient requires outpatient therapy in order to reduce Activities of Daily Living or Instrumental Activities of Daily Living assistance to a premorbid level. Patient requires therapy plan in order to function in community.
Rehabilitation Potential: Excellent

000121623268

McLeod Health
Rehab Services
555 East Cheves St
Florence, SC 29502
McLeod Health

000121623268

NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

Motivation/Commitment to Therapy: Good.
The patient has been instructed to contact the clinic if any questions or problems should arise. Patient participated in plan of care development today and establishing of the following goals:
Short Term Goals: Time frame to achieve short term goal(s):
1 week
1. Pt will have full wound closure.
2. Pt will be I with HEP.

Long Term Goals: Time frame to achieve long term goal(s):
4 weeks
1. Pt will increase TAM by 50 degrees on each digit.
2. Pt will begin strengthening when appropriate PROM is available.
3. Pt will be I with all ADL and IADL activities.
4. Pt will tolerate work simulation without increase in pain.
5. Pain will be 3 or lower during functional use.

PLAN
Treatment Frequency, Duration, and Interventions: Continued occupational therapy recommendations: 3 times/week x 4 weeks
Procedures: - ADL TRAINING - EVALUATION - EXERCISE - FUNCTIONAL/THERAPEUTIC ACTIVITY - HOME INSTRUCTION - MANUAL THERAPY - MASSAGE - MODALITIES - ORTHOTICS - ORTHOTIC FIT AND TRAINING - RE-EVALUATION

Visit Number: Today's visit is number 1

Treatment Rendered:
Evaluation 20 minutes.
Massage 15 minutes.
Exercise 30 minutes.

Provider Certification/Prescription: This is to certify that the above named patient, who is under my care, requires skilled Occupational Therapy services as described in the above treatment plan. I further certify that the services outlined in this plan are skilled and medically necessary. I have reviewed this plan for rehabilitation services, and I recommend **and prescribe** that these services continue from 02-21-12 to 03-21-12 to meet the goals stated above. **Treatment Diagnosis:** hand pain

Physician signature: _____ Date: _____ Time: _____
Referring Physician: Dr Hassler

000121623268

McLeod Health
Rehab Services
555 East Cheves St
Florence, SC 29502

000121623268

McLeod Health

NAME: BARR, KENNETH	Account ID: 000121623268
ROOM: HC	Date of Birth:
ADMIT DATE: 04/24/2012	Med. Record # : 00076499
CHART: cindy	

Date/Time: 2/22/12 2:30 pm

Start Time: 13:00 End Time: 14:10
Session Duration: 70

OP HC Note - Treatment - UE Hand Revised

Occupational Therapy
Outpatient Upper Extremity Hand Treatment Note

Referring Clinician: Dr Hassler
Rehabilitation Precautions/Restrictions: Per diagnosis: none

SUBJECTIVE
Patient Report: I am doing ok
Clinical/Medical Status Changes: none
Pain : 5 out of 10
Pain Interventions: moist heat

OBJECTIVE
Interventions: Patient received the following interventions:
STM, scar and retrograde massage applied to entire dorsum of R hand.
PROM to R wrist in all planes.
Extensive PROM to all digits with emphasis placed on ring and small fingers. Each joint ranged separately and then in hook and composite fashion.

FA: Pt used R hand for in hand manipulation via placement of 100 small pegs. Good use of ring and small finger noted.

Education/HEP: complete non resistive housework to encourage functional use of hand
Pain Reassessment: 3 out of 10

ASSESSMENT
Treatment Diagnosis: hand pain
Response to Visit: Tolerated session without difficulty.
Progress Toward Goals: SHORT TERM GOAL REVIEW:
1. Pt will have full wound closure. - Progressing one small area present at most distal portion of wound.

Time frame to achieve short term goal(s): 1 week

PLAN
Treatment Frequency, Duration, and Interventions: Continued occupational therapy recommendations: 3 times per week x 4 weeks
Procedures: - ADL TRAINING - EVALUATION - EXERCISE - FUNCTIONAL/THERAPEUTIC ACTIVITY -

000121623268

McLeod Health
Rehab Services
555 East Cheves St
Florence, SC 29502

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McLeod Health

NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

HOME INSTRUCTION - MANUAL THERAPY - MASSAGE - MODALITIES - ORTHOTICS - ORTHOTIC FIT AND TRAINING - RE-EVALUATION
The patient has been instructed to contact our clinic if any questions or problems should arise.

Visit Number: Today's visit is number 2

Treatment Rendered:
Exercise 20 minutes.
Massage 10 minutes.
Functional/Therapeutic Activities 23 minutes.

Signed by: CINDY BELK - MSR, OTR/L

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McLeod Health
Rehab Services
555 East Cheves St
Florence, SC 29502

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McLeod Health

NAME: BARR, KENNETH
ROOM: HC
ADMIT DATE: 04/24/2012
CHART: cindy

Account ID: 000121623288
Date of Birth:
Med. Record # : 00076499

Date/Time: 2/24/12 9:37 am

Start Time: 0:00 End Time: 0:00
Session Duration: 0

OP HC Note - Missed Visit Hand Center

Completed Orders	Description	Num.Performed
OTHCCAN	OTHC - PT. CANCEL	1.00

Occupational Therapy Hand Center
Outpatient Missed Visit Note

The patient did not attend the therapy appointment on 02-24-12. at 9:00 .

Reason: Pt had a conflict come up.
Future Appointment: The patient has additional appointments.

Signed by: CINDY BELK - MSR, OTR/L

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Florence, SC 29502

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McLeod Health

NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

Date/Time: 2/27/12 3:15 pm **Start Time:** 11:00 **End Time:** 12:00
Session Duration: 60

OP HC Note - Treatment - UE Hand Revised

Occupational Therapy
Outpatient Upper Extremity Hand Treatment Note

Referring Clinician: Dr Hassler
Rehabilitation Precautions/Restrictions: Per diagnosis: none

SUBJECTIVE
Patient Report: I am a little more sore today. I am also worried about my finances
Clinical/Medical Status Changes: none
Pain : 5 out of 10
Pain Interventions: fluidotherapy, retrograde massage

OBJECTIVE
Interventions: Patient received the following interventions:
STM, scar and retrograde massage applied to entire dorsum of R hand.
PROM to R wrist in all planes.
Extensive PROM to all digits with emphasis placed on ring and small fingers. Each joint ranged separately and then in hook and composite fashion.

FA: Pt used R hand for in hand manipulation via placement of 100 small pegs. Good use of ring and small finger noted.

Education/HEP: complete non resistive housework to encourage functional use of hand and scar massage
Pain Reassessment: 3 out of 10

ASSESSMENT
Treatment Diagnosis: hand pain
Response to Visit: Tolerated session without difficulty.
Progress Toward Goals: Pt is progressing. May benefit from dynamic splinting.

PLAN
Treatment Frequency, Duration, and Interventions: Continued occupational therapy recommendations: 3 times per week x 4 weeks
Procedures: - ADL TRAINING - EVALUATION - EXERCISE - FUNCTIONAL/THERAPEUTIC ACTIVITY - HOME INSTRUCTION - MANUAL THERAPY - MASSAGE - MODALITIES - ORTHOTICS - ORTHOTIC FIT AND TRAINING - RE-EVALUATION

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NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

The patient has been instructed to contact our clinic if any questions or problems should arise.

Visit Number: Today's visit is number 3

Treatment Rendered:
Exercise 20 minutes.
Massage 10 minutes.
Functional/Therapeutic Activities 10 minutes.
WP 20 mins

Signed by: CINDY BELK - MSR, OTR/L

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NAME: BARR, KENNETH	Account ID: 000121623268
ROOM: HC	Date of Birth:
ADMIT DATE: 04/24/2012	Med. Record # : 00076499
CHART: cindy	

Date/Time: 2/29/12 10:48 am

Start Time: 10:30 End Time: 11:50
Session Duration: 80

OP HC Note - Treatment - UE Hand Revised

Occupational Therapy
Outpatient Upper Extremity Hand Treatment Note

Referring Clinician: Dr Hassler
Rehabilitation Precautions/Restrictions: Per diagnosis: none

SUBJECTIVE
Patient Report: I am OK. Just very stiff.
Clinical/Medical Status Changes: none
Pain : 6 out of 10
Pain Interventions: fluidotherapy, retrograde massage

OBJECTIVE
Interventions: Patient received the following interventions:
-Fluidotherapy x20 minutes
-STM, scar and retrograde massage applied to entire dorsum of R hand, wrist and forearm x15 minutes
PROM to R wrist in all planes 2 sets x10 reps each
Extensive PROM to all digits with emphasis placed on ring and small fingers. Each joint ranged separately and then in hook and composite fashion.

ORTHOTICS:
Fabricated dynamic flexion splint for MP pull this date. Splint was fabricated using polyflex material, placing the wrist in sl extension . Post was added to volar surface of wrist splint and velfoam loops were attached to each MP joint for dynamic pull. Splint appeared to fit well and provided comfortable and tolerable pull this date. Pt was issued splint instructions and precautions to wear splint up to 10 minutes out of every waking hour as tolerated. Pt acknowledged understanding instructions and demonstrated ability to don/doff splint independently.

Education/HEP: Continue as instructed and add splint wear instructions
Pain Reassessment: 3 out of 10

ASSESSMENT
Treatment Diagnosis: hand pain
Response to Visit: Tolerated session without difficulty.
Progress Toward Goals: Pt is progressing. Adjust dynamic splint as needed and assess need to add

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NAME: BARR, KENNETH	Account ID: 000121623268
ROOM: HC	Date of Birth:
ADMIT DATE: 04/24/2012	Med. Record # : 00076499
CHART: cindy	

extensor pull component to splint

PLAN

Treatment Frequency, Duration, and Interventions: Continued occupational therapy.recommendations: 3 times per week x 4 weeks
Procedures: - ADL TRAINING - EVALUATION - EXERCISE - FUNCTIONAL/THERAPEUTIC ACTIVITY - HOME INSTRUCTION - MANUAL THERAPY - MASSAGE - MODALITIES - ORTHOTICS - ORTHOTIC FIT AND TRAINING - RE-EVALUATION
The patient has been instructed to contact our clinic if any questions or problems should arise.

Visit Number: Today's visit is number 4

Treatment Rendered:
Exercise 15 minutes.
Massage 15 minutes.
Orthotics 30
WP 20 mins

Signed by: BETH EINZIGER - OTR/L

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NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

Date/Time: 3/2/12 11:16 am **Start Time:** 10:00 **End Time:** 11:10
Session Duration: 70

OP HC Note - Treatment - UE Hand Revised

Occupational Therapy
Outpatient Upper Extremity Hand Treatment Note

Referring Clinician: Dr Hassler
Rehabilitation Precautions/Restrictions: Per diagnosis: **none**

SUBJECTIVE
Patient Report: I am OK. I think the splint is helping
Clinical/Medical Status Changes: none
Pain : 6 out of 10
Pain Interventions: fluidotherapy, retrograde massage

OBJECTIVE
Interventions: Patient received the following interventions:
-Fluidotherapy x20 minutes
-STM, scar and retrograde massage applied to entire dorsum of R hand, wrist and forearm x15 minutes
PROM to R wrist in all planes 2 sets x10 reps each
Extensive PROM to all digits with emphasis placed on ring and small fingers. Each joint ranged separately and then in hook and composite fashion.

ORTHOTICS:
night extension splint was fabricated for ring and small fingers to decrease extensor lag at MP. Bands on dynamic flexion splint were tightened.

Education/HEP: Continue as instructed and add splint wear instructions
Pain Reassessment: 3 out of 10

ASSESSMENT
Treatment Diagnosis: hand pain
Response to Visit: Tolerated session without difficulty.
Progress Toward Goals: Pt is progressing.

PLAN
Treatment Frequency, Duration, and Interventions: Continued occupational therapy recommendations: 3 times per week x 4 weeks
Procedures: - ADL TRAINING - EVALUATION - EXERCISE - FUNCTIONAL/THERAPEUTIC ACTIVITY -

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McLeod Health

NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

HOME INSTRUCTION - MANUAL THERAPY - MASSAGE - MODALITIES - ORTHOTICS - ORTHOTIC FIT AND TRAINING - RE-EVALUATION
The patient has been instructed to contact our clinic if any questions or problems should arise.

Visit Number: Today's visit is number 4

Treatment Rendered:
Exercise 15 minutes.
Massage 15 minutes.
orthotic fit and training 20 mins
WP 20 mins

Signed by: CINDY BELK - MSR, OTR/L

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McLeod Health

NAME: BARR, KENNETH	Account ID: 000121623268
ROOM: HC	Date of Birth:
ADMIT DATE: 04/24/2012	Med. Record # : 00076499
CHART: cindy	

Date/Time: 3/6/12 8:25 am

Start Time: 14:00 End Time: 15:00
Session Duration: 60

OP HC Note - Treatment - UE Hand Revised

Occupational Therapy
Outpatient Upper Extremity Hand Treatment Note

Referring Clinician: Dr Hassler
Rehabilitation Precautions/Restrictions: Per diagnosis: **none**

SUBJECTIVE
Patient Report: the tip of my scar is sensitive.
Clinical/Medical Status Changes: none
Pain : 6 out of 10
Pain Interventions: fluidotherapy, retrograde massage

OBJECTIVE
Interventions: Patient received the following interventions:
-Fluidotherapy x20 minutes
-STM, scar and retrograde massage applied to entire dorsum of R hand, wrist and forearm x10 minutes
PROM to R wrist in all planes 2 sets x10 reps each
Extensive PROM to all digits with emphasis placed on ring and small fingers. Each joint ranged separately and then in hook and composite fashion.
Passive MP flexion with active IP flexion 10 reps.

Functional Activity: Pt completed 100 small peg placement with small finger to thumb opposition. Pt was able to complete up to 5 peg in hand manipulation upon removal.

Education/HEP: Continue as instructed and add splint wear instructions
Pain Reassessment: 3 out of 10

ASSESSMENT
Treatment Diagnosis: hand pain
Response to Visit: Tolerated session without difficulty.
Progress Toward Goals: Pt is progressing. Will benefit from IP pull with dynamic splint

PLAN
Treatment Frequency, Duration, and Interventions: Continued occupational therapy recommendations: 3 times per week x 4 weeks
Procedures: - ADL TRAINING - EVALUATION - EXERCISE - FUNCTIONAL/THERAPEUTIC ACTIVITY -

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NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

HOME INSTRUCTION - MANUAL THERAPY - MASSAGE - MODALITIES - ORTHOTICS - ORTHOTIC FIT AND TRAINING - RE-EVALUATION
The patient has been instructed to contact our clinic if any questions or problems should arise.

Visit Number: Today's visit is number 5

Treatment Rendered:
Exercise 15 minutes.
Massage 10 minutes
WP 20 mins
FA 15 mins

Signed by: CINDY BELK - MSR, OTR/L

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NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record #:** 00076499
CHART: cindy	

Date/Time: 3/7/12 2:38 pm **Start Time:** 13:00 **End Time:** 14:15
Session Duration: 75

OP HC Note - Treatment - UE Hand Revised

Occupational Therapy
Outpatient Upper Extremity Hand Treatment Note

Referring Clinician: Dr Hassler
Rehabilitation Precautions/Restrictions: Per diagnosis: none

SUBJECTIVE
Patient Report: I am just ok
Clinical/Medical Status Changes: none
Pain : 6 out of 10
Pain Interventions: fluidotherapy, retrograde massage

OBJECTIVE
Interventions: Patient received the following interventions:
-Fluidotherapy x20 minutes
-STM, scar and retrograde massage applied to entire dorsum of R hand, wrist and forearm x10 minutes
PROM to R wrist in all planes 2 sets x10 reps each
Extensive PROM to all digits with emphasis placed on ring and small fingers. Each joint ranged separately and then in hook and composite fashion.
Passive MP flexion with active IP flexion 10 reps.

Functional Activity: 100 post placement on O'Connor board using small finger to thumb opposition.

Orthotic fit and training: hooks were placed to ring and small finger as well as guide hoop placed into palm of splint to assist with IP pull in combination with MP joints.

Education/HEP: Continue as instructed and add splint wear instructions
Pain Reassessment: 3 out of 10

ASSESSMENT
Treatment Diagnosis: hand pain
Response to Visit: Tolerated session without difficulty.
Progress Toward Goals: Pt is progressing. Will benefit from IP pull with dynamic splint
PLAN
Treatment Frequency, Duration, and Interventions: Continued occupational therapy recommendations: 3

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NAME: BARR, KENNETH	Account ID: 000121623268
ROOM: HC	Date of Birth:
ADMIT DATE: 04/24/2012	Med. Record # : 00076499
CHART: cindy	

times per week x 4 weeks
Procedures: - ADL TRAINING - EVALUATION - EXERCISE - FUNCTIONAL/THERAPEUTIC ACTIVITY - HOME INSTRUCTION - MANUAL THERAPY - MASSAGE - MODALITIES - ORTHOTICS - ORTHOTIC FIT AND TRAINING - RE-EVALUATION
The patient has been instructed to contact our clinic if any questions or problems should arise.

Visit Number: Today's visit is number 6

Treatment Rendered:
Exercise 15 minutes.
Massage 10 minutes.
WP 20 mins
FA 15 mins
Orthotic fit and training 10 mins

Signed by: CINDY BELK - MSR, OTR/L

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NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

Date/Time: 3/12/12 8:15 am

Start Time: 10:00 **End Time:** 11:10
Session Duration: 70

OP HC Note - Treatment - UE Hand Revised

Occupational Therapy
Outpatient Upper Extremity Hand Treatment Note

Referring Clinician: Dr Hassler
Rehabilitation Precautions/Restrictions: Per diagnosis: none

SUBJECTIVE
Patient Report: I am just ok
Clinical/Medical Status Changes: none
Pain : 6 out of 10
Pain Interventions: fluidotherapy, retrograde massage

OBJECTIVE
Interventions: Patient received the following interventions:
-Fluidotherapy x20 minutes
-STM, scar and retrograde massage applied to entire dorsum of R hand, wrist and forearm x10 minutes
US applied to dorsum of hand over scar 8 mins at 3 mhz at 1.0 intensity for 8 mins.

PROM to R wrist in all planes 2 sets x10 reps each
Extensive PROM to all digits with emphasis placed on ring and small fingers. Each joint ranged separately and then in hook and composite fashion.
Passive MP flexion with active IP flexion 10 reps.

Orthotic fit and training: hooks were readjusted to apply a more appropriate line of pull. Pt verbalized increased comfort with splint.

Education/HEP: Continue as instructed and add splint wear instructions
Pain Reassessment: 3 out of 10

ASSESSMENT
Treatment Diagnosis: hand pain
Response to Visit: Tolerated session without difficulty.
Progress Toward Goals: Pt is progressing. May add merrit component to splint to apply increased dynamic pull on small finger MP joint.

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NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

PLAN

Treatment Frequency, Duration, and Interventions: Continued occupational therapy recommendations: 3 times per week x 4 weeks
Procedures: - ADL TRAINING - EVALUATION - EXERCISE - FUNCTIONAL/THERAPEUTIC ACTIVITY - HOME INSTRUCTION - MANUAL THERAPY - MASSAGE - MODALITIES - ORTHOTICS - ORTHOTIC FIT AND TRAINING - RE-EVALUATION
The patient has been instructed to contact our clinic if any questions or problems should arise.

Visit Number: Today's visit is number 7

Treatment Rendered:
Exercise 15 minutes.
Massage 10 minutes.
WP 20 mins
US 8 mins
Orthotic fit and training 10 mins

Signed by: CINDY BELK - MSR, OTR/L

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NAME: BARR, KENNETH	Account ID: 000121623268
ROOM: HC	Date of Birth:
ADMIT DATE: 04/24/2012	Med. Record # : 00076499
CHART: cindy	

Date/Time: 3/14/12 2:22 pm

Start Time: 11:00 End Time: 12:00
Session Duration: 60

OP HC Note - Treatment - UE Hand Revised

Occupational Therapy
Outpatient Upper Extremity Hand Treatment Note

Referring Clinician: Dr Hassler
Rehabilitation Precautions/Restrictions: Per diagnosis: none

SUBJECTIVE
Patient Report: I am just ok
Clinical/Medical Status Changes: none
Pain : 6 out of 10
Pain Interventions: fluidotherapy, retrograde massage

OBJECTIVE
Interventions: Patient received the following interventions:
-Fluidotherapy x20 minutes
-STM, scar and retrograde massage applied to entire dorsum of R hand, wrist and forearm x10 minutes
US applied to dorsum of hand over scar 8 mins at 3 mhz at 1.0 intensity for 8 mins.
Russian E stim to finger flexors for 10 mins with active contribution during on cycle
PROM to R wrist in all planes 2 sets x10 reps each
Extensive PROM to all digits with emphasis placed on ring and small fingers. Each joint ranged separately and then in hook and composite fashion.
Passive MP flexion with active IP flexion 10 reps.

Orthotic fit and training: Merit component added to small finger for increased MP pull

Education/HEP: Continue as instructed and add splint wear instructions
Pain Reassessment: 3 out of 10

ASSESSMENT
Treatment Diagnosis: hand pain
Response to Visit: Tolerated session without difficulty.
Progress Toward Goals: Pt is progressing.

PLAN

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McLeod Health

NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record #:** 00076499
CHART: cindy	

Treatment Frequency, Duration, and Interventions: Continued occupational therapy recommendations: 3 times per week x 4 weeks
Procedures: - ADL TRAINING - EVALUATION - EXERCISE - FUNCTIONAL/THERAPEUTIC ACTIVITY - HOME INSTRUCTION - MANUAL THERAPY - MASSAGE - MODALITIES - ORTHOTICS - ORTHOTIC FIT AND TRAINING - RE-EVALUATION
The patient has been instructed to contact our clinic if any questions or problems should arise.

Visit Number: Today's visit is number 8

Treatment Rendered:
Exercise 15 minutes.
WP 15 mins
US 8 mins
Orthotic fit and training 10 mins
Russian stim 10 mins

Signed by: CINDY BELK - MSR, OTR/L

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McLeod Health

NAME: BARR, KENNETH	Account ID: 000121623268
ROOM: HC	Date of Birth: 8/17/1969
ADMIT DATE: 04/24/2012	Med. Record # : 00076499
CHART: cindy	

Date/Time: 3/16/12 10:10 am

Start Time: 9:00 End Time: 10:10
Session Duration: 70

OP HC Note - Treatment - UE Hand Revised

Occupational Therapy
Outpatient Upper Extremity Hand Treatment Note

Referring Clinician: Dr Hassler
Rehabilitation Precautions/Restrictions: Per diagnosis: none

SUBJECTIVE
Patient Report: I am just ok
Clinical/Medical Status Changes: none
Pain : 6 out of 10
Pain Interventions: fluidotherapy, retrograde massage

OBJECTIVE
Interventions: Patient received the following interventions:
-Fluidotherapy x20 minutes
-STM, scar and retrograde massage applied to entire dorsum of R hand, wrist and forearm x10 minutes
US applied to dorsum of hand over scar 8 mins at 3 mhz at 1.0 intensity for 8 mins.
Russian E stim to finger flexors/ extensors in alternation for 10 mins with active contribution during on cycle
PROM to R wrist in all planes 2 sets x10 reps each
Extensive PROM to all digits with emphasis placed on ring and small fingers. Each joint ranged separately and then in hook and composite fashion.
Passive MP flexion with active IP flexion 15 reps.

Education/HEP: Continue as instructed and add splint wear instructions
Pain Reassessment: 3 out of 10

ASSESSMENT
Treatment Diagnosis: hand pain
Response to Visit: Tolerated session without difficulty.
Progress Toward Goals: Pt is progressing.

PLAN
Treatment Frequency, Duration, and Interventions: Continued occupational therapy recommendations: 3

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NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

times per week x 4 weeks
Procedures: - ADL TRAINING - EVALUATION - EXERCISE - FUNCTIONAL/THERAPEUTIC ACTIVITY - HOME INSTRUCTION - MANUAL THERAPY - MASSAGE - MODALITIES - ORTHOTICS - ORTHOTIC FIT AND TRAINING - RE-EVALUATION
The patient has been instructed to contact our clinic if any questions or problems should arise.

Visit Number: Today's visit is number 9

Treatment Rendered:
Exercise 25 minutes.
WP 15 mins
US 8 mins
Russian stim 10 mins

Signed by: CINDY BELK - MSR, OTR/L

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McLeod Health

NAME: BARR, KENNETH	Account ID: 000121623268
ROOM: HC	Date of Birth:
ADMIT DATE: 04/24/2012	Med. Record # : 00076499
CHART: cindy	

Date/Time: 3/19/12 1:29 pm

Start Time: 11:00 End Time: 12:00
Session Duration: 60

OP HC Note - Treatment - UE Hand Revised

Occupational Therapy
Outpatient Upper Extremity Hand Treatment Note

Referring Clinician: Dr Hassler
Rehabilitation Precautions/Restrictions: Per diagnosis: none

SUBJECTIVE
Patient Report: I am really sore
Clinical/Medical Status Changes: none
Pain : 6 out of 10
Pain Interventions: fluidotherapy, retrograde massage

OBJECTIVE
Interventions: Patient received the following interventions.
-Fluidotherapy x20 minutes
-STM, scar and retrograde massage applied to entire dorsum of R hand, wrist and forearm x10 minutes
US applied to dorsum of hand over scar 8 mins at 3 mhz at 1.0 intensity for 8 mins.

PROM to R wrist in all planes 2 sets x10 reps each
Extensive PROM to all digits with emphasis placed on ring and small fingers. Each joint ranged separately and then in hook and composite fashion.
Passive MP flexion with active IP flexion 15 reps.

Functional Activity: Pt complete small peg placement with thumb to ring/small fingers for opposition. Pt removed pegs in pick and hold fashion to encourage active flexion of ring and small fingers. Pt completed grasping handfuls of pegs with good flexion noted at MP joints.

Education/HEP: Continue as instructed and add splint wear instructions
Pain Reassessment: 3 out of 10

ASSESSMENT
Treatment Diagnosis: hand pain
Response to Visit: Tolerated session without difficulty.
Progress Toward Goals: Pt is progressing.

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McLeod Health

NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

PLAN

Treatment Frequency, Duration, and Interventions: Continued occupational therapy recommendations: 3 times per week x 4 weeks

Procedures: - ADL TRAINING - EVALUATION - EXERCISE - FUNCTIONAL/THERAPEUTIC ACTIVITY - HOME INSTRUCTION - MANUAL THERAPY - MASSAGE - MODALITIES - ORTHOTICS - ORTHOTIC FIT AND TRAINING - RE-EVALUATION

The patient has been instructed to contact our clinic if any questions or problems should arise.

Visit Number: Today's visit is number 10

Treatment Rendered:

Exercise 22 minutes.
WP 15 mins
US 8 mins
FA 15 mins

Signed by: CINDY BELK - MSR, OTR/L

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McLeod Health

NAME: BARR, KENNETH	Account ID: 000121623268
ROOM: HC	Date of Birth:
ADMIT DATE: 04/24/2012	Med. Record # : 00076499
CHART: cindy	

Date/Time: 3/21/12 1:27 pm

Start Time: 11:00 End Time: 12:00
Session Duration: 60

OP HC Note - Treatment - UE Hand Revised

Occupational Therapy
Outpatient Upper Extremity Hand Treatment Note

Referring Clinician: Dr Hassler
Rehabilitation Precautions/Restrictions: Per diagnosis: none

SUBJECTIVE
Patient Report: I am really sore
Clinical/Medical Status Changes: none
Pain : 6 out of 10
Pain Interventions: fluidotherapy, retrograde massage

OBJECTIVE
Interventions: Patient received the following interventions:
-Fluidotherapy x20 minutes
-STM, scar and retrograde massage applied to entire dorsum of R hand, wrist and forearm x10 minutes

PROM to R wrist in all planes 2 sets x10 reps each
Extensive PROM to all digits with emphasis placed on ring and small fingers. Each joint ranged separately and then in hook and composite fashion.
Passive MP flexion with active IP flexion 15 reps.

Formal measurments were taken to send to MD office. Measurements will be in contact note.

Education/HEP: Continue as instructed and add splint wear instructions
Pain Reassessment: 3 out of 10

ASSESSMENT
Treatment Diagnosis: hand pain
Response to Visit: Tolerated session without difficulty.
Progress Toward Goals: Pt is progressing.

PLAN

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McLeod Health
Rehab Services
555 East Cheves St
Florence, SC 29502

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McLeod Health

NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

Treatment Frequency, Duration, and Interventions: Continued occupational therapy recommendations: 3 times per week x 4 weeks
Procedures: - ADL TRAINING - EVALUATION - EXERCISE - FUNCTIONAL/THERAPEUTIC ACTIVITY - HOME INSTRUCTION - MANUAL THERAPY - MASSAGE - MODALITIES - ORTHOTICS - ORTHOTIC FIT AND TRAINING - RE-EVALUATION
The patient has been instructed to contact our clinic if any questions or problems should arise.

Visit Number: Today's visit is number 11

Treatment Rendered:
Exercise 30 minutes.
WP 15 mins
massage 8 mins

Signed by: CINDY BELK - MSR, OTR/L

000121623268

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555 East Cheves St
Florence, SC 29502

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McLeod Health

NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

Date/Time: 3/21/12 1:40 pm **Start Time:** 0:00 **End Time:** 0:00
Session Duration: 0

OP OT HC Note - Contact Note

This contact note is regarding Mr Kenneth Barr. Mr Barr has attended 11 therapy sessions at McLeod OT hand center. Mr Barr has made good gains with the ROM in his fingers and wrist. He has been fabricated a dynamic MP flexion splint to be worn each waking hour with the use of the attached Merritt component. He also has a night extension splint to be worn while sleeping to help counteract the extension lag of the ring and small fingers. Significant scar massage and US has been used over dorsum of hand to reduce the tightness of the scar. It is recommended that Mr Barr continue therapy to increase motion and function of his hand. The current AROM of the fingers and wrist are as follows :

AROM:
index: MP: 0/88 PIP: 0/98 DIP: 0/50 TAM: 233
long MP: -15/75 PIP: -3/105 DIP: 0/52 TAM: 214
ring: MP: -15/60 PIP: -20/88 DIP: 0/50 TAM: 163
small: MP: -35/44 PIP: -25/65 DIP: 0/30 TAM: 79

Wrist:
Extension: 45
flexion: 15
UD: 10
RD. 15

Thank you for this referral,

Cindy Belk MSR, OTR/L

Signed by: CINDY BELK - MSR, OTR/L

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555 East Cheves St
Florence, SC 29502
McLeod Health

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NAME: BARR, KENNETH	Account ID: 000121623268
ROOM: HC	Date of Birth:
ADMIT DATE: 04/24/2012	Med. Record #.: 00076499
CHART: cindy	

Date/Time: 3/23/12 8:17 am

Start Time: 11:00 End Time: 12:00
Session Duration: 60

OP HC RE Evaluation - UE Hand Revised

Occupational Therapy
Outpatient Upper Extremity/Hand Evaluation - UE Hand

Provider #420051
HCIN: 248219326
Medical Diagnosis: RIGHT HAND COMPLEX LACERA
Demographics:
Age:
Gender: Male
Primary Language: English
Hand Dominance: Right
Referring Physician: Dr Hassler
Concurrent Services: None.
Previous treatment for this condition: No previous treatment.
Past Medical History: Carpal tunnel release of R hand, smoker and depression
History of Present Illness:
Date of Injury: 01-25-12
Date of Surgery: 01-26-12
Method of injury/illness: hand went through glass door
Surgical procedure: ECU repair and side to side anastomosis of extensor digitorum quinti tendon to EDC tendon of ring finger. Laceration of abductor digit quinti tendon was not repaired
Medications and Allergies: none
Rehabilitation Precautions/Restrictions/Barriers to Treatment: No treatment/activity precautions.

SUBJECTIVE 3
Social History: Marital Status: Married
Children: 3
Employment Status: Painter for Darlington county school district
Recreational Activities/Hobbies: fishing
Premorbid Functional Level: Patient/caregiver reports the following functional limitations: independent
Patient Goals: regain use of his hand
Self-Care Management: Patient reported limitations with the following ADL tasks: needs assistance for fasteners, cutting food
Pain: 6 out of 10

OBJECTIVE

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NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

Observation: healed scar and reduced edema
Sensation: sensation is reported to be normal
Range of Motion:
Right hand/Upper Extremity: (extension/flexion in degrees unless otherwise noted)

AROM:
index: MP: 0/88 PIP: 0/98 DIP: 0/50 TAM: 233 was 146
long: MP: -15/75 PIP: -3/105 DIP: 0/52 TAM: 214 was 90
ring: MP: -15/60 PIP: -20/88 DIP: 0/50 TAM: 163 was 36
small: MP: -35/44 PIP: -25/65 DIP: 0/30 TAM: 79 was 8

Wrist:
Extension: 45 same
flexion: 15 was 0
UD: 10 was 5
RD: 15 was 10

Pain Interventions:fludiotherapy
Pain Reassessment: 5 out of 10

Treatment: Scar massage followed by extensive PROM to ring and small fingers. 20 reps of passive MP flexion combined with active IP flexion. pt completed O'Connor board using tweezers to address fine motor skills.

Education: continue with dynamic splinting and functional use of hand at home.

ASSESSMENT
Necessity: Patient requires therapy plan in order to return to work. Patient requires outpatient therapy in order to reduce Activities of Daily Living or Instrumental Activities of Daily Living assistance to a premorbid level. Patient requires therapy plan in order to function in community.
Rehabilitation Potential: Excellent
Motivation/Commitment to Therapy: Good.
The patient has been instructed to contact the clinic if any questions or problems should arise. Patient participated in plan of care development today and establishing of the following goals:
Previous goals:
Short Term Goals: Time frame to achieve short term goal(s):
1 week
1. Pt will have full wound closure. MET
2. Pt will be I with HEP. MET
Long Term Goals: Time frame to achieve long term goal(s):
4 weeks

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NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

1. Pt will increase TAM by 50 degrees on each digit. MET
2. Pt will begin strengthening when appropriate PROM is available. Not appropriate at this time
3. Pt will be I with all ADL and IADL activities. MOD I
4. Pt will tolerate work simulation without increase in pain. not ready to address
5. Pain will be 3 or lower during functional use. not met

New Goals: 4 weeks
1. Pt will increase TAM of ring and small fingers by an additional 50 degrees.
2. Pt will begin strengthening when appropriate tissue lengthening has been achieved.
3. Pt will have pain of a 3 or lower during functional use of hand.
4. Pt will tolerate work simulation tasks without increase pain.

PLAN

Treatment Frequency, Duration, and Interventions: Continued occupational therapy recommendations: 3 times/week x 4 weeks
Procedures: - ADL TRAINING - EVALUATION - EXERCISE - FUNCTIONAL/THERAPEUTIC ACTIVITY - HOME INSTRUCTION - MANUAL THERAPY - MASSAGE - MODALITIES - ORTHOTICS - ORTHOTIC FIT AND TRAINING - RE-EVALUATION

Visit Number: Today's visit is number 12

Treatment Rendered:
Re eval 10 minutes.

Exercise 30 minutes.
WP 20 mins

Provider Certification/Prescription: This is to certify that the above named patient, who is under my care, requires skilled Occupational Therapy services as described in the above treatment plan. I further certify that the services outlined in this plan are skilled and medically necessary. I have reviewed this plan for rehabilitation services, and I recommend **and prescribe** that these services continue from 03-23-12 to 04-23-12 to meet the goals stated above. **Treatment Diagnosis:** hand pain

Physician signature: _____ Date: _____ Time: _____
Referring Physician: Dr Hassler

Signed by: CINDY BELK - MSR, OTR/L

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555 East Cheves St
Florence, SC 29502
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NAME: BARR, KENNETH	Account ID: 000121623268
ROOM: HC	Date of Birth:
ADMIT DATE: 04/24/2012	Med. Record #: 00076499
CHART: cindy	

Date/Time: 3/26/12 1:51 pm

Start Time: 0:00 End Time: 0:00
Session Duration: 0

OP HC Note - Missed Visit Hand Center

Completed Orders	Description	Num Performed
OTHCCAN	OTHC - PT. CANCEL	1.00

Occupational Therapy Hand Center
Outpatient Missed Visit Note

The patient did not attend the therapy appointment on 03-26-12 at 11:00 .

Reason: Scheduling conflict
Future Appointment: The patient has additional appointments.

Signed by: CINDY BELK - MSR, OTR/L

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NAME: BARR, KENNETH	Account ID: 000121623268
ROOM: HC	Date of Birth:
ADMIT DATE: 04/24/2012	Med. Record # : 00076499
CHART: cindy	

Date/Time: 3/27/12 5:13 pm

Start Time: 13:00 End Time: 14:00
Session Duration: 60

OP HC Note - Treatment - UE Hand Revised

Occupational Therapy
Outpatient Upper Extremity Hand Treatment Note

Referring Clinician: Dr Hassler
Rehabilitation Precautions/Restrictions: Per diagnosis: **none**

SUBJECTIVE
Patient Report: I am really sore
Clinical/Medical Status Changes: none
Pain : 6 out of 10
Pain Interventions: fluidotherapy, retrograde massage

OBJECTIVE
Interventions: Patient received the following interventions:
-Fluidotherapy x20 minutes
-STM, scar and retrograde massage applied to entire dorsum of R hand, wrist and forearm x10 minutes

PROM to R wrist in all planes 2 sets x10 reps each
Extensive PROM to all digits with emphasis placed on ring and small fingers. Each joint ranged separately and then in hook and composite fashion.
Passive MP flexion with active IP flexion 15 reps.
functional gripping via the use of 5# bulk putty to increase active pull through at MP joints.

Education/HEP: Continue as instructed and add splint wear instructions
Pain Reassessment: 3 out of 10

ASSESSMENT
Treatment Diagnosis: hand pain
Response to Visit: Tolerated session without difficulty.
Progress Toward Goals: Pt is progressing.

PLAN
Treatment Frequency, Duration, and Interventions: Continued occupational therapy recommendations: 3 times per week x 4 weeks

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NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

Procedures: - ADL TRAINING - EVALUATION - EXERCISE - FUNCTIONAL/THERAPEUTIC ACTIVITY - HOME INSTRUCTION - MANUAL THERAPY - MASSAGE - MODALITIES - ORTHOTICS - ORTHOTIC FIT AND TRAINING - RE-EVALUATION
The patient has been instructed to contact our clinic if any questions or problems should arise.

Visit Number: Today's visit is number 13

Treatment Rendered:
Exercise 20 minutes.
WP 15 mins
massage 5 mins
FA 20

Signed by: CINDY BELK - MSR, OTR/L

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NAME: BARR, KENNETH
ROOM: HC
ADMIT DATE: 04/24/2012
CHART: cindy

Account ID: 000121623268
Date of Birth:
Med. Record # : 00076499

Date/Time: 3/28/12 1:23 pm

Start Time: 11:10 End Time: 12:00
Session Duration: 50

OP HC Note - Treatment - UE Hand Revised

Occupational Therapy
Outpatient Upper Extremity Hand Treatment Note

Referring Clinician: Dr Hassler
Rehabilitation Precautions/Restrictions: Per diagnosis: **none**

SUBJECTIVE
Patient Report: I am really sore. I helped to lift a trailer for the back of my truck and my hand started swelling some.
Clinical/Medical Status Changes: none
Pain : 6 out of 10
Pain Interventions: fluidotherapy, retrograde massage

OBJECTIVE
Interventions: Patient received the following interventions:
-Fluidotherapy x20 minutes
-STM, scar and retrograde massage applied to entire dorsum of R hand, wrist and forearm x10 minutes

PROM to R wrist in all planes 2 sets x10 reps each
Extensive PROM to all digits with emphasis placed on ring and small fingers. Each joint ranged separately and then in hook and composite fashion.
Passive MP flexion with active IP flexion 15 reps.

Pt instructed on Active IP motion while in dynamic splint for MP flexion of small finger

Education/HEP: Continue as instructed and add splint wear instructions
Pain Reassessment: 3 out of 10

ASSESSMENT
Treatment Diagnosis: hand pain
Response to Visit: Tolerated session without difficulty.
Progress Toward Goals: Pt is progressing.

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McLeod Health

NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

PLAN

Treatment Frequency, Duration, and Interventions: Continued occupational therapy recommendations: 3 times per week x 4 weeks
Procedures: - ADL TRAINING - EVALUATION - EXERCISE - FUNCTIONAL/THERAPEUTIC ACTIVITY - HOME INSTRUCTION - MANUAL THERAPY - MASSAGE - MODALITIES - ORTHOTICS - ORTHOTIC FIT AND TRAINING - RE-EVALUATION
The patient has been instructed to contact our clinic if any questions or problems should arise.

Visit Number: Today's visit is number 14

Treatment Rendered:
Exercise 30 minutes.
WP 15 mins
massage 5 mins

Signed by: CINDY BELK - MSR, OTR/L.

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NAME: BARR, KENNETH	Account ID: 000121623268
ROOM: HC	Date of Birth:
ADMIT DATE: 04/24/2012	Med. Record # : 00076499
CHART: cindy	

Date/Time: 3/30/12 12:05 pm

Start Time: 11:00 End Time: 12:00
Session Duration: 60

OP HC Note - Treatment - UE Hand Revised

Occupational Therapy
Outpatient Upper Extremity Hand Treatment Note

Referring Clinician: Dr Hassler
Rehabilitation Precautions/Restrictions: Per diagnosis: **none**

SUBJECTIVE
Patient Report: I am really sore.
Clinical/Medical Status Changes: none
Pain : 6 out of 10
Pain Interventions: fluidotherapy, retrograde massage

OBJECTIVE
Interventions: Patient received the following interventions:
-Fluidotherapy x20 minutes
-STM, scar and retrograde massage applied to entire dorsum of R hand, wrist and forearm x10 minutes

PROM to R wrist in all planes 2 sets x10 reps each
Extensive PROM to all digits with emphasis placed on ring and small fingers. Each joint ranged separately and then in hook and composite fashion.
Passive MP flexion with active IP flexion 15 reps.

5# bulk putty manipulation with emphasis on gripping with active pull through at MP joints.

Education/HEP: Continue as instructed and add splint wear instructions
Pain Reassessment: 3 out of 10

ASSESSMENT
Treatment Diagnosis: hand pain
Response to Visit: Tolerated session without difficulty.
Progress Toward Goals: Pt is progressing.

PLAN
Treatment Frequency, Duration, and Interventions: Continued occupational therapy recommendations: 3

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NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

times per week x 4 weeks
Procedures: - ADL TRAINING - EVALUATION - EXERCISE - FUNCTIONAL/THERAPEUTIC ACTIVITY - HOME INSTRUCTION - MANUAL THERAPY - MASSAGE - MODALITIES - ORTHOTICS - ORTHOTIC FIT AND TRAINING - RE-EVALUATION
The patient has been instructed to contact our clinic if any questions or problems should arise

Visit Number: Today's visit is number 15

Treatment Rendered:
Exercise 35 minutes
WP 15 mins
massage 5 mins

Signed by: CINDY BELK - MSR, OTR/L

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NAME: BARR, KENNETH
ROOM: HC
ADMIT DATE: 04/24/2012
CHART: cindy

Account ID: 000121623268
Date of Birth:
Med. Record # : 00076499

Date/Time: 4/2/12 9:14 am

Start Time: 8:10 End Time: 9:11
Session Duration: 61

OP HC Note - Treatment - UE Hand Revised

Occupational Therapy
Outpatient Upper Extremity Hand Treatment Note

Referring Clinician: Dr Hassler
Rehabilitation Precautions/Restrictions: Per diagnosis: none

SUBJECTIVE
Patient Report: I am really sore.
Clinical/Medical Status Changes: none
Pain : 6 out of 10
Pain Interventions: fluidotherapy, retrograde massage

OBJECTIVE
Interventions: Patient received the following interventions:
-Fluidotherapy x20 minutes
-STM, scar and retrograde massage applied to entire dorsum of R hand x 5 mins

Extensive PROM to ring and small fingers. Each joint ranged separately and then in hook and composite fashion x 15
Passive MP flexion with active IP flexion 15 reps. Active MP and PIP extension x 15 RF and SF;
Place and hold in composite flexion all joints x 5 with 5 sec holds
therapeutic activity: grasp small pegs with with opposition of thumb and small finger x 10; removal of same pegs with opposition of thumb and SF with 5 sec holds each peg;

Education/HEP: Continue as instructed and add splint wear instructions
Pain Reassessment: 6 out of 10

ASSESSMENT
Treatment Diagnosis: hand pain
Response to Visit: Tolerated session without difficulty. Challenged by opposition tasks today.
Progress Toward Goals: Pt is progressing.

PLAN
Treatment Frequency, Duration, and Interventions: Continued occupational therapy recommendations: 3 times per week x 4 weeks
Procedures: - ADL TRAINING - EVALUATION - EXERCISE - FUNCTIONAL/THERAPEUTIC ACTIVITY -

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NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

HOME INSTRUCTION - MANUAL THERAPY - MASSAGE - MODALITIES - ORTHOTICS - ORTHOTIC FIT AND TRAINING - RE-EVALUATION
The patient has been instructed to contact our clinic if any questions or problems should arise.

Visit Number: Today's visit is number 15

Treatment Rendered:
Exercise 24 minutes.
WP 20 mins
massage 5 mins
ther activity 15 mins

Signed by: KRISTA STEPHENS - OTR/L

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Rehab Services
555 East Cheves St
Florence, SC 29502

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McLeod Health

NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

Date/Time: 4/3/12 8:43 am

Start Time: 8:01 **End Time:** 9:01
Session Duration: 60

OP HC Note - Treatment - UE Hand Revised

Occupational Therapy
Outpatient Upper Extremity Hand Treatment Note

Referring Clinician: Dr Hassler
Rehabilitation Precautions/Restrictions: Per diagnosis: none

SUBJECTIVE
Patient Report: I am really sore.
Clinical/Medical Status Changes: none
Pain : 6 out of 10
Pain Interventions: fluidotherapy, retrograde massage

OBJECTIVE
Interventions: Patient received the following interventions:
-Fluidotherapy x20 minutes
-STM, scar and retrograde massage applied to entire dorsum of R hand x 5 mins

Extensive PROM and joint mobs, including distraction and mobilization of MP joint glide between SF and RF and RF and MFI, to ring and small fingers. Each joint ranged separately and then in hook and composite fashion x 15. Extensive PROM/stretch and joint mobs to right wrist flexion/extension. Wrapped hand in composite flexion for passive stretch with coban x 2 mins.

AROM including tendon gliding exercises x 5 each with focus on SF and RF.

Education/HEP: Reinforced need for stretch and HEP compliance. Encouraged patient to stretch composite flexion hourly to every 2 hours while awake. Encouraged patient to complete tendon gliding exercises 2x/day for 15 mins each Explained extensively role of scar tissue and adhesions in limitation of ROM Patient to bring in his paint brush next treatment for therapy.
Pain Reassessment: 6 out of 10

ASSESSMENT
Treatment Diagnosis: hand pain
Response to Visit: Continues to demonstrate decreased RF and SF ROM. Patient with fair pain tolerance.
Progress Toward Goals: Pt is progressing slowly.

PLAN

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McLeod Health

NAME:	BARR, KENNETH	**Account ID:**	000121623268
ROOM:	HC	**Date of Birth:**	
ADMIT DATE:	04/24/2012	**Med. Record # :**	00076499
CHART:	cindy		

Treatment Frequency, Duration, and Interventions: Continued occupational therapy recommendations: 3 times per week x 4 weeks
Procedures: - ADL TRAINING - EVALUATION - EXERCISE - FUNCTIONAL/THERAPEUTIC ACTIVITY - HOME INSTRUCTION - MANUAL THERAPY - MASSAGE - MODALITIES - ORTHOTICS - ORTHOTIC FIT AND TRAINING - RE-EVALUATION
The patient has been instructed to contact our clinic if any questions or problems should arise.

Visit Number: Today's visit is number 16

Signed by: KRISTA STEPHENS - OTR/L

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NAME: BARR, KENNETH
ROOM: HC
ADMIT DATE: 04/24/2012
CHART: cindy

Account ID: 000121623268
Date of Birth:
Med. Record # : 00076499

Date/Time: 4/5/12 12:03 pm

Start Time: 10:30 End Time: 11:35
Session Duration: 65

OP HC Note - Treatment - UE Hand Revised

Occupational Therapy
Outpatient Upper Extremity Hand Treatment Note

Referring Clinician: Dr Hassler
Rehabilitation Precautions/Restrictions: Per diagnosis: **none**

SUBJECTIVE
Patient Report: Patient reports he had a bad day with pain yesterday but today is better.
Clinical/Medical Status Changes: none
Pain : 5 out of 10
Pain Interventions: fluidotherapy, retrograde massage

OBJECTIVE
Interventions: Patient received the following interventions:
-Fluidotherapy x20 minutes
-STM, scar and retrograde massage applied to entire dorsum of R hand and forearm

Extensive PROM and joint mobs, including distraction and mobilization of MP joint glide between SF and RF and RF and MF, to all fingers with attention to all joints of SF and RF. Each joint ranged separately and then in hook and composite fashion x 15. Extensive PROM/stretch and joint mobs to right wrist flexion/extension. Blocking exercises for RF and SF performed x 10 each joint as well as tendon gliding x 5 for composite fist and duck bill positions.
Ther activity: patient completed 31/2 mins of functional activity with right hand using his paint brush to "paint" wall. Patient completed this time without rest break. Noted shaking in hand as muscles fatigued and patient reported fatigued at end of time period.

Education/HEP: Reinforced need for stretch and HEP compliance. Added SF to thumb opposition exercises to HeP as well as endurance activity of "painting" at home with paint brush. Suggested he "paint" 1x/day and increas # mins by 1 daily if tolerated without increase in pain. Goal is for patient to tolerate 8-10 mins painting by next treatment 4/12/12.
Pain reassessment 6/10 following activity
ASSESSMENT
Treatment Diagnosis: hand pain
Response to Visit: Continues to demonstrate decreased RF and SF ROM. Patient with fair pain tolerance. May benefit from mobilization in pool.
Progress Toward Goals: Pt is progressing slowly.

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Florence, SC 29502

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McLeod Health

NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

PLAN

Treatment Frequency, Duration, and Interventions: Continued occupational therapy recommendations: 3 times per week x 4 weeks
Procedures: - ADL TRAINING-- EVALUATION - EXERCISE - FUNCTIONAL/THERAPEUTIC ACTIVITY - HOME INSTRUCTION - MANUAL THERAPY - MASSAGE - MODALITIES - ORTHOTICS - ORTHOTIC FIT AND TRAINING - RE-EVALUATION
The patient has been instructed to contact our clinic if any questions or problems should arise.
Treatment rendered: exercise
FA
modalities
manual

Visit Number: Today's visit is number 17

Signed by: KRISTA STEPHENS - OTR/L

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555 East Cheves St
Florence, SC 29502
McLeod Health

000121623268

NAME: BARR, KENNETH	Account ID: 000121623268
ROOM: HC	Date of Birth:
ADMIT DATE: 04/24/2012	Med. Record # : 00076499
CHART: cindy	

Date/Time: 4/12/12 2:13 pm

Start Time: 11:00 End Time: 12:00
Session Duration: 60

OP HC Note - Treatment - UE Hand Revised

Occupational Therapy
Outpatient Upper Extremity Hand Treatment Note

Referring Clinician: Dr Hassler
Rehabilitation Precautions/Restrictions: Per diagnosis: none

SUBJECTIVE
Patient Report: I strained my hand yesterday lifting some luggage
Clinical/Medical Status Changes: none
Pain : 5 out of 10
Pain Interventions: fluidotherapy, retrograde massage

OBJECTIVE
Interventions: Patient received the following interventions.
-Fluidotherapy x20 minutes
-STM, scar and retrograde massage applied to entire dorsum of R hand and forearm

Extensive PROM and joint mobs, including distraction and mobilization of MP joint glide between SF and RF and RF and MF, to all fingers with attention to all joints of SF and RF. Each joint ranged separately and then in hook and composite fashion x 15. Extensive PROM/stretch and joint mobs to right wrist flexion/extension. Blocking exercises for RF and SF performed x 10 each joint as well as tendon gliding x 5 for composite fist and duck bill positions.

BTE started today with tools: 162, 504, 302 and 701. good incorporation of ring and small fingers noted.

UBE 10 mins at 60 revs

Education/HEP: Increase functional use of R UE

Pain reassessment 6/10 following activity
ASSESSMENT
Treatment Diagnosis: hand pain
Response to Visit: Continues to demonstrate decreased RF and SF ROM Patient with fair pain tolerance.
Progress Toward Goals: Pt with increasing functional motion in hand.
PLAN

000121623268

McLeod Health
Rehab Services
555 East Cheves St
Florence, SC 29502

000121623268

McLeod Health

NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

Treatment Frequency, Duration, and Interventions: Continued occupational therapy recommendations: 3 times per week x 4 weeks
Procedures: - ADL TRAINING - EVALUATION - EXERCISE - FUNCTIONAL/THERAPEUTIC ACTIVITY - HOME INSTRUCTION - MANUAL THERAPY - MASSAGE - MODALITIES - ORTHOTICS - ORTHOTIC FIT AND TRAINING - RE-EVALUATION
The patient has been instructed to contact our clinic if any questions or problems should arise.
Treatment rendered: exercise
FA
modalities
manual

Visit Number: Today's visit is number 18

Signed by: CINDY BELK - MSR, OTR/L

000121623268

McLeod Health
Rehab Services
555 East Cheves St
Florence, SC 29502
McLeod Health

000121623268

NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

Date/Time: 4/13/12 12:00 pm

Start Time: 11:00 **End Time:** 12:00
Session Duration: 60

OP HC Note - Treatment - UE Hand Revised

Occupational Therapy
Outpatient Upper Extremity Hand Treatment Note

Referring Clinician: Dr Hassler
Rehabilitation Precautions/Restrictions: Per diagnosis: **none**

SUBJECTIVE
Patient Report: I go back to the MD in 2 weeks and he is going to decide then if I need to have another surgery.
Clinical/Medical Status Changes: none
Pain : 5 out of 10
Pain Interventions: fluidotherapy, retrograde massage

OBJECTIVE
Interventions: Patient received the following interventions:
-Fluidotherapy x20 minutes
-STM, scar and retrograde massage applied to entire dorsum of R hand and forearm

Extensive PROM and joint mobs, including distraction and mobilization of MP joint glide between SF and RF and RF and MF, to all fingers with attention to all joints of SF and RF. Each joint ranged separately and then in hook and composite fashion x 15. Extensive PROM/stretch and joint mobs to right wrist flexion/extension. Blocking exercises for RF and SF performed x 10 each joint as well as tendon gliding x 5 for composite fist and duck bill positions.

BTE with tools: 162, 504, 302 and 701. good incorporation of ring and small fingers noted.

Green bulk putty manipulation for 5 reps of ball construction

Education/HEP: Increase functional use of R UE

Pain reassessment 6/10 following activity
ASSESSMENT
Treatment Diagnosis: hand pain
Response to Visit: Continues to demonstrate decreased RF and SF ROM. Patient with fair pain tolerance.
Progress Toward Goals: Pt with increasing functional motion in hand.

000121623268

McLeod Health
Rehab Services
555 East Cheves St
Florence, SC 29502

000121623268

McLeod Health

NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

PLAN

Treatment Frequency, Duration, and Interventions: Continued occupational therapy recommendations: 3 times per week x 4 weeks

Procedures: - ADL TRAINING - EVALUATION - EXERCISE - FUNCTIONAL/THERAPEUTIC ACTIVITY - HOME INSTRUCTION - MANUAL THERAPY - MASSAGE - MODALITIES - ORTHOTICS - ORTHOTIC FIT AND TRAINING - RE-EVALUATION

The patient has been instructed to contact our clinic if any questions or problems should arise.

Treatment rendered: exercise

FA

modalities

manual

Visit Number: Today's visit is number 19

Signed by: CINDY BELK - MSR, OTR/L

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555 East Cheves St
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McLeod Health

NAME: BARR, KENNETH	Account ID: 000121623268
ROOM: HC	Date of Birth:
ADMIT DATE: 04/24/2012	Med. Record # : 00076499
CHART: cindy	

Date/Time: 4/16/12 4:46 pm

Start Time: 11:00 End Time: 12:00
Session Duration: 60

OP HC Note - Treatment - UE Hand Revised

Occupational Therapy
Outpatient Upper Extremity Hand Treatment Note

Referring Clinician: Dr Hassler
Rehabilitation Precautions/Restrictions: Per diagnosis: none

SUBJECTIVE

Patient Report: Client reported that he would be returning to see Dr. Hassler to determine whether or not he will need further surgery. Client reported feeling unsettled about the condition and function of his hand to return to his job as a maintenance person for Darlington County schools.

After today's session, client reported gratitude for today's activities to help them perceive the strengths and limitations of his right hand. This information would help him decide on a surgical or nonsurgical outcome.

Clinical/Medical Status Changes: Client reported no significant change in his right hand function
Pain : 5 out of 10
Pain Interventions: active range of motion.

OBJECTIVE

Interventions: Patient received the following interventions:

Exercise:

Passive range of motion: Client received gentle, prolonged passive range of motion to his right hand namely his right ring finger and right small finger. These fingers displayed decreased range of motion and stiffness especially at the MCP and PIP joints. These fingers were not able to close and make a fist.

Because client reported feeling unsettled and depressed because he did not understand the condition of his hand with respect to performing his job duties. As a result he completed the following hand function tests:

Minnesota Rate of Manipulation Test
Placing test – client completed 4 trials(58, 57, 54, 51. Total 220 seconds) Client rated 71 percentile.
Turning test – Client completed for trials (53, 54, 50, 48,. Total 205 seconds). Client rated 29th percentile.

Purdue Pegboard Test
Right-hand: 17 – 88 percentile
Left-hand: 15 – 60 percentile

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NAME:	BARR, KENNETH	**Account ID:**	000121623268
ROOM:	HC	**Date of Birth:**	
ADMIT DATE:	04/24/2012	**Med. Record # :**	00076499
CHART:	cindy		

Both hands: 14 – 97 percentile
Right plus Left plus both: 85th percentile
Assembly: 40 – 65 percentile

Grip strength: Client demonstrated the following grip strength characteristics:

Jamar Dynamometer Grip Test, Position 2

Trial	Right	Left
1	37	103
2	28	90
3	32	95
Mean	32.33	98.00
Std.Dev.	3.68	5.35
CV	11.39%	5.58%

	Norm-mean		Norm-SD	Patient-Mean	Patient-SD
RIGHT	116	23	32.33	-3.64	
LEFT	108	20	98.00	-0.60	

Home instruction/education: Client and this therapist discussed the outcomes of this testing as it relates to hand function and job performance. Client demonstrated significant ability in right-hand fine motor and gross motor coordination; however he showed significantly low right-hand grip strength ability.

Education/HEP: Increase functional use of R UE

ASSESSMENT

Treatment Diagnosis: hand pain

Response to Visit: Continues to demonstrate decreased RF and SF ROM.

Progress Toward Goals: Pt with increasing functional motion in hand.

PLAN

Treatment Frequency, Duration, and Interventions: Continued occupational therapy recommendations: 3 times per week x 4 weeks

Procedures: - ADL TRAINING - EVALUATION - EXERCISE - FUNCTIONAL/THERAPEUTIC ACTIVITY - HOME INSTRUCTION - MANUAL THERAPY - MASSAGE - MODALITIES - ORTHOTICS - ORTHOTIC FIT AND TRAINING - RE-EVALUATION

The patient has been instructed to contact our clinic if any questions or problems should arise.

Treatment rendered:
Exercise: 45 min.
Home instruction: 15 min.

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NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

Visit Number: Today's visit is number 20

Signed by: JOHN ZELENKA - OTR/L

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McLeod Health

000121623268

NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

Date/Time: 4/18/12 4:15 am

Start Time: 11:00 **End Time:** 12:00
Session Duration: 60

OP HC Note - Treatment - UE Hand Revised

Occupational Therapy
Outpatient Upper Extremity Hand Treatment Note

Referring Clinician: Dr. Hassler
Rehabilitation Precautions/Restrictions: Per diagnosis: none

SUBJECTIVE
Patient Report: Client reported no significant change in his condition. He is still planning his follow-up with Dr. Hassler.

Earlier today, client reported that he stop by his place of business. He spoke with a supervisor, who told client that when he returns to work he must be a full duty. Client is now concerned about the amount of time that will be spent away from work after another surgery in therapy.

Clinical/Medical Status Changes: none

Pain : Client reported level VI of 10 pain.
Pain Interventions: Fluidotherapy, retrograde massage

OBJECTIVE
Interventions: Patient received the following interventions:

Fluidotherapy: 20 min . 110°F. Client reported that this temperature felt comfortable. He did not show any objective pain behaviors

Soft tissue massage: Client received scar in retrograde massage to the dorsum of his right hand and distal forearm.

Exercise: Client received active and passive range of motion to all the joints of his right small and ring fingers. They continued to show limited passive range of motion and active range of motion especially in his MCP and PIP joints. This exercise included distraction, mobilization, joint gliding, composite fisting and duck bill positions.

Education/HEP: Client received instruction to continue his previously implemented home exercise program.

After therapy, client reported level VI discomfort in his right hand.

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NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

ASSESSMENT

Treatment Diagnosis: hand pain

Response to Visit: Continues to demonstrate decreased RF and SF ROM. Patient with fair pain tolerance.

Progress Toward Goals: Client demonstrated improvement with active and passive range of motion exercise; however, these improvements seem to be temporary in nature. Client may need tendon release surgery.

PLAN

Treatment Frequency, Duration, and Interventions: Continued occupational therapy recommendations: 3 times per week x 4 weeks

Procedures: - ADL TRAINING - EVALUATION - EXERCISE - FUNCTIONAL/THERAPEUTIC ACTIVITY - HOME INSTRUCTION - MANUAL THERAPY - MASSAGE - MODALITIES - ORTHOTICS - ORTHOTIC FIT AND TRAINING - RE-EVALUATION

The patient received instruction to contact our clinic if any questions or problems should arise.

Treatment rendered:
Exercise: 30 min.
Massage: 10 min.

Visit Number: Today's visit is number 20

Signed by: JOHN ZELENKA - OTR/L

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Rehab Services
555 East Cheves St
Florence, SC 29502
McLeod Health

000121623268

NAME: BARR, KENNETH	Account ID: 000121623268
ROOM: HC	Date of Birth:
ADMIT DATE: 04/24/2012	Med. Record # : 00076499
CHART: cindy	

Date/Time: 4/20/12 12:16 pm

Start Time: 11:05 End Time: 12:15
Session Duration: 70

OP HC Note - Treatment - UE Hand Revised

Occupational Therapy
Outpatient Upper Extremity Hand Treatment Note

Referring Clinician: Dr Hassler
Rehabilitation Precautions/Restrictions: Per diagnosis: none

SUBJECTIVE
Patient Report:reports it is hard to not be busy like he is used to
Clinical/Medical Status Changes: none
Pain : 6 out of 10
Pain Interventions: fluidotherapy, retrograde massage

OBJECTIVE
Interventions: Patient received the following interventions:
-Fluidotherapy x12 minutes with both hands in machine for allow left hand to assist right with exercise.
-STM, scar and retrograde massage applied to entire dorsum of R hand and forearm

Extensive PROM and joint mobs, including distraction and mobilization of MP joint glide between SF and RF and RF and MF, to all fingers with attention to all joints of SF and RF. Extensive PROM/stretch and joint mobs to right wrist flexion/extension.

Strengthening:
with 1/2# weight wrist extension curls x 5
with no weight wrist flexion curls x 5

Functional Activity; functional circuit x 2 rounds as follows:
reach and grasp easy grip pegs at shoulder level x 30
tricep presses with lavender theraband 2 x 10 while holding tennis ball with right hand
functional lifting floor to waist with empty milk crate x 1st round; 2nd round added carry of crate in clinic
BTE with large screwdriver tool x 45 seconds x 2
ice following exercise x 5 mins

Education/HEP: Increase functional use of R UE;

Pain reassessment 6+/10 following activity

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NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

ASSESSMENT

Treatment Diagnosis: hand pain

Response to Visit: demonstrates poor funtional use of right arm due to abnormal movement patterns developed over time with continued guarding of right UE; Patient appears very depressed and is very hesitant to use Right UE in tasks. May benefit from work recovery program, especially if goal is for RTW. May also benefit from mobilization of wrist/digits and normalization of RUE movements with aquatic therapy.

Progress Toward Goals: Pt with increasing functional motion in hand.

PLAN

Treatment Frequency, Duration, and Interventions: Continued occupational therapy recommendations: 3 times per week x 4 weeks

Procedures: - ADL TRAINING - EVALUATION - EXERCISE - FUNCTIONAL/THERAPEUTIC ACTIVITY - HOME INSTRUCTION - MANUAL THERAPY - MASSAGE - MODALITIES - ORTHOTICS - ORTHOTIC FIT AND TRAINING - RE-EVALUATION

The patient has been instructed to contact our clinic if any questions or problems should arise.

Treatment rendered: exercise

FA

modalities

Visit Number: Today's visit is number 20

Signed by: KRISTA STEPHENS - OTR/L

000121623268

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Florence, SC 29502

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NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

Date/Time: 4/24/12 8:29 am

Start Time: 11:00 **End Time:** 12:00
Session Duration: 60

/OP HC Evaluation - UE Hand Revised

Occupational Therapy
Outpatient Upper Extremity/Hand Evaluation - UE Hand

Provider #420051
HCIN: 248219326
Medical Diagnosis: RIGHT HAND COMPLEX LACERA
Demographics:
Age:
Gender: Male
Primary Language: English
Hand Dominance: Right.
Referring Physician: Dr Hassler
Concurrent Services: None.
Previous treatment for this condition: No previous treatment.
Past Medical History: Carpal tunnel release of R hand, smoker and depression
History of Present Illness:
Date of Injury: 01-25-12
Date of Surgery: 01-26-12
Method of injury/illness: hand went through glass door
Surgical procedure: ECU repair and side to side anastomosis of extensor digitorum quinti tendon to EDC tendon of ring finger. Laceration of abductor digit quinti tendon was not repaired
Medications and Allergies: none
Rehabilitation Precautions/Restrictions/Barriers to Treatment: No treatment/activity precautions.

SUBJECTIVE 3
Social History: Marital Status: Married
Children: 3
Employment Status: Painter for Darlington county school district
Recreational Activities/Hobbies: fishing
Premorbid Functional Level: Patient/caregiver reports the following functional limitations: independent
Patient Goals: regain use of his hand
Self-Care Management: Patient reported limitations with the following ADL tasks: needs assistance for fasteners, cutting food
Pain: 6 out of 10

OBJECTIVE

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NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

Observation: healed scar and reduced edema
Sensation: sensation is reported to be normal
Range of Motion:
Right hand/Upper Extremity: (extension/flexion in degrees unless otherwise noted)

AROM:
Index: MP: 0/88 PIP: 0/104 DIP: 0/54 TAM: 246
long: MP: -12/82 PIP: -3/102 DIP: 0/52 TAM: 221
ring: MP: -14/64 PIP: -24/94 DIP: 0/56 TAM: 176 was 163
small: MP: -40/52 PIP: -28/72 DIP: 0/30 TAM: 86 was 79

Wrist:
Extension: 55 (increase10 degrees)
flexion: 30 degrees (increase from 15 degrees0
UD. 20
RD: 30

grip strength: 38# right grip

Pain Interventions:fludiotherapy
Pain Reassessment: 5 out of 10

Treatment: extensive PROM to ring and small fingers. 20 reps of passive MP flexion combined with active IP flexion. Extensive PrOm to wrist flexion and extension.
Strengthening as follows:
1/2# weight x 2 x 5 wrist extension curls
2x5 wrist flexion curls
grip strengthening with gripper x 10 with 5 second holds on lowest setting

Educationongoing.

ASSESSMENT
Necessity: Patient requires therapy plan in order to return to work. Patient requires outpatient therapy in order to reduce Activities of Daily Living or Instrumental Activities of Daily Living assistance to a premorbid level. Patient requires therapy plan in order to function in community.
Rehabilitation Potential: Excellent
Motivation/Commitment to Therapy: Good.
The patient has been instructed to contact the clinic if any questions or problems should arise. Patient participated in plan of care development today and establishing of the following goals:
Previous goals:

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Florence, SC 29502

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McLeod Health

NAME:	BARR, KENNETH	**Account ID:**	000121623268
ROOM:	HC	**Date of Birth:**	
ADMIT DATE:	04/24/2012	**Med. Record # :**	00076499
CHART:	cindy		

1. Pt will increase TAM of ring and small fingers by an additional 50 degrees. not met
2. Pt will begin strengthening when appropriate tissue lengthening has been achieved. met
3. Pt will have pain of a 3 or lower during functional use of hand. not met
4. Pt will tolerate work simulation tasks without increase pain. met

New goals:
1. Increase grip right hand to 45#.
2. tolerate work simulation tasks x 45 mins without incresae pain.
3. Patient will be compliant with HEP including structured plan for increasing activity with right hand in home tasks.

PLAN

Treatment Frequency, Duration, and Interventions: Continued occupational therapy recommendations: 3 times/week x 4 weeks
Procedures: - ADL TRAINING - EVALUATION - EXERCISE - FUNCTIONAL/THERAPEUTIC ACTIVITY - HOME INSTRUCTION - MANUAL THERAPY - MASSAGE - MODALITIES - ORTHOTICS - ORTHOTIC FIT AND TRAINING - RE-EVALUATION

Visit Number: Today's visit is number 13

Treatment Rendered:
Re eval 10 minutes.

Exercise 30 minutes.
WP 20 mins

Provider Certification/Prescription: This is to certify that the above named patient, who is under my care, requires skilled Occupational Therapy services as described in the above treatment plan. I further certify that the services outlined in this plan are skilled and medically necessary. I have reviewed this plan for rehabilitation services, and I recommend **and prescribe** that these services continue from 04/23/12 to 05-23-12 to meet the goals stated above. **Treatment Diagnosis:** hand pain

Physician signature: _____ Date: _____ Time: _____
Referring Physician: Dr Hassler

Signed by: KRISTA STEPHENS - OTR/L

000121623268

McLeod Health
Rehab Services
555 East Cheves St
Florence, SC 29502
McLeod Health

000121623268

NAME: BARR, KENNETH	Account ID: 000121623268
ROOM: HC	Date of Birth:
ADMIT DATE: 04/24/2012	Med. Record # : 00076499
CHART: cindy	

Date/Time: 5/1/12 2:53 pm

Start Time: 11:00 End Time: 12:00
Session Duration: 60

OP HC Note - Treatment - UE Hand Revised

Occupational Therapy
Outpatient Upper Extremity Hand Treatment Note

Referring Clinician: Dr Hassler
Rehabilitation Precautions/Restrictions: Per diagnosis: **none**

SUBJECTIVE
Patient Report:reports it is hard to not be busy like he is used to
Clinical/Medical Status Changes: none
Pain : 6 out of 10
Pain Interventions: fluidotherapy, retrograde massage

OBJECTIVE
Interventions: Patient received the following interventions:
-Fluidotherapy x20 minutes with both hands in machine for allow left hand to assist right with exercise.
-STM, scar and retrograde massage applied to entire dorsum of R hand and forearm

Extensive PROM and joint mobs, including distraction and mobilization of MP joint glide between SF and RF and RF and MF, to all fingers with attention to all joints of SF and RF. Extensive PROM/stretch and joint mobs to right wrist flexion/extension.

Functional Activity: Pt completed 5# bulk putty for manipulation and functional gripping. Graded clothes pins 4-8#

Education/HEP: Increase functional use of R UE;

Pain reassessment 6+/10 following activity
ASSESSMENT
Treatment Diagnosis: hand pain
Response to Visit: Pt is doing better with functional use of hand.
Progress Toward Goals: Pt with increasing functional motion in hand.
PLAN
Treatment Frequency, Duration, and Interventions: Continued occupational therapy recommendations: 3 times per week x 4 weeks
Procedures: - ADL TRAINING - EVALUATION - EXERCISE - FUNCTIONAL/THERAPEUTIC ACTIVITY -

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NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

HOME INSTRUCTION - MANUAL THERAPY - MASSAGE - MODALITIES - ORTHOTICS - ORTHOTIC FIT AND TRAINING - RE-EVALUATION
The patient has been instructed to contact our clinic if any questions or problems should arise.
Treatment rendered: exercise
FA
modalities

Visit Number: Today's visit is number 22

Signed by: CINDY BELK - MSR, OTR/L

000121623268

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Rehab Services
555 East Cheves St
Florence, SC 29502
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000121623268

NAME: BARR, KENNETH	**Account ID:** 000121623268
ROOM: HC	**Date of Birth:**
ADMIT DATE: 04/24/2012	**Med. Record # :** 00076499
CHART: cindy	

Date/Time: 5/3/12 11:20 am

Start Time: 0:00 **End Time:** 0:00
Session Duration: 0

OP OT HC Note - Contact Note

Spoke with patient who states he has seen consulting MD yesterday. He is now awaiting surgery and has been advised by MD to put OT on hold for now. Will cancel remaining appts and await word about continuation from patient or new orders from MD.

Signed by: KRISTA STEPHENS - OTR/L

Camden Orthopaedic Associates
507 Walnut Street
Camden, SC 29020

Joseph P. Jackson, Jr., M.D., F.A.C.S. Telephone (803) 4329300

05/02/12 Kenneth Barr DOB: #14916 Orthopaedic Exam

Problem: Complex hand injury

Kenneth is a pleasant · year old right-handed gentleman who had worked for about three years in the Darlington School District essentially doing carpentry, painting and maintenance. He also had a business where he did similar things on the outside. His wife is a teacher at a Christian school. He has three children. Likes to fish and work on bird houses. On or about January 25th was removing a glass door, using sort of a scraper tool that slipped and his hand went through the glass and he sustained a complex laceration to the dorso ulnar aspect of the hand. Dr. Hassler derided the abductor to the little finger and then did a side to side transfer of the extensor to the little finger to the ring finger. The patient three months after injury is still on three Lorcet a day. He continues to smoke and he has 1-2 packs per day for 25 years. Fortunately, he does not drink.

Allergies: NKDA

Medications: Aspirin, Cymbalta, Zantac, Lorcet.

Surgery: On 1/26/12 he also had a carpal tunnel release on the right hand, appendectomy. He had the removal of tarsal coalitions and he also had surgery for a pneumothorax.

ROS: Acid reflux, anxiety and depression.

Family History: Dad deceased from prostate cancer. Mother incidentally has lupus.

Social History: As listed.

Objective: BP 125/72. P-76. R-18. Ht 5'10". Wt 142 lbs. The patient looks depressed, stated age of 42, wears glasses. His grip was a pitiful 10 lbs without my touching him. When I touched him he got up to 30 on the right; 85 on the left. Observing the hand he has a jagged hypertrophic scar over the fifth ray with loss of the bulk of the intrinsic musculature over the metacarpal and no palpable function of the extensor tendon. The

resting posture of the hand looks normal. There is no hyperhidrosis. Has a well-healed carpal tunnel scar. He has two surgical incisions going diagonally from the fifth metacarpal for about 10 cm to the middle of the wrist and apparently this was the only approach used. Looking at the ring finger he has motion of 15-60° for the MP; 30-75° of the PIP; 0-45° for the DIP. His PIP joint is swollen and somewhat deformed. Little finger MPJ active range of motion is fixed at 45° of flexion; PIP 30° flexion contracture down to 75; DIP stuck at a 15° flexion. Trying to make a fist he lacks 3.5 cm from touching the distal palmar crease on the ring finger and 4 cm on the little finger. He has good active extension at the index, long and ring fingers and just a trace of extension of the little finger.

Assessment: #1. This patient is in all probability addicted to Lorcet. #2. Being smoker makes success more difficult, especially if he has an underlying sympathetic dystrophy because it just stirs up sympathetic nervous system and impairs healing. Because of the adverse effects of nicotine he has to quit smoking. #3. This will be a daunting task and cannot be done at one setting.

Plan: I told the patient that he needs to quit smoking. We will get him over to Dr. Brandt to help him get on a pain cocktail for pain management and that he is going to have to deal with the pain but we cannot help his pain with surgery. However, we can answer the complaints of not being able to grip a hammer and loss of strength if we have even modest success. I showed him the Joe Slade's chapter in the Hand Surgery update 2007, which illustrates a mini open type approach to try to get the capsulotomy done and that would be only on the PIP joints. I think that we can address his PIPJs with a flexion and extensor outrigger to help the motion. If we get reasonable return of motion then I think that a tendon transfer of the extensor indices proprius to the little finger might be required later on. I told the patient we certainly cannot make any promises, that we will try our best but even I do my best and he does his best we may not succeed because likely the S Car forms is genetic. He is willing to accept those risks and we will try to do this next Tuesday. This report was dictated in front of the patient for accuracy and completeness. Since the patient made the decision for surgery today I went ahead and did a complete history and physical, recorded elsewhere and executed the consent form. We sent the patient back to work with no restriction. We also suggested some activities at home such as loading with a block to sand his bird houses and anti-reflex sympathetic dystrophy.

JPJ/sm

MAY 02 2012

KERSHAWHEALTH MEDICAL CENTER
CAMDEN, S.C. 29020

PATIENT:	BARR, KENNETH	RM#:	-
DOCTOR:	Joseph P Jackson, Jr., MD	MR#:	0000356729
ADM DATE:	05/08/2012	PT#:	010000902850
		DOB:	

SURGEON: Joseph P Jackson, Jr., MD

DATE OF SURGERY: 05/08/2012

PREOPERATIVE DIAGNOSIS:
Extensor tendon contracture of the little and ring fingers.

POSTOPERATIVE DIAGNOSIS:
Same.

OPERATION:
Dorsal capsulotomies under fluoro control. Extensor tenolysis.

ANESTHESIA:
Dr. Degenhart, Bier block.

TOURNIQUET TIME:
43 minutes.

INDICATIONS AND JUDGMENT:
This is a 42-year-old gentleman who 1/25/12 was repairing a window. His hand slipped off of a tool and went through a window. He sustained segmental lacerations of the little finger extensor tendons. He had side-to-side repair of the little finger extensor to the ring finger. He had developed stiffness. He has been on pain medicine for three months. He is a smoker. I have encouraged him to stop this. We asked Dr. Brandt to help us with pain management. I thoroughly counseled him that this will probably be a two-stage procedure if we can restore joint motion, i.e., he lacked touching the distal palmar crease by several centimeters on each side, that we would probably need to do an extensor transfer.

DESCRIPTION:
We identified the patient, the hand, and the two digits in the operating room. Had a time-out. He had a Bier block after being given a gram of Rocephin. I used an 18 gauge needle and placed this into the little finger MPJ under fluoroscopy. Made a small incision about a centimeter or so. Used a hemostat to come in underneath the extensor tendon and rupture the capsule of the joint. I made an incision in the webspace and got the capsule from the other side. I then took a Freer elevator and ran it dorsally over the extensor

14916

KERSHAWHEALTH MEDICAL CENTER
CAMDEN, S.C. 29020

PATIENT:	BARR, KENNETH	RM#:	-
DOCTOR:	Joseph P Jackson, Jr., MD	MR#:	0000356729
ADM DATE:	05/08/2012	PT#:	010000902850

tendon and then beneath the extensor tendon well over the dorsum of the hand. I made a third incision on the radial side of the MPJ of the ring finger after localizing the joint with an 18 gauge needle. Did an identical procedure using a small hemostat to sweep proximally, distally, preserving the extensor tendon. I then took the Freer and separated the tendon from the underlying skin dorsally and then from the bone periosteum underneath the tendon proximally. At this point I was able to passively complete full flexion down into the palm. We secured hemostasis with Bovie cautery. Applied manual pressure, deflated the tourniquet. After the patient had returned to motion, I showed him that he could make a full fist which he did with difficulty. The last 20-30 degrees of MPJ flexion were a little bit difficult for him. The joint sort of jumped into flexion. He was able to extend to neutral. The tenodesis effect was used to good effect to at least get both extensor tendons out to the little and ring finger, at least to neural, and verifying that the were intact. We irrigated and closed the skin with skin sutures of 5-0 nylon interrupted and then once again dropped the drapes and showed the patient that he could make a full fist and achieve active extension. We set up flexor and extensor tendon splinting for him with the hand therapist in advance of this encounter. Dr. Brandt will see him tomorrow morning for pain management.

_____ ***
Joseph P Jackson, Jr., MD

JPJ/rcl
D: 05/08/2012 12:04 P
T: 05/10/2012 11:15 A

cc: Terrence Hassler, MD
Joseph P Jackson, Jr., MD

05/09/12 Kenneth Barr DOB: #14916 Orthopaedic Exam

Problem:

S: The patient saw Phil Carey, our OT yesterday. He brought his splint in, I looked at them, we will make some adjustments.

O: He has pretty good passive motion and flexion. Pretty good extension. Went over the tenodesis effect with him.

A: I think that he is doing well.

P: Patient education. He will be seeing Dr. Brandt, our pain specialist, early afternoon and go over to see Phil Carey today. We will see him back here Friday. We will take the dressing off today.

JPJ/sm

MAY 11 2012

70° flexion 7 Little
10° extension

70° -f 7 Ring
15° extension

05/11/12 Kenneth Barr DOB: #14916 Orthopaedic Exam

Problem:

S: Patient has seen Dr. Brandt for pain management. Has seen Phil Carey, is in a dorsal cap splint in the intrinsic plus position.

O: With effort we can full passive flexion of the MPJ of the little finger and excellent active flexion of the ring finger. Measured ROM: 10° of extension down to 70° of flexion, active little and 15° extension down to 70 of the ring finger. Wounds look acceptable. Still has some swelling.

A: I think that he is doing fairly well.

P: Emphasized that this is the optimum time for getting improved motion, maintaining the gains that we got at surgery. We will see him back on 15 May.

JPJ/sm

05/15/12 Kenneth Barr DOB: #14916 Orthopaedic Exam

Problem:

S: Has some weather ache with the cloudy, stormy weather.

O: The splint is satisfactory. He still has about a 10° extensor lag for the little finger down to active flexion of 70. Can almost touch the distal palmar crease with the little finger. Lacks less than a cm and can do so with the ring finger. This represents significant functional gain.

A: Holding his own.

P: See him Friday and get his sutures out. Emphasized that he should be working 10 minutes out of every waking hour and the most important thing to get is flexion, especially of the little finger. He will be seeing Dr. Brandt on the 24th and hopefully we will get it down so he can see Phil Carey once a week.

JPJ/sm

MAY 16 2012

05/18/12 Kenneth Barr DOB: **#14916 Orthopaedic Exam**

Problem:

S: About 10 days out.

O: Can almost make a full fist with the ring finger. Lacks about a cm or so on the little finger and he still does not get the idea that he has got to grasp the proximal phalanx of the little finger and get that final 10-15° of MPJ flexion. Wounds look good.

A: Has made some progress.

P: Continue diligent hand therapy hourly at home and see me next Tuesday. Take sutures out today.

JPJ/sm
5-22-12

70° mp - ring

MAY 22 2012

passively 0- 45° little

lacks 1 1/2 cm touching distal palmar crease

05/22/12 Kenneth Barr DOB: **#14916 Orthopaedic Exam**

Problem:

S: Fourteen days post op.

O: Lacks a cm and a half from the little finger touching the distal palmar crease. Measured flexion 0-45°, which represents a 30° loss of flexion of the little finger. Each time I ask the patient about the scrunchie that he can put on to passively flex the fingers he gives me a blank look.

A: He is losing motion, that may be due to his fibrosis index or a motivational issue.

P: He is to continue to see the pain specialist to get off weaned off of pain medicine. I told him that he could go back to work, he says "well I cannot go back to work until I am completely released" and I told him that is not real practical, that he may be encounter some hand care professional for a long time and also I could not do a tendon transfer for his little finger until we establish the fact that he has enough motion to make it worthwhile, which looks to be doubtful at this time. He can synchronize the OT and pain visits, come in Thursday of next week and I will see him when I am back from my vacation on the 30th.

JPJ/sm

(R) 65 - intake 30
(L) 92 - intake 85

MAY 30 2012

down to 4/10
dc Dr. Brandt -
to ? Dr. Rainwater

Phil pm
doesn't like to hurt
himself

lacks 1cm. dist. palmar
ring touching palm
& little

opt. MP
Active 30° ring
- 75°

PIP - 25° - 90 ring

little MP 30° contracture
passive 0-30°

1st p.o. visit 10-70° little
15-70° ring

05/30/12 Kenneth Barr DOB: **#14916. Orthopaedic Exam**

Problem:

S: About three weeks post op, he is going to see Dr. Rainwater, he is off of pain medicines. Dr. Rainwater is a psycho therapist that will be helping with that. He has been given an as needed return to Phil Carey, the hand therapist. The pain specialist has discharged him.

O: Grip on the right is 65, on intake it was 30. On the left 92, on intake it was 85. ROM directly measured shows that he can touch the distal palmar crease with some difficulty. Active MP ROM of the ring finger is 30° down to 75; PIP 25 down to 90; little has just a 30° flexion contracture as opposed to an extension contracture. Passively ROM is 0-30.

A: He has done well maintaining the gains at surgery of the ring finger. He has lost gains at surgery which was from 0-90 on the little finger and it is not worthwhile to do a tendon transfer until he gets better motion.

P: Told him that I think that a return to full duty next Monday, which would be 4 June, without restrictions, would be indicated and we will follow him until we have soft tissue hemostasis and perhaps entertain a repeat capsulotomy and tenolysis under local with the goal in mind that if we could get 0-80 or so ROM on the MPJ of the little finger then a tendon transfer of the DIP would be indicated.

Joseph P. Jackson, Jr., M.D., F.A.C.S.

JPJ/sm

cc: Dr. Hassler

JUN 0 1 2012

6/29/12 R hand 7/10 after 15min beginning work, unable to grip - wears a glove to help with gripping paint brush + roller handle

126/70 P 76 R 20

grip R 65 30

L 90 85

06/29/12 Kenneth Barr DOB: #14916 Orthopaedic Exam

Problem:

S: About two months out. Back at work, which I am really proud. No pain medicine. He is smoking again, not happy with that. He is wearing a glove. Helps him grip better. That is fine with me.

O: BP 126/70. P-76. R-20. Grip is 65 on the right, which is up from 30 on intake; 90 on the left, 85 on intake. He can almost touch his distal palmar crease. He has probably 0 - 70° of MPJ of the ring finger and his little finger is stuck in extension. However, he has gotten much better PIP joint motion. Accounting for the ability to make a composite fist.

A: He has done a good job and I am glad he is back at work.

P: Work on quitting smoking again. Told him that some time in the future, if he wants to, we could attempt another capsulotomy, minimally invasive style on his little finger. Since he won't have two digits to work on then maybe we could do that and only if we could get motion restored would we do a tendon transfer.

Joseph P. Jackson, Jr., M.D., F.A.C.S.

JPJ/sm

cc: Terry Hassler, M.D.

8/29/12 grip (R) (L) JUL 0 3 2012

9/12/12 C/ wife. called + stated patient was ill + going to see Family MD

2012 PATIENT INFORMATION / CENTER FOR PAIN CONTROL, LLC

FORM MUST BE FILLED OUT IN ITS ENTIRETY

LAST NAME: Barr | FIRST NAME: Kenneth | MIDDLE: Lee | DATE OF BIRTH: | SOCIAL SECURITY #: 248-21-9326

MAILING ADDRESS | CITY | STATE | ZIP | HOME PHONE# | CELL PHONE#

EMPLOYER: Darlington City School District | OCCUPATION: Carpenter/painter

BUSINESS ADDRESS: Smith Ave. | CITY: Darlington | STATE: SC | ZIP: 29532 | BUSINESS PHONE#

PRIMARY PHYSICIAN: Dr. Chapman | REFERRING PHYSICIAN: Dr. Jackson

CONTACT PERSON IN CASE OF EMERGENCY: Anna Barr | RELATION

OK TO RELEASE HEALTH OR FINANCIAL INFORMATION TO THIS PERSON? YES / NO (CIRCLE ONE)

RESPONSIBLE PARTY/INSURED PARTY INFORMATION

LAST NAME: Barr | FIRST NAME: Kenneth | MIDDLE: Lee | DATE OF BIRTH: | SOCIAL SECURITY#:

RELATIONSHIP TO PATIENT: Myself | OK TO RELEASE HEALTH OR FINANCIAL INFORMATION TO THIS PERSON? YES / NO

EMPLOYER: Darl. City School District | BUSINESS ADDRESS: Smith Ave | CITY: Darlington | STATE: SC | ZIP: 29532 | BUSINESS PHONE#:

NOTIFICATION OF PATIENT PRIVACY POLICY: THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) HAS MANDATED THAT ALL HEALTH CARE PROVIDERS MAKE AVAILABLE THE NOTICE OF PRIVACY PRACTICES. THIS NOTICE IS POSTED IN OUR FRONT DESK AREA FOR YOUR REVIEW. UPON REQUEST, A COPY OF THE PRIVACY NOTICE WILL BE MADE AVAILABLE TO YOU. IN SIGNING BELOW, YOU ACKNOWLEDGE THAT YOU UNDERSTAND A COPY OF THIS OFFICE'S PRIVACY STATEMENT WILL BE AVAILABLE TO YOU SHOULD YOU REQUEST IT AND IS AVAILABLE FOR VIEWING IN THIS OFFICE'S FRONT DESK AREA. PLEASE READ THE POSTED PRIVACY POLICY OR REQUEST A COPY OF THE PRIVACY POLICY.

X SIGNATURE: [signature] DATE: 5-9-12

I AUTHORIZE THIS OFFICE TO LEAVE MESSAGES PERTAINING TO MY HEALTH CARE OR FINANCES AT THE FOLLOWING PHONE #S: (843) 858-2206 (843) 858-9104

I AUTHORIZE RELEASE OF MY HEALTH OR FINANCIAL INFORMATION TO THE FOLLOWING INDIVIDUALS: Anna Barr

PRIMARY INSURANCE: BCBS State

Policy #: ZCS031635250 | Name Insured: Kenneth Barr

SECONDARY INSURANCE: (IF APPLICABLE) N/A

Policy# | Name Insured:

TERTIARY INSURANCE:
NAME OF INSURED | DATE OF BIRTH | SOCIAL SECURITY#

FINANCIAL POLICY: PAYMENT OF MEDICAL FEES IS THE RESPONSIBILITY OF THE PATIENT AND IS DUE AT THE TIME OF SERVICE. IF WE ARE FILING YOUR INSURANCE, IT IS YOUR RESPONSIBILITY TO PAY US ANY DEDUCTIBLE, CO-INSURANCE, OR ANY BALANCE NOT PAID BY YOUR INSURANCE COMPANY AT THE TIME OF SERVICE.
I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO CENTER FOR PAIN CONTROL, LLC FOR SERVICES RENDERED. I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO PROCESS INSURANCE CLAIMS. I ACKNOWLEDGE THE RESPONSIBILITY TO PAY ANY DEBT INCURRED DURING MY TREATMENT.

X SIGNATURE: [signature] DATE: 5-9-12

A. PAIN HISTORY

1. CHIEF COMPLAINTS: This y/o right handed CM presents with pain in his Right hand follow hand surgery yesterday by Dr Jackson. Pt also hurts in neck and lower back as well as severe headaches as well as his (B) shoulder blades - Onset of lower back start over 20 y/o after a fall injury but has been increasing in severity over the last 2 years. Neck pain present for over 10 years; shoulder blades have been painful for last 2 year. Onset of headach 2010 when awoke with a severe Headach and was noted to have Mini strokes - and noted to have a aneurysm over the (C) supraorbital Region. Pt was seen by a neurologist Dr Skinner (Florence).

Pain described: nagging ach in his lower back very stiff usually @ night in morning worse by movement increases back pain. Neck pain aching pain no shooting pain: Shoulder blade pain is more of a tightness - relaxation. Headaches: constant ache encompassing his entire head. Pain also behind his eyes. (Rt) Hand wrist past of pain. Pt did undergo surgery to his (Rt) hand by Dr Hassler on 1/25/12 Pt had injury (hand) and through glass cutting 3 tendon - Revision surgery (Rt) Hand Surgery yesterday

Cervical Back Pain: _____ Dorsal Back Pain: _____ Low Back Pain : _____ Headache: _____

Facial Pain: _____ Chest Pain: _____ Abdominal Pain: _____ Pelvic Pain: _____

Upper Extremities: ____{L}____{R}____ Lower Extremities: ____{L}____{R}____

2. PAIN DESCRIPTION:

Musculoskeletal: ✓ Neurogenic: ✓ Visceral: ____ Vascular: ____

Symptom Dramatization: Ø Symptom Exaggeration: Ø Nervous: Y Depressed: Y

Anxious: Y Irritation: Y Sleep Disturbances: Y Y / ____ Hours Sleep Per Night: 5

Appetite Problems: Y Y / ____ Weight Loss/Gain: Amt: 20 lbs Diet: Y ____ /N N
since Jan. gained 7 back

Knowledge of Pain Language: Y Y /N ____

Subjective Pain Intensity(SPIR x 10=SPI)0-100% Current: 8 Best: 5 Worst: 9

Relieving Factors: meds

Aggravating Factors: stress makes headaches worse
hand & back hurt all the time)

3. ONSET: (Rt) hand S/P accident Jan 25, 2012 severed
3 tendons through glass door. also c/o headaches,
upper & lower back pain

Date: ____ Work-Related Injury: Y ____ /N N Third Party Liability: Y ____ /N N

B. HABITS:

ETOH: Amount per day denies X ____ years
Tobacco: Pack year 1 ppd x 25 yrs
Illicit Drugs: marijuana as a teen

C: ALLERGIES?RXN: NKDA

History of anticoagulant medication: Y ____ /N N Easy Bruisbility: Y ____ /N N

Medications: Opiods: ____

Antidepressant: ____

NSAID: ____

Other: ____ See List

D. MEDICAL HISTORY:

LMP: ——

PMHx: arthritis, migraines, depression/anxiety, prostatitis, mini strokes, spontaneous pneumothorax

PSHX: (R) feet, (Rt) carpal tunnel, appendectomy (Rt) hand

Review of Systems: "See Attached Sheet"

CONSTITUTIONAL: No fever, chills, history of swollen lymph nodes or weight loss.

EYES: No pink or red eye or history of conjunctivitis, blurred vision, dry eyes, blind spots or tender scalp.

EARS, NOSE, MOUTH AND THROAT: No dry mouth, change in sense of smell or taste, tinnitis, decreased hearing, epistaxis, sinusitis, sore throat or hoarseness.

CARDIOVASCULAR: No chest pain, shortness of breath, palpitations, history of orthopnea (>1 pillow),paroxysmal nocturnal dyspnea or diaphoresia.

RESPIRATORY: No cough, wheezing, sob or dyspnea.

GASTROINTESTINAL: No abdominal burning, loss of appetite, nausea, vomiting, melena, hematochezia, difficulty swallowing, diarrhea (lasting longer than two weeks), history of jaundice or constipation.

GENITOURINARY: No known history of pain on urination, increased frequency of urination, blood in the urine, swelling around eyes or ankles, urinary urgency or burning with urination.

INTEGUMENTARY: No history of seizures, convulsions, near-syncopal or syncopal episodes, history of strokes, perception of strange tastes or odors, difficulty initiating movement, localized numbness, tingling or tremor.

PSYCHIATRIC: No history of hallucinations or suicidal ideation or attempts.

ENDOCRINE: No history of diabetes or of high blood sugar or of glucose in the urine, thyroid disease, osteoporosis, goiter, history of heat intolerance or hot flashes.

HEMATOLOGIC/LYMPHATIC: No history of anemia, easy bleeding or bruising or swollen lymph nodes.

ALLERGIC/IMMUNOLOGIC: No history of hay fever, recurrent infections or of asthma.

ADDITIONAL COMMENTS:

SYMPTOMS Check symptoms you currently have or have had in the past year.

GENERAL

- ✓ CHILLS
- ✓ DEPRESSION
- ✓ DIZZINESS
- ✓ FAINTING
- O FEVER
- ✓ FORGETFULNESS
- ✓ HEADACHE
- ✓ LOSS OF SLEEP
- ✓ LOSS OF WEIGHT
- ✓ NERVOUSNESS
- O NUMBNESS
- ✓ SWEATS

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ✓ ARMS O HIPS
- ✓ BACK O LEGS
- O FEET O NECK
- ✓ HANDS O SHOULDERS

GENITO-URINARY
- O BLOOD IN URINE
- ✓ FREQUENT URINATION
- O LACK OF BLADDER
- O PAINFUL URINATION

GASTROINTESTINAL

- ✓ APPETITE POOR
- O BLOATING
- ✓ BOWEL CHANGES
- O CONSTIPATION
- ✓ DIARRHEA
- O EXCESSIVE HUNGER
- O EXCESSIVE THIRST
- O GAS
- O HEMORRHOIDS
- ✓ INDIGESTION
- O NAUSEA
- O RECTAL BLEEDING
- O STOMACH PAIN
- O VOMITING
- ✓ VOMITING BLOOD

CARDIOVASCULAR
- ✓ CHEST PAIN
- O HIGH BLOOD PRESSURE
- O IRREGULAR HEART BEAT
- O LOW BLOOD PRESSURE
- O POOR CIRCULATION
- O RAPID HEART BEAT
- O SWELLING OF ANKLES

EYE, EAR, NOSE, THROAT

- O BLEEDING GUMS
- O BLURRED VISION
- O CROSSED EYES
- O DIFFICULTY SWALLOWING
- O DOUBLE VISION
- ✓ EARACHE
- O EAR DISCHARGE
- O HAY FEVER
- O HOARSENESS
- O LOSS OF HEARING
- O NOSEBLEEDS
- O PERSISTENT COUGH
- ✓ RINGING IN EARS
- ✓ SINUS PROBLEMS
- O VISION – FLASHES
- O VISION – HALOS

SKIN
- O BRUISE EASILY
- O HIVES
- ✓ ITCHING
- O CHANGE IN MOLES
- O RASH
- O SCARS
- O SORE THAT WON'T HEAL

MEN ONLY

- O BREAST LUMP
- O ERECTION DIFFICULTIES
- O LUMP IN TESTICLE
- O PENIS DISCHARGE
- O SORE ON PENIS
- O OTHER

WOMEN ONLY
- O ABNORMAL PAP SMEAR
- O BLEEDING BETWEEN PERIODS
- O BREAST LUMP
- O EXTREME MENSTRUAL PAIN
- O HOT FLASHES
- O PAINFUL INTERCOURSE
- O VAGINAL DISCHARGE
- O OTHER

Date of last menstrual period _____

ARE YOU PREGNANT? _____

PSYCHIATRIC
- ✓ DEPRESSION
- ✓ ANXIETY
- O SUICIDAL THOUGHTS
- O SUICIDE ATTEMPTS
- O BIPOLAR DISORDER

CONDITIONS CHECK CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST

- O AIDS
- O ALCOHOLISM
- O ANEMIA
- O ANOREXIA
- ✓ APPENDICITIS
- ✓ ARTHRITIS
- O OSTEO
- O RHEUMATOID
- O OTHER
- O ASTHMA
- O BLEEDING DISORDERS
- O BREAST LUMP
- ✓ BRONCHITIS
- O BULIMIA
- O CANCER
- O CATARACTS
- O CHEMICAL DEPENDENCY
- O CHICKEN POX
- O DIABETES
- O EMPHYSEMA
- O EPILEPSY
- O GLAUCOMA
- O GOITER
- O GONORRHEA
- O GOUT
- O HEART DISEASE
- O HEPATITIS
- O HERNIA
- O HERPES
- O HIGH CHOLESTEROL
- O HIV POSITIVE
- O KIDNEY DISEASE
- O LIVER DISEASE
- O LUPUS
- O MEASLES
- ✓ MIGRAINE HEADACHE
- O MISCARRIAGE
- O MONONUCLEOSIS
- O MULITPLE SCLEROSIS
- O MUMPS
- O PACEMAKER
- O PNEUMONIA
- O POLIO
- ✓ PROSTATE PROBLEM
- O PSYCHIATRIC CARE
- O RHEUMATIC FEVER
- O SCARLET FEVER
- ✓ STROKE mini strokes
- ✓ ~~SUICIDE ATTEMPT~~
- O THYROID PROBLEMS
- O TONSILLITIS
- O TUBERCULOSIS
- O TYPHOID FEVER
- O ULCERS
- O VAGINAL INFECTIONS
- O VENEREAL DISEASE

SURGERIES: TYPE AND DATE OF SURGERY: Both feet (1985 & 1992) carpal tunnel right wrist (22 yrs ago), pancreatis (1979), Lungs collaped (1998) hand surgery (2012)

MEDICATIONS LIST MEDICATIONS YOU ARE CURRENTLY TAKING	ALLERGIES/TYPE OF REACTION TO MEDICATIONS OR SUBSTANCES
Lorecet - 10-325mg	
Cymbetta - 60mg	None
baby aspirin 81mg	
zantac - 300mg twice a day	
PHARMACY NAME Walgreens PHONE NO. (843) 332-4623	

E. SOCIAL PROFILE:

Age: ___ Sex: M Race: W Marital Status: (M) S D W (if w, #yrs ___)

Number of Children: 1 son(S) 2 daughter(s)
Ages: 10 16, 6
Living at Home: 3 children
2 adults

F: EDUCATIONAL BACKGROUND:
Graduated High School

G: EMPLOYMENT HISTORY:
Current or most recent Job Descritpion: Carpenter, painter

# of years at Present job: 3 # of jobs in the last 5 years: 2 currently working: Y ___ /N ✓

Benefits: Disability ✓ Workman's Comp ___ Other ___ None ___
Litigation: Pending ___ / Settled ___

H. SOCIAL ACTIVITY:

Satisfactory ✓ Unsatisfactory ___

L. SEXUAL ACTIVITY:

Active ✓ Inactive ___ Satisfactory ✓ Unsatisfactory ___

J. MAJOR SUPPORT SYSTEM:

Family: wife, mom, sister & children
Friends: Several friends
Church: Liberty Baptist Church

Estimated hours of activity in a 24 hour period: Some days 1-2-8 and some days little act.
Salary change since onset of pain: no
Previous treatments: Physical Therapy ✓ Occupational Therapy ___
Behavioral Medicine ✓ Chiropractic ___ Massage ___
Cymbalta

Comments: ___

K: SPIRITUALITY:
Were you raised in any particular faith? Yes ✓ No ___
Is this the same faith you practice now? Yes ✓ No ___
Church: Liberty Baptist Active: ✓ Inactive: ___
Do you find comfort in your faith? Yes ✓ No ___ (Sometimes)
Does prayer help you? Yes ✓ No ___

L: PHYSICAL EXAMINATION:

General Appearance: This - 410 CM no acute distress He is A & O X3.

Vitals: Hgt 5'10" Wgt 142 BP 125/82 HR 58 Resp 18 SpO2 100% T 98.2 Vas 8

Head: - Normocephalic atraumatic

Neck: no meningeal tenderness

Eyes: PERLA EOMI

Ears: EAC patent TM intact

Nose: Nares patent

Throat: Teeth poor repair Uvula deviated to (R)

Heart: Reg + split S1 S2

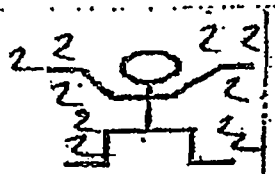
Lungs: (B) CTA

Abdomen: Soft BSX4 Nontender

Extremities: Present X 4 Peripheral Pulse: ✓ Intact ✓ Equal Bilaterally ✓ Defined (RP) due to bowing

Skin: WNL

Change in cutaneous sensation (Dermatome level): No Δ (B) L2-S2



Babinski ABSENT: Y ✓ /N ___

Change in Pin Prick Sensation: SAME

Trophic changes: Y ___ /N ✓

Motor function change: Y ___ /N ___

Muscle Strength: Upper: Grip R 5/5 ; Bicep R 5/5 ; Tricep R 5/5

Lower: Dorsiflection R 5/5 ; Plantar Extension R 5/5 ; Hamstring R 5/5 ;

Quadriceps R 5/5

Straight Leg Raise: Supine: R ___ L ___ Sitting: R 90° L 90°

Musculoskeletal Review:

Ambulation: WNL Toe Walk + (-) Heel Walk + / (-)

Standing Balance: WNL

Active & Passive ROM: C Good

T Good

L F 60° Ext 20°

Postural or vertebral column defect: Y ___ /N ___

Limb defects: Y ___ /N ___

PHYSICAL EXAMINATION CONTINUED) (+) (R+) Hand in Case

Trigger Point or Zone: (+) cervical paraspinals - pain (B) C4 - T1

(+) splenius capitis levator scapulae spasm (+) jump signs

(+) Mild (B) Lesser occipital tenderness

(+) Thoracic paraspinous spasm (mild) T1 - T8 (B)

Lumbar paraspinous spasm L3-S1

(+) Lumbar facet tenderness L4/L5 L5/S1

(+) SIJ tenderness

(+) (B) inguinal Node (+) postauricular Nodes (B)(D) > (R)

(-) axillary or preauricular Nodes

OBJECTIVE DATA

X-ray: Y_____/N_____ Date:_____ MRI: Y_____/N:_____ Date:_____

Labs: Y_____/N_____ Date:_____ Beck's Depression Inventory Score: 25 /10

M ASSESSMENT / DIAGNOSIS

Cervicalgia c chronic spasm of muscle.

Cephalgia: occipital Neuralgia (MIN) / Possible analgesic Rebound Headache

Lower lumbar Pain

Degenerative disc disease

Probable lumbar facet Syndrome

Back spasm (Thoracic & lumbar

- Polymyalgia

- lymphadenopathy Malignancy possible

- Connective disc Disease

Depression Beck 25/10 causing pain amplification

Pt s/p recent hand Surgery (acute pain process)

- Anxiety Disorder (NOS)

EMORY CLASSIFICATION: Tentative (I) | II | III | IV

O. PLAN OF M NAGEMENT:

1 - X-Ray lumbar spine c̄ obliques with flexion extension series
2 - X-Ray cervical spine c̄ flexion extension series
3 - Urine Drug screen
4 - BUN Creatinine LFT
5 - ANA, RA, C-reactive protein, ESR
6 - CBC c̄ Diff.
7 - Obtain Notes from Dr Skinner (Neurologist)
Florence SC.
8 - Possible diagnostic/therapeutic occipital Nerve Block
9 - Possible TPI
10 - Possible analgesic rebound headache protocol
11 - Behavior Medicine eval (tx c̄ MMPI P3
12 - No steroid containing intervention until released from hand surgery
13 - Possible Neurology eval by Dr Frank Pusey
14 - Possible Dx/Tx Facet Joint Nerve Blocks under fluoroscopy
15 - Possible Rheumatology eval
16) Reassess 2 weeks
17) start Zanaflex 4mg #30 1/4-1 po q 6hs for spasm
18) Start Buspar 15mg 1/3 po TID for anxiety

CENTER FOR PAIN CONTROL, LLC

Thomas E. Brandt, Jr. DO

1165 Hwy 1 South
Suite 300
Lugoff, SC 29078
1-803-408-3033
Fax: 408-3011

SOCIAL AND MEDICAL HISTORY

Name: Kenneth Lee Barr

Age: ___ Height: 5'10 Weight: 142

Name of family physician: Dr. Chapman

Name of referring physician: Dr. Jackson

Marital Status:
- ___ Single
- ✓ Married — How long? 20
- ___ Separated — How long? ___
- ___ Divorced — How long? ___
- ___ Widowed — How long? ___

How many children? 3 Ages: 10, 10, 6

Who are the relatives living with you? wife & children

Are any relatives being treated at this facility now or in the past? NO

Is your injury worker's compensation related? ___ Yes ✓ No

Are you working now? ___ Yes ✓ No
If no, is it due to the pain? ___ Yes ✓ No

Are you retired? ___ Yes ✓ No
If yes, number of years: ___ Last day worked: ___

Are you disabled? ___ Yes ✓ No
If yes, number of years: ___

Is anyone in your family disabled? ✓ Yes ___ No
If yes, who and reason: mom - Lupus

Have you ever had a previous work related injury? ___ Yes ✓ No

If yes, did you receive a disability? _____ Yes ✓ No
If yes, percentage received: _____

Do you smoke? ✓ Yes _____ No
If yes, number of packs per day: 1 How long? 25

Do you drink alcohol? _____ Yes ✓ No
If yes, how much do you drink per week? _____
What do you drink? (circle one)
Beer Wine Liquor

Have you ever used illegal drugs? ✓ Yes _____ No
If yes, what? marijuana (as a teenager)

Highest level of education: 12

Do you have any hobbies? ✓ Yes _____ No
If yes, please list: Wood working, fishing & sports, gardening

Does the pain interfere with hobbies? ✓ Yes _____ No
If yes, (circle one) slightly moderately severely

Have you had a major crisis in your life in the last 2 years? ✓ Yes _____ No
If yes, what? hand injury that happened on June 26
In Aug. 2010 started having major headaches. was out of work 6 wks with this problem.
Which of the following tests have you had to evaluate your present pain problem?
Saw Neurologist.

TEST	DATE	WHERE
MRI X-RAYS	✓	McLeods
Double CT SCAN w/ dye	✓	McLeod
BONE SCAN		
MYELOGRAM		
EMG NERVE TEST		
MRI		

FAMILY HEALTH HISTORY: Please check all that apply.

✓ Cancer Type? _____
_____ Heart disease
_____ Stroke
✓ High blood pressure
✓ Arthritis
✓ Diabetes
_____ Emphysema
_____ Bleeding disorder
_____ Alcoholism
_____ Psychiatric Care

Please describe your pain: I have lower back pain that is chronic every day. My hand hurts from injury since Jan 2012. Headaches still hurt.

When did the pain begin? back pain for sev. yrs. - hand Jan 2012 headaches 2 yrs

What were you doing when the pain began? back pain fell at work, has gotten worse over the years. Hand was an accident at home. Headaches started all of a sudden. Had been renovating home

What makes your pain worse? Headaches - Stress hand and back hurts all the time.

What makes your pain better? Taking medicine helps relieve pain but not completly.

Do you have any problems with bowel or bladder related to your pain?

____ Yes ✓ No

If yes, please describe: _____

BECK INVENTORY

Name: Kenneth Lee Bare Date: 5-9-17

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the PAST WEEK, INCLUDING TODAY. Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

25/10

1.
0 I do not feel sad today.
1 I feel sad.
2 I am sad all the time and I can't snap out of it.
3 I am so sad or unhappy that I can't stand it.

2.
0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel that the future is hopeless and that things cannot improve.

3.
0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 As I look back on my life, all I can see is a lot of failures.
3 I feel I am a complete failure as a person.

4.
0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.

5.
0 I don't feel particularly guilty.
1 I feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6.
0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7.
0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.

8.
0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.

9.
0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10.
0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.

11.
0 I am no more irritated now than I ever am.
1 I get annoyed or irritated more easily than I used to.
2 I feel irritated all the time now.
3 I don't get irritated at all by the things that used to irritate me.

12.
0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13.
0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions than before.
3 I can't make decisions at all anymore.

14.
0 I don't feel I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel that there are permanent changes in my appearance that make me look unattractive.
3 I believe that I look ugly.

15.
0 I can work about as well as before.
1 It takes an extra effort to get started doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16.
0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18. 0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19. 0 I haven't lost much weight, if any, lately.
1 I have lost more than 5 pounds.
2 I have lost more than 10 pounds.
3 I have lost more than 15 pounds.

I am purposely trying to lose weight by eating less. Yes _____ No ✓

20. 0 I am no more worried about my health than usual.
1 I am worried about physical problems such as aches and pains, or upset stomach, or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think about anything else.

21. 0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested I sex now.
3 I have loss interest in sex completely.

PATIENT NAME Kenneth Pan

REFERRING PHYSICIAN J. Jackson

INITIAL ASSESSMENT DATE 5/9/12 INITIAL VAS 8

DATE	ASSESSMENT/VITAL SIGNS	VAS	MEDICATIONS	PROC	%REL	ACT	SL	RN/MD
5/9/12	125/82·58·18·100/.982	8	Initial Assessment					(SA)
5/21/12	125/61·76·18·98/.95	2-7	C/O Pain to L Back, neck					R Rhind MN
5/25/12	Faxed referral to Northwalk Lanwater							(CS)

VAS – VISUAL ANALOG SCALE ACT – ACTIVITY LEVEL %REL - % RELIEF
PROC – PROCEDURE SL – SLEEP PATTERN

CENTER FOR PAIN CONTROL, LLC
1165 Hwy. 1 South • Suite 300
Lugoff, SC 29078
Phone (803) 408-3033 • Fax (803) 408-3011

THOMAS E. BRANDT, JR., D.O.

FOR Kenneth Barr DATE 5/9/12

℞ ADDRESS

Zanaflex 4mg
#30
1/4-1 po Q HS for night time spasm

DISPENSE AS WRITTEN D.O. SUBSTITUTION PERMITTED D.O.

LABEL REFILL One TIMES DEA # BB3880805

TAKE THIS TO YOUR REGISTERED PHARMACIST OF CHOICE

CENTER FOR PAIN CONTROL, LLC
1165 Hwy. 1 South • Suite 300
Lugoff, SC 29078
Phone (803) 408-3033 • Fax (803) 408-3011

THOMAS E. BRANDT, JR., D.O.

FOR Kenneth Barr DATE 5/9/12

℞ ADDRESS

Buspar 15mg
#30
1/3 po TID for anxiety

DISPENSE AS WRITTEN D.O. SUBSTITUTION PERMITTED D.O.

LABEL REFILL One TIMES DEA # BB3880805

TAKE THIS TO YOUR REGISTERED PHARMACIST OF CHOICE

CENTER FOR PAIN CONTROL, LLC
1165 Hwy. I South • Suite 300
Lugoff, SC 29078
Phone (803) 408-3033 • Fax (803) 408-3011

THOMAS E. BRANDT, JR., D.O.

FOR Kenneth Barr DATE 5/9/12

℞ ADDRESS

Dr. Rainwater Eval/Tx.
Chronic Pain / Depression /
Anxiety

DISPENSE AS WRITTEN. D.O. SUBSTITUTION PERMITTED D.O.

LABEL REFILL TIMES DEA # BB3880805

TAKE THIS TO YOUR REGISTERED PHARMACIST OF CHOICE

CENTER FOR PAIN CONTROL, LLC
1165 Hwy 1 South Suite 300 Lugoff, SC 29078
Thomas E. Brandt, Jr. D.O.

PROGESS NOTE
PATIENT NAME: Kenneth Bam DATE: 5/24/12 MRN: 2542.

SUBJECTIVE: The patient presents today for evaluation and treatment.

Pt reports pain in his head neck and lower back. Pt states I am about out of pain medicine again. Pt reports lower back achiness and stiff just like his neck. Pt reports he is taking Hydrocone 10/325 every 3/day. Pt continues to have a pain attacks. Pt reports bus pass not working

OBJECTIVE: BP 125/61 HR 76 RESP 18 SPO2% 98% TEMP 98.3 VAS 7

HEART Reg S(W)

LUNG (B) CTA

ABD Soft BSX4 nontender

MS 5/5 5/5

NEUROLOGIC EXAM

ASSESSMENT/DIAGNOSIS:

- lower lumbar pain
- etiology unclear
- Myalgia
- anxiety disorder, concern for somatization disorder

Extensive discline lumbar facet L3-5 (B)

PLAN

1) Await appt c Behavior Medicine Dr Rawlinson
2) Refer Psychiatrist for med management
3) Increase Buspar 15mg → 30mg 1 pt TID
4) Start Mobic 7.5mg TID Before food
5) Long discussion about labs x-ray - concern sensitization
6) Refer CBT
7) Copy of labs x-ray report provided to patient
8) Return 3 weeks

CENTER FOR PAIN CONTROL, LLC
1165 Hwy. 1 South • Suite 300
Lugoff, SC 29078
Phone (803) 408-3033 • Fax (803) 408-3011

THOMAS E. BRANDT, JR., D.O.

FOR Kenneth Barr DATE 5-24-12

℞ ADDRESS

Buspar 30mg

#30

1/3 po Tid

D.O. D.O.

DISPENSE AS WRITTEN SUBSTITUTION PERMITTED

LABEL REFILL 0 TIMES DEA # BB3880805

TAKE THIS TO YOUR REGISTERED PHARMACIST OF CHOICE

CENTER FOR PAIN CONTROL, LLC
1165 Hwy. 1 South • Suite 300
Lugoff, SC 29078
Phone (803) 408-3033 • Fax (803) 408-3011

THOMAS E. BRANDT, JR., D.O.

FOR Kenneth Barr DATE 5-24-12

℞ ADDRESS

Mobic 7.5mg

#60 (sixty)

1 po BID c food

D.O. D.O.

DISPENSE AS WRITTEN SUBSTITUTION PERMITTED

LABEL REFILL One TIMES DEA # BB3880805

TAKE THIS TO YOUR REGISTERED PHARMACIST OF CHOICE

CENTER FOR PAIN CONTROL, LLC
1165 Hwy. 1 South • Suite 300
Lugoff, SC 29078
Phone (803) 408-3033 • Fax (803) 408-3011

THOMAS E. BRANDT, JR., D.O.

FOR Kenneth Barr DATE 5/25/10

℞ ADDRESS

Dr Martha la ecral/tx
Depression/anxiety
Chronic pain

D.O. D.O.

DISPENSE AS WRITTEN SUBSTITUTION PERMITTED

LABEL REFILL TIMES DEA # BB3880805

TAKE THIS TO YOUR REGISTERED PHARMACIST OF CHOICE

The Center For Pain Control, LLC
Master Diagnosis and Summary List

Patient Name: Kenneth Barr Pharmacy & phone #:

Dx #		Date	Significant Diagnosis	Dx #	Date	Significant Diagnosis
			arthritis			prostatitis
			migraines			mini strokes
			depression/anxiety			sport. pneumothorax

D/C	Pain related meds Dose & instructions	Pt. Use	Rx. Dr.	Date last Rx & Amount (Amount Remaining)	Problems
	Percocet 10/325 mg				
	Cymbalta 60mg				

D/C	General Health Meds & Dose Instructions	Meds used in past (problems)
*	Asa 81 mg	
	Zantac 300mg BID	

Allergies (Type of Reaction)

NKDA

Date	Significant Operative and Invasive Procedures	Date	Significant Operative and Invasive Procedures
	(B) feet		(Rt) hand
	(Rt) carpal tunnel		
	appendectomy		

Date	Physical Therapy and Medical Equipment

SCIENTIFIC ARTICLE

Predictors of Pain Intensity and Disability After Minor Hand Surgery

Ana-Maria Vranceanu, PhD, Jesse B. Jupiter, MD, Chaitanya S. Mudgal, MD, David Ring, MD, PhD

Purpose To test the null hypothesis that there is no relationship between coping mechanisms and depression measured before surgery, and pain intensity and disability after surgery, as assessed at the time of suture removal.

Methods A total of 120 patients (39 electing surgery for carpal tunnel syndrome, 65 for trigger finger, and 16 for a benign tumor) completed questionnaires measuring depression, pain self-efficacy (confidence that one can perform various activities despite pain), pain anxiety (fear and anxiety in response to pain sensations), and pain catastrophizing (maladaptive cognitive activities such as pain-related rumination, magnification, and helplessness) before surgery. Before the surgery and at the time of suture removal (10 to 14 days after surgery) participants completed the Disabilities of the Arm, Shoulder, and Hand questionnaire (DASH) and a numerical pain intensity rating scale.

Results At the time of suture removal, there was a significant correlation between pain intensity and depression ($r = 0.45$, $p<.001$), pain catastrophizing ($r = 0.41$, $p<.001$), pain anxiety ($r = 0.32$, $p<.01$), and self-efficacy ($r = -0.29$, $p<.01$). Disability correlated with self-efficacy ($r = -0.34$; $p<.001$) and depression ($r = 0.49$; $p<.001$), but not with pain anxiety and catastrophizing ($p>.05$). In multivariate analyses, depression was the sole predictor of both disability and pain intensity and accounted for 26% of the variance in DASH scores and 25% of the variance in pain intensity, after removing the influence of preoperative DASH and diagnosis, which accounted for 14% variance.

Conclusions Psychosocial factors, especially depression, explain a notable proportion of the variation in pain intensity and disability after minor hand surgery. *(J Hand Surg 2010;35A: 956–960. © 2010 Published by Elsevier Inc. on behalf of the American Society for Surgery of the Hand.)*

Type of study/level of evidence Prognostic I.

Key words Carpal tunnel syndrome, minor hand surgery, local anesthesia, pain intensity, depression.

ELECTRODIAGNOSTICALLY confirmed idiopathic median nerve dysfunction at the carpal tunnel (carpal tunnel syndrome [CTS]), idiopathic trigger finger (TF), and benign finger tumors are common, discrete conditions, with objective, verifiable pathology amenable to surgical intervention. Despite the relatively narrow variation in impairment and pathophysiology associated with these diseases and their surgical treatment, there is substantial variation in postoperative pain intensity and disability.[1] Several studies have identified the influence of patient demographics, work status, overall health,

smoking status, intake of pain medication, and depression on outcomes of surgery for various pain conditions, including CTS or TF.[2–7]

Research also suggests that pain-specific coping strategies are important in reports of disability and pain intensity,[8–12] including outcomes of back pain surgery.[13,14] Pain catastrophizing, pain self-efficacy, and pain anxiety are normal aspects of human psychology that occur on a continuum and affect our experience of pain.[15–18] Based on prior studies, it is likely that these pain-specific coping factors are important in early surgical outcomes in patients with CTS, TF, and benign finger tumors, and might explain patients' differing reports of pain intensity and disability after the relatively consistent nociceptive stimulus of minor hand surgery.

This is important for 2 reasons. First, patient dissatisfaction, high pain intensity, and disproportionate disability can be misinterpreted as indicating a technical shortcoming or complication, which can lead to unnecessary or inappropriate treatment. Second, if pain intensity and disability during the early period after minor hand surgery indeed depend on presurgery pain coping strategies, addressing these factors before surgery, via evidence-based, short-term, pain-specific cognitive behavioral interventions, could decrease postoperative self-reported hand- and arm-specific disability and pain intensity and improve patient satisfaction. Experts on chronic pain emphasize a window of opportunity in which proper handling of acute pain can limit the risk of developing a chronic pain condition.[16] The optimal time to recognize and treat important psychosocial influences on pain and disability would be before elective hand surgery.

The purpose of this study was to evaluate the association between psychological factors and reports of pain intensity and disability after elective minor hand surgery. We tested the null hypothesis that there is no relationship between coping mechanisms (pain catastrophizing, pain anxiety, and pain self-efficacy) and depression measured before surgery, and pain intensity and disability after surgery, as assessed at the time of suture removal.

MATERIALS AND METHODS

All adult, English-speaking patients who requested surgery for electrodiagnostically confirmed idiopathic median nerve dysfunction at the carpal tunnel, TF, or a benign hand tumor were invited to enroll under a protocol approved by our Human Research Committee. Patients requesting revision of prior surgery for the identical problem were excluded. The study was described in detail and the 3 treating surgeons and study staff obtained informed consent. No eligible patient declined enrollment. We enrolled a total of 120 consecutive patients.

There were 69 women and 51 men, with a mean age of 61 years (range, 18–86 y of age; standard deviation [SD], 10.4 y of age). Thirty-nine patients requested carpal tunnel release, 65 requested release of one or more TFs, and 16 patients requested removal of a benign hand tumor. Forty-eight participants worked full-time, 12 worked part-time, 43 were retired, 6 were homemakers, and 11 were unemployed. None of the study participants were under workers' compensation status.

This study employed an observational, prospective cohort design. Demographics and depression, pain catastrophizing, pain anxiety, and pain self-efficacy data were collected on the day of enrollment. Self-reported, upper extremity–specific disability and pain intensity were assessed before surgery and again at the time of suture removal between 10 and 14 days after surgery. All enrolled participants (100%) completed follow-up at suture removal.

Measures

The Patient Health Questionnaire–Depression[17] scale is a valid measure designed to screen for depressive disorder consistent with the Diagnostic and Statistical Manual of Mental Disorders-IV classification (APA).[18] The measure has 9 items, answered on a 4-point Likert scale, from "not at all" (0) to "nearly every day" (3), such that higher scores show more severe depressive symptoms.

The Pain Catastrophizing scale[19] is a reliable and valid measure of negative pain-related cognitions. It has 13 items answered on a 4-point Likert Scale from "not at all" (0) to "all of the time" (3). Items are grouped into 3 subscales: rumination (tendency to spend a lot of time dwelling on the pain), helplessness (feeling hopeless and helpless when in pain), and magnification (thinking of the worst when in pain). A total catastrophizing score is computed by adding all items.

The Pain Anxiety scale[20] is a reliable and valid measure of anxiety about pain. It has 20 items answered on a 6-point Likert scale from "never" (0) to "always" (5). Items are grouped into 4 subscales: avoidance (avoiding activities that cause pain), fearful thinking (fear thoughts related to pain), cognitive anxiety (difficulty thinking when in pain), and physiological response (somatic anxiety symptoms in response to pain). A total pain anxiety scale is computed by adding all items.

The Pain Self-Efficacy questionnaire (Nicholas MK, presented at the annual conference of the British Psychological Society, 1989) is a reliable and valid measure of self-efficacy (confidence that one can perform various activities despite pain) about pain. It has 10 items answered on a 7-point Likert scale from "not at all confident" (0) to "completely confident" (6). Items are added to give a total score.

The Disabilities of the Arm, Shoulder, and Hand questionnaire (DASH[21]) is a 30-item disability/symptom scale concerning the patient's upper extremity disability during the preceding week. The items ask about the degree of difficulty in performing different physical activities because of arm, shoulder, or hand problems (21 items); the severity of each of the symptoms of pain, activity-related pain, tingling, weakness, and stiffness (5 items); as well as the problem's impact on social activities, work, sleep, and self-image (4 items). Items are answered on 5-point Likert scales. The scores for all items are then used to calculate a scaled score ranging from 0 (no disability) to 100 (most severe disability). The score for the disability/symptom scale is called the DASH score, and was assessed before and after surgery.

The Numerical Rating scale is a reliable and valid measure of pain intensity[22] from 0 (no pain) to 9 (worst pain ever). Pain was assessed before and after surgery.

Statistical analyses

Power analyses (G power software[23]) indicated that a total of 120 patients would provide 85% statistical power, with alpha of 0.05, for a medium effect size of $r = 0.3$ (for correlational analyses) and effect size of $f^2 = 0.15$ for regressions with 4 main predictors (pain catastrophizing, pain anxiety, pain self-efficacy, and depressive symptoms).

Descriptive statistics for the demographic variables were done via frequencies (for categorical variables) and means with standard deviations for continuous variables. Next, we conducted analyses of variance to assess for potential differences in demographics and primary study variables among the 3 diagnostic groups. We then calculated bivariate correlations between predictor and outcome variables. Primary analyses were conducted with multiple linear regressions. We conducted 2 sets of regressions for the 2 outcome variables: namely, postsurgery disability and pain intensity. Dummy codes were created for categorical variables entered in the regression equation. Regressions included 2 steps. In the first step, we included demographic variables and preoperative DASH and pain intensity, respectively, if those were significantly related to primary outcome variables ($p<.05$). This first step removes the effect of these variables from the analysis. In the second step, we entered as predictors only those variables that were significantly related to disability and pain intensity, respectively, in correlational analyses.

RESULTS

Preoperative assessment

There were no significant differences in pain catastrophizing (mean, 20.5; SD, 8.3), pain anxiety (mean, 17.9; SD, 19.3), pain self-efficacy (mean, 48.9; SD, 13.4), depressive symptoms (mean, 2.9; SD, 3.2), or pain (mean, 4.3; SD, 2.8) among categorical demographics variables, or the 3 diagnostic groups ($p<.05$). However, there was a significant difference in presurgery disability (mean, 50.4; SD, 18.3) among patients in the 3 groups ($p=.003$). Post hoc analyses using the Bonferroni correction showed that patients with TF had significantly higher disability compared with patients with benign tumors ($p=.002$). Significant difference was observed only between TF and benign tumor. There was no significant association among continuous demographic variables and coping, depressive symptoms, pain, and disability.

Postoperative assessment

All patients returned for suture removal. Pain intensity at the time of suture removal (mean, 2.5; SD, 2.3) correlated significantly with all 3 measures of coping mechanisms and with depressive symptoms, but did not correlate with presurgery pain intensity (Table 1). When all 4 variables were entered into a multiple linear regression model, the overall model was significant ($F = 3.2$, $p=.01$) and accounted for 25% of the variance in pain intensity, but depressive symptoms were the only significant predictor of pain intensity ($\beta = .33$, $p=.03$).

Postoperative DASH disability scores (mean, 49.3; SD, 18.3) correlated significantly with depressive symptoms and self-efficacy, but not with pain catastrophizing and pain anxiety. Postsurgery DASH was also significantly related to presurgery DASH (Table 1). A linear regression model controlling for presurgery DASH and for specific diagnosis (entered as 3 dummy code variable predictors in step 1) with depressive symptoms and self-efficacy entered as predictors of postsurgery DASH scores in step 2 was significant ($F = 7.49$, $p<.001$) and accounted for 26% of the variance, after removing the effect of preoperative DASH and diagnosis (which accounted for 14% variance). Depressive symptoms ($\beta = .35$,

TABLE 1. Bivariate Correlations Among Main Study Variables

p=.01) were the only significant predictor of DASH scores.

DISCUSSION.

Our findings are consistent with prior work and show that depressive symptoms are a key variable in reports of disability and pain intensity after surgery.[5,24–26] This suggests the possibility that some of the disproportionate pain and disability after otherwise uncomplicated and objectively successful surgery may be a function of untreated depressive symptoms. Future studies should replicate this finding by carefully assessing and controlling for other factors related to unsuccessful surgeries. That coping mechanisms in response to pain in the form of pain anxiety, catastrophizing, and self-efficacy were significantly intercorrelated and significantly related to depressive symptoms, but not predictive of disability or pain intensity, suggests that these variables may influence disability and pain intensity indirectly through increased depressive symptoms. Future studies should explore this hypothesis through mediation analyses, in which statistical tests can assess the significance and amount of variance in the association between a predictor and an outcome variable that is explained by another variable called a *mediator*.[27] Although our model explained a notable amount of variance in disability and pain intensity, most of the variance remains unexplained and further study is merited.

The results of this study are consistent with prior reports that show the pivotal role of depressive symptoms in reports of disability in pain conditions[28–30] and other medical conditions.[31] Analyses of data from 245 studies, with 404 participants ages 18 to 60 years, from 60 countries all over the world, as part of the World Health Organization Survey,[31] showed that between 9% and 23% of participants with a chronic disease also have depressive symptoms. Furthermore, the comorbid state of depressive symptoms incrementally worsens health compared with depressive symptoms alone, with chronic disease alone, and with any combination of chronic diseases without depressive symptoms.

Treatment of depressive symptoms is a public health priority. It represents one of the largest opportunities to reduce illness and disability, and to improve the overall health of populations. Medication can be a useful treatment for major depression, but behavioral therapies can have comparable efficacy and lower the risk of future episodes of major depression. Cognitive behavioral therapy is an empirically based, short-term treatment that has been found successful in reducing depression symptoms[32–34] and is useful for the entire spectrum of depression, as even symptoms that do not meet the full criteria for major depression negatively affect health. Surgeons should be mindful of the negative impact of depressive symptoms on postoperative outcomes and assess mood, understanding, and resiliency before elective hand surgery. They can do this by adopting some aspects of the cognitive behavioral therapy techniques in the approach to and conceptualization of the illness, demonstrating empathy while remaining mindful of the impact of psychosocial factors in general and depression in particular, in addition to disease, on illness and illness behavior. It may prove advisable to delay elective surgery while patients work on improving depressive symptoms. This comprehensive care may be best delivered in collaborative, multidisciplinary teams that include a behavioral medicine specialist. Addressing

depressive symptoms before elective medical or surgical procedures has the potential to increase the success of medical and surgical treatments, decrease health care costs, limit unnecessary surgeries (unnecessary revision surgeries in particular), and hinder transition from acute to chronic pain.[16,35,36]

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Biopsychosocial Interview

Patient Kenneth Lee Barr Date of birth _____ Age ____ Date 5-29-2012

Who is your regular doctor, your family doctor? Dr. Mac Chapman

Which doctor referred you to our office? Dr. Brandt

Why were you referred to our office? to get anxiety controlled

Please list other doctors you have seen for this problem: _____

FAMILY

How would you describe your growing up years? ☐ easy ☑ average ☐ hard

What was your father's job? Roofer / carpenter ; mother's job? mill / retail

How many brothers and sisters did you have? 0 1 (2) 3 4 5 6 7 8 9

Did you complete high school? ☑ Yes ☐ No If no, what grade did you complete? 6 7 8 9 10 11 12

Any college or other training? none

Was school ☐ easy, ☑ average or ☐ hard for you? What were your grades like? ☐ A/B ☐ B/C ☑ C/D

Are you currently ☐ Single ☑ Married ☐ Widowed ☐ Divorced?

How many times have you been married? 0 (1) 2 3 4 5 How many children do you have? 0 1 2 (3) 4 5 with now

What has been your main job? Painting, carpentry / gunsmiths back to work on Monday to my job!

Are you working? ☐ Yes ☑ No, if no, why not? on long term disability for injury.

What was your last job? self-employed How long? 6 yrs

Any military service? ☑ No ☐ Yes If yes, what branch _____ for how long _____?

Have you ever been arrested? ☑ No ☐ Yes If yes, what for? _____

MEDICAL

Please place a checkmark by any of the following problems that you have now or have had in the past:

___High blood pressure	___Diabetes	___Asthma	___Allergies	___Cancer
___Liver disease	✓ Stroke (mini)	___Heart attack	___Thyroid	___Bladder
✓ Heartburn	___Hearing loss	✓ Arthritis	___HIV/AIDS	

___Other: _____

PAIN Please list your areas of pain from the *worst* to the *least*. Please also *rate* your pain severity where 0 is no pain and 10 is "pain so severe you would literally pass out."

Where is your pain located?	*How often do you hurt?*	*How long have you hurt?*	*How bad is the pain?*
back/neck (worst)	☐ Off and on ☑ Most of the time ☐ All of the time	5 months/years	0 1 2 3 4 5 6 7 8 9 10
R hand due to injury	☑ Off and on (now) ☐ Most of the time ☐ All of the time	4 months/years	0 1 2 3 4 5 6 7 8 9 10
headaches	☑ Off and on (now) ☐ Most of the time ☐ All of the time	1 yr 10 mths ___ months/years	0 1 2 3 4 5 6 7 8 9 10
_____	☐ Off and on ☐ Most of the time ☐ All of the time	___ months/years	0 1 2 3 4 5 6 7 8 9 10
_____ (least)	☐ Off and on ☐ Most of the time ☐ All of the time	___ months/years	0 1 2 3 4 5 6 7 8 9 10

MEDICATIONS

Please list the drugs you take every day, the dosage if you know it, and the reason (which medical problem) you take the medication.

Medication name:	Dose:	Reason:
Cymbalta	60 mg once daily	for anxiety
Tizanidine	4 mg once at bedtime	for muscle spasms in back.
Buspirone	15 mg 2/3 tablet 3 times daily	for anxiety
Meloxicam	7.5 mg 1 twice daily	anti-flammatory
Hydrocodone	10/325 1 every 6 hrs. (now taking 1/2 of tablet every 6 hrs.)	pain
	absent db now & only 2 left	

SURGICAL Please list all of your surgeries.

Surgery	When	Surgeon	Was it helpful?
finger procedure	5-8-12	Dr. Jackson	Yes (Some) No
R hand surgery due to injury	1-26-12	Dr. Hassler	(Yes) Some No
lung collapse	1998	Dr. Minchef	(Yes) Some No
L & R feet	L ? R 1993	?	(Yes) Some No
R carpal tunnel	?	?	(Yes) Some No
appendicitis	?	?	(Yes) Some No

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Have you ever had any problems with anesthesia? ☑ No ☐ Yes, explain _____

Do you have headaches: ☑ Rarely (now) ☐ ____ times a week ☐ Daily
Do you *also* have *severe* headaches that are worse than your "typical" headaches? ☐ No ☑ Yes
If yes, how many times a week do you have these *severe* headaches? _____ a week. every so often

Does you pain vary with the time of day? ☑ No ☐ Yes
If yes, is it worse ☐ in the mornings when you are getting up, or ☐ in the evening after you've been active?

Do you find that stress, tension and anxiety tend to make your pain worse? ☑ Yes ☐ No
esp c the H.A.

TREATMENTS

Which pain treatment have you had?	Benefit?				
☑ Medication	☐ None	☐ Low	☑ Medium	☐ High	
☐ Physical Therapy	☐ None	☐ Low	☐ Medium	☐ High	
☐ Surgery	☐ None	☐ Low	☐ Medium	☐ High	
☑ Steroid Injections	☐ None	☑ Low	☑ Medium	☐ High	(did at first)
☐ Nerve Blocks	☐ None	☐ Low	☐ Medium	☐ High	
☐ Biofeedback	☐ None	☐ Low	☐ Medium	☐ High	
☐ Acupuncture	☐ None	☐ Low	☐ Medium	☐ High	
☑ Chiropractic care	☐ None	☐ Low	☑ Medium	☐ High	
☐ TENS unit	☐ None	☐ Low	☐ Medium	☐ High	
☐ Counseling	☐ None	☐ Low	☐ Medium	☐ High	
☐ Other: _____	☐ None	☐ Low	☐ Medium	☐ High	

What level (percentage) of relief do you expect from the spinal column stimulator? Don't know _____%

How would you feel if you only had a 50% reduction in pain from the stimulator?
☐ Great ☑ Acceptable ☐ Disappointed ☐ Wouldn't have been worth it.

How worried are you about having the stimulator device permanently implanted in your body?
☐ Not at all ☐ A little ☑ Somewhat ☐ A lot

How would you feel about being able to take fewer pain pills?
☑ Great ☐ Acceptable ☐ Disappointed ☐ Worried

Doesn't stimulate NOT working

EMOTIONAL

How depressed are you about, because of, your pain? ☐ Not at all ☐ A little ☐ Somewhat ☑ A lot

Did you struggle with being blue or anxious/worried before you had a pain problem? ☑ No ☐ Yes
If yes, has your pain made your depression and anxiety worse? ☐ No ☐ Yes

Have you ever felt you would benefit from counseling? ☑ No ☐ Yes

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CBA Psychological Testing Pre-authorization Request Form

* - *required information*

Clinician's First Name*: Avie Clinician's Last Name*: Rainwater

Licensure*: Phd Phone*: 843-667-4949 Fax*: 843-667-3349

Mailing Address*: LifeCare Psychology Group, LLC 800 E. Cheves St., Suite 390

City*: Florence State*: SC ZIP*: 29506

E-mail: KRainwater@LifeCareGroup.org

Clinician's NPI*: 1900869146 Group NPI: 129-582-9026

Patient's First Name*: Kenneth Patient's Last Name*: BARR

Date of Birth*: _____ ID Card Number*: ZCS 036 35 2 50

Diagnosis:

Axis I*: 300.4 Axis IV: work, finances, social

300.02

R/O 307.89

Axis II: none Axis V: Initial GAF*: 50

Axis III: Chronic Pain (multi-site) Current GAF*: 50

Referral Source: Tom Brandt, D.O.

CPT Code Requested*: (6) 96101 ___ 96102 ___ 96118 ___ 96119 ___ Other: _____

Date of Testing*: 5.30.12

Is testing for educational purposes*? ___ Yes X No

If yes, explain: _____

Specific Reason for Referral (what does the referral source want to know?)*:

Is the pt's depression and anxiety 2° his pain or is it simply being exacerbated by his pain? Does he need any medication changes?

Please complete the second page of this form.

AUTHORIZED

Current Clinical History to Include Signs/Symptoms Requiring Testing*: Pt c̄ multi-year chronic pain as well as recent job injury (@ 6 mos ago) + history of anxiety (incl. panic) as well as depression (labile).

Results of Diagnostic Interview (note date and evaluator)*: Pt c̄ ↘ coping over the p̄ 4-6 wks + resulting ↑ of affective disruption. Need to R/O if this is now developing to mixed pain disorder (307.89)

What information will testing provide that could not or has not been determined through diagnostic interview, review of records, a second opinion and/or consultation? (Please include information about prior treatment including medication trials, prior testing, etc.)* Pt has not responded well to psychopharmacology + has been ↑ using opiates. Clarify current level of affective struggle correlated c̄ pain + to R/O 307.89

A Rossnick
5.30.12

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AVIE J. RAINWATER, III, PH.D., ABPP, BCIA, AAPM
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MICHAEL A. ROYCROFT, M.A., LPC, NCC
PATRICIA S. BATES, M.A., NCC
M. RUTH BLAIR, M.A., LPCI

5.30.2012

Thomas E. Brandt, D.O.
Center for Pain Control
1165 Highway One South
Suite 300
Lugoff SC 29078

RE: BARR, Kenneth L. (Lee)

Dear Tom:

I saw Mr. Barr in the office today and overall feel he is doing quite well. He does note a history of anxiety and that this has been much worse over the past 4-6 weeks. It appears the majority of his increased anxiety is due to being out of work for the past 18 weeks with his hand injury, related financial stress and being "bored out of my mind." Fortunately, he is going to be able to return to work on 6/4 and thinks "that will do me a world of good." I agree with his thinking.

I do think his medications could use some adjusting. He notes that he had been on Prozac for a long time and was changed to Cymbalta to see if that combination drug might also help with his headaches. He notes that he hasn't had much impact on the headaches, if at all, and that his anxiety has been much worse. I note that he has also been started on Buspar recently to combat the anxiety. I think the best course of action would be to d/c the Cymbalta and Buspar and restart the Prozac since that has worked well for him in the past.

I do not think Mr. Barr needs to be seen in psychotherapy at this time. I think his return to work will be very therapeutic. I have told him to call for a follow up appointment if he doesn't acclimate to working as well as he anticipates. Thank you, Tom, for this kind referral and the confidence in our group that it represents. Please feel free to call me with any questions.

Avie J. Rainwater, III, PH.D., ABPP
Diplomate, American Board of Professional Psychology
Fellow, American Academy of Clinical Psychology
Senior Fellow, Biofeedback Certification Institute of America
Diplomate, American Academy of Pain Management
Associate Professor of Psychiatry and Family Medicine (MUSC)

Cc: Mac Chapman, M.D.
Joseph P. Jackson, M.D.
Roland L. Skinner, III, M.D.

American Academy of Clinical Psychology

NOTE: The reader and his/her agents are required by SC 19-11-95 and HIPAA regulations to fully protect the confidentiality of this psychological information.

FAX 5-31-12

Progress Notes Kenneth Barr (MR# 001789557)

Progress Notes by Paul B. Pritchard, MD signed at 2/2/2016 8:28 PM

Author: Paul B. Pritchard, MD Service: (none) Author Type: Physician
Date of Service: 2/2/2016 Filed: 2/2/2016 8:28 PM Status: Addendum
Editor: Paul B. Pritchard, MD (Physician)

INDEPENDENT MEDICAL EXAMINATION: February 2, 2016

Kenneth Barr,
MRN 1789557
Date of birth:

By request of Ms. Kirsten L. Barr of Trask & Howell, L.L.C., Mount Pleasant, SC

Re: Kenneth L. Barr v Darlington County School District and SC School Boards Insurance Trust
W.C.C. File No.: 1507304
Carrier File No.: WC016314
Date of Acident: May 21, 2015

Credentials of the examiner:

Education:
A.B. (chemistry), Duke University
M.D., Medical University of South Carolina

Training:
Internship, internal medicine, University of Virginia
Residency, neurology, University of Virginia
Fellowship, clinical neurophysiology, Harvard Medical School

Medical licensure:
South Carolina # 5721

Board certification:
Neurology (American Board of Psychiatry and Neurology)
Clinical Neurophysiology (American Board of Clinical Neurophysiology)

Current employment:
Professor of Neurology, Medical University of South Carolina

This is the first office visit for this 46 year old right-handed man who was accompanied by his wife. I explained that he is here for an IME by request of Ms. Kirsten Barr of Trask & Howell, L.L.C., and I reviewed the list of documents which Ms. Barr furnished to me in

advance of the appointment today. I further explained that I will not participate in his medical care and that the IME is for evaluation purposes only. I told him that he may obtain a copy of my report through his attorney.

Mr. Barr conveyed the following documents to me, which I reviewed with him:

1. A three page "summary of scores," marked as pages 6-8, which he said represents results of a neuropsychology evaluation. The document was not otherwise identified, and it appears to represent a portion of a larger report.
2. Material Safety Data Sheets, including the following products:
   a. Armorseal Resthane/urethane floor coating, clear (Sherwin-Williams)
   b. Minwax Polyshades Interior stain & polyurethane gloss finish (American Chestnut)
   c. Industrial enamel, pure white (Sherwin-Williams)
   d. DTM acrylic primer/finish, white (Sherwin-Williams)
   e. Krylon Pain All fast dry enamel (Sherwin-Williams)
   f. Pro-Industrial multi-surface acrylic coating, extra white (Sherwin-Williams)
   g. DTM Acrylic semigloss acrylic coating, extra white (Sherwin-Williams)
   h. Pro Industrial pre-catalyzed waterbased semi-gloss epoxy, extra white (Sherwin Williams)

   Note: Section 11 for these products indicates that exposure to several of them may cause neurological injury and that several of them may be carcinogenic, at least in laboratory animals.
3. Radiology reports as follows:
   a. CT brain, 3/16/2015, Carolina Pines Regional Medical Center
   b. MRI brain, 11/1/2015, Carolina Pines Regional Medical Center
   c. Two EKG reports, one from Carolina Pines and one from Hartsville Medical Group.
4. CDs which I reviewed with the patient and his wife, as follows:
   a. CT brain of 4/22/2015: normal to my view.
   b. MRI brain of 1/9/2014: scattered T2 hyperintensities in white matter.
   c. CT angiogram of brain of 9/29/2010 and 9/23/2011: no aneurysms confirmed.

Ms. Barr furnished the following records, which I enumerated to Mr. Barr as follows:

1. Laboratory report (serum drug levels) ordered by Marshall White, MD for drugs of abuse, all negative.
2. Deposition of Kenneth L Barr done September 9, 2015.
3. Deposition of Larry Stegner done September 9, 2015.
4. Sumter Neurology & Pain Management, Marshall A White, MD, 10-17-12 through 7-16-15.
5. McLeod Neurological Associates, Dr. Roland Skinner, III, MD, 9-23-2010 through 10-16-15.
6. The Medical Group, 4-20-05 through 4-7-15.
7. Florence Neurosurgery & Spine 10-18-10.
8. McLeod Urgent Care, Darlington 6-9-11 through 11-20-11.
9. Camden Orthopedics 5-2-12 through 9-12-12.
10. Thomas Brandt, MD 5-9-12 through 5-24-12.
11. Kershaw Health Medical Center 5-11-12.

12. Transcript of Mr. Barr's school records.

Otherwise, the IME is based upon the interview and examination of Mr. Barr. Our face to face evaluation consumed a full two hours which does not take into account the time for review of medical records and the time required to prepare this report.

The essence of Mr. Barr's concern is that he contends that he was exposed to a variety of painting and other materials in the course of his employment by the Darlington County School District. Mr. Barr further contends that the products to which he was exposed produce a high volume of volatile organic compounds (VOC). He also contends that he was not informed that he should wear personal protective devices or that such devices were provided to him.

Although I reviewed the Material Safety Data Sheets (MSDS) which he provided today, I cannot say to which of these products he may have been exposed. The patient's wife came with him, but she did not contribute to the information gathered today, apart from expressing her assent from time to time.

Mr. Barr reported that he has suffered from headaches for a number of years which he says began when he started to work for the Darlington County Schools. The records show that his primary care physician evaluated him for headaches in September 2010 and that he referred Mr. Barr to Dr. Roland Skinner, a neurologist in Florence, for further evaluation. He was later evaluated by Dr. Marshall White in Sumter. His wife interjected that the headaches became prominent in 2011, approximately two years after he started the job. As his symptoms became evident, he sought alternative duties on the job so that he could continue to work, but he reports that he was released from the job in 2015. At this time he says that he does not receive compensation.

He went on to provide the following summary of symptoms which he attributes to exposure to chemicals for which he submitted MSDS sheets:

1. By January 2015 his attention span had decreased, and his concentration was impaired.
2. Around the same time his memory became "terrible," although he believes that it may have started to decline in 2014. He says that he grew less able to engage in his hobby of building bird houses because he couldn't remember the correct measurements he needed by February 2015.
3. Because of progressive fatigue, he was unable to spend an appropriate amount of time with his family. He grew briefly tearful on sharing this information.
4. He described an episode of disorientation in March 2015 during a trip to Lowe's to get school supplies.
5. Headaches became more frequent and more severe, progressing to daily headaches of moderately severe intensity at this point. They represent daily holocranial pain which includes steady, throbbing, and pressure components. Sometimes they are associated with nausea. When they become severe he ceases his activities and lies down. Occasionally they wake him from sleep. Currently he takes valproate, 250 mg daily as prophylaxis, but this is not helpful. Previous, unhelpful approaches have included topiramate, Tramadol, and Goody powders. He uses Tylenol and Naproxen with little benefit. Other medications include

clonazepam for anxiety and Prozac. He started Prozac well before his employment by the school system.

Past medical history: Previous surgeries include repair of carpal tunnel syndrome, ankle surgery X 2, appendectomy during childhood, endoscopic knee surgery, and repair of tendons in his right wrist and hand.

Allergies: no known drug allergies.

Current medications:
Naproxen, 500 mg BID
Prozac, 50 mg daily
Nexium, 50 mg daily
Valproate, 250 mg HS
Clonazepam, 0.5 mg BID
Aspirin, 81 mg daily.

Review of systems: a general review of systems was otherwise unremarkable except as outlined above except for eyeglasses to correct myopia.

Social history: native Darlington but life-long resident of Hartsville, SC except a brief period of time in Pensacola, FL. His parents were divorced when he was 8 years old. He was married in 1992, with no prior marriages. They have three children, including a daughter who is 19 years old, a son who is 13, and another daughter who is 10, all of whom live with them, in addition to one grandson. Leisure: metal detecting, building bird houses. He smokes ¾ pack of cigarettes per day, dips snuff, and takes an occasional drink of moonshine (the legal variety purchased at the liquor store). He denies use of illegal drugs.

Educational history: attended kindergarten and then enrolled in Emmanuel Baptist School, which he attended through graduation at age 17. He says that he was a strong student in math and sciences and that he was weakest in history, which he had to repeat. He was active in sports, particularly soccer.

Vocational history: he considered joining the military after he completed high school but never got around to doing so. His first job was working for his father, who was in the roofing and carpentry business. Other employment has included work in sales (mens' ware), self-employment as a painter (but he specified that he tried to use latex paint rather than oil-based paint), and working as a painter for a nuclear plant. He first began working for the school district as a painter in 2009. He said that Dr. Marshall White insisted that he stop his exposure to paints and other organic compounds on the basis of his diagnosis with encephalopathy which he related to paint exposure. For a period of time he was given other duties, but he was released from employment in August 2015.

Family history: father died at age 72 of metastatic carcinoma of prostate. His mother is 73 and has lupus erythematosus and rheumatoid arthritis. He has a 55 year old brother and a 52 year old sister, both in good health.

Physical examination: BP 120/75, pulse 57 and regular, height 5'11", weight 135 pounds. Report of headache with 7/10 intensity. He was well nourished and in no acute distress.

Normocephalic/atraumatic. Normal ocular fundi. Neck supple. No neck bruits. Chest clear. Regular cardiac rhythm without murmurs or gallop. Skin clear except for operative scars on his right hand. Extremities normal except for flexion deformity of the 4th and 5th fingers of his right hand which he attributed to previous tendon injuries from a laceration.

Neurological examination: he was alert, oriented, pleasant, and cooperative. Despite his concerns about his memory, he organized the history well and did so in detail. He scored a perfect score of 30/30 on the Montreal Cognitive Assessment (MOCA) exam. His speech was fluent and well articulated. He had normal comprehension, naming, repetition, and word finding. Pupils were 3-4 mm., equal and reactive. Eyes conjugate with full ocular movement and no nystagmus. Facial sensation and motor trigeminal function intact. No facial weakness. Hearing intact to finger rub and tuning fork. Symmetrical movement of the face, tongue, and soft palate. Gait normal, including heel, toe, and tandem gait. No titubation of head or trunk. No appendicular ataxia. Negative Romberg's sign. No abnormal movements. Sensory testing normal including light touch, pin prick, joint position, vibration, tactile localization, and stereognosis. Visual fields full without visual extinction. Deep tendon reflexes were 1-2 + and symmetrical, with flexor plantar responses.

Assessment:

1. Report of headaches and cognitive impairment following alleged exposure to VOCs (volatile organic compounds) through his job as a painter for the Darlington County School District. By history, they are consistent with chronic daily headache.
2. Although he has been diagnosed as having an encephalopathy, the neurological exam today was normal, including normal scores for orientation, memory, calculations, and language function on exam and the Montreal Cognitive Assessment. Mr. Barr did not have findings to support a diagnosis of encephalopathy on today's exam.
3. The partial neuropsychology report Mr. Barr provided me indicated generally average to low average scores and scores in the impaired range for visual scanning, letter fluency, and inhibition (Delis-Kaplan Executive Functioning System), and motor skills for the grooved pegboard test. On the other hand, he made normal to above average and even superior scores for recall on the Rey Complex Figure Test and Hopkins Verbal Learning Test. The latter do not support memory impairment, nor did the average scores on the Wechsler Memory Scale do so.
4. Mr. Barr's academic records indicated generally average work at Emmanuel Baptist School but poor performance in history, which he was compelled to repeat.
5. I cannot speak authoritatively on the potential for impairment from the various paint and other compounds to which he reports on the job exposure. The medical literature indicates that Denmark stands out as the only country in the European Union which regards paint exposure as a workers' compensation issue, based on a graduate student's paper which was re-examined and recanted by other psychologists in her department.

As I explained to Mr. Barr and his wife, I would recommend that he be evaluated by an occupational medicine physician who has training and experience in toxicology.

I offer all of the above within a reasonable degree of medical certainty.

Paul B. Pritchard, III, MD
Professor of Neurology

Electronically signed by Paul B. Pritchard, MD at 2/2/2016 8:24 PM
Electronically signed by Paul B. Pritchard, MD at 2/2/2016 8:28 PM

Revision History

Created by

Encounter creation information not available

Mark T. Wagner, Ph.D.
Licensed Clinical Psychologist
Private Consulting Practice

February 12, 2016

Kirsten L Barr
Trask & Howell, LLC
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Mt. Pleasant, SC 29465
kbarr@trask-howell.com
Chrystal Dively cdively@trask-howell.com

RE: Kenneth Barr v. Darlington County School District

Kirsten Barr had sent me the medical records on Kenneth Barr (no relation) to review in the lawsuit Kenneth Barr versus Darlington County School District. I had planned to use these records in conjunction with an independent medical examination scheduled with Kenneth Barr. For reasons that were not completely clear to me, his attorney blocked this scheduled evaluation. While it is my general protocol to see any individual to whom I might be asked to offer a written opinion, legal banter prevented this from occurring. Even so, Mr. Barr did undergo a neuropsychological evaluation and the methods used would have been similar to my methodology. With the caveat that I would have preferred to have interviewed him in person and examined him, I was unable to personally exam him for this case. Whether physical presence for my examination would have altered my opinions is an open question, but I think this to be unlikely based on the material I have reviewed.

Records Reviewed: The records that were provided for my review include: notes from his primary care physician at The Medical Group spanning the period from April 20, 2005 through April 7, 2015; pain management notes from Dr. Thomas Bryant spanning the period from May 9, 2012 through May 24, 2012; notes from Hartsville Orthopedics spending January 30, 2012 through August 29, 2013; Camden Orthopedics spanning May 2, 2012 through September 12, 2012; McLeod Neurological Associates spanning the period from September 23, 2010 through October 16, 2012; a note from Florence Neurosurgical and Spine on October 18, 2010; six notes from Marshall White, M.D. with three notes for headache between late 2012 and January, 2013 with another series of notes from April 23, 2015

through July 16, 2015; some notes from McLeod Urgent Care in 2011; an x-ray from Kershaw Health Medical Center; an angiogram from McLeod Regional Medical Center; a note from Lifecare Psychology Group, Carolina Pines Regional Medical Center spanning the period from April 22, 2005 through March 16, 2015; a deposition of Larry Stegner; a deposition of Kenneth Barr; and some additional recent notes from Posttraumatic Resources; an IME from Paul Pritchard MD; and Mr. Barr's academic records with standardized testing results.

Record Review: Records from the primary care physician(s) at The Medical Center, revealed a very long history of subjective complaints with numerous visits over a ten-year period for symptoms of headache, dizziness, anxiety, chronic pain, fatigue, chest pain with negative cardiac workup, noncompliant with smoking cessation despite repeated discussion with his doctor, an abnormal MRI showing small vessel cerebral vascular disease at a very young age of 41 necessitating anticoagulant treatment with aspirin for stroke prevention and consideration of the use of Plavix. Wellbutrin and Prozac were used as early as 2006 for psychological symptoms. Celexa was used in 2008. Celexa was increased in 2009. Klonopin had been prescribed. There was a diagnosis of generalized anxiety disorder in 2010. Tension headaches were diagnosed in 2010.

Mr. Barr was convinced that he had been exposed to lead, but laboratory testing revealed that this was not the case. There was report of him being very irritable at home with a short fuse and raising his voice against family members was reported in late 2010 in the context of poor sleep. Zoloft had been prescribed. There were frequent notes of noncompliance with recommendations for smoking cessation. Complaints of mental confusion and "I can't think straight" were reported in early 2011. Mr. Barr had ongoing treatment of his cervical pain with radiculopathy that was thought to be potentially contributory to the irritability and possibly complaints of mental confusion. There was reference to a neurological evaluation by Dr. Skinner that included a rather extensive work-up that was unrevealing. A referral to the headache clinic at MUSC was recommended, but I am did not think that ever happened.

Stress at work was reported in summer 2011 with him stating, "...feels more anxious when he leaves his comfort zone of the Hartsville school district." In October 2011, Mr. Barr was reportedly too anxious to even go to the hospital to see his six-year-old daughter stating, "I am anxious and tired all the time." There was a discussion about him seeing a psychologist Dr. Rainwater, and a doctor at the pain clinic. Persistent complaints of myalgia were reported. BuSpar had been used for fatigue that was thought to be multifactorial. Repeated discussions about smoking

cessation had taken place with continued noncompliance. Basic neurological exams by his PCP were negative. In a mental status exam on June 28, 2013 recent and remote memory were reported as normal. Additional exams in 2013 revealed ongoing and similar subjective complaints.

In summary then, over the decade from 2005 through 2015, Mr. Barr saw various primary care physicians in this practice regarding complaints that were essentially unchanged over this span of time. There was no evidence of a qualitative change in his subjective somatic and/or neuropsychiatric complaints that might be suggestive of a developing encephalopathy. As far back as 2006 he had been talking 5 different psychoactive medications to regulate his psychiatric symptoms. Had I seen him, one of the things I might have wanted to rule out is a pre-existing somatoform disorder and/or other psychopathology.

Mr. Barr saw Dr. Thomas Bryant for pain treatment with complaints of low back pain with an onset of over 20 years before the first visit. This would date the onset of low back pain to be around 1992 reportedly related to a fall injury. He had been reporting chronic neck pain dating back to 2002. Headache pain was reported to this doctor to have an onset in 2010, but 2007 to his primary care doctor. There was reference to Dr. Skinner having told him that he had mini-strokes. Stress was reportedly making his headaches worse suggesting a tension headache quality (that was later also suspected by Dr. Skinner). There was a hand accident followed by hand surgery. Of interest, there was a scientific article in this doctor's notes entitled "*Predictors of pain intensity and disability after minor hand surgery*." In summary, chronic bodily pains began around 1992. Had I examined him I would have tried to get a better chronology of the evolution of his chronic pain complaints and how this had affected his work and life. I would have also been interested in why this scientific article was found in his records and what the doctor might have been thinking and/or what had been said to him.

Notes from Hartsville Orthopedics reviewed right hand surgery, right knee popping and a history of right knee arthroscopic surgery. Apparently in 2012, he heard a loud pop in his knee with the job the required him to be constantly climbing up and down ladders as a painter. He later expectedly became uncomfortable on ladders. I would have been interested in hearing how this fear impacted his work.

Notes from Camden Orthopedics showed effort problems when assessing hand strength with "a pitiful 10 pound" grip strength, but improving to 30 pounds with prodding. There was an interesting discussion on May 22, 2012 when Mr. Barr was resistant to go back to work when encouraged to return by his orthopedist saying,

"Well, I cannot go back to work until I'm completely released." This doctor informed him that this was not practical, as he would not likely encounter a hand specialist for a long time. Instead Mr. Barr was released to full duty on June 6, 2012 without restrictions, but then there was a handwritten narrative on June 29 indicating that he was unable to grip paintbrushes because of his weak hand. I would have been interested on how hand pain impacted his work as a painter as he had been resistant to return to work.

Dr. Skinner saw Mr. Barr on September 23, 2010 for headaches and dizziness. Additional complaints included difficulty concentrating, lack of energy, lack of interest in activities previously enjoyed, difficulty at work, feeling depressed even though he had been on an antidepressant chronically, and chronic anxiety problems. Dr. Skinner was concerned about microvascular ischemic changes seen on an MRI. A neurological examination was normal and the mental status component of the examination also was normal. Hyperintensities on T2 were noticed mostly in the frontal white matter bilaterally. This finding is consistent with "mini-stroke" or developing cerebrovascular disease. This doctor felt that the headaches were of the tension variety and/or possibly related to sinus issues. An angiogram showed a questionable aneurysm that was quite upsetting to Mr. Barr, but later determined not to be of significance. Dr. Skinner was also concerned about Mr. Barr's opiate narcotic use and the possibility of dependence or addiction. This doctor considered a diagnosis of fibromyalgia because of the multiple somatic complaints and Mr. Barr's preoccupation with his symptoms. There was concern about over-the-counter analgesic abuse with rebound headache in August 18, 2011. In the last note on November 2011, this doctor reported that changes in temperature, atmospheric pressure, and certain smells would trigger headaches. There was a long discussion about the dangers of analgesic rebound. Throughout all these visits, the basic neurological examination and mental status component were all within normal limits. I would have wanted to hear a lot more about opiate use/abuse and OTC abuse potentially creating rebound headaches and the impact this may have had on work as well as daily functioning.

In summary, Dr. Skinner noted depression, abnormal brain imaging, multiple environment triggers for headaches, and referenced possible somatoform disorder.

Mr. Barr had one visit to a neurosurgeon for the possible aneurysm and headaches. In October 2010 headaches were rated as "7" associated with this visit. Loss of work over the past three months was noted and a smoking history of 27 years was recorded. This doctor diagnosed chronic headache syndrome and discounted the

significance of the "tiny blip" on the angiogram and did not feel that this would even classify as an aneurysm.

Dr. White saw Mr. Barr for three visits in late 2012 and January 2013. These visits were all handwritten notes for headache complaints. The neurological exams were non-focal and non-lateralizing signs (i.e. normal). None of the exams included mental status testing. Topamax and Klonopin were tried for headache without much success. There was over a two-year gap until the next visit, which was on April 23, 2015. Mr. Barr presented with the same complaints of severe headaches, fatigue, confusion, but had a new complaint of memory loss. This was in spite of the fact that his primary care physician found no evidence of memory loss, nor did any other doctor who was seeing him at the time reference any complaint of memory loss or objective findings to support the subjective complaint. I did not see that Dr. White had performed any kind of mental status exam, and in fact, there were no comments about any of the specific cognitive complaints.

In Dr. White's records on May 13, 2015, there was an email note asking for records because of a pending lawsuit. On May 21, 2015 Mr. Barr presented with pretty much the same complaints and again Dr. White's neurological exam was unremarkable except he wrote, "VOC-related neurological symptoms." He wrote, "stop exposure!" According to the very terse note, the "neurological symptoms" seem to be migraine, fatigue and memory loss (which had been very longstanding complaints). There was reference to flat affect (a symptom of depression), but Mr. Barr had repeated treatments for refractory depression. There was reference to slow processing speed and I was completely uncertain what subjective symptoms or objective evidence supported this statement. It is noteworthy that psychomotor retardation (or slow processing speed) is a cardinal symptom of depression. Dr. White put Mr. Barr out of work until further notice.

The last visit to Dr. White was on July 16, 2015 where he described having "very poor memory and fatigue." He was completely unclear what evidence supported this opinion and it was certainly not contained within any of his documentation produced by Dr. White. I note that fatigue had been a chronic complaint as far back as 2005. It is noteworthy that no other provider ever documented poor memory, and in fact, other medical records objectively document the reverse (i.e. normal memory). Dr. White planned a trial of a psychostimulant and prescribed Adderall with no refills. Lastly, there was a note from Dr. White on October 21, 2015 indicating that Mr. Barr reported that he was having back pain and severe headaches over the past 2 1/2 years, but in fact, these symptoms dated back to at least 1992 and 2007, respectively. There was also report of depression and anxiety,

but those symptoms dated back to 2006. Dr. White wrote that he felt that it was clear that exposure to chemicals at work were causing neuropsychiatric symptoms of memory difficulties, depression, anxiety and slow processing speed. Other than his professional opinion, there was no objective evidence to support this statement. It was Dr. White's opinion that Mr. Barr had VOC-related encephalopathy (based on the symptoms reported above), which has led to severe permanent brain damage and dementia. He felt that Mr. Barr was permanently and totally disabled and unsuitable for any kind of rehabilitation that would prevent him from ever reentering the workforce. I definitely would have wanted to hear about alleged exposure, paints used, and precautions employed.

It was also noteworthy that in deposition, Dr. White repeatedly came back to memory impairment as being one of the main pieces of evidence to support his opinions, even though he never performed memory tests (or even memory screening). Instead, he seemed to rely on Dr. Lind's exam for objective evidence of memory loss and the evidence is lacking. On December 23, 2015 Dr. White wrote that he reviewed Dr. Lind's report and "...the neuropsychological test results confirm my previous opinions expressed...." Inconsistent with Dr. White's impression of impaired memory, Dr. Lind reported "Working Memory, Composite Score 86 = *Average*," "Wechsler Memory Scale, Logical Memory 1, Scaled Score 10 = *Average*," Wechsler Memory Scale, Logical Memory 2, Scaled Score 9 = *Average*," "Rey Complex Figure Test (i.e. visual memory), Immediate Recall, 98th = *Superior*," "Rey Complex Figure Test (i.e. visual memory), Delayed Recall 88th = *Above Average*," Rey Complex Figure Test (i.e. visual memory), Recognition 54th = *Average*," Hopkins Verbal Learning Test, Total Recall T 44 = *Average*, Hopkins Verbal Learning, Delayed Recall, T 59 = *Above Average*, Hopkins Verbal Learning, Retention T 68 = *Above Average*." Any way that memory was measured by Dr. Lind, the results were Average or above. Importantly, "Average" is what the average person in the United States can do. That is to say, if the population of the US is 318 million, Mr. Lind's memory performance exceeded 159 million residents of the US, corrected for age. One score yielded performance in the upper 2nd percentile (meaning better than 98 percent of the US population! Clearly Mr. Barr's memory performance was his major area of cognitive strength and greatly exceeds his IQ. Memory impairment is the most vulnerable cognitive domain with chronic toxic solvent exposure. There was no objective evidence of any hint of memory impairment.

In summary, Dr. White had treated Mr. Barr's headaches and suddenly there was a qualitative change in his notes with a diagnosis of severe encephalopathy seemingly immediately after a lawsuit had been filed in 2015. His notes are

extremely terse and the objective evidence from his examinations documented in the medical records does not support his diagnostic formulation or opinions. He felt that memory loss was one of the major objective findings supporting encephalopathy or dementia, but Mr. Barr's objective memory performance is actually better than most neurologically intact normal people in the US.

There was one visit to Dr. Rainwater on May 30, 2012 for anxiety due to being out of work for the past 18 weeks because of the hand injury, related financial strain and being "bored out of my mind." Dr. Rainwater felt that it would be therapeutic for Mr. Barr to get back to work and did not feel there was a need for additional therapy. I would have liked to have heard how many days of work were missed and for what reasons.

The main theme from Mr. Barr's employer's deposition was that this person felt that Mr. Barr was doing a fine job and he would hire him back if he did not take so much time off from work. This person even offered him another non-painting job, but Mr. Barr refused because it was at a lower pay scale.

In Mr. Barr's deposition he stated that the main reason that he was out of work was because of headaches. He said that if it were not for the headaches he would return to work. This statement was highly inconsistent with Dr. White's opinion of severe brain damage and dementia. In addition, Mr. Barr said that he only had memory loss when his headaches were bad, which was again inconsistent with Dr. White's opinion(s) but consistent with the normal performance on memory within the neuropsychological exam. Throughout the deposition, Mr. Barr demonstrated excellent memory for details with the many questions he was asked. He had a great deal of difficult coming up with specific examples of things that he might forget with the report of the normal kind of forgetting that most people do such as remembering what he had for dinner the previous night. Mr. Barr reported that he always wore a respirator, used good ventilation and only used a roller or brush rather than aerosolized applications.

Mr. Barr saw Paul Pritchard, M.D. for an IME on February 2, 2016. Dr. Pritchard had much of the records that were available to me, but also had material safety data sheets. Dr. Pritchard could not say which of these products Mr. Barr may have been exposed to in his workplace or how much. A work history of roofing, carpentry, and painter was obtained. Headache pain was rated as "7" for this visit. In exam, Dr. Pritchard felt that despite Mr. Barr's concerns about memory, he was organized with the history he provided and in the detail he presented. A perfect score of 30/30 on the Montréal Cognitive Assessment exam was obtained. The

basic neurological exam was detailed and unremarkable. Dr. Pritchard did not feel that there was any evidence to support encephalopathy or dementia and actually had very strong objective neurological evidence to the contrary. He felt headaches were consistent with the chronic daily variety. He felt that the neuropsychological testing was inconsistent with the diagnosis of encephalopathy or dementia. Dr. Prichard deferred on speaking authoritatively about the potential for impairment from various paint or other compound exposures.

In summary, Dr. Pritchard performed a very detailed review of the records, a meticulous neurological examination, and an above standard of care mental status examination that was highly inconsistent with Dr. White's opinion. Further, Dr. Pritchard's exam was extremely well documented allowing for careful peer-review scrutiny of the objective basis he used to form his opinions. The results of his exam were also spelled out in documentation, so any other doctor would be able to replicate the findings.

Lastly, Mr. Barr was the seen by Nicholas Lind, PsyD. The visit was on December 16, 2015. The referral was from Mr. Barr's attorney. Questions posed were whether cognitive complaints were consistent with brain damage secondary to the VOC exposure, and whether there was evidence of emotional impairment secondary to such exposure. Of grave concern, the only records that were provided for this doctor to review were the notes from Marshall White, M.D.! The history obtained from Mr. Barr indicated that headaches began 1 1/2 years after he started working at Darlington County School District suggesting a very strong causal relationship. This history, however; was not consistent with headache onset that preceded working for Darlington School District. Rather, headaches were reported to the primary care physician as early as 2007, which discounts an otherwise misleading potentially strong causal relationship. Dr. Lind obtained a history of depression and panic attacks that dated back 10 years requiring the use of medication to normalize his mood, and again, the time frame was inconsistent with the facts as recorded in Mr. Barr's medical records. On exam, Mr. Barr became tearful when talking about emotionally laden topics consistent with his ongoing treatment-refractory depression. On objective neuropsychological evaluation, effort was without evidence of feigning, at least in the TOMM test. The MMPI was given and showed evidence of emotional distress with somatic preoccupation of physical, something noted by various doctors well before the onset of alleged VOC exposure. A self-report questionnaire placed him in the severe range of subjective symptoms of depression, a symptom reported as early as 2006. A self-report questionnaire placed him in the moderate range of subjective anxiety symptoms also reported as early as 2006. IQ was measured as Low Average or FSIQ 88. This

doctor guesstimated intellectual functioning to be Average prior to alleged VOC exposure, but his standardized testing (reviewed below) objectively demonstrated otherwise. In spite of Dr. White and Lind's suspicion of impairment in processing speed, objective evidence did not support this finding with an index score on Processing Speed that was consistent with his intellect (PSI 86). In spite of his complaints of difficulty with concentration and attention, working memory was actually normal and consistent with the average performance relative to the national age cohort normative sample. The Brief Test of Attention test, which specifically targets divided attention, showed normal and average performance. Apparently, Mr. Barr employed a less than ideal strategy on the computerized measure of attention and showed conflicting results on this test as compared to the Brief Test of Attention test and Working Memory index score on the WAIS-IV. Executive function was intact on the Wisconsin Card Sort Test, but selectively weak normal on the DKEFS, again an inconsistent finding. Fine motor dexterity was impaired bilaterally, but then Mr. Barr did have hand surgery with chronic complaints and a "pitiful" finding by his Camden Orthopedics doctor with hand strength testing. Additionally, slow performance on this task is quite typical with patients suffering from depression.

This doctor affirmed the two questions that were posed by the plaintiff attorney. With regard to brain damage, this doctor was not given any of Mr. Barr's previous medical records. Perhaps because of this and/or other reasons, this doctor did not consider alternative explanations for the very few weak finding on his exam. Notably, this doctor did not consider extremely poor academic performance with impaired standardized testing from high school. Instead, this doctor guesstimated premorbid intellect to be Average. This guesstimate was inconsistent with the facts. This doctor did not consider the abnormal MRI with evidence of micro-ischemic vascular disease (mini-stokes) with hyperintensities mostly in the frontal white matter bilaterally to be a potential explanation for weak test scores. This doctor did not consider pseudo-dementia secondary to long-standing treatment refractory anxious depression; the possibility of variable performance associated with this very long battery of tests and only one effort measure within the battery; or premorbid psychopathology that clearly put predated exposure at Darlington County School District. This doctor also did not consider the fact that there were conflicting results in the same cognitive domain with some scores being average and some scores being weak within that same cognitive domain. Allegedly, deficit scores were never replicated to establish reliable impairment.

Mr. Barr's academic records were reviewed. His overall GPA was very weak at 77.72. "Minimal passing" at the school he attended was a score of 70. How this

school ranks relative to other SC schools is an open question. His class rank was 13 out of 16 students. On standardized testing SAT was verbal 240 and math 330. A second testing was verbal 270 and math 310. In combination with his low class standing, "D plus" GPA performance and standardized testing, Dr. Lind's opinion was that he was of Average premorbid intellect seems completely unfounded. Indeed, standardized testing before any alleged exposure placed him in the lower percentiles of the general population. Such poor academic performance could be attributable to low intellect, underachievement, or behavioral problems such as extensive tardiness. There was no evidence of extensive tardiness. The behavioral ratings of Mr. Barr indicated that he was a conscientious student. The most likely explanation for the poor academic performance is probable below average intellect. His best academic performance on the SAT placed him at the 6th percentile for verbal and the 8th percentile for quantitative relative to his age cohort. There was another standardized test called the Stanford Test of Academic Skills that yielded an overall score placing Mr. Barr in the low average range for skills that this test measured. I was less familiar with this test than I was with the SAT or PSAT.

Opinions

1.) Mr. Barr has a very long history of subjective neuropsychiatric symptoms that are the same before and after the alleged VOC exposure. Neuropsychiatric symptoms date back to at least 2005 and include headache, anxiety, dizziness, chronic pain, fatigue, chest pain with negative cardiac workup, noncompliance with smoking cessation recommendations, abnormal MRI with evidence of small vessels cerebrovascular disease, irritability, poor sleep, panic attacks, narcotic pain issues, analgesic over-the-counter rebound issues, and many associated symptoms of anxious depression.

2.) The major short-comings from Dr. Lind's examination were two fold; a.) Dr. Lind was not given (and did not ask for) Mr. Barr's extensive medical history containing chronic neuropsychiatric symptoms, most of which are reportedly new onset and are now being attributed to VOC exposure, but which had existed for up to a decade or more prior to the alleged exposure, and b.) the guesstimate that Mr. Barr's expected IQ was average was unfounded. Even to the untrained eye, Mr. Barr's academic record reads like Dr. Lind's "Summary of Scores" in the neuropsychological exam. Generally, he had below average performance in school with some F's, D's and some passes. Indeed, Mr. Barr's neuropsychological test scores are highly consistent with his prior academics, and more importantly his standardized test scores, all obtained well before any alleged exposure. He

has had limited academic success with an overall GPA that was in the "D+" range with many failed classes. He has had very poor scores on standardized testing on the SAT with performance in the lower 10th percentile of the general population. Lastly, he has not demonstrated intellectual prowess in his vocational accomplishments. While it is my opinion that Mr. Barr's neuropsychological scores are primarily related to below average intellect and poor academic standing, one can not ignore other confounding factors, notably the abnormal MRI with hyperintensities mostly in the frontal white matter bilaterally and chronic noncompliance with smoking cessation. This area of the brain is responsible for deficits in disinhibition and other executive dysfunction. Likewise, depression slow processing speed is a cardinal symptom of clinical depression and would result in slow performance on fine motor and psychomotor tasks. Lastly, in Dr. Lind's summary data, the right hand was worse than the left hand, and Mr. Barr did have a lot of orthopedic issues with "pitiful" right hand performance measured in Hartsville and by Camden Orthopedics per their notes.

3.) With the exception of Dr. White's opinions, all objective basic neurological exams with associated mental status examination by numerous physicians that have examined Mr. Barr have been unremarkable from a neuropsychiatric perspective. Even Dr. White's examination failed to demonstrate any objective neurological findings and his documentation is so limited that his notes do not allow for peer-review of his opinions. Additionally his documentation does not allow for any other doctor to replicate abnormal findings to confirm or refute his opinions. This is clearly not the case with the defense neurologist who was extremely forthcoming with detailed documentation of his examination findings with a completely normal exam. To the extent that Dr. White relied on the neuropsychological test results to form his opinions, those finding were also normal and consistent with Mr. Barr's background education and prior standardized scores. Indeed, Mr. Barr's objective memory performance was exceptionally strong and exceeded that of most neurologically intact people in the US reference population.

4.) There was no objective evidence in the examinations or reports that I reviewed that would support a neurobehavioral syndrome consistent with VOC exposure. There were no biological markers to support exposure. There is no document of any other organ system involvement to support exposure. Additionally, not only is there no objective evidence of any distinctive neuropsychiatric impairment. There is no evidence to support that Mr. Barr has dementia related to severe encephalopathy as opined by Dr. White. Dementia requires severe cognitive impairment (not documented in

any of the objective cognitive testing by Lind, Pritchard, White or others) with severe impairment of basic ADL/IADL's require other assistance for daily activities (not documented by any doctor, record, or even in Mr. Barr's own deposition). Indeed, his employer in sworn deposition said that the quality of his work was solid and he would be hired back if it were not for the fact that he takes too much time off for his various chronic health problems. Also in sworn deposition, Mr. Barr's statement is that the main reason that he is out of work is because of headaches and he only has episodic memory loss when he is having severe headaches. This is a common complaint with anyone that experiences severe headaches. Both swore depositions are highly inconsistent with encephalopathy or dementia.

All opinions offered were given with a reasonable degree of neuropsychological certainty.

Mark Wagner, PhD
Professor of Neurology
Medical University of South Carolina

MEDICAL UNIVERSITY OF SOUTH CAROLINA
COLLEGE OF MEDICINE
CURRICULUM VITAE

NAME: Mark T. Wagner DATE: June, 2015

OFFICE ADDRESS: Department of Neurosciences, Division of Neurology PHONE #: 792-3221
Medical University of South Carolina wagnermt@musc.edu

EDUCATION:

YEARS	TRAINING	LOCATION
1972–1976	B.A., Psychology	Metropolitan University Denver, Colorado
1976–1979	M.A., Experimental Psychology	University of the Pacific Stockton, California
1979–1985	Ph.D., Clinical Psychology (Specialty: Neuropsychology)	Memphis University Memphis, Tennessee
1984–1985	Teaching Fellow in Psychiatry (Psychology)	Boston University Medical Center Boston, Massachusetts

LICENSURE: South Carolina #536, South Carolina Board of Examiners in Psychology (Clinical Psychology)

New York State #10272, University of the State of New York Education Department, State Board for Psychology (Clinical Psychology)

FACULTY APPOINTMENTS:

YEARS	RANK	DEPARTMENT	INSTITUTION
1984–1985	Teaching Fellow	Psychiatry	Boston University Medical Center
1985–1987	Senior Instructor	Preventive Medicine, Family Practice, & Rehab Medicine	University of Rochester School of Medicine & Dentistry
1987–1989	Assistant Professor	Preventive & Rehab Medicine	University of Rochester School of Medicine & Dentistry
1989–1992	Assistant Professor	Orthopaedics, Rehab Medicine	University of Rochester School of Medicine & Dentistry
1992–1995	Assistant Professor	Neurology	Medical University of South Carolina
1992–1995	Assistant Professor	Psychiatry & Behavioral Sciences	Medical University of South Carolina
1995–2000	Associate Professor	Psychiatry & Behavioral Sciences	Medical University of South Carolina
1995–2011	Associate Professor	Neurology	Medical University of South Carolina
2011- Present	Professor	Neurology	Medical University of South Carolina

HOSPITAL APPOINTMENTS:

YEARS	POSITION	INSTITUTION
1978–1979	Research Assistant	University of the Pacific/Stockton Police Department
1980–1981	Research Assistant	Federal Correction Institute
1981–1982	Student Psychologist	St. Joseph Hospital
1982–1983	Student Psychologist	Memphis Mental Health Institute
1983–1984	Neuropsychology Technician	University of Tennessee/Memphis University
1985–1992	Director of Neuropsychological Services	Monroe Community Hospital
1985–1992	Adjunct Staff in Clinical Psychology	Monroe Community Hospital
1992–2001	Director of Neuropsychological Services, Memory Disorder Clinic	Medical University of South Carolina
1992–2001	Associate Director, Psychological Assessment Center	Medical University of South Carolina
1992–Present	Consulting Medical Staff	Medical University of South Carolina

MEMBERSHIP IN PROFESSIONAL/SCIENTIFIC SOCIETIES

NATIONAL SOCIETIES

American Congress of Rehabilitation Medicine
New York Neuropsychological Group
International Neuropsychological Society
American Psychological Association, Division of Clinical Neuropsychology
National Academy of Neuropsychology — Fellow Status

EDITORIAL POSITIONS

Peer Reviewer, Epilepsia
Peer Reviewer, Journal of Geriatric Psychiatry and Neurology

Peer Reviewer, The International Journal of Psychiatric Medicine, 2006-Present.

Peer Reviewer, Neuropsychology Review, 1996–Present

Peer Reviewer, Journal of Traumatic Stress, 1998–Present

Peer Reviewer, Archives of Physical Medicine and Rehabilitation, 1990–Present

Peer Reviewer, International Journal of Neuropharmacology, 1997–Present

Peer Reviewer, Harcourt College Publishers, 2001- Present

Peer Reviewer, Journal of the International Neuropsychological Society

Grant Reviewer, Alzheimer Association 2000- Present

EXTRAMURAL GRANTS/AWARD AMOUNT

PRINCIPAL INVESTIGATOR

1991–1992 Principal Investigator, "Neurocognitive Dysfunction and Awareness of Cognitive Deficit as Factors Affecting Continent Behavior in the Nursing Home Population." National Institute of Aging, Award: $21,252

1994–1995 Principal Investigator, "Neuropsychological and Neuropsychiatric Manifestations of Eosinophilia Myalgia Syndrome." Showa Denko American, Award: $123,000

1998–2000 Principal Investigator, "Rehabilitation of Cognitive Deficits Associated with Secondary Progressive Multiple Sclerosis." National Institute of Child Health and Human Development, R-21, MD36990-01: $71,654.

CO-INVESTIGATOR/CONSULTANT

1994 Consultant, "Clinical Trial of Mentane with Alzheimer's disease." Hoechst-Roussel Pharmaceuticals Inc.

1995 Co-Investigator, "Enhancing Family Caregiving with Life Story Book and Life Review." Alzheimer's Association, 3/1997–2/2000, Award: $152,014.

1995 Consultant, "Twenty-Four Week Efficacy and Safety Study of Propentofylline (HWA 285) in Patients with Vascular Dementia." Hoechst-Roussel Pharmaceuticals Inc.

2000 Consultant, An Open-Label, Single-Arm Study of Simvastatin as a Therapy for Multiple Sclerosis.

2001 Teichner, G, & Wagner, M.T. Increasing treatment compliance with acetylcholinesterase inhibitors in patients with mild to moderate Alzheimer's disease. Grant Application; Alzheimer's Association (rejected).

2002 Co-investigator, Life Review: Managing chronic stress in Alzheimer dyads, NIH/NINR, Barabra Haight, Ph.D., PI.

2003 Co-investigator, Human Pilot Study – Safety and Efficacy of 3,4-Methylenedioxymethamphetamine (MDMA) Assisted Psychotherapy in the Treatment of Chronic PTSD Michael C. Mithoefer, M.D, Mark T. Wagner, Ph.D.

2004 Co-Director of Clinical Core, Alzheimer Disease Research Center, Mintzer & Bachman.

2004 Consultant, Translational Research in Addiction Center- Project 4, 5 yrs, NIH/NIDA/DHHS, Ron See, Ph.D.

2008 Co-investigator. RNS System Pivotal Clinical Investigation 2yr

Consultant

2012 FMRI in Anterior Temporal Epilepsy Surgery (FATES).

2012 Radiosurgery or Open Surgery for Epilespy (ROSE)

2011-2012 Consultant Eladian Partners, LLC

2000-2011	Consultant Automated Trading Desk, LLC
2004-Present	Consultant Hawkes Learning Systems
2000-Present	Consultant MAPS

ACADEMIC COMMITTEES

1986–1987	Center on Aging Steering Committee, Monroe Community Hospital, Rochester, New York
1988–1992	Stroke Group Organizational Chairperson, University of Rochester Medical Center, Monroe Community Hospital, Rochester, New York
1985–1992	Administrative Committee, Inpatient Rehabilitation Service Program, Monroe Community Hospital, Rochester, New York
1991–1992	Instructional Committee on Animal Research, Chairperson, Monroe Community Hospital, Rochester, New York
1992–present	Administrative Committee, Memory Disorder Clinic Service Program, Neurology, Medical University of South Carolina
1992–2000	Administrative Committee, Consultation-Liaison Service, Institute of Psychiatry, Medical University of South Carolina
1992–Present	Psychology Internship Education Committee, Medical University of South Carolina
1994–Present	Ad Hoc Committee Chief, Medical University of South Carolina Internship Program
1994–Present	Neuropsychology State Interest Group, Secretary
1997-1999	Estuary Association Syndrome Committee sponsored by the CDC.
2001-Present	MUSC Neuroscience Institute, Member
2010- Present	Executive member MUSC Sarcoidosis Comprehensive Care, Research, and Education Center (SACRED).
2014- Present	Committee judge. Student Research Award. National Academy of Neuropsychologists.

OTHER

2013	Knight Alzheimer Disease Research Center Memory and Aging Project, CDR Rater Certified

MAJOR TEACHING RESPONSIBILITIES

1985–1992	Preceptor, Lecturer, and Seminar Leader for Medical Student and Residency (Physical Medicine and Rehabilitation, Neurology, and Geriatric Medicine) Educational Program, University of Rochester Medical School
1992–Present	Research Preceptor, Medical University of South Carolina Summer Medical Student Research Program, Medical University of South Carolina
1992–Present	Research Preceptor, Clinical Psychology Post-doctoral and Internship Training Programs, Medical University of South Carolina

1992–2000	Seminar Orientation Lecturer, Institute of Psychiatry Inpatient PGY1 & 2 residents, Medical University of South Carolina
1992–2000	Seminar Lecturer, Psychology Seminar Series for Psychiatry residents PGY1-3, Medical University of South Carolina
1992–Present	Seminar Lecturer, Clinical Psychology Post-doctoral and Internship Didactic Seminar Series, Medical University of South Carolina
1992–Present	Clinical Teaching Supervisor, Clinical Psychology Internship Training Program Faculty, Institute of Psychiatry, Medical University of South Carolina
1992–2000	Clinical Teaching Supervisor, Clinical Psychology Post-doctoral Training Program Faculty, Institute of Psychiatry, Medical University of South Carolina
2000–Present	Clinical Teaching Supervisor, Clinical Psychology Post-doctoral Training Program Faculty, Department of Neurology, Medical University of South Carolina
1994–2002	Clinical Correlate Consultant, Parallel Curriculum Medical School Education Program, Medical University of South Carolina
1997–2002	Faculty Tutor, Parallel Curriculum Medical School Education Program, Medical University of South Carolina
2000-Present	Clinical Teaching Supervisor, PGY-4 Neurology and Psychiatry Residents, Department of Neurology, Medical University of South Carolina
2014- Present	Neurology/Rehabilitation Medicine Medical Student Clerkship Instructor

POST-DOCTORAL FELLOWS

John Hummer, Ph.D.

William Wellborn III, Ph.D.

Karen B. Spangenberg, Ph.D.

Katrina R. Ryals, Ph.D.

Rebecca Mathews, Ph.D.

Sari Newman, Ph.D.

Joanne Festa, Ph.D.

Gordon Teichner, Ph.D.

Joy Wymer, Ph.D.

Noelle Carlozzi, Ph.D.

Travis Turner, Ph.D.

Jamee Nicolettt, PhD.

Joseph Schacht, Ph.D.

Laurie Brenner, Ph.D.

RESEACH MENTORSHIPS

Madhabika Nayak, Ph.D. 1994

Patricia O'Connell, Ph.D. 1995

Tamera Brown, Ph.D. 1996

Laurie Ryan, Ph.D. 1997

Joanne Festa, Ph.D. 1998

Joanne Davis, Ph.D. 1999

Jyothilakshmi Vayalarkara, Ph.D. 2000

Scott Machin, Ph.D. 2001

Angela McBride, Ph.D. 2002

Sarah Marion, Ph.D. 2003

Joy Wymer, Ph.D. 2004

Jessica Smerz, Ph.D. 2005

Melina Griss, Ph.D. 2006

Nichole Mickley, Ph.D. 2007

Chistopher Contardo, Ph.D. 2008

Ana Soper, Ph.D. 2009

Joni Howard, Ph.D. 2010

Laurie Brenner, Ph.D. 2011-12

Malene Abell, Ph.D. 2014-2015

UNDERGRADATE MENTORSHIPS

Blakely Mulder, B.S. 2013

Morgan Prieur, B.S. 2014

MAJOR CLINICAL INTERESTS AND RESPONSIBILITIES

Department of Neurology, Section of Neuropsychology, Medical University of South Carolina. Director of Neuropsychological Services. Consultation for general adult neurological inpatient and outpatient services at Medical University Hospital programs. Staff of post-doctoral and internship psychologists. Responsibilities include administrative, supervisory, and teaching activities.

Psychological Assessment Center, Consultation-Liaison Service, Institute of Psychiatry, Medical University of South Carolina. Director of psychological and neuropsychological consultation for general adult psychiatric inpatient units at the Institute of Psychiatry, other Medical University Hospital programs, and outpatient services. Staff of post-doctoral and internship psychologists. Responsibilities include administrative, supervisory, and teaching activities.

Psychological Assessment Center, Consultation-Liaison Service, Psychological Assessment Center, Consultation-Liaison Service, Institute of Psychiatry, Medical University of South Carolina. Co-director of psychological and neuropsychological consultation for general adult psychiatric inpatient units at the Institute of Psychiatry, other Medical University Hospital programs, and outpatient services. Staff of post-doctoral and internship psychologists. Responsibilities include administrative, supervisory, and teaching activities.

Director of Neuropsychology Services, University Hospital Memory Disorder Clinic, Department of Neurology, Medical University of South Carolina. Memory Disorder Clinic specializing in outpatient diagnostic evaluation of elderly adults with questions of possible Alzheimer's Disease.

Clinical supervisor, Inpatient Child Psychiatric Services, Institute of Psychiatry, Medical University of South Carolina. Supervision of two psychometricians where intellectual and objective psychological diagnostic evaluation services are provided to patients admitted for inpatient psychiatric hospitalization.

Clinical Neuropsychologist, Private Practice, University Medical Associates (UMA). Outpatient diagnostic service for patients referred for neurocognitive and/or psychological evaluation. Special interest in neurological disorders affecting the elderly including degenerative dementias, cerebral vascular disease, depression, and in the younger population closed-head injury.

INVITED LECTURES

"Recovery of function from stroke: Cognitive and psychosocial implications." Rehabilitation Medicine Grand Rounds, University of Rochester Medical Center, Rochester, New York, 1987.

"Post-stroke depression." Rehabilitation Medicine Grand Rounds, University of Rochester Medical Center, Rochester, New York, 1988.

"Cognitive rehabilitation: Theory and practice." Rehabilitation Medicine Grand Rounds, University of Rochester Medical Center, Rochester, New York, 1989.

"Neuropsychology of aging." Geriatric Grand Rounds, Monroe Community Hospital/University of Rochester, Rochester, New York, 1989.

"Neurobehavioral syndromes following focal damage." Rehabilitation Medicine Grand Rounds, University of Rochester Medical Center, Rochester, New York, 1990.

"Activation, arousal, and the frontal lobes." Geriatric Grand Rounds, Monroe Community Hospital/University of Rochester, Rochester, New York, 1991.

"Anosognosia following brain injury." Rehabilitation Medicine Grand Rounds, University of Rochester Medical Center, Rochester, New York, 1991.

"Organization of higher cortical function." Rehabilitation Medicine Grand Rounds, University of Rochester Medical Center, Rochester, New York, 1992.

"Aging, depression, or dementia." South Carolina Alzheimer's Association Annual Spring Seminar, Medical University of South Carolina, Charleston, South Carolina, 1994.

"Normal aging vs Alzheimer's disease." South Carolina Alzheimer's Association Annual Spring Seminar, Medical University of South Carolina, Charleston, South Carolina, 1997.

"Assessment of normal versus pathologic aging." Toward Healthy Aging: An Interdisciplinary Geriatrics Conference, Medical University of South Carolina, Charleston, South Carolina, 1998.

"Neuropsychological issues in stroke rehabilitation." Stroke Update '99,. Medical University of South Carolina and South Carolina Task Force of the American Heart Association and Midlands AHEC Conference, Columbia, South Carolina, 1999.

"Alternative therapies: Understanding your options." National Multiple Sclerosis Society Conference, Charleston, SC, 1999.

Topics on Alzheimer disease. Xth Annual Nat Rosenfeld Memorial Alzheimer Conference. Charleston, S.C. annual presentations 1994 to present.

COMMUNITY SERVICE

Rochester Family Stroke Support Educational Program, Rochester, New York, 1988–1992.

Charleston County's Gifted and Talented Mentor Program, Charleston, South Carolina, 1992–1993.

WTMA Radio Station, quest appearance on Senior Connection with Mary Peters "Alzheimer disease and related dementias," 2003, 2004.

Approved as an expert witness in federal court. Per United States District Court, District of South Carolina, Charleston Division Civil Action No 2:01-4006-08 Sol Blatt, Jr. Senior United States District Judge, August 14, 2003.

Multiple Sclerosis Support Group Meeting, Educational lecture series. Charleston, South Carolina, 2005.

Psychosocial aspects of epilepsy. Fourth Annual Statewide Epilepsy Support Conference, 2004.

Epilepsy Across the Lifespan: A Balancing Act for Families, Fifth Annual Statewide Epilepsy Support Conference, 2005.

Faculty Advisor, MUSC collegiate bicycle racing team. 2007- present.

JOURNAL PUBLICATIONS

Mithoefer MC, Wagner MT, Mithoefer AT, Jerome I, Martin S, Yazar-Klosinski, B, Brewerton TD, Michel, Y & Doblin R (2013). Durability of Improvement in PTSD Symptoms, and absence of harmful effects or drug dependency after MDMA-assisted Psychotherapy: A Prospective Long-Term Follow-up Study, Journal of Psychopharmacology, 27(1): 28-39.

Sun X, Nicholas J, Walker A, Wagner MT, Bachman D. (2012). APOE genotype in the diagnosis of Alzheimer's disease in patients with cognitive impairment. American Journal of Alzheimers Disease & Other Dementias, 27, 315-320.

Mithoefer, MC, Wagner MT, Mithoefer, AT, Jerome L, Doblin, R. (2011). The safety and efficacy of ±3,4-methylenedioxymethamphetamine-assisted psychotherapy in subjects with chronic, treatment-resistant posttraumatic

stress disorder: the first randomized controlled pilot study, Journal of Psychopharmacology, 25(4): 439–452.

Price KL, DeSantis SM, Saladin ME, Tolliver BK, Simpson AN, Baker NL, Wagner MT, McRae-Clark AL, Brady KT. (2011). The Impact of Clinical and Demographic Variables on Cognitive Performance in Methamphetamine-dependent Individuals in Rural South Carolina. American Journal on Addiction, 20(5):447-55.

RNS System Pivotal Clinical Investigation (2011). Distant author. Epilepsy and Behavior.

Bachman, D.L., Stuckey, M.; Ebeling, M., Wagner, M.T., Evans, W.J., Hirth, V., Walker, A., Memom, M., Joglekar, R., Faison, W., Mintzer, J.E. (2009). Establishment of a Predominantly African American Cohort for the Study of Alzheimer's Disease: the South Carolina Alzheimer's Disease Clinical Core. Dementia and Geriatric Cognitive Disorders, 27, 329-336.

Wagner, MT, Wymer, JH, Carlozzi, NE, Bachman, DL, Walker, A, Mintzer, J; Alzheimer Study Group. (2007). Preliminary examination of progression of Alzheimer's disease in a rural Southern African America cohort. Arch Clin Neuropsychol., 22, 405-414.

Wagner, C.L., Wagner, M.T., Ebeling, M, Chatman, K.G., Cohen, M., & Hulsey, T.C. (2006). The role of personality and other factors in a mother's decision to initiate breastfeeding. Journal of Human Lactation, 22, 16-26.

Wagner, M.T., Marion, S.D. & Judson, M.A. (2005). The effects of fatigue and treatment with methylphenidate on sustained attention in sarcoidosis. Sarcoidosis, vasculitis and diffuse lung disease. 22, 235.

Wagner, M.T., Wymer, J.H., Wagner, M.T., Topping, K.B., & Pritchard, P.B. (2005). Use of the Personality Assessment Inventory as an efficacious and cost effective diagnostic tool for nonepileptic seizures. Epilepsy and Behavior, 301-304.

Wagner, MT, Wymer, JH, Teichner, G, Bachman, DL (2004). Diagnostic challenges of using CSF assay of tau and beta-amyloid1-42 in atypical degenerative dementias and mild cognitive impairment (MCI) of the Alzheimer type. Dementia, 4, 25-26.

Wagner, MT, Teichner, G., Bachman, DL (2004), Diagnostic Challenges of Using CSF assay of tau and beta amyloid$_{42}$ in Atypical Degenerative Dementias of the Alzheimer's Type. Archives of Clinical Neuropsychology.

Wymer, JH, Rayls, K, & Wagner, MT (2004). Utility of a Clinically Derived Abbreviated Form of the WAIS-III. Archives of Clinical Neuropsychology.

Teichner, G., & Wagner, M.T. (2004). The Test of Memory Malingering (TOMM): Normative Data from Cognitively Intact, Cognitively Impaired, and Geriatric Patients with Dementia. Clinical Neuropsychology.

Varon, D, Pritchard, PB, Wagner, MT, Topping, K (2003). Transient Kluver-Bucy Syndrome following partial complex status epilepticus. Epilepsy & Behavior, 4, 348-351.

Haight, B.K., Bachman, D.L., Hendrix, S., Wagner, M.T., Meeks, J., & Johnson, J. (2003). Life review: Treating the dyadic family unit with dementia. Clinical Psychology and Psychotherapy, 10:3.

Wagner CL, Eicher DJ, Wagner MT, Tribble LA. (2001). Cord blood TGF varies with gestation. Prenatal and Neonatal Medicine, 6:227-233.

Bachman, DL, Wagner, MT, DePalma, M, Spangenberg, KB, Hendrix, SA, Perlman, DJ. (2000). Caregiver attitudes about patients told they have Alzheimer disease after truth disclosure. Journal of Clinical Geropsychology, 6, 309-313.

Spangerberg, K.B., Wagner, M.T., Hendrix, S., & Bachman, D.L. (1999). Firearm presence in households of patients with Alzheimer's disease. Journal of the American Geriatric Society, 47, 1183–1186.

Epstein, S.A., Kay, G., Claw, D. Henton, R., Klein, D., Krupp, L., Kuck, J., Vinitor, L., Masur, D., Wagner, M.T., Waid, R., & Zisook, S. (1999). Psychiatric disorders in patients with fibromyalgia: A multicenter investigation. Psychosomatics, 40, 57–63.

Haight, B.K., Bachman, D.L., Hendrix, S., Wagner, M.T., Meeks, A. (1998). Life review: Treating the dyadic family unit with Alzheimer's disease. The Gerontologist, 38 (Special Issue I).

Wagner, M.T., Spangenberg, K.B., Bachman, D.L., O'Connell, P. (1998). Unawareness of cognitive deficit in Alzheimer disease. Neuropsychology Abstracts, 7, 34.

Wagner, C.L., Forsthe, D.W., Wagner, M.T. (In press). The effect of recombinant TGF alpha human milk and human milk macrophage media on gut epithelial proliferation is decreased in the presence of neutralizing antibody. Biology of the Neonate.

Spangenberg, K., Wagner, M.T., & Bachman, D.L. (1998). Neuropsychological analysis of a case of abrupt onset mirror sign following a hypotensive crisis in a patient with vascular dementia. Neurocase, 4, 149–154.

Spangenberg, K., Henderson, S., & Wagner, M.T. (1997). Validity of a recall and recognition condition to assess visual memory in the CERAD battery. Applied Neuropsychology, 4, 154–159.

Wagner, M.T., O'Connell, P., & Bachman, D.L. (1997). Unawareness of cognitive deficit in Alzheimer's disease and related dementias. Alzheimer's Disease and Associated Disorders, 11, 125–131.

Wagner, M.T., & Bachman, D.L. (1996). Neuropsychological features of diffuse Lewy body disease. Neuropsychology Abstracts, 5, 27.

Wagner, M.T. & Bachman, D. (1996). Diffuse Lewy Body Disease: Serial neurocognitive investigation with biopsy confirmation. Archives of Clinical Neuropsychology, 11, 175–184.

Wagner, M.T., Spicer, K., & Bachman, D.L. (1995). Clinical expression and diagnosis of atypical cortical degenerative syndromes. Journal of Clinical Psychology in Medical Settings, 2, 275–288.

Wagner, C.L., Kramer, B.M., Kendig, J.W., Brooks, J.G., Cox, C., Wagner, M.T., & Phelps, D. (1995). School age follow up of a single dose prophylactic surfactant cohort. Developmental and Behavioral Pediatrics, 16, 1–7.

Wagner, M.T. & Cushman, L.A. (1994). The functional significance of the subcortical vascular syndrome in the rehabilitative setting. Archives of Physical Medicine and Rehabilitation, 75, 193–197.

Wagner, M.T., & Cushman, L.A. (1994). Neuroanatomic and neuropsychological predictors of unawareness of cognitive deficit in the vascular population. Archives of Clinical Neuropsychology, 9, 57–69.

Wagner, M.T., & Cushman, L.A. (1992). Intellectual and memory functions after cortical and subcortical stroke. NeuroRehabilitation, 2, 45-52.

McDaniel, K.M., Wagner, M.T., & Greenspan, B. (1991). The role of brain Single photon emission computed tomography in the diagnosis of primary progressive aphasia. Archives of Neurology, 48, 1257-1260.

Wagner, M., Williams, J., & Long, C.J. (1991). The role of social networks in recovery from head injury. International Journal of Clinical Neuropsychology, 12, 1-7.

Wagner, M. (1989). Swingshift encephalopathy. Academic Medicine, 584.

Lichstein, K., Wagner, M.T., Krisak, J., & Steinberg, F. (1987). Stress management for acting-out inpatient adolescents. Journal of Child and Adolescent Psychotherapy, 4, 19-31.

Wagner, M.T. (1986). Simultaneous bilateral EMG biofeedback for treatment of spasmatic torticollis. Clinical Biofeedback and Health, 2.

Wagner, M.T. & Khanna, P. (1986). A neuropsychological model of hypnosis. International Journal of Psychosomatics, 33, 26-28.

Bolter, J., Wagner, M.T., & Long, C.J. (1982). The utility of the Thurstone Word Fluency Test in identifying cortical damage. Clinical Neuropsychology, 15, 77-81.
Wagner, M. & Hannon, R. (1981). Hemispheric asymmetries in faculty and student musicians and non-musicians during melody recognition tasks. Brain and Language, 13, 379-388.

Wagner, M.T. (1981). Controlling nocturnal bruxism through the use of aversive conditioning during sleep. American Journal of Clinical Biofeedback, 4, 87-92.

Wagner, M.T. (1980). A combined behavioral approach for the treatment of migraines. Journal of the American Society of Psychosomatic Dentistry and Medicine, 27, 89-93.

PEER REVIEWED PUBLISHED ABSTRACTS

Prichard, PB, Lajeunesse, P, Wagner, MT (2010). To laugh or not to laugh: dichotomy favoring right temporal lobe onset of seizure. Epilepsia Suppl., 1:217.

Contardo, C, Walker, A, Wagner, MT: Neuropsychological and CSF markers of early and late Alzheimer disease. Archives of Clinical Neuropsychology 32(6):675, 2008.

Pritchard, PB, Topping, K, Wagner, MT: Utility of SPECT scans in nonepileptic seizures.Epilepsia 44:84, Suppl. 9, 2003.

Pritchard, PB, Wagner, MT, Topping, K: Prediction of nonepileptic seizures with the Personality Assessment Inventory. Epilepsia 43:161, Suppl. 7, 2002.

Wagner CL, Wagner MT, Hulsey TC. Does personality influence maternal breastfeeding decision? Pediatr Res 2002; 50(4):27.

Teichner, G, Wagner, MT (2001). Test of Memory Malingering (TOMM)- validation data from a geriatric sample. Archives of Clinical Neuropsychology, 16(8): 588.

Teichner, G., Wagner, M.T., Golden, C.J., & Newman, S.A.. (2000). A Neurorehabilitation Intervention for Brain-Injured Children Exhibiting Aggression. Archives of Clinical Neuropsychology.

Teichner, G., Wagner, M.T., & Newman, S.A. (2000). Psychometric Validation and Clinical Application of the Test of Memory Malingering (TOMM). Archives of Clinical Neuropsychology.

Teichner, G., Wagner, M.T., Bachman, D.L., Brannon, N., Hendrix, S., & Newman, S.A. (2000). A Case Study of Posterior Cortical Atrophy. Archives of Clinical Neuropsychology.

Newman, S., Teichner, G., & Wagner, M.T. (November, 2000). Clinical application of the Rey-15item Test in a Geriatric sample. Archives of Clinical Neuropsychology.

Wagner, M.T., Newman, S., Teichner, G., Horner, M., Bachman, D., & Tyor, W. (1999). The many faces of Pick's disease. Archives of Clinical Neuropsychology, 14.

Wagner, M.T., Newman, S., Teichner, G., Horner, M., Carter, T., & Bachman, D. (1999). The many faces of Pick's disease. Archives of Clinical Neuropsychology, 14, 617.

Wagner, M.T., Rayls, J.R., & Tyor, W.R. (1999). Use of methotrexate in the treatment of progressive cognitive morbidity associated with secondary progressive multiple sclerosis. Journal of the International Neuropsychological Society, 5, 96–97.

Webb, S.A., Wagner M.T., & Wagner, C.L. (1998). The effect of experience and profession on discussing end-of-life decisions with families in the neonatal intensive care unit. Pediatrics 102(3Pt2), S763-764.

Rayls, K., Girdlestone, C., & Wagner, M.T. (1998). Short forms of the WAIS-III for the elderly: A comparison of three abbreviated versions. Archives of Clinical Neuropsychology, 14, 62–63.

Rayls, K., Wagner, J., & Wagner, M.T. (1998). A clinically derived short form of the WAIS-III: Utility in a sample of young adults. Archives of Clinical Neuropsychology, 14, 90.

Wagner, M.T., Spangenberg, K.B., Herlong, J., Vincent, D., & Horton, J.A. (1997). New frontiers: Neuropsychology during therapeutic cerebral intervention and neuroradiology. Archives of Clinical Neuropsychology, 12, 442–423.

Spangenberg, K.B., Wagner, M.T., Bachman, D.L., & Hendrix, S. (1997). Delusional misidentification symptom (mirror sign) following watershed infarction: A neurobehavioral case study. Archives of Clinical Neuropsychology, 2, 408.

Spangenberg, K.B., Henderson, S., & Wagner, M.T. (1996). A new measure of verbal memory in the CERAD battery. The Clinical Neuropsychologist, 10, 323.

Wagner, M.T. & Bachman, D.L. (1996). Clinical/pathologic correlates of primary progressive aphasia. Archives of Clinical Neuropsychology, 11, 460–461.

Wagner, M.T., Bachman, D.L., & O'Connell, P. (1995). Serial neurocognitive investigation of early onset non-familial Alzheimer's disease. The Clinical Neuropsychologist, 9, 287.

Wagner, M.T., O'Connell, P., & Bachman, D.L. (1995). Measurement of unawareness of cognitive deficit in Alzheimer's disease. The Clinical Neuropsychologist, 9, 275.

Wagner, M.T., O'Connell, P., & Bachman, D.L. (1995). Unawareness of cognitive deficit in Alzheimer's disease and other dementias. The Clinical Neuropsychologist, 9, 285.

Wagner, M.T. & Bachman, D. (1995). Diffuse Lewy Body Disease: Serial neurocognitive investigation with biopsy confirmation. The Clinical Neuropsychologist, 8, 339.

Hummer, J.#, Fink, C.#, Waid, R., & Wagner, M.T. (1994). WMS-R and MMPI-2 profiles of ADHD-RT versus learning disabled adults. The Clinical Neuropsychologist, 8, 335.

Wagner, M.T., Bachman, D., Cushman, L., Waid, R., & Hummer, J.# (1994). Severity of dementia as a risk factor for driving. Archives of Clinical Neuropsychology, 9, 196.

Wagner, M.T., Bachman, D., Hummer, J.#, & Waid, R. (1994). Asymmetric cortical degenerative syndromes: Neurocognitive, neuroradiographic, and natural history case presentation. Archives of Clinical Neuropsychology, 9, 196–197.

Wagner, C.L., Wagner, M.T., & Kendig, J. (1994). Longitudinal neurodevelopmental outcome of very low birth weight infants followed from birth to 5–7 years. Archives of Clinical Neuropsychology, 9, 195–196.

Hummer, J.T.#, Waid, R., Rodenbough, J., Sutherland, S., Wagner, M.T., & Keil, J. (1994). Memory performance in depressed versus non-depressed community elderly. Archives of Clinical Neuropsychology, 9, 142.

Wagner, M.T., Barber, P.+, & Zacchigna, L.J.* (1988). Longitudinal comparison of the Barthel Index and the FIM during the first six months of recovery from stroke. Archives of Physical Medicine and Rehabilitation, 69, 755.

Wagner, M.T. (1988). Cortical versus subcortical stroke: The effect on higher cortical functions. Archives of Physical Medicine and Rehabilitation, 69, 759.

Wagner, M.T. & Zacchigna, L.J.* (1988). The impact of cognitive versus physical disability on psychosocial functioning following stroke. Archives of Physical Medicine and Rehabilitation, 69, 798.

Wagner, M.T., Williams, J.M., & Long, C.J. (1986). The influence of social support on the recovery from head injury. Journal of Clinical and Experimental Neuropsychology, 8, 42.

BOOKS AND OTHER MONOGRAPHS

Wagner CL, Wagner MT. Factors Influencing a Mother's Decision to Breastfeed. Short and long term effects of breast feeding on child health. In: Koletzko B. (ed), Plenum Publishing Company, London, 2000: 435-436.

Wagner, M.T., Rayls, K.R., & Bachman, D.L. (1999). The measurement of unawareness of cognitive loss and its application in Alzheimer's disease. Research and Practice in Alzheimer Disease, Paris Serdi.

Wagner, M.T., Nayak, M.#, & Fink, C.# (1995). Bedside screening of neurocognitive function. In L. Cushman & M.J. Scherer (Eds.), Psychological assessment in medical rehabilitation settings. Washington, D.C.: APA Books.

Nickoley, S., Wagner, M.T., & Hamill, R.M. (1995). The management of continent behavior in Alzheimer's Disease patients. In A. Romaine-Davis, J. Boondas, & A. Lenihan (Eds.), Encyclopedia of home care for the elderly. Westport, CT: Greenwood Publishing.

Long, C.J. & Wagner, M.T. (1986). Computer applications in neuropsychology. In D. Wedding, A. Horton, & J. Webster (Eds.), The neuropsychology handbook: Behavioral and clinical aspects. New York: Plenum Press.

Wagner, M.T. & Danse, M. (1986). Psychosocial issues in cognitive rehabilitation. In C.J. Long & J.M. Williams (Eds.), The rehabilitation of cognitive disabilities. New York: Plenum Press.

CONFERENCE PRESENTATIONS

Wagner, MT & Prieur, ME (2015). Too quiet: A case of auditory Charles Bonnet Syndrome. Presented at the International Neuropsychological Society 43rd Annual Conference. Denver, Colorado.

Pritchard, P, Wagner, MT, Mabell, M. & Kersey, P (2015). Episodic misperception of time associated with temporal lobe epilepsy. Presented at the International Neuropsychological Society 43rd Annual Conference. Denver, Colorado.

Wagner, MT, Mulder, B., Sohn, M., Walker, A. (2014). Posterior cortical atrophy of the non-Alzheimer. Presentation at the National Academy of Neuropsychologists 34th Annual Conference. Fajardo, Puerto Rico.

Wagner, MT & Wymer, J. (2014). Pitfalls in the use of biomarkers for the diagnosis of pre-clinical Alzheimer disease Presentation at the National Academy of Neuropsychologists 34th Annual Conference. Fajardo, Puerto Rico.

Klineova, S, Milanak, M, Walker, AJ, Wagner, MT (2013). Multiple sclerosis trait theory: assessment of the multiple sclerosis personality type. Presented at The 29th Congress of the European Committee for Treatment and Research in Multiple Sclerosis (ECTRIMS) Copenhagen, Denmark.

Pritchard, PB, Wagner, MT, Bachman, DL (2012). Episodic autobiographical dysfunction in transient amnesia: effectiveness of antiepileptic drugs. Presented at the Annual Meeting of the American Epileptic Society, .

Klineova, Sylvia, Milanak, Melissa, Walker, A, Wagner, MT (2012). Multiple sclerosis trait Therory: Assessment of the multiple sclerosis personality. Medical University of South Carolina Neuroscience Research Day. Charleston, SC.

Sun, X., Walker, A., Wagner, MT, Bachman, DL (2012). Evaluation of cerebral spinal fluid biomarker of Alzheimer disease in patients with cognitive impairment. Medical University of South Carolina Neuroscience Research Day. Charleston, SC.

Wagner MT, Brenner LA, Walker AJ (2012). Accuracy of the diagnosis of "worried well" for individuals presenting for memory evaluation with fears of developing Alzheimer disease. Presented at the Annual Meeting of the National Academy of Neuropsychology. Marco Island, FL.

Michael C. Mithoefer, MD, Mark Wagner, PhD, Ann T. Mithoefer, BSN, Lisa Jerome, PhD and Rick Doblin, PhD, (2011) Long term follow-up of subjects who completed a clinical trial of (MDMA)-assisted psychotherapy for treatment-resistant posttraumatic stress disorder (PTSD) International Society for Traumatic Stress Studies 27th Annual Meeting, Montreal, Canada.

Quattlebaum, E., Adams, R, Wagner, MT, Williams, N. (2011). A Unique Case of Anton's Syndrome. Presented at the Medical University South Carolina Student Research Day, Charleston, SC.

Sun, X., Nicholas, J., Walker, AJ, Wagner, MT, Bachman, D. (2011). The value of APOE genotype in the diagnosis of Alzheimer's disease in patients with cognitive impairment. Presented at the MUSC Neurosciences Day Annual Conference, Charleston, SC.

Wagner, MT, Brenner, LA, Walker, AJ (2012). The sensitivity of the clinical diagnosis of amnestic MCI confirmed by CSF biomarkers and longitudinal follow-up. Presented at the 39th Annual Conference of the International Neuropsychological Society, Boston, MA.

Wagner, MT, Brenner, LA, Pritchard, PB (2011). Out-of body experience and autoscopy in a case of focal epilepsy. Presented at the 39th Annual Conference of the International Neuropsychological Society, Boston, MA.

Wagner, MT, Brenner, LA, Walker, AJ (2011). Application of technological innovations for neurorehabilitation. Presented at the 39th Annual Conference of the International Neuropsychological Society, Boston, MA.

Brenner, LA., Wagner, MT., Roberts, DR (2011). Alexia with agraphia with right frontotemporal lobe damage. Presented at the 39th Annual Conference of the International Neuropsychological Society, Boston, MA.

Price KL, DeSantis SM, Simpson AN, Tolliver BT, McRae-Clark AL, Saladin ME, Baker NL, Wagner MT, Chapman E, Garrett M, Brady KT. (2010). Cognitive Performance in Methamphetamine-dependent Individuals from Rural South Carolina: Potential Impact of Demographic Variables. Presented at the Translational Research in Methamphetamine Addiction conference in Pray, Montana.

Pritchard, PB, Lajeunesse, P, Wagner, MT (2010). To laugh or not to laugh: Dichotomy favoring right temporal lobe onset of seizure. Presented at the Annual Meeting of the American Epileptic Society, San Antonio, TX.

Mithoefer, MC, Wagner MT, Mithoefer, AT, Jerome L, Doblin, R, (2009). The Safety and Efficacy of 3,4-Methylenedioxymethamphatemine (MDMA)-Assisted Psychotherapy for Treatment-Resistant Posttraumatic Stress Disorder (PTSD): A Double Blind Randomized Placebo-Controlled Pilot Study, Future Directions in PTSD, Prevention, Diagnosis and Treatment, Program and Abstracts, The Institute for Advanced Studies, Jerusalem, Israel.

Martha J. Morrell and the RNS System Pivotal Investigators (2009). Results of multicenter double blinded randomized controlled pivotal investigation of the RNSTM system for treatment of intractable partial epilepsy in adults. Presented at the Annual Meeting of the American Epilepsy Society.

Soper, A., Wagner, M.T., Topping, K, Prichard, P.B. (2008). Transient epileptic amnesia: A case series of a treatable memory disorder. Presented at the Annual Meeting of the National Academy of Neuropsychologists. Atlanta, GA.

Wagner, M.T., Soper, A.C., Mithoefer, A., Mithoefer, M. (2008). Risk assessment of cognitive morbidity associated with the use of therapeutic methylenedioxymethamphetamine. Presented at the Annual Meeting of the National Academy of Neuorpsychologists. Atlanta, GA.

Wagner, M.T., Soper, A.C., McRae-Clark, A.L., Saladin, M.E., Tolliver, B.K., Price, K.L., Brady, K. (2008). Presented at the Annual Meeting of the National Academy of Neuropsychologists. Atlanta, GA.

Mithoefer, M. & Wagner, M.T. (2008). Methylenedioxymethamphetamine assisted psychotherapy in the treatment of posttraumatic stress disorder- A phase II clinical trial. Presented at the Annual Meeting of the International Society for Traumatic Stress Studies. Chicago, Illinois.

Contardo, C, Walker, A, Wagner, MT (2008). Neuropsychological and CSF markers of early and late Alzheimer disease. Presented at the National Academy of Neuropsychology 28th Annual Meeting, NY, NY.

Mithoefer, M & Wagner, M.T. (2007). Methylenedioxymethamphetamine Assisted Psychotherapy in the treatment of posttraumatic stress disorder: Update on study progress. Annual Congress of the European College of Neuropsychopharmacology. Vienna.

Mintzer, J.E., Wymer, J.H., Hulsey, T.C., Ebeling, M., Wagner, M.T., Stuckey, M., & Bachman, D. (July, 2006). A comparison of patterns of deterioration between African American and Caucasian Alzheimer's patients. Poster session presented at the 10th International Conference on Alzheimer's Disease and Related Disorders. Madrid, Spain.

Carlozzi, N.E., Wagner, M.T. & Walker, A.J. (2006, January). Dual therapy (donepezil/memantine) for Alzheimer disease in mild cognitive impairment. Presented at the 34th Annual Conference of the International Neuropsychological Society, Boston, MA.

Griss, M.E., & Wagner, M.T. (2005, November). Frontal Meningioma Presenting as an Atypical Bipolar Disorder. Presented at the 40th Annual Medical University of South Carolina Student Research Day, Charleston, SC.

Smerz, J.M., Wagner, M.T. Bachman, DM (2005). Effect of Apo E Epsilon 4 Status on Cognitive Domains as a Function of Age and Symptom Duration in Alzheimer's Disease. Presented at the National Academy of Neuropsychologists, Tampa, FL.

Wagner, M.T., Smerz, J.M., Walker, AJ (2005). Identifying preclinical Alzheimer's disease using neurobehavioral markers of MCH confirmed by CSF-tau and AB42. Presented at the National Academy of Neuropsychologists, Tampa, FL.

Wymer, J.H., Wagner, M.T., Bachman, D.M., Mintzer, J.E. (2005). Do current BNT norms generalize to older African Americans from the rural South? Presented at the National Academy of Neuropsychologists, Tampa, FL.

Wymer, J.H., Wagner, M.T., Bachman, D.M., Mintzer, J.E. (2005). Accuracy of WTAR predictions for older African Americans from the rural South. Presented at the National Academy of Neuropsychologists, Tampa, FL

Pritchard, PB, Topping, K, Wagner, MT (December, 2004). Gelastic seizures of temporal lobe origin. Presented to the annual meeting of the Americal Epilepsy Society. New Orleans, LA.

Smerz, J.M, Wagner, M.T., Walker, A.J. (March, 2004). Identifying preclinical Alzheimer disease using neurobehavioral markers of MCI confirmed by CSF-tau and AB42. Presented at the 39th MUSC Student Research Day. Charleston, S.C.

Wymer, J.H. & Wagner, M.T. (March, 2004). The varying factor structure of mild cognitive impairment as a function of premorbid IQ. Poster session presented at the first annual Aging Research Day. Charleston, SC.

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Spangenberg, K.B.#, Henderson, S.#, & Wagner, M.T. (August, 1996). A new measure of visual memory in the CERAD battery. Paper presented at the 104th Annual Convention of the American Psychological Association, Toronto, Canada.

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Hummer, J.T.#, Waid, L.R., Rodenbough, J., Sutherland, S.E., Wagner, M.T., & Keil, J.E. (October, 1993). Memory performance in depressed versus non-depressed community elderly. Paper presented at the 13th Annual Conference of the National Academy of Neuropsychology, Phoenix, Arizona.

Beliles, K.+, Waid, R., Wagner, M., Hummer, J.#, Cofer, J., & Wolhlreich, M. (October, 1993). Neuropsychiatric status and selection for liver transplantation. Paper presented at the International Liver Transplant Society Meeting. Toronto, CA.

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Wagner, M.T., Bachman, D., Cushman, L., Waid, R., & Hummer, J.# (October, 1993). Severity of dementia as a risk factor for driving. Paper presented at the National Academy of Neuropsychology annual Meeting. Phoenix, AZ.

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Wagner, M.T., & Cushman, L.A. (November, 1992). Neurocognitive predictors of unsafe risk behavior in the rehabilitative stroke population. Paper presented at the American Congress of Rehabilitative Medicine 69th Annual Session. San Francisco, CA.

Wagner, M.T., & Cushman, L.A. (November, 1992). Unawareness of neurocognitive deficit following stroke. Paper presented at the American Congress of Rehabilitative Medicine 69th Annual Session. San Francisco, CA.

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Nickoley, S. & Wagner, M. (July, 1991). Promoting urinary continence in the nursing home setting. Paper presented at the New York State Best Practices Conference: New York Department of Health and Hunter-Mount Sinai Geriatric Education Center. Albany, New York City, Rochester, NY.

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Wagner, M.T., Cushman, L.A. & Friedman, P.+ (November, 1989). Generalized cognitive decline as an indicator of "dementia" in unilateral cerebrovascular lesion. Paper presented at the National Academy of Neuropsychologists Conference. Washington, D.C.

Wagner, M.T. (November, 1989). The WAIS-R profile as a psychometric marker of Alzheimer's Disease. Paper presented at the National Academy of Neuropsychologists Conference. Washington, D.C.

Wagner, M.T. (October, 1987). Comparison of the effects of cortical and subcortical stroke on higher cortical functions. Paper presented at the National Academy of Neuropsychologists Conference. Chicago, IL.

Wagner, M.T. & Aggarwal, U. (April, 1987). Geriatric stroke rehabilitation: A clinical, educational, and research opportunity. Paper presented at the Spring Symposium on Aging. Rochester, NY.

Wagner, M.T., Williams, J.M., & Long, C.J. (July, 1986). The influence of social support on the recovery from head injury. Paper presented at the International Neuropsychology Society European Conference. Veldhoven, The Netherlands.

Wagner, M.T. & Danse, M. (May, 1986). The influence of psychosocial issues involved in conceptualizing a cognitive remediation program. Paper presented at the Fourth Annual Human Neuropsychology Conference. Memphis, TN.

Wagner, M.T., Williams, J.M., & Long, C.J. (October, 1985). The relationship between recovery from head injury and social support. Paper presented at the National Academy of Neuropsychologists Annual Conference. Philadelphia, PA.

Wagner, M.T., Bolter, J., & Long, C.J. (August, 1984). Sex differences in cerebral asymmetry. Paper presented at the International Neuropsychology Society Annual Conference. Houston, TX.

RESEARCH IN PROGRESS

Soper, A & Wagner, MT (2010). Emotional State Changes and Their Awareness During the Pre-Surgical Wada Intracarotid Sodium Amobarbital Procedure. (In review.)

Wagner, M.T, Mithoefer, MC, Mithoefer, AT (2010). Long-term follow up of ±3,4-methylenedioxymethamphetamine-assisted psychotherapy subjects using the NEO psychological analysis to investigate enduring personality change following catastrophic experience. In preparation for publication.

Howard, J.T. & Wagner, M.T. (2010). Utility of Two Select-Item Short Forms of the WAIS-IV in a Clinical Population. Final internship paper in preparation for publication.

Note: Medical students*
Graduate students#
Residents+

Sincerely,

Mark Wagner, Ph.D.
Professor of Neurology

L. Randolph Waid, Ph.D.
Licensed Clinical Psychologist

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Kirsten L. Barr, Esquire
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February 12, 2016

RE: Kenneth L. Barr

Dear Ms. Barr:

Per your request, I reviewed records regarding Mr. Kenneth L. Barr, a year-old male who was previously employed as a maintenance painter for the Darlington County School District. Mr. Barr has been employed with the school district since June, 2009. Currently, Mr. Barr has filed a Workers' Compensation claim alleging that he suffers from physical brain injury. Mr. Barr has been under the care of Dr. Marshall White, neurologist, who has opinioned that Mr. Barr suffers from an encephalopathic condition which has rendered him with severe permanent brain damage. Dr. White also assessed Mr. Barr as being totally and permanently disabled. There was review of extensive records including the following:

1. Medical records from The Medical Group/Raymond M. Chapman, M.D.
2. Medical records from McLeod Urgent Care Center.
3. Medical records from Camden Orthopedics.
4. Medical records from Hartsville Orthopedics.
5. Medical records from Florence Neurosurgery and Spine Clinic.
6. Report from Avie J. Rainwater, III, Ph.D.
7. Medical records from McLeod Regional Medical Center.
8. Medical records from Roland L. Skinner, III, neurologist.
9. Medical records from Thomas Brandt, M.D.
10. Report of deposition conducted with Larry Stegner, 09/09/15.
11. Report of deposition conducted with Kenneth L. Barr, 09/09/15.
12. Report of deposition conducted with Rowland L. Skinner, III, 12/10/15.
13. Medical records from Marshall A. White, M.D., neurologist.
14. Report of CT scan of the brain conducted on Mr. Barr on 03/16/15.
15. Report of evaluation conducted by Nicholas A. Lind, Psy.D.
16. Mr. Barr's educational records from Darlington County School District.
17. Report of review of medical records conducted by Mark Wagner, Ph.D.

Review of extensive records revealed Mr. Kenneth Barr to have a history for psychological and somatic difficulties that proceeded his being hired by the Darlington County School District. Commencing in 2006, there was placement on psychotropic medications for assistance with Mr. Barr's disruptive pain and psychological difficulties. Review of records from Dr. Thomas Brandt revealed the onset of low back pain to be around 1992 secondary to a fall injury. There was report of chronic neck pain dating back to 2002. Mr. Barr also complained of headache difficulties to his primary care physician in 2007.

Mr. Barr commenced in neurological intervention with Dr. Roland Skinner, III, in September, 2010. Intervention was directed toward headaches and dizziness. There was also complaint with regard to difficulties concentrating, lack of energy, lack of interest in activities that were previously enjoyed, and feelings of depression. Neurological examination conducted by Dr. Skinner was normal as was the mental status component of the examination. Neuroradiographic studies revealed hyperintensities on T2 noticed mostly in the frontal white matter bilaterally. The findings are nonspecific and generally associated with ischemic disease. Angiogram showed a questionable aneurysm that was later determined to not be significant nor in need of any surgical procedure. Dr. Skinner expressed concerns regarding Mr. Barr's

analgesic usage leading to rebound headaches. Mr. Barr was warned regarding excessive usage of over the counter analgesics.

Mr. Barr commenced in neurological intervention with Marshall White, M.D. in late 2012. The focus of intervention was again directed toward headaches and there was use of medications. Dr. White came to believe that Mr. Barr's headaches were related to exposure to volatile organic compounds (VOC) at work. There was recommendation to cease employment and avoid exposure to such agents. There was report by Dr. White that Mr. Barr was experiencing poor memory and fatigue. Yet, that report was inconsistent with records from other physicians who were involved in evaluation/intervention of Mr. Barr. There was concern regarding anxiety, though it is evident that Mr. Barr has a long history for anxiety/depressive difficulties. Dr. White opinioned that Mr. Barr suffering from VOC related encephalopathy that had led to severe permanent brain damage and dementia.

More recently, Kenneth Barr was evaluated by Nicholas Lind, Psy.D. As was amply pointed out in Dr. Mark Wagner's review of the records, Mr. Barr did quite well on tests assessing anterograde memory. The finding is inconsistent with Dr. White's opinion that Mr. Barr suffers from memory impairment or has severe encephalopathy. Review of Mr. Barr's performance across tests assessing attention/concentration revealed variable results. Overall, there was no compelling evidence that Mr. Barr's neuropsychological test results were representative of severe impairment in brain behavior functioning.

Review of deposition conducted with Kenneth Barr revealed him to report that the main reason he was out of work was due to disruptive headaches. Mr. Barr described having memory difficulties when experiencing the interfering aspects of headaches. During the conduction of the deposition, Mr. Barr demonstrated a good ability to recall the details of his history as well as the ability to sustain his attention/focus to the demands of the deposition.

More recently, Mr. Barr underwent an independent medical examination conducted by Paul Pritchard, M.D. (02/02/16). Dr. Pritchard reported that Mr. Barr performed quite well on the Montreal Cognitive Assessment Exam. Dr. Pritchard's neurological examination failed to reveal any evidence for encephalopathy or dementia. Dr. Pritchard assessed Mr. Barr's headaches to be consistent with the chronic daily variety. He also opinioned that the neuropsychological test results were inconsistent with a diagnosis of encephalopathy or dementia.

Review of Dr. Lind's evaluation of Mr. Barr revealed that he was unaware that Mr. Barr's headaches actually commenced well before the starting of employment with Darlington County School District. It was also noted that during Dr. Thomas Brandt's evaluation of Mr. Barr, he was experiencing disruptive headaches, though Mr. Barr had been away from the school district property for 6 months. Dr. Lind did note Mr. Barr's history for depression and panic attacks that were troublesome prior to his commencing of employment capacities at Darlington County School District. Dr. Lind's evaluation included psychological testing which was revealing of an individual who was experiencing somatic symptoms and being highly focused on his health/somatic problems. There was also report of experiencing disruptive depression and anxiety. As mentioned, Dr. Lind's evaluation of Mr. Barr's anterograde memory revealed him to be functioning in the average to above average range. There was variability noted on tests assessing attention/concentration. There was report of some reduced motor dexterity that Dr. Lind viewed as being consistent with prolonged exposure to volatile organic compounds. Yet, records reveal that Mr. Barr has a well documented history for hand pain. Dr. Lind also estimated Mr. Barr's intellectual functioning to be in the average range, though review of the educational school records certainly raised concerns that Mr. Barr's premorbid intellectual functioning was below the average range. In Dr. Wagner's review of the records, he fully discussed Mr. Barr's educational history that was poor as well as his significantly below average performance on standardized testing such as the Scholastic Aptitude Test.

<u>Opinions:</u>

1. I am in agreement with my colleague, Dr. Mark Wagner, that Mr. Barr has long history for neuropsychiatric symptoms that pre-dated his commencing of employment capacities at Darlington

County School District where there was potential for exposure to volatile organic compounds. Disruptive symptoms included headaches, anxiety, chronic pain, fatigue, chest pain with negative cardiac work up, as well as MRI study revealing evidence of small vessel cerebrovascular disease. There were also complaints as they related to panic attacks, irritability, narcotic pain issues, and analgesic over-the-counter rebound issues.

2. Dr. Lind's neuropsychological evaluation revealed Mr. Barr to perform well, particularly on tests assessing anterograde memory. Indeed, Mr. Barr's performance on a battery of neuropsychological tests failed to reveal evidence of severe impairment affecting brain behavior functioning. Some of the test performances that were in the low average range would be considered as being consistent with Mr. Barr's premorbid intellectual abilities. There is also the potential possibility that Mr. Barr's hyperintensities that are mostly located in the frontal lobe white matter bilaterally could be contributing to the subtle findings of deficits in disinhibition and other executive functions. Likewise, depression and emotional difficulties can also contribute significantly to the findings of mild compromise with regard to processing speed.

3. Review of the records including previous reports of evaluations conducted by multiple physicians as well as Dr. Lind's neuropsychological test results simply do not support Dr. Marshall White's opinion that Mr. Barr suffers from an encephalopathic condition that has led to severe permanent brain damage with severe compromise in brain behavior functions. As noted above, Mr. Barr's performance on objective tests assessing anterograde memory was in the average to above average range. Review of records failed to reveal any biological markers to support that Mr. Barr is suffering from a neurobehavioral syndrome consistent with VOC exposure. Mr. Barr is not suffering from a dementing disorder as that also would involve evidence of severe cognitive impairments via conduction of neuropsychological testing. Evaluation of Mr. Barr as well as review of his provision of a deposition is also inconsistent with him being severely compromised in his brain behavior functioning. Indeed, Mr. Bower's primary complaint is one of disruptive headaches that existed prior to his engagement in employment with Darlington County School District.

In closing, review of records reveal that Mr. Kenneth Barr continues to be disrupted by headaches that have been fairly refractory to treatment. Yet, review of records failed to provide compelling evidence that exposure to volatile organic compounds resulted in biological makers or that exposure was causal for Mr. Barr's current somatic, emotional, or cognitive complaints. While there is evidence of ischemic changes in the bifrontal white matter, these are nonspecific and are not attributable to exposure to volatile organic compounds. Thus, there is no evidence to indicate that Mr. Barr suffered physical brain injury as a direct result of his employment with the Darlington County School District. Nor is there any compelling evidence that Mr. Barr currently suffers from an encephalopathic condition that has resulted in severe brain damage.

Please feel free to contact me if you have any questions regarding the review of records that was performed regarding Kenneth L. Barr.

L. Randolph Waid, Ph.D.
Licensed Clinical Psychologist (SC License #333)

LRW/cmf

February 14, 2016

Kirsten L. Barr
Trask & Howell, L.L.C.
763 Johnnie Dodds Boulevard
Mt. Pleasant, SC 29465

Re: Barr v Darlington County School District

Dear Ms. Barr:

I have reviewed the documents that you sent me and have formed an opinion on this matter. Specifically, I have reviewed the following documents:

0) Medical Records from Dr. Thomas Brandt 5/09/2012 – 5/24/2012;
1) Deposition of Kenneth Barr, 9/09/2015;
2) Deposition of Larry Stegner, 9/09/2015;
3) Medical Records from Dr. Marshall Allyn White, 10/17/2012 -7/16/2015;
4) Medical Records from McLeod Neurological Associates, 9/23/2010 - 10/16/2012;
5) Medical Records from McLeod Regional Medical Center, 9/29/2010 – 9/23/2011;
6) Letter from LifeCare Medical Group, 5/30/2012;
7) Medical Records from The Medical Group, 4/20/2005 -4/7/2015;
8) Medical Records from Florence Neurosurgery & Spine, 10/18/2010;
9) Medical Records from McLeod Urgent Care – Darlington, 6/9/2011 – 11/20/2011;
10) Medical Records from Camden Orthopaedic Associates, 5/02/2012 – 9/12/2012;
11) Medical Records from Hartsville Orthopaedics, 1/30/2012 – 8/29/2013;
12) Medical Evaluation Report from Nicholas A. Lind, PsyD, 12/16/2015;
13) Letter from Dr. Marshall A. White, 12/23/2015;
14) Medical Evaluation Report from Dr. Paul B. Pritchard, III, 2/2/2016; and
15) Material Safety Data Sheets for:
    a) Armorseal Rexthane/Urethane floor coating, clear (Sherwin Williams);
    b) Minwax Polyshades Interior Stain & Polyurethane gloss finish, American Chestnut (Minwax);
    c) Industrial enamel, pure white (Sherwin Williams);
    d) DTM acrylic primer/finish, white (Sherwin Williams);
    e) Krylon Paint All Fast Dry Enamel 1 (Sherwin Williams);
    f) Krylon Paint All Fast Dry Enamel 2 (Sherwin Williams);
    g) Pro-Industrial multisurface acrylic coating, extra white (Sherwin Williams);
    h) Anti-Graffiti coating, clear (Sherwin Williams);
    i) Pro Industrial Multi-Surface Acrylic Coating, extra white (Sherwin Williams);

j) ConFlex XL texture high build (Sherwin Williams);
k) DTM Acrylic semigloss acrylic coating, extra white (Sherwin Williams); and
l) Pro Industrial pre-catalyzed waterbased semi-gloss epoxy, extra white (Sherwin Williams).

According to the information provided to me, Kenneth L. Barr was employed by the Darlington County School District in 2009 as a painter. Prior to that, Mr. Barr was also employed as a painter for other businesses and was also self-employed as a painter for approximately 5 years before beginning work with the school district. It also appears that Mr. Barr continued moonlighting with his personal painting business during his employment with the school district. At some point after 2009, Mr. Barr began suffering from headaches for which he has sought medical treatment. Mr. Barr also contends that he suffers from symptoms such as decreased attention span, diminished concentration, terrible memory, progressive fatigue, and at least one instance of disorientation. Mr. Barr attributes his symptoms to exposure of volatile organic compounds (VOCs) which he was exposed to while employed with the school district.

VOCs are compounds that contain carbon and have a relatively low boiling point (less than 100°C) and a high vapor pressure and therefore readily evaporate. These compounds are used as solvents, but are also found in common household items. Many VOCs are known to be harmful to humans, but many are also considered to be non-toxic. The effects on the health of a person exposed to VOCs depends on the substance itself, length of exposure, and type of exposure. For example, some VOCs such as benzene are known carcinogens, but can also affect the bone marrow, immune system, and nervous system. Other VOCs are also toxic to the liver and kidneys. Exposure to VOCs can occur via the oral, inhalational, or dermal route. Oral exposure involves consuming contaminated foods or, more commonly, water. The inhalational route occurs by breathing in the vapor and dermal absorption can occur when liquids or highly concentrated vapors are exposed to the skin.

The Material Safety Data Sheets (MSDS) that were provided by Mr. Barr to Dr. Pritchard are for products that contain VOCs that are known to be potentially harmful. Some of these products, such as the Armorseal Rexthane, which is a urethane floor coating, are used for tasks other than painting. The two products that Mr. Barr names in his deposition as products that he used the most often, DTM and Pre-catalyzed epoxy, contain compounds that have a relatively low vapor pressure and are not considered by some sources to be a VOC. Mr. Barr also states that he used a respirator on every inside job. Utilization of a properly fitted air-purifying respirator (APR) eliminates the exposure to VOCs. As I stated above, exposure to VOCs can also occur through dermal penetration. This route of exposure only occurs when liquids are applied to the skin or the skin is exposed to high concentrations of VOCs such as would be seen when spraying these compounds in a poorly ventilated area. Since Mr. Barr states that he did not spray paint, this mechanism of exposure would be extremely limited in his case.

Acute exposure to VOCs causes irritation to the eyes, skin, and respiratory tract, headache, dizziness, nausea, loss of coordination, and central nervous system (CNS) depression. Mr. Barr reported only headaches which he associated with exposure to VOCs. As part of his neurological workup over the years Mr. Barr has had CT scans, angiograms and MRIs. These tests have revealed only some vascular disease and he was diagnosed with migraine headaches and prescribed several medicines to treat the migraines. One of the hallmarks of VOC induced neurotoxicity is cerebral atrophy or white matter lesions. Neither of these has been documented in Mr. Barr. Additionally, in 2012 Mr. Barr was restricted from working around paint fumes for a period of six weeks with no improvement of his symptoms.

When humans are exposured to significant levels of VOCs, those compounds and/or their metabolites can be detected in the blood or urine. There is no evidence in this case of any VOCs or their metabolites being detected in the blood or urine of Mr. Barr.

Finally, Mr. Barr has been prescribed a number of medications that can have adverse effects on memory, cognition, and the ability to concentrate. Medications such as tramadol, hydrocodone, clonazepam, and valproic acid cause CNS depression which can result in symptoms such as those seen with Mr. Barr. Compounds such as duloxetine, buspirone, and fluoxetine can also cause CNS depression and sexual dysfunction. The use of the compounds either alone or in combination can cause symptoms similar to those seen in Mr. Barr.

It is my opinion that, within a reasonable degree of scientific and medical certainty, Mr. Barr's symptoms are not likely due to exposure of VOCs while he was employed by the Darlington County School District. This is based on the fact that 1) there is no toxicological evidence of exposure; 2) there is no definitive medical evidence that VOC exposure occurred; 3) there is no definitive medical evidence that Mr. Barr's symptoms are caused by exposure to VOCs; 4) the products that were used most frequently by Mr. Barr did not contain highly volatile VOCs; 5) when Mr. Barr was painting inside, he used an APR and the area was ventilated; 6) Mr. Barr's headaches are not associated with exposure to paint fumes; 7) Mr. Barr's medications can cause impairment of neurological functions; 8) Mr. Barr suffered no ill affects that are commonly seen with acute exposure to VOCs; 9) Mr. Barr has no renal or hepatic injury which can be attributed to VOC exposure; and 10) even if Mr. Barr had an exposure to VOCs, it is more likely that it occurred at a previous job or while he was moonlighting as a self-employed painter (because he did not wear proper protection during those times).

Please let me know if you have any questions or if I can be of further assistance in this matter.

Sincerely,

David H. Eagerton

David H. Eagerton, Ph.D., F-ABFT
Associate Professor of Pharmacology

Attachment

References

Dick, F.D., "Solvent Neurotoxicity," *Occup Environ Med*, 2006; 63:221-226.

http://pubchem.ncbi.nlm.nih.gov/compound2-_2-Methoxyethoxy_ethanol, accessed 1/29/2016

Lexicomp monographs for tramadol, duloxetine, busipirone, topiramate, clonazepam, and fluoxetine, accessed January 2016.

David H. Eagerton, Ph.D., F-ABFT

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148 Autumn Oaks Lane
Lexington, SC 29072

11/14

PROFESSIONAL EXPERIENCE

Oct. 2009-Present
Assistant Professor of Pharmacology
Presbyterian College, School of Pharmacy
Clinton, South Carolina
Design, coordinate, and teach Pharmacology, Pathophysiology, Biochemistry, and Clinical Toxicology to pharmacy students; perform research in Clinical and Forensic Toxicology; participate as a faculty member on committees; and serve as professional advisor to Doctor of Pharmacy students.

Aug. 2011-Present
Consultant Laboratory Director
eLab Consulting Services, Inc.
Atlanta, Georgia
Serve as interim Laboratory Director and Technical Supervisor for COLA accredited Physician Office Laboratories who contract with eLab to perform toxicological testing. Duties include review and approval of all procedures, quality assurance and quality control documentation; review of all proficiency test data; and maintenance of accreditation.

Aug. 1997-Oct. 2009
Chief Toxicologist
South Carolina Law Enforcement Division
Columbia, South Carolina
Plan, coordinate, and direct all operations of the SLED Forensic Toxicology Department, which includes both death investigation and DUI sections; Maintain Training, Certification, and QA/QC programs for the Toxicology Department; Serve as consultant and expert witness in regard to Forensic Toxicology and the SLED Toxicology Department.

July 2007-Aug. 2009
Preceptor
University of South Carolina, College of Pharmacy
Columbia, South Carolina
Supervise Pharmacy students in an advanced practice rotation.

PROFESSIONAL EXPERIENCE (continued)

Feb. 1993- Aug. 1997
Forensic Toxicologist
South Carolina Law Enforcement Division
Columbia, South Carolina
Analyze biological samples for the presence of alcohol, other drugs, or poisons; interpret the results of those analyses, and testify in a court of law regarding those analyses and as to the effects those substances may have on a person.

Jan. 1995- Dec. 1998
Adjunct Professor
University of South Carolina, College of Pharmacy
Columbia, South Carolina
Teach Pharmacology/Toxicology to pharmacy students and graduate students.

Sept. 1986- Jan. 1993
Poison Control Consultant
Palmetto Poison Center
Columbia, South Carolina
Answer emergency calls concerning toxicological exposures from both the lay public and physicians, and to recommend the appropriate treatment protocols for those exposures.

May 1989- June 1992
Research Assistant
University of South Carolina, College of Pharmacy
Columbia, South Carolina
Perform novel research in the area of cancer pharmacology for doctoral degree.

June 1986- May 1989
Teaching Assistant
University of South Carolina, College of Pharmacy
Columbia, South Carolina
Teach Pharmacology and Pharmaceutics laboratories.

EDUCATION

June 1986- Dec. 1992
University of South Carolina, College of Pharmacy, Columbia South Carolina. Ph.D. in Pharmacology; "Biochemical Factors Influencing The Function of Thymidylate Synthase As A Target For Fluoropyrimidines"

Aug. 1985- May 1986
University of South Carolina, College of Pharmacy, Columbia, South Carolina. Third Year Pharmacy School.

Aug. 1980- Aug. 1985
University of South Carolina, Department of Biological Sciences, Columbia, South Carolina. B.S. in Biology.

CONTINUING EDUCATION

1993-2009	South Carolina Law Enforcement Toxicology Lecture Series, Columbia, South Carolina.
1993	South Carolina Criminal Justice Academy, Columbia, South Carolina. Basic Police Officer Training.
1993	Abbott Laboratories, Irving, Texas. Abbott Datatrac training.
1993	Forensic Toxicology workshop presented at the meeting of the Southern Association of Forensic Scientists, Savannah, Georgia.
1994	"Current Approaches In Forensic Toxicology" workshop presented by the Forensic Toxicologist Certification Board at the Joint Congress of The International Association of Forensic Toxicologists and The Society of Forensic Toxicologists, Tampa, Florida.
1995	"Rapid Drug Detection" workshop presented by ANSYS, Inc., Columbia, South Carolina.
1997	"Homicide by Child Abuse" workshop presented by The South Carolina Health Alliance, Charleston, South Carolina.
1997	"Fetal and Pediatric Pharmacology" workshop presented by The Society of Forensic Toxicologists, Snowbird, Utah.
1997	"The Pharmacology of Herbal Preparations" workshop presented by the Society of Forensic Toxicologists, Snowbird, Utah.
1997-Present	South Carolina Law Enforcement Division Supervisor/Management Training Series, Columbia, South Carolina.
1997	"Leadership Skills" workshop presented in conjunction with the Moscow Police Command College, Columbia, South Carolina.
1998	American Society of Crime Lab Directors / Laboratory Accreditation Board (ASCLD/LAB) Inspector Training, Columbia SC.
1998	"Forensic Ethanol Analysis and Interpretation" workshop presented by the Forensic Toxicologist Certification Board at the Spring 1998 Meeting of the Southern Association of Forensic Scientists, New Orleans, LA.

CONTINUING EDUCATION (continued)

1998	"Contemporary Practice in Clinical Toxicology" workshop presented by the American Association of Clinical Chemists, Baltimore, MD.
1998	"Medical Response to Biological Warfare and Terrorism" workshop presented by the CDC and USAMRID, Columbia, SC.
1998-Present	South Carolina Law Enforcement Forensic Sciences Lecture Series, Columbia, South Carolina.
1999	"Post Mortem Pediatric Forensic Toxicology" workshop presented by the American Academy of Forensic Sciences, Orlando, Florida.
1999	"Fatal Child Abuse" workshop presented by The South Carolina Health Alliance, Charleston, South Carolina.
1999	"Hazardous Materials Technician" presented by The Columbia Fire Department, Columbia, South Carolina.
1999	"Supervisory/Management Training for Criminal Justice Professionals" workshop presented by Gordon Graham at Midlands Area Technical College, Columbia, South Carolina.
1999	"Risk Assessment/ Management" workshop sponsored by SLED, Columbia, South Carolina.
2000	"South Carolina Summit on Traffic Safety" workshop presented by The South Carolina Department of Transportation, Greenville, South Carolina.
2000	"DUI 101" workshop presented by The South Carolina Commission on Prosecution Coordination, Columbia, South Carolina.
2000	"WMD HAZMAT Technician (COBRA)" training by The United States Department of Justice Center for Domestic Preparedness, Anniston, Alabama.
2000	"Counter-Terrorism for the 21st Century" workshop presented by L.E.O.S.T Inc., Columbia, South Carolina.
2001	"NHTSA Faculty Development Workshop" presented by The National Highway Safety Administration and the National Judicial College, Reno, Nevada.
2001	"TERM - Vulnerability Analysis" presented by Total Security Services International, Inc., Boston Massachusetts.

CONTINUING EDUCATION (continued)

2001 "The Science of Solid Phase Extraction" presented by United Chemical Technologies, Inc., Columbia, South Carolina.

2001 "TWGFEX Symposium on Fire and Explosion Debris Analysis and Scene Investigation" presented by The National Center for Forensic Science, Orlando, Florida.

2001 "Weapons of Mass Destruction Technician Training" presented by The Special Operations Response Team, Columbia, South Carolina.

2001 "National Terrorism Response Workshop" presented by Hicks and Associates and the Terrorism Research Center, McLean Virginia.

2001 "Felony DUI and Accident Reconstruction" workshop presented by The South Carolina Commission on Prosecution Coordination, Columbia, South Carolina

2002 "Biological Sampling and Detection" 40 hour course on Detection, Sampling, and Analysis of Weapons Grade Biological Agents, West Desert Test Center, Dugway Proving Ground, Dugway, Utah.

2003 "WMD Tactical Operations" 40 hour course on operations level WMD Tactical Operations, Louisiana State University.

2003 "Agilent 5973 MSD Instrument Operations" 24-hour course presented by Agilent Technologies.

2003 "31st Annual Symposium on Crime Laboraotry Development" presented by the FBI and the Carlsen School of Business, Minneapolis, Minnesota.

2003 "Forensic Toxicology Review" presented by the Society of Forensic Toxicologists and the American Association of Clinical Chemists, Raleigh, North Carolina.

2004 "NGA Regional Bioterrorism Workshop" presented by the National Governors Association Center for Best Practices, New Orleans, Louisianna.

2004 "Interviewing: Identifying and Overcoming Deception" presented by the South Carolina Law Enforcement Division, Columbia, South Carolina.

2004 "Laboratory Symposium on Forensic Toxicology" presented by the FBI Laboratory and National Institute of Justice, Washington, DC.

CONTINUING EDUCATION (continued)

2004	"Joint SOFT/TIAFT Meeting" presented by the FBI Laboratory and Society of Forensic Toxicologists and The International Association of Forensic Toxicologists, Washington, DC.
2004	"I-100 Introduction To The Incident Command System" presented by the South Carolina Forestry Commission, Columbia, South Carolina.
2004	"I-200 Basic Incident Command System" presented by the South Carolina Forestry Commission, Columbia, South Carolina.
2005	"NIMS-ICS 300 Intermediate Training Course" presented by EMAC International, Columbia, South Carolina.
2005	"NIMS-ICS 400 Advanced Training Course" presented by EMAC International, Columbia, South Carolina.
2005	"IS-00700 National Incident Management System (NIMS)" presented by FEMA, Columbia, South Carolina.
2005	"ISO/IEC 17025:1999" presented by the American Society of Crime Laboratory Directors Laboratory Accreditation Board, Columbia, South Carolina.
2005	"ASCLD/LAB International Assessor Training " presented by the American Society of Crime Laboratory Directors Laboratory Accreditation Board, Columbia, South Carolina.
2005	"Forensic Toxicology of Pesticides" presented by the Society of Forensic Toxicologists, Nashville, Tennessee.
2005	"Receptor Site Theory and Drug Interactions" presented by the Society of Forensic Toxicologists, Nashville, Tennessee.
2005	"Oral Fluids – Research and Applications" presented by the Society of Forensic Toxicologists, Nashville, Tennessee.
2006	"Method Validation and Measurement Uncertainty" presented by the Society of Forensic Toxicologists, Austin, Texas.
2006	"Postmortem Pharmacokinetics" presented by the Society of Forensic Toxicologists, Austin, Texas.

CONTINUING EDUCATION (continued)

2006	"Addiction and Pain Management for Forensic Toxicologists" presented by the Society of Forensic Toxicologists, Austin, Texas.
2006	"New Antidepressants and Antiepileptics: Clinical Pharmacology, Pharmacogenomics, Gene Expression, and Neurobiology of Depression and Suicide and Forensic Toxicology" presented by the Society of Forensic Toxicologists, Austin, Texas.
2006	"BEAST LIMS Training" presented by Porter Lee, Columbia, South Carolina.
2006	"Supervisor Training" presented by Jack Enter and SLED, Columbia, South Carolina.
2007	Agilent Technologies Speed School , Charleston, South Carolina.
2007	"Drugs and Driving" presented by the American Academy of Forensic Sciences, San Antonio, Texas.
2007	"Pediatric Toxicology" presented by the American Academy of Forensic Sciences, San Antonio, Texas.
2007	"Public safety Sampling for WMD" presented by Louisiana State University and the Office for Domestic Preparedness, Lexington, South Carolina.
2007	"The Toxicology of Plants" presented by the Society of Forensic Toxicologists, Raleigh-Durham, North Carolina.
2007	"Toxicological Analysis of Drug-Facilitated Crimes" presented by the Society of Forensic Toxicologists, Raleigh-Durham, North Carolina.
2007	"LC/MS in the 21st Century" presented by the Society of Forensic Toxicologists, Raleigh-Durham, North Carolina.
2007	"Anti-Terrorism for SC Law Enforcement" presented by the LECC Anti-terrorism Training Subcommittee, Columbia, South Carolina.
2008	FirstDefender Chemical Identification System, Columbia, South Carolina.
2008	"WMD/Terrorism Awareness For Emergency Responders", presented by Texas A&M University and the Department of Homeland Security.
2008	"Botulism", presented by Texas A&M University and the Department of Homeland Security.

CONTINUING EDUCATION (continued)

2008	"Children and Nerve Agents", presented by Texas A&M University and the Department of Homeland Security.
2009	"Best Practices for Volumetric Measurement", presented by RTI International.
2010	Collaborative Institutional Training Initiative (CITI) Human Subject Protection Training Course for Clemson University, Greenville Hospital Systems, and Palmetto Health Richland.
2012	School on Alcoholism and Other Drug Dependencies, University of Utah School of Medicine.
2012	"Updating Knowledge of 17025 (1999 to 2005)" ASCLD/LAB.
2013	School on Alcoholism and Other Drug Dependencies, University of Utah School of Medicine.
2013	"BLS for Healthcare Providers" American Heart Association.
2013	"Theory and History of Comprehensive Multi-Dimensional Gas Chromatography (GC x GC)" LECO.
2013	Collaborative Institutional Training Initiative (CITI) Human Subject Protection Training Course – Update for Clemson University, Greenville Hospital Systems, and Palmetto Health Richland.
2014	School on Alcoholism and Other Drug Dependencies, University of Utah School of Medicine.

INSTRUMENTATION/EXPERIENCE

Analysis of biological samples for the presence of drugs or poisons
Liquid Chromatography including both High Performance Liquid Chromatography and Fast Protein Liquid Chromatography
Gas Chromatography/Mass Spectrometry (both Electron Impact and Chemical Ionization)
High Performance Liquid Chromatography/Atmospheric Pressure Ionization-Electrospray Mass Spectrometry
High Performance Liquid Chromatography/Tandem Mass Spectrometry
Thin Layer Chromatography (Toxilab)
Head-space Gas Chromatography

INSTRUMENTATION/EXPERIENCE (Continued)

Antigen-Antibody based detection and quantitation techniques including Enzyme-Linked Immunosorbent assay, Radio-Immunoassay, and Fluorescence Polarization Immunoassay
Liquid/Liquid and Liquid/Solid extraction techniques
Expert Testimony in South Carolina magistrate, general sessions, United States Federal, and United States military courts
Certified Toxicologist
Certified BAC Datamaster Operator
Certified Law Enforcement Officer (Class 1)
Human and bacterial protein purification monoclonal and polyclonal antibody development
Mammalian and bacterial cell culture
Biochemical analysis of intracellular folates
Gel Electrophoresis including Western and Southern blots, Iso-Electric Focusing, and Two-Dimensional Gels
Atomic Absorption spectroscopy
Radionuclide-Linked Enzyme Assays
In vivo animal research
UV/VIS Spectrophotometry
Fourier-Transform Infrared Spectrophotometry (FTIR)
Raman Spectroscopy
Polymerase Chain Reaction (PCR) Assays
Microbiological Assays
Analysis of Air samples with Multi-gas meters, Photo Ionization Detectors (PID), and Chemical Agent Monitors (CAM)
Radiological Survey and Detection Instruments
Diplomate of the Forensic Toxicology Certification Board
American Society of Crime Lab Directors/Laboratory Accreditation Board (ASCLD/LAB) Inspector
WMD HAZMAT Technician (COBRA)
HAZMAT Technician
Member of SLED WMD Response Team

PUBLICATIONS

Shealy, K., **Eagerton, D.**, and Threatt, T., Engaging the Community: Presbyterian College School of Pharmacy's (PCSP) Approach, Proceedings of The American Association of Colleges of Pharmacy, Grapevine, Texas, 2014.

Huestess, A., Asbill, S., **Eagerton, D. H.**, and Arnold, J. *In Vitro* Skin Penetration and Skin Content of Progesterone from Various Topical Formulations. *International Journal of Pharmaceutical Compounding* 2014; 18 (6): 512-515.

PUBLICATIONS (continued)

Eagerton, D. H., Goodbar, N. H., Dansby, M. C., Abel, S. N., Bell, W. C. Morphine Overdose in a 6 1/2 Week-Old Infant: A Case Report. *Austin J Pharmacol Ther* 2014; 2 (10) 4.

Shealy, K. M., O'Day, P., **Eagerton, D. H.** The Needs and Opportunities for Medication Disposal Programs. *Journal of Pharmacy Technology* 2014; 30 (5): 147-50.

Eagerton, D. H., Sease, J. M. (in press) Liver Cirrhosis and Complications. In S. Scott Sutton (Ed.), *McGraw-Hill's NAPLEX Review Guide*. New York, New York: McGraw Hill.

Eagerton, D., Shealy, K., and Reeder, G. Development and Implementation of a Medication Take-Back Event Led by a School of Pharmacy, Proceedings of Society of American Pharmacist's Association, Los Angeles, California, 2013.

Goodbar, N.H., Foushee, J.A., **Eagerton, D.H.**, Brush, K.C., and Johnson, A.A., Analysis of the HCG Diet on Patient Outcomes, *Ann Pharmacother.* 2013; *47*(5), 5.

Farrell, C.L., Frederick-Duus, K.D., **Eagerton, D.H.**, Pedigo, N.G., Asbill, C.S. and Gouge, E., Biotechnology Lab Practicum: Preparing Pharmacy Students For The Next Generation Of Pharmacy From Pharmacogenomics To Biological Therapeutics, Proceedings of The American Association of Colleges of Pharmacy, Orlando, Florida, 2012.

Eagerton, D.H., "Drug Testing in Urine" in Handling Traffic Cases in South Carolina 2nd edition, R.M. Cole, ed., South Carolina Bar Continuing Legal Education Division, Columbia SC, 1998.

McKinnon, T.A., Smith, Dustin W., and **Eagerton, D.H.**, A Comprehensive Analysis of 24 Opioid Analgesics Utilizing Liquid Chromatography-Tandem Mass Spectrometry (LC-MS/MS), Proceedings of Society of Forensic Toxicologists, Oklahoma City, Oklahoma, 2009.

McKinnon, T.A., and **Eagerton, D.H.**, A Comprehensive Analysis for Benzodiazepines in Biological Matrices Utilizing LC-MS/MS Following a Class-Specific Solid Phase Extraction, Proceedings of Society of Forensic Toxicologists, Raleigh-Durham, North Carolina, 2007.

Bell, W.C., and **Eagerton, D.H.**, Pediatric Case of Fatal Codeine / Promethazine Overdose, Proceedings of Society of Forensic Toxicologists, Austin Texas, 2006

PUBLICATIONS (continued)

Grambow, T.W., Shacker, L.J., Smith, D.W., and **Eagerton, D.H.**, Thiopental Levels and Distribution from South Carolina Lethal Injection Cases, Proceedings of Society of Forensic Toxicologists, Austin Texas, 2006.

Eagerton, D.H., and Shacker, L.J., Case Study: DUI with Multiple Prescription Drugs, Proceeding of the American Academy of Forensic Sciences, San Antonio, Texas, 2007.

Steven M. DuBose, **David H. Eagerton**, Alejandra G. Lewis, and Stephen L. Morgan, "Forensic analysis of benzodiazepines in body fluids by multigradient High performance liquid chromatography/mass spectrometry," paper 2520-3, PittCon 2003, Orlando, FL, 10 March 2003.

Alexander A. Nieuwland, Steven M. DuBose, **David H. Eagerton**, Alejandra G. Lewis, and Stephen L. Morgan, " Forensic analysis of benzodiazepines in blood and urine samples by fastgas Chromatography/mass spectrometry," paper 2520-4, PittCon 2003, Orlando, FL, 10 March 2003.

Assistant Editor of "Current Approaches in Forensic Toxicology" Presented by the Forensic Toxicology Certification Board, Inc., Society of Forensic Toxicologists and the International Association of Forensic Toxicologists Joint Congress, Tampa, Florida, 1994.

Eagerton, D.H., Berger, S.H., and Knapp, L.W., Proc. Amer. Assoc. Cancer Research. 32, 1448 (1991)

Eagerton, D.H., Mosser, D.F., and Berger, S.H., Proc. Amer. Assoc. Cancer Research. 31, 2506 (1990)

Eagerton, D.H., and Berger, S.H. "Folinic Acid As A Source of Intracellular 5,10-Methylenetetrahydrofolate in Human Carcinoma Cells", in The Chemistry and Biology of Pteridines 1989 (Curtis and Ghisla, eds.) Walter de Gruyter and Co.

Eagerton, D.H., and Berger, S.H., Bulletin of South Carolina Acad. of Science. 53, (1991)

Eagerton, D.H., and Berger, S.H., Bulletin of South Carolina Acad. of Science. 52, (1990)

Eagerton, D.H., and Berger, S.H., Bulletin of South Carolina Acad. of Science. 51. (1989)

PRESENTATIONS

"Prescription for Disaster: Current Trends in Drug Abuse" at 2014 Annual Children's Law Conference, October 2014.

"Drug Screening in Abuse and Neglect Cases" training for attorneys and Guardians ad Litem, September 2014.

PRESENTATIONS (continued)

"Forensic Toxicology 101" at Evidentiary Challenges in Child Abuse and Neglect Proceedings Workshop, September 2014.

"Prescription for Disaster" at Presbyterian College School of Pharmacy-ASP-APhA Chapter Meeting, March 2014.

"ABCs of Drug Testing in Child Welfare Cases" at Children's Law Center Office of Indigent Defense Workshop, February 2014.

"Prescription for Disaster" at Presbyterian College Counseling Service, November 2013.

"Alcohol and Social Events" at Presbyterian College School of Pharmacy LEAP Retreat, August 2013.

"Drug Testing" at American Association of Colleges of Pharmacy Annual Meeting, Substance Abuse SIG, July 2013.

"Alcohol and Other Drugs of Abuse – A Health Professional Student Perspective" at SC College of Pharmacy-MUSC Campus Workshop on Alcohol Awareness, February 2013.

"Alcohol " at Presbyterian College ADP Seminar on Alcohol Awareness, March 2013.

"ABCs of Drug Testing in Child Welfare Cases" at Children's Law Center Workshop, December 2013.

"Drugs of Abuse" at Gateway Counseling Service, Workshop, November 2012.

"The Toxicology of Ethanol" at Presbyterian College Grand Chapter, March 2012.

"Toxicology" at Annual Public Defender Conference, September 2011.

"Grandpa's Bottle, Wine or a Drug?" at Aging Research Symposium, February 2011.

"Challenges in Forensic Toxicology" at Presbyterian College Biology Seminar Series, March 2011.

"Toxicology" for Prosecuting The Impaired Driver, March 2011, May 2011, and June 2011.

"Toxicology and Drug Testing" at Annual Children's Law Conference, November 2010.

PRESENTATIONS (continued)

"Toxicology" for The Impaired Driver: Nuts and Bolts of DUI Prosecution, February 2010, March 2010, May 2010, and June 2010.

"Challenges in Forensic Toxicology" at the Western Carolinas Section of the American Chemical Society, Newberry, South Carolina, October 2008

"Stimulants" at the Drugs and Driving Workshop sponsored by the Society of Forensic Toxicologists, West Palm Beach, Florida, May 2008.

"Alcohol and Other Drugs of Impairment" at the DUI Training Workshop sponsored by the South Carolina Commission on Prosecution Coordination, June 2008, July2008, February 2009, June 2009, and August 2009.

"CSI - Toxicology" at Newberry College, Newberry, South Carolina, November 2007, and March 2010.

"Toxicology of Alcohol" at the ABCs of DUI Workshop sponsored by the South Carolina Commission on Prosecution Coordination, April, June July, and August, 2007.

"Case Study: DUI with Multiple Prescription Drugs" at the American Academy of Forensic Sciences, San Antonio, Texas, February 2007.

"GABA Receptors" at the Receptor Site Theory Workshop sponsored by the Society of Forensic Toxicologists, October 2005.

"Toxicology in The Drugged Driver" at Prosecuting the Drugged Driver Course sponsored by the National District Attorneys Association National Advocacy Center, November 2005.

"Biological Agents Used as Weapons of Mass Destruction" at the South Carolina Law Enforcement Division Forensic Services Seminar Series, October 2001.

"Central Nervous System Depressants" at the Forensic Toxicology Review workshop presented by the Society of Forensic Toxicologists and the American Association of Clinical Chemists, October 2001.

"The Role of the Forensic Laboratory in WMD Events" at Forensic Epidemiology for Health Care Workers and Law Enforcement, 2003 through 2005.

"Toxicology of Abused Drugs" advanced training for South Carolina Criminal Justice Academy, January 2003 and June 2003.

PRESENTATIONS (continued)

"Date Rape and Club Drugs" workshop presented at 22nd Annual School Nurse Conference, November, 2002.

"Medical Perspectives -Blood, Breath, and Urine" at the South Carolina Criminal Justice Academy Advanced DUI Training, October 2002.

"Toxicological Perspectives" at the Felony DUI and Accident Reconstruction Workshop sponsored by the South Carolina Commission on Prosecution Coordination, August 2001.

"Case Studies in Forensic Toxicology" at the South Carolina Law enforcement Division Forensic Services Seminar Series, October 2000.

"Medicolegal Perspective of DUI" at the DUI for the Prosecutor Workshops sponsored by the South Carolina Commission on Prosecution Coordination, August 2000, March 2001, and April 2001.

"The Role of SLED Toxicology in Alcohol and Drug Testing" at the BAC Workshop sponsored by the South Carolina Office of Highway Safety, May 2000.

"Challenges in Forensic Toxicology" presented to the University of South Carolina chapter of the American Chemical Society, March 2000, September 2000 and August 2001.

"Date Rape and Club Drugs" workshop presented at Sumter School District Health Fair, May 2000.

"Drug-Facilitated Rape" at the South Carolina Law enforcement Division Forensic Services Seminar Series, May 1999.

"Drug and Alcohol Analysis and DRE Evaluation" at the SC Bar Association Workshop on Handling Traffic Cases in South Carolina, August 1998.

"Toxicology of Abused Drugs" at the SC Coroner's Association meeting, October 1998.

"Forensic Toxicology of Abused Drugs" workshop presented at 1997 Fall Training Conference of the South Carolina Department of Social Services County Directors and Supervisors Association, October 1997.

"Rohypnol and Other Drugs Associated with 'Date Rape'" at the Rape Crisis Network training, October, 1997.

PRESENTATIONS (continued)

"Rohypnol and Other Drugs Associated with 'Date Rape'" at the August Meeting of the South Carolina Campus Law Enforcement Officers Association, 1997.

"Laboratory Testing of Flunitrazepam and Other Drugs Associated with 'Date Rape'" at the Rape Crisis Council of Pickens County Rohypnol Seminar, 1997.

"Applications of High Performance Liquid Chromatography / Atmospheric Pressure Ionization - Electrospray / Mass Spectrometry in Forensic Toxicology" at the Western Carolina Chromatography Discussion Group, 1996.

"Pharmacology of Abused Drugs" at South Carolina State University C.A.D.E.P.P. training, 1996, 1997, 2000, and 2001.

"Cocaine Agitated Delirium" at South Carolina Law Enforcement Division In-Service training, 1993-1994.

"Tolerance and Dependence" at South Carolina Law Enforcement Division Toxicology In-Service Training, 1993.

"Alcohol Analysis" at Law Enforcement training on alcohol sponsored by MADD, December, 1993.

"Biochemical Factors Influencing the Function of Thymidylate Synthase as a Target for Fluoropyrimidines" Seminar presented at the Duke University Department of Immunology, July, 1992.

"Preparation and Characterization of Monoclonal Antibodies to Human Thymidylate Synthase" at the annual meeting of the South Carolina Academy of Science, 1991.

HONORS

2010 – 2011 Teacher of the Year (Presbyterian College School of Pharmacy)

1991 Sigma Xi Graduate Student Research Presentation
Award: First Place

Rho Chi Honor Society

Fellow- American Board of Forensic Toxicology (F-ABFT)

American Society of Crime Laboratory Directors - Laboratory Accreditation Board Inspector

HONORS (Continued)

American Society of Crime Laboratory Directors - Laboratory Accreditation Board International Assessor

Expert Witness Faculty Member of the National District Attorneys Association National Advocacy Center
"Prosecuting the Drugged Driver" 10/99, 3/01, 3/02, 1/04, 11/05, 11/08, 8/09, 3/10
"Lethal Weapon - DUI Homicide" 8/99, 8/00, 8/01, 8/02, 7/03, 7/04, 7/05
"Homicide Prosecution" 4/98 – 2001

Expert Witness Faculty Member of the National College of District Attorneys, Charleston, SC, 6/08, 6/09.

Adjunct Instructor for South Carolina Criminal Justice Academy

Member of the South Carolina Bioterrorism Advisory Committee

Founding President of the Palmetto Association of Toxicologists

Austin Journal of Pharmacology and Therapeutics Editorial Board

Reviewer – Journal of Pharmacy Technology

Thieme Publishers Reviewer for "Biochemistry – An Illustrated Review"

Reviewer and Judge for Junior Science and Humanities Symposium 2014

PROFESSIONAL AFFILIATIONS

Society of Forensic Toxicologists
Southern Association of Forensic Scientists
American Association of Clinical Chemists
American Association of Clinical Toxicologists
American Academy of Colleges of Pharmacy
Palmetto Association of Toxicologists

PERMANENT GRADE SHEET

Grade First
School Year 1975-76

Student Kenneth Barr
Teacher Brammer

A - 95-100
B - 88-94
C - 78-87
D - 70-77
F - 0-69

S - Satisfactory
U - Unsatisfactory

SUBJECT	1 L	1 N	2 L	2 N	3 L	3 N	4 L	4 N	5 L	5 N	6 L	6 N	F L	F N
CONDUCT			B		A		B		A		B		B	
BIBLE			B	90	A-	85	A	98	B	91	B	90	B	93
ENGLISH					C-									
READING & PHONICS			B-	88	[illegible]	78	D+	77	C-	78	B	92	C	83
SPELLING							B+	94	A	98	A	98	A	97
ARITHMETIC			A	96	B+	94	B	91	A-	96	B	93	B+	94
SCIENCE														
SOCIAL STUDIES														
WRITING			B	89	C	85	C	79	C	84	C+	87	C	85
ART							S		S		S		S	
MUSIC							S		E		S		S	
P.E.							S		E		E		B	
HONOR ROLL			✓											
(Check indicates) needs improvement														
Manifests a responsive att. toward spir. matters														
Is humble and shows Christian love toward others														
Manifests in life (honesty & truthfulness)														
Is respectful and obedient											✓			
Assumes responsibility for his own work														
Is courteous, helpful and cooperative														
Respects rights and property of others														
Works independently without disturbing others														
Perseveres in face of difficulties . . . tries			✓											
Listens attentively														
Uses time to good advantage							✓							
Is conscientious and prompt in compl. assign.														
Practices neatness (written work, care of desk, etc.)														
Understands need for school rules and obeys them														
DAYS PRESENT	28		29		31		30		29		29		174	
DAYS ABSENT	0		1		2		0		0		0		3	
UNEXCUSED ABSENCES	0		0		0		0		0		0		0	
DAYS TARDY	1		1		0		0		0		0		2	
UNEXCUSED TARDINESS	0		1		0		0		0		0		1	

Teacher's Comments
1.
2.
3.
4.
5.
6.

STUDENT (PROMOTED)(RETAINED) TO GRADE Promoted -2

PERMANENT GRADE SHEET

Grade 2
School Year 1976 - 1977

Student Barr, Ken
Teacher Miss Kazian

A - 95-100
B - 88-94
C - 78-87
D - 70-77
F - 0-69

S - Satisfactory
U - Unsatisfactory

SUBJECT	1 L	1 N	2 L	2 N	3 L	3 N	4 L	4 N	5 L	5 N	6 L	6 N	F L	F N
CONDUCT	A		B		B		B		B		B		B	
BIBLE	B	90	C	86	B	90	C	85	B	92	B	94	B	90
ENGLISH														
READING & PHONICS	C	84	B	91	C	83	B	89	B	90	B	89	B	88
SPELLING	A	98	A	97	A	99	A	98	A	99	A	99	A	99
ARITHMETIC	A	96	B	92	B	89	C	85	C	83	B	90	B	88
SCIENCE														
SOCIAL STUDIES														
WRITING	B		B		B-		B-		C+		C+		B-	
ART														
MUSIC	S		S		S		S		S		S		S	
P.E.	S		S		S		S		S		S		S	
HONOR ROLL													✓ A-B	
(check indicates) (✓) Needed improvement														
Manifests a responsive att. toward spir. matters														
Is humble and shows Christian love toward others														
Manifests in life (honesty & truthfulness)														
Is respectful and obedient														
Assumes responsibility for his own work														
Is courteous, helpful and cooperative														
Respects rights and property of others														
Works independently without disturbing others														
Perseveres in face of difficulties . . . tries					✓		✓							
Listens attentively			✓						✓		✓			
Uses time to good advantage														
Is conscientious and prompt in compl. assign.														
Practices neatness (written work, care of desk, etc.)														
Understands need for school rules and obeys them														
							33							
DAYS PRESENT	28		29		23		26		27		31		164	
DAYS ABSENT	0		0		3		7		4		0		14	
UNEXCUSED ABSENCES	0		0		0		0		0		0		0	
DAYS TARDY	0		0		0		0		0		0		0	
UNEXCUSED TARDINESS	0		0		0		0		0		0		0	

Teacher's Comments

1.
2.
3.
4. Ken gives up too easily, before trying to do his best.
5.
6.

STUDENT (PROMOTED) (RETAINED) TO GRADE 3

PERMANENT GRADE SHEET

Grade 3
School Year 1977-78

Student Barr, Ken
Teacher JANET SPAULDING

A - 95-100
B - 88-94
C - 78-87
D - 70-77
F - 0-69

S - Satisfactory
U - Unsatisfactory

SUBJECT	1 L	1 N	2 L	2 N	3 L	3 N	4 L	4 N	5 L	5 N	6 L	6 N	F L	F N
CONDUCT	A	96	B	93	B	93	B	93	B	85	C	86	B	91
BIBLE	A	100	B	94	B	93	B	92	B	89	C	85	B	92
ENGLISH	B	92	B	90	B	89	B	94	B	93	C	81	B	90
READING & PHONICS	B	91	88	B	C	80	C	78	C-	78	C	79	C	82
SPELLING	A	96	98	A	A	95	A	98	B	90	B	89	B	94
ARITHMETIC	A	97	91	B	C	80	C	80	D	74	D	73	C	83
SCIENCE							C	87	C	81	D	71	C	80
SOCIAL STUDIES	C+	87	89	B	C	83							C	86
WRITING	A	96	95	A	B	90	B	90	B	90	B	91	B	92
ART	S		S		S		S		S		S			
MUSIC	S		S		S		S		S		S			
P.E.	S		S		S		S		S		S			
HONOR ROLL			✓											
Check indicates (✓) Needs Improvement														
Manifests a responsive att. toward spir. matters														
Is humble and shows Christian love toward others			✓											
Manifests in life (honesty & truthfulness)														
Is respectful and obedient														
Assumes responsibility for his own work														
Is courteous, helpful and cooperative														
Respects rights and property of others														
Works independently without disturbing others											✓			
Perseveres in face of difficulties . . . tries					✓		✓		✓		✓			
Listens attentively									✓		✓			
Uses time to good advantage														
Is conscientious and prompt in compl. assign.														
Practices neatness (written work, care of desk, etc.)														
Understands need for school rules and obeys them														
DAYS PRESENT	30		29		30		28		32		29		178	
DAYS ABSENT	0		1		0		1		0		0		2	
UNEXCUSED ABSENCES	0		0		0		0		0		0		0	
DAYS TARDY	0		0		0		0		0		0		0	
UNEXCUSED TARDINESS	0		0		0		0		0		0		0	

Teacher's Comments

1.
2. Ken shows attitude problems when corrected about things.
3.
4. I'm working with Ken but he still gives up & quits in slightly difficult things.
5.

UDENT (PROMOTED)(RETAINED) TO GRADE 4

PERMANENT GRADE SHEET

Grade 4
School Year 1978-'79

Student Kent Barr
Teacher Mrs. B. Johnson

A - 95-100
B - 88-94
C - 78-87
D - 70-77
F - 0-69

S - Satisfactory
U - Unsatisfactory

SUBJECT	1 L	1 N	2 L	2 N	3 L	3 N	4 L	4 N	5 L	5 N	6 L	6 N	F L	F N
CONDUCT	B	88	B	88	B	88	B	88	B	88	B	88	B	88
BIBLE	B	88	B	85	B	91	B	89	C	85	C	87	B	89
ENGLISH	C	80	C	79	C	80	C	86	C	80	D	77	C	80
READING & PHONICS	C	85	C	86	C	86	C	86	C	86	C	86	C	86
SPELLING ✓	D	78	C	86	D	77	B	91	B	90	B	90	C	85
ARITHMETIC	C	84	C	85	D	70	C	83	D	71	C	87	C	79
SCIENCE	C	85	C	81	D	75	B	90	C	81	A	95	C	85
SOCIAL STUDIES ✓	F	45	C	82	F	67	C	78	F	65	C	80	D	71
WRITING	B	89	B	89	B	89	B	89	B	89	B	89	B	89
ART														
MUSIC	B		C		C		B-		C		C		C	
P.E.														
Band			B	90	B	90	A	95	B	92	A	92	B	92
HONOR ROLL														
(Check indicates (✓) Needs improvement														
Manifests a responsive att. toward spir. matters														
Is humble and shows Christian love toward others														
Manifests in life (honesty & truthfulness)														
Is respectful and obedient														
Assumes responsibility for his own work														
Is courteous, helpful and cooperative														
Respects rights and property of others														
Works independently without disturbing others	✓		✓		✓		✓		✓		✓			
Perseveres in face of difficulties . . . tries														
Listens attentively	✓		✓		✓		✓		✓		✓			
Uses time to good advantage														
Is conscientious and prompt in compl. assign.														
Practices neatness (written work, care of desk, etc.)														
Understands need for school rules and obeys them														
DAYS PRESENT	30		32		29		24		33		27		175	
DAYS ABSENT	0		0		0		0		0		0		0	
UNEXCUSED ABSENCES	0													
DAYS TARDY	0		0		0		0		0		0		0	
UNEXCUSED TARDINESS	0													

Teacher's Comments
1. Can do much better. Needs to try harder.
2. Does not settle down in class.
3. Dropped considerably in several subjects
4.
5.
6.

STUDENT (PROMOTED)(RETAINED) TO GRADE _____

PERMANENT GRADE SHEET

Grade 5
School Year 1979-1980

Student Barr, Kenneth
Teacher Mr. Heller

A - 95-100
B - 88-94
C - 78-87
D - 70-77
F - 0-69

S - Satisfactory
U - Unsatisfactory

SUBJECT	1 L	1 N	2 L	2 N	3 L	3 N	4 L	4 N	5 L	5 N	6 L	6 N	F L	F N
CONDUCT	B	90	B	90	B	90	C	80	C	80	C	80	C	85
BIBLE	C	81	C	82	D-	70	C+	87	B	89	D	75	C	82
ENGLISH	D	74	D	74	C	81	C	84	D	76	C-	78	C	79
READING & PHONICS	C	84	C	85	C	83	C+	87	D	74	F	66	C	86
SPELLING	B	89	C	81	B	88	C	79	C-	78	C	80	C	83
ARITHMETIC	D-	70	F	60	F	53	F	47	F	60	D	71	F	60
SCIENCE	D	75	C	81	F	68	D-	70	D	72	D-	70	D	73
SOCIAL STUDIES	C-	78	C-	78	F	55	C	83	D	75	D-	70	D	73
WRITING	C+	87	B	89	B	89	C	86	B+	88	C	86	C+	87
ART														
MUSIC	B+	94	B	89	B+	94	A-	76	B	93	A	96	B+	94
P.E.														
HONOR ROLL														
Check, indicate (✓) Needs Improvement														
Manifests a responsive att. toward spir. matters														
Is humble and shows Christian love toward others														
Manifests in life (honesty & truthfulness)														
Is respectful and obedient														
Assumes responsibility for his own work														
Is courteous, helpful and cooperative														
Respects rights and property of others														
Works independently without disturbing others	✓		✓		✓				✓		✓		✓	
Perseveres in face of difficulties . . . tries							✓		✓		✓		✓	
Listens attentively	✓		✓		✓		✓		✓		✓		✓	
Uses time to good advantage									✓					
Is conscientious and prompt in compl. assign.							✓							
Practices neatness (written work, care of desk, etc.)														
Understands need for school rules and obeys them														
DAYS PRESENT	29		33		31		25		30		31		179	
DAYS ABSENT	0		0		0		0		0		0		0	
UNEXCUSED ABSENCES	0		0		0		0		0		0		0	
DAYS TARDY	0		0		0		0		0		0		0	
UNEXCUSED TARDINESS	0		0		0		0		0		0		0	

Teacher's Comments
1.
2.
3.
4.
5.
6.

STUDENT (PROMOTED) (RETAINED) TO GRADE 6.

PERMANENT GRADE SHEET

Grade 6
School Year 1980-81

Student Ken Barr
Teacher Chittam

A - 95-100
B - 88-94
C - 78-87
D - 70-77
F - 0-69

S - Satisfactory
U - Unsatisfactory

SUBJECT	1 L	1 N	2 L	2 N	3 L	3 N	4 L	4 N	5 L	5 N	6 L	6 N	F L	F N
CONDUCT	B		C		C		C		C		C		C	
BIBLE	D		F	64	D	71	C	85	A	95	D	76	D	76
ENGLISH	D	76	C	84	C+	87	B	88	D+	77	D	74	C	83
READING & PHONICS	D	75	C	78	C+	97	C	83	C	78	D	70	C	79
SPELLING	D	71	D+	77	D	76	D	76	D	72	D	71	D	73
ARITHMETIC	D	73	F	61	D	70	F	60	D	74	D	73	D	70
SCIENCE	D		F	58	F	57	F	67	F	55	F	62	F	62
SOCIAL STUDIES	F	68	D	70	F	67	D	73	B	92	D	71	D	74
WRITING														
ART														
MUSIC							C	85	B					
P.E.	S		S		S		S		S		S			

HONOR ROLL

Checks - Indicate - Needs Improvement

Manifests a responsive att. toward spir. matters							
Is humble and shows Christian love toward others							
Manifests in life (honesty & truthfulness)							
Is respectful and obedient							
Assumes responsibility for his own work				✓			
Is courteous, helpful and cooperative					✓		
Respects rights and property of others			✓				
Works independently without disturbing others					✓	✓	
Perseveres in face of difficulties . . . tries				✓	✓	✓	
Listens attentively	✓	✓	✓	✓		✓	
Uses time to good advantage		✓	✓			✓	
Is conscientious and prompt in compl. assign.		✓					
Practices neatness (written work, care of desk, etc.)							
Understands need for school rules and obeys them							

DAYS PRESENT	29	30	33	30	29	29	180
DAYS ABSENT	0	0	0	0	0	0	0
UNEXCUSED ABSENCES	0	0	0	0	0	0	0
DAYS TARDY	0	0	0	0	0	0	0
UNEXCUSED TARDINESS	0	0	0	0	0	0	0

Teacher's Comments
1.
2.
3.
4.
5.
6.

STUDENT (PROMOTED)(~~RETAINED~~) TO GRADE 7

Emmanuel Baptist School
H. S. Permanent Grade Sheet

Grade 7 Student Ken Barr
School Year 1981-82 Homeroom Teacher K. Heller

A - 95-100 D - 7077 S - Satisfactory
B - 88-94 F - 0-69 U - Unsatisfactory
C - 78-87

GRADING PERIOD

SUBJECT	1		2		3		Exam		Sem.		4		5		6		Exam		Sem.		FINAL		TEACHER
CONDUCT		B		C		B				B		B		B		A				B		B	
BIBLE	78	C-	66	F	75	C-	56	F	70	D-	83	C	74	D	82	C	63	F	76	D	73	D	Heller
ENGLISH	68	F	63	F	71	D	40	F	61	F	74	D	75	D	88	B-	72	D	79	C	70	D-	Heller
MATH	90	B	98	A	75	C			83	C	86	B	89	B	84	C	59	F	77	D	80	C	Kilpatrick
SCIENCE	80	C	60	F	70	D-			70	D-	72	D	76	D	75	D	70	D	72	D	71	D	Smith
FOREIGN LANGUAGE																							
SOCIAL STUDIES	65	F	70	D-	70	D-	64	F	67	F	63	F	66	F	75	D	67	F	68	F	68	F	Brewer
Health + Safety	81	C	90	B	96	A			89	B	87	C+	70	D-	79	C	—		79	C	84	C	Smith
ART																							
MUSIC																							
P.E.	88	B	95	A-	95	A-			95	A-	95	A-	90	B	100	A			95	A	95	A	Harris
HONOR ROLL																							

CHARACTER TRAITS

	1	2	3			4	5	6				
1. Punctuality												
2. Neatness												
3. Accuracy												
4. Quietness												
5. Industry	✓	✓	✓				✓					
6. Obedience												
7. Truthfulness												
8. Attentiveness		✓	✓			✓	✓					
9. Cooperation												
10. Responsibility		✓										
11. Courteous												
DAYS PRESENT	28	29	33		90	30	24	31		85	175	
DAYS ABSENT	0	1	0		1	0	4	0		4	5	
UNEXCUSED ABSENCES	0	0	0		0	0	0	0		0	0	
DAYS TARDY	0	1	0		1	0	1	0		1	2	
UNEXCUSED TARDINESS	0	1	0		1	0	0	0		0	1	

SUBJECT	MARKING PERIOD	REMARKS
Social Studies	2nd period	Needs to pay better attention

STUDENT (PROMOTED) (RETAINED) TO GRADE 8.

Emmanuel Baptist School
H. S. Permanent Grade Sheet

Grade 8
School Year 82-83

Student Barr, Kenneth Lee
Homeroom Teacher R. Figg

A - 95-100
B - 88-94
C - 78-87
D - 7077
F - 0-69
S - Satisfactory
U - Unsatisfactory

GRADING PERIOD

SUBJECT	1		2		3		Exam	Sem.		4*		5	6		Exam		Sem.		FINAL		TEACHER
CONDUCT	A-	95	B										A						A		
BIBLE	D-	70	F	65	F	62	+	F	62		69		C	83			D	76	F	69	Mr Chittam
ENGLISH	D	76	C	80	F	68	+	D	75		75		D	71	D+	77	D	74	D	75	Miss Dunlap
MATH	C-	78	F	49	D	73	+	F	67		78		D	72			D	75	D	71	Mr Edwards
SCIENCE Earth	D	74	B	90	C	85	+	C	83		75		A	98	+		C+	87	C	85	Mr Figg
FOREIGN LANGUAGE																					
SOCIAL STUDIES SC. HIST	D	70	D	76	D	75	+	D	74		53		F	61			F	57	F-	66	Mrs Brewer
Health	C-	78	F	51	D	75		F	68				B	93	+		B	93	C	81	Mr. Chittam
ART																					
MUSIC																					
P.E.	B+	94	B+	94	A	96		A-	95		91		A	96	+		94	B+	A-	95	Mr Chittam
HONOR ROLL																					

CHARACTER TRAITS														
1. Punctuality														
2. Neatness														
3. Accuracy														
4. Quietness														
5. Industry			✓											
6. Obedience														
7. Truthfulness														
8. Attentiveness			✓											
9. Cooperation														
10. Responsibility	✓													
11. Courteous														
DAYS PRESENT	30		30							30				
DAYS ABSENT	0		0							0				
UNEXCUSED ABSENCES														
DAYS TARDY			1											
UNEXCUSED TARDINESS														

SUBJECT	MARKING PERIOD	REMARKS

STUDENT (PROMOTED) (RETAINED) TO GRADE 9

* This column was determined from grades Ken received while enrolled at Pensacola Christian School during the middle portion of this year. No grades appear in the 5th six weeks column. [illegible] under the 9 weeks system.

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Emmanuel Baptist School
H. S. Permanent Grade Sheet

Grade 9
School Year 83-84

Student Kenneth Lee Barr
Homeroom Teacher Miss Dixon

A - 95-100
B - 88-94
C - 78-87
D - 7077
F - 0-69
S - Satisfactory
U - Unsatisfactory

GRADING PERIOD

SUBJECT	1		2		3		Exam		Sem.		4		5		6		Exam		Sem.		FINAL		TEACHER
CONDUCT	A		A		B						B		A		A					A		A	
BIBLE	C	79	C	80	C	90	B	82	B-	88	C	79	C-	78	C-	78	C	85	C	82	C	85	BAYNE
ENGLISH	C	82	D+	76	C	80	F	57	D	74	D	75	C	78	C	80	C	79	C	78	D	76	DIXON
MATH Algebra	B	90	D	73	F	68	D+	77	D+	77	F	51	C	79	C	80	F	33	F	61	D-	70	SHIRES
SCIENCE	D	76	C	85	C	82	D	72	C-	74	C	80	D	73	C	82	C	83	C	81	C	80	ANDERSON
FOREIGN LANGUAGE																							
SOCIAL STUDIES																							
Typing	B-	89	B	91	B	91	C+	80	B	89	B	93	B	92	B	91	C+	87	B	89	B	90	SMITH
ART																							
MUSIC																							
P.E.	B	88	C+	87	A-	95	B	86	B	89	A	98	A	96	A	98	elector		A	97	B	93	BAYNE
HONOR ROLL																							

CHARACTER TRAITS

1. Punctuality												
2. Neatness												
3. Accuracy												
4. Quietness												
5. Industry			✓			✓						
6. Obedience												
7. Truthfulness												
8. Attentiveness			✓									
9. Cooperation												
10. Responsibility												
11. Courteous												
DAYS PRESENT	27	29	30			29	30	30				
DAYS ABSENT	3		0			0	0	0				
UNEXCUSED ABSENCES		1										
DAYS TARDY	1	2				1						
UNEXCUSED TARDINESS												

SUBJECT	MARKING PERIOD	REMARKS

STUDENT (PROMOTED) (RETAINED) TO GRADE 10th

Emmanuel Baptist School
H. S. Permanent Grade Sheet

Grade 10th.
School Year 1984-85

Student Kem Barr
Homeroom Teacher Mrs. Shires

A - 95-100
B - 88-94
C - 78-87
D - 7077
F - 0-69
S - Satisfactory
U - Unsatisfactory

GRADING PERIOD

SUBJECT	1		2		3		Exam		Sem.		4		5		6		Exam		Sem.		FINAL		TEACHER
CONDUCT	B		B		C						B		B		A								
BIBLE	C	79	C	80	C-	78	D	75	D	75	C	79	D	76	D	77	D	75	D	76	D	77	Mr Fizg.
ENGLISH	C	81	D	72	F	60	F	56	F	67	C	81	D	75	C	87	F	57	D	75	D	71	Mrs. Radix
MATH Algebra II.	C-	78	D	71	B-	88	F	64	D	75	D	71	F	54	D	74	F	65	F	64	D-	70	Mrs. Shires
SCIENCE Biology	C	80	C	82	C	86	D	76	C	81	C	86	D	74	D+	77	F	53	D	72	D+	77	Mr Kilpatrick
FOREIGN LANGUAGE Spanish	B	91	C	80	C	79	D	76	C	82	C+	87	C+	87	C	85	C	80	C	85	C	84	Mr. Anderson
SOCIAL STUDIES World History	F	64	F	66	F	50	F	52	F	58	C	80	F	59	D	75	F	66	D	70	D	64	Miss Brewer
ART																							
MUSIC																							
P.E.																							
HONOR ROLL																							

CHARACTER TRAITS												
1. Punctuality												
2. Neatness												
3. Accuracy												
4. Quietness		✓	✓			✓						
5. Industry			✓				✓					
6. Obedience												
7. Truthfulness												
8. Attentiveness			✓									
9. Cooperation												
10. Responsibility	✓						✓					
11. Courteous												
DAYS PRESENT	28	30	29		87	30	30	30		90	177	
DAYS ABSENT	—	0	1		1	0	0	0		0	3	
UNEXCUSED ABSENCES	2	0	0		2	0	0	0		0	0	
DAYS TARDY	0	0	0		0	0	0	0		0	0	
UNEXCUSED TARDINESS	0	0	0		0	0	0	0		0	0	

SUBJECT	MARKING PERIOD	REMARKS
Biology	1st	can do better
Biology	4th.	Could do better

STUDENT (PROMOTED) (RETAINED) TO GRADE _____.

Emmanuel Baptist School
H. S. Permanent Grade Sheet

Grade Junior
School Year 1985-1986

Student Barr, Kenneth Lee
Homeroom Teacher Mr. David E. Bayne

A - 95-100
B - 88-94
C - 78-87
D - 7077
F - 0-69
S - Satisfactory
U - Unsatisfactory

GRADING PERIOD

SUBJECT	1		2		3		Exam		Sem.		4		5		6		Exam		Sem.		FINAL		TEACHER
CONDUCT	B		B		B				B		A			B	A		X	X	A-		B		
BIBLE	C	85	B	91	B	92	C	83	B-	88	95	A-	95	A-	A-	95	X	X	A-	95	B	92	Mr. Bayne
ENGLISH	D	76	D	76	C	82	F	60	D	74	50	F	87	C+	B	92	C	85	C	79	D+	77	Miss Harrison
MATH Geometry	B-	83	D	76	F	62	D	75	D	71	62	F	62	F	C	85	F	55	F	66	D-	70	Mrs. Shires
SCIENCE Chemistry	B-	88	B	89	B	90			B	89	83	C	90	B	B-	88	D	72	C	83	C	86	Mr. Marsi
FOREIGN LANGUAGES Sp. II	C+	87	D+	77	C	80	C	80	C	81	84	C	79	C	B	92	F	60	C	79	C	80	Mr. Anderson
SOCIAL STUDIES Am. Hist.	D+	77	F	60	D+	77	F	63	F	69	72	D	69	F	C	79	F	63	D	71	D-	70	Miss Brewer
ART																							
MUSIC																							
P.E.																							
HONOR ROLL																							

CHARACTER TRAITS

	1	2	3	Exam	Sem.	4	5	6	Exam	Sem.	FINAL	
1. Punctuality												
2. Neatness												
3. Accuracy												
4. Quietness	✓	✓	✓				✓					
5. Industry												
6. Obedience												
7. Truthfulness												
8. Attentiveness			✓				✓					
9. Cooperation												
10. Responsibility												
11. Courteous												
DAYS PRESENT	29	30	30		89	30	30	30	90		179	
DAYS ABSENT	1	0	0		1	0	0	0	0		1	
UNEXCUSED ABSENCES	0	0	0		0	0	0	0	0		0	
DAYS TARDY	0	0	0		0	0	0	0	0		0	
UNEXCUSED TARDINESS	0	0	0		0	0	0	0	0		0	

SUBJECT	MARKING PERIOD	REMARKS

STUDENT (PROMOTED) (RETAINED) TO GRADE 12

SECONDARY SCHOOL RECORD

479

1. STUDENT IDENTIFICATION

STUDENT'S FULL LEGAL NAME: LAST, FIRST, MI: Barr, Kenneth Lee

SEX	COMMON NAME	OTHER LAST NAMES USED	BIRTH DATE	SOC. SEC. NUMBER
Male	Ken			

PARENT OR LEGAL GUARDIAN:
NAME: Mrs. Louise Barr ADDRESS:
CITY: STATE ZIP

2. SCHOOL IDENTIFICATION

NAME Emmanuel Baptist School
ADDRESS Route 1, Box 82
CITY Hartsville PHONE: (803) 332-0164
STATE South Carolina ZIP: 29550 SCHOOL CODE: 410994

3. STUDENT'S ACADEMIC HISTORY

MINIMUM PASSING MARK 70 OTHER PASSING MARKS USED (AND NUMERICAL EQUIVALENT)

GRADE & YRS.	COURSES TAKEN (AND SPECIAL LEVEL WHERE APPROPRIATE)	MARKS	CREDITS	GRADE & YRS.	COURSES TAKEN (AND SPECIAL LEVEL WHERE APPROPRIATE)	MARKS	CREDITS
	NOTE: Grade 9-83/84 Grade 10-84/85 Grade 11-85/86 Grade 12-86/87						
	LANGUAGE ARTS (4 units)*				BUSINESS EDUCATION		
9	English I *	76	1	9	Typing	90	1
10	English II*	71	1	12	Accounting	75	1
11	English III*	77	1	12	Computer	70	1/2
12	English IV *	73	1				
12	Speech	86	1/2				
	FOREIGN LANGUAGE				PHYSICAL EDUCATION (1 unit)*		
10	Spanish I	84	1	9	P. E.	93	1
11	Spanish II	80	1				
	MATH (3 units)*				OTHER		
9	Algebra I	70	1	9	Bible I	85	1
10	Algebra II	70	1	10	Bible II	77	1
11	Geometry	70	1	11	Bible III	92	1
				12	Bible IV	83	1
	SOCIAL SCIENCE (3 units)*						
10	World History	70	½				
11	American History*	70	1				
12	Government *	62	0				
12	Economics *	64	0				
12	World History	85	1/2				
S.S.	Economics	95	1/2				
S.S.	Government	97	1/2				
	NATURAL SCIENCE (2 units)*						
9	Science	80	1				
10	Biology	77	1				
11	Chemistry	86	1				

*Required for S.C. diploma, plus 7 elective units of credit.

4. STUDENT'S ACADEMIC SUMMARY

ACADEMIC STANDING				NUMBER OF CREDITS EARNED									
AT THE END OF:	GPA	CLASS RANK	CLASS SIZE	LANGUAGE ARTS	FOREIGN LANGUAGE	MATH	SOCIAL SCIENCE	NATURAL SCIENCE	FINE ARTS	PRACTICAL ARTS	BUSINESS	PHYSICAL EDUCATION	OTHER
4 Years	77.72	13	16	4 1/2	2	3	2	3	0	0	2 1/2	1	4

SIGNIFICANT DATES
ENTRY: REENTRY:
WITHDRAWAL:
ANTICIPATED GRADUATION: 5/87
GRADUATION: May 1987

*ENTER NUMBER AND "SEMESTERS," "TRIMESTERS," "QUARTERS," "GRADE," "YEARS," ETC.

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5. ADDITIONAL STUDENT INFORMATION

STUDENT'S NAME, LAST NAME FIRST

Additional information about this student, as checked below, is provided either in this space or on attached pages.

☐ A. Interests, activities, and achievements. ☐ B. Special features of student's program. ☐ C. Special problems or needs. ☐ D. Personal inventory or checklist. ☐ E. Written comments. ☐ F. Other _____

Soccer 9,10,11, 12

Basketball 12

6. TEST SCORES (PRIMARILY GRADES 10,12)

PSAT (85)	SAT (Mar. 86)	SAT (Dec 86)
Verbal - 22	Verbal - 240	Verbal - 270
Math - 29	Math - 330	Math - 310
	TSWE - 27	TSWE - 38

7. ADDITIONAL SCHOOL INFORMATION

Additional information about our school, as checked below, is provided on the attached pages or school profile.

☐ A. Accreditation information ☐ B. Method of computing GPA ☐ C. Method of computing class rank ☐ D. Key to symbols and titles ☐ E. Explanation of curriculum ☐ F. Description of marking system ☐ G. Frequency distribution ☐ H. Other

8. PREVIOUS SECONDARY SCHOOLS ATTENDED

NAME OF SCHOOL	STREET ADDRESS	CITY	STATE	ZIP	FROM MONTH	FROM YEAR	TO MONTH	TO YEAR

9. SCHOOL OFFICIALS

SCHOOL PRINCIPAL	PERSON TO CONTACT FOR ADDITIONAL INFORMATION	SIGNATURE OF OFFICIAL CERTIFYING THIS TRANSCRIPT (School Seal If Available)
NAME: _____	NAME: _____	NAME: _____
	TITLE: _____	TITLE: _____ DATE: _____

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ADMISSIONS TESTING PROGRAM
The College Board

COLLEGE COUNSELING REPORT

EMMANUEL BAPTIST SCHOOL
410994

SCORE REPORT FOR KENNETH L BARR

Address	Sex	Birth Date	Social Security Number	Report Date
	M			3/28/86
	Telephone Number		Registration Number	Test Center Code
			0659122	41-275

TEST SCORES — MARCH 1986 SCHOLASTIC APTITUDE TEST

Test	Score	Score Range (200 300 400 500 600 700 800)	Percentiles: College-bound Seniors National	College-bound Seniors State	National H.S. Sample
SAT V	240	<<<>>>	03	07	07
SAT M	330	<<<>>>	12	23	23
TSWE	27		10	14	

See the reverse side of this report for more information about these scores.

Name BARR

SUMMARY OF TEST SCORES

Test Date	Grade Level	SAT Verbal	SAT Verbal Subscores: Reading	SAT Verbal Subscores: Vocabulary	SAT Math	TSWE	Achievement Tests: Test Date	Grade Level	1	2	3
Mar 86	11th	240	20	28	330	27					
									Average of All Reported Achievement Tests		

KENNETH L

(REPORTED ON STUDENT DESCRIPTIVE QUESTIONNAIRE 3/86)

COLLEGES THAT RECEIVED A SCORE REPORT	Code
FLORNC-DARLNGTN TCOL	5207
FRANCIS MARION COLL	5442

EDUCATIONAL BACKGROUND

Courses	Years	Honors	Average Grade
ARTS AND MUSIC	None		
ENGLISH	4		C
FOREIGN LANGUAGES	2		B
MATHEMATICS	4		D
NATURAL SCIENCES	3		B
SOCIAL SCIENCES	3		D

Computer Experience	Grade Point Average	Class Rank	H.S. Graduation Date
No	C	Fourth fifth	May 31

STUDENT'S PLANS (REPORTED ON STUDENT DESCRIPTIVE QUESTIONNAIRE 3/86)

Degree Goal	First Choice of Major	Certainty of First Choice
Undecided	Technical and Vocational	

Other Majors Listed	Requested Services

Preferred College Characteristics	College Programs and Activities
Type: Undecided,Public Size: Undecided Setting: Undecided Distance from home: Undecided Other: Undecided,No housing plans	Varsity sports

Advanced Placement or Exemption Plans

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ADMISSIONS TESTING PROGRAM
The College Board

COLLEGE COUNSELING REPORT

EMMANUEL BAPTIST SCHOOL
410994

SCORE REPORT FOR KENNETH L BARR

Address	Sex	Birth Date	Social Security Number	Report Date
	M			12/23/86
	Telephone Number		Registration Number	Test Center Code
			5001093	41-220

TEST SCORES — DECEMBER 1986 SCHOLASTIC APTITUDE TEST

Test	Score	Score Range (200 300 400 500 600 700 800)	Percentiles: College-bound Seniors National	College-bound Seniors State	National H.S. Sample
SAT V	270	<<<>>>	06	12	14
SAT M	310	<<<>>>	08	15	16
TSWE	38		32	40	

See the reverse side of this report for more information about these scores.

SUMMARY OF TEST SCORES

Test Date	Grade Level	SAT Verbal	SAT Verbal Subscores: Reading	Vocabulary	SAT Math	TSWE
Dec 86	12th	270	28	26	310	38
Mar 86	11th	240	20	28	330	27

Achievement Tests: Test Date	Grade Level	1	2	3

(REPORTED ON STUDENT DESCRIPTIVE QUESTIONNAIRE 12/86)

COLLEGES THAT RECEIVED A SCORE REPORT

	Code
SPARTNBRG METHODST C	5627
UNIV SOUTH CAROLINA	5818
PIEDMONT BIBLE COL	5555
FRANCIS MARION COLL	5442

EDUCATIONAL BACKGROUND

Courses	Years	Honors	Average Grade
ARTS AND MUSIC	None		C
ENGLISH	4		
FOREIGN LANGUAGES	2		B
MATHEMATICS	3		C
NATURAL SCIENCES	3		B
SOCIAL SCIENCES	3		C

Computer Experience	Grade Point Average	Class Rank	H.S. Graduation Date
Yes	B-	Fourth fifth	May 28

STUDENT'S PLANS (REPORTED ON STUDENT DESCRIPTIVE QUESTIONNAIRE 12/86)

Degree Goal	First Choice of Major	Certainty of First Choice
Bachelor's	Physical education	Very certain

Other Majors Listed	Requested Services
	Educational planning Financial aid info Part-time job

Preferred College Characteristics	College Programs and Activities
Type: Undecided Size: Up to 1,000 Setting: Medium city Distance from home: Undecided Other: Coed,On-campus housing	Intramural sports Varsity sports

Advanced Placement or Exemption Plans

Name BARR KENNETH L

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(N. 30536)

Emmanuel Baptist School
H. S. Permanent Grade Sheet

Grade 12th
School Year 1986-87

Student Ken Rau
Homeroom Teacher Brown

A - 95-100
B - 88-94
C - 78-87
D - 7077
F - 0-69
S - Satisfactory
U - Unsatisfactory

GRADING PERIOD

SUBJECT	1		2		3		Exam		Sem.		4		5		6		Exam		Sem.		FINAL		TEACHER
CONDUCT	A		A		A				A		A		A										
BIBLE	B	90	A-	95	B	89	C	83	B	90	C	84	D	76	C-	78	F	65	D	76	C	83	Zigg
ENGLISH	D	73	D	73	C+	87	D	72	D	76	D	74	F	68	D	76	F	62	D	70	D	73	Hanson
MATH																							
SCIENCE																							
FOREIGN LANGUAGE																							
SOCIAL STUDIES Bus. Econ	F	53	F	59	D	70	F	65	F	62	F	57	F	62	F	64	D	72	F	64			Brown
Accounting	D	75	C-	78	B-	88	D	74	C	79	B	90	F	55	B	89	F	51	D	71	D	75	Zigg
Gov/Church	D	74	C	79	C	79	F	46	D-	70	C	84	C	82	B	90	B-	88	C	86			Zigg
~~ART~~ World History	C	86	B	90	B-	81	D	74	C	85													Pitcher
MUSIC																							
P.E.																							
HONOR ROLL																							

CHARACTER TRAITS

1. Punctuality												
2. Neatness												
3. Accuracy												
4. Quietness												
5. Industry												
6. Obedience												
7. Truthfulness												
8. Attentiveness												
9. Cooperation												
10. Responsibility												
11. Courteous												
DAYS PRESENT	30	30	30		90	28	30	29		87	177	
DAYS ABSENT	0	0	0		0	2	0	1		3	3	
UNEXCUSED ABSENCES	0	0	0		0	0	0	0		0	0	
DAYS TARDY	1	1	0		2	0	0	1		1	3	
UNEXCUSED TARDINESS	0	0	0		0	0	0	0		0	0	

SUBJECT	MARKING PERIOD	REMARKS

STUDENT (PROMOTED) (RETAINED) TO GRADE _____

EMMANUEL

SUMMER SCHOOL
GRADE REPORT

Date July 30, 1987

Teacher Arrowood Subject Economics / Government

STUDENT	LETTER GRADE	UNIT	HOME SCHOOL
KEN BARR	97 - A GOVT 95 - A ECON	1 Govt / Econ	EMMANUEL

485

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DARLINGTON COUNTY SCHOOL DISTRICT
SECONDARY REPORT CARD

STUDENT NAME: KEN BARR	GRADE	HOME RM. TEACHER: S. S. -87	SEX: M ✓ F
SCHOOL: HARTSVILLE SR HIGH	YEAR: 19 87 19 ___	SUBJECT: GOV'T / ECON	PERIOD	SUBJECT TEACHER: ARROWOOD

APPRAISAL OF FACTORS AFFECTING SUCCESS IN SCHOOL

GRADING PERIOD	1 YES	1 NO	2 YES	2 NO	3 YES	3 NO	4 YES	4 NO
IS ATTENTIVE AND COOPERATIVE								
PARTICIPATES IN CLASS								
USES TIME TO ADVANTAGE								
DAILY ASSIGNMENTS PREPARED								
BRINGS NECESSARY SUPPLIES TO CLASS								
IS CAREFUL WITH PROPERTY								
EXCESSIVE ABSENCES								
POSITIVE ATTITUDE TOWARD SUBJECT								

GRADING PERIOD	1	2	EXAM	SEM.	CREDIT	3	4	EXAM	SEM.	CREDIT	TOTAL CREDIT
SCHOLASTIC ACHIEVEMENT		97	E	97	1/2		95	E	95	1/2	1
ABSENCES EXCUSED											
ABSENCES UNEXCUSED											

GRADE CODE: A - EXCELLENT (95-100) · B - ABOVE AVERAGE (85-94) · C - AVERAGE (75-84) · D - BELOW AV. (70-74) · F - NO CREDIT

TEACHER IS AVAILABLE DURING:

PARENTS ARE URGED TO MAKE AN APPOINTMENT TO DISCUSS STUDENT PROGRESS.

REPORT PERIOD

1 COMMENTS

PARENT'S SIGNATURE _____

2 COMMENTS

PARENT'S SIGNATURE _____

3 COMMENTS

PARENT'S SIGNATURE _____

4 COMMENTS

PARENT'S SIGNATURE _____

T44081 McBee® ADOPTED 9/84

picked up diploma
7-30-87

UNIVERSITY OF SOUTH CAROLINA
Continuing Education
Correspondence Study

High School Grade Report

This is to certify that the below named student enrolled in Continuing Education for the following courses and received grades and credits as indicated below. A copy of this grade report will be sent to the student's high school.

5-20-87

Kenneth Lee Bart

Course	Cat. No.	Date of Enrollment	Grade	Units Credit	Descriptive Title of Course
COVI	036N	From 2-10-87 To 5-13-87			Civil Government
		From To			
		From To			

High School Principal

Principal
Immanuel Baptist School
Route 1, Box 32
Hartsville, SC 29550

Sylvia A. Krapfl
Director, Correspondence Study

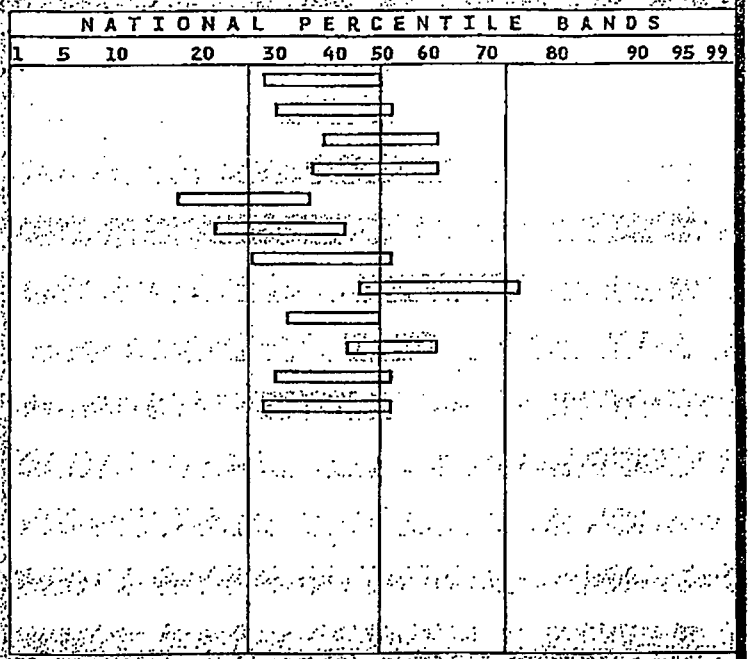
White: Student's Copy
Canary: Correspondence Study Copy
Pink: High School Copy

Stanford TEST OF ACADEMIC SKILLS

SKILLS ANALYSIS FOR KENN L BARR

TEACHER
SCHOOL EMMANUEL BAPTIST SCH 0000000247 GRADE 12 TEST DATE 3/16/87 COPY 1
SYSTEM A A C S SC STANFORD NORMS GR 12.8 LEVEL TASK 2 FORM E PROCESS NO 011146-000

TESTS / NUMBER OF ITEMS	RAW SCORE	NATL PR-S	LOCAL PR-S	GRADE EQUIV
READING COMPREHENSION 50	38	40-5	19-3	11.0
READING VOCABULARY 37	28	42-5	24-4	11.8
SPELLING 40	31	51-5	42-5	PHS
ENGLISH 54	39	50-5	30-4	12.4
MATHEMATICS 48	20	27-4	14-3	8.9
SOCIAL SCIENCE 50	36	32-4	21-3	10.1
SCIENCE 50	36	39-4	28-4	10.7
USING INFORMATION 30	23	62-6	34-4	PHS
READING 87	66	42-5	20-3	11.4
TOTAL ENGLISH 94	70	53-5	36-4	12.6
BASIC BATTERY TOTAL 229	156	42-5	24-4	11.8
COMPLETE BATTERY TOTAL 329	228	40-5	24-4	11.0



AGE 17 YRS 7 MOS

READING SKILLS GROUP: DEVELOPMENTAL

CONTENT CLUSTERS	RAW SCORE/NUMBER OF ITEMS	BELOW AVERAGE	AVERAGE	ABOVE AVERAGE
READING COMPREHENSION	38/50		✓	
Textual Reading	16/17		✓	
Functional Reading	15/17		✓	
Recreational Reading	7/16	✓		
Literal Comprehension	19/25		✓	
Inferential Comprehension	19/25		✓	
READING VOCABULARY	28/37		✓	
SPELLING	31/40		✓	
Homophones	7/ 9		✓	
Phonetic Principles	11/16		✓	
Structural Principles	13/15		✓	
ENGLISH	39/54		✓	
Conventions	15/21		✓	
Language Sensitivity	6/ 9		✓	
Reference Skills	8/12		✓	
Paragraph Arrangement	10/12		✓	
MATHEMATICS	20/48		✓	
Concepts of Number	4/12	✓		
Computation	7/18	✓		
Applications	9/18		✓	
SOCIAL SCIENCE	36/50		✓	
Geography	7/ 7			✓
History	4/ 7		✓	
Anthropology	3/ 5	✓		
Sociology	7/ 7			✓
Political Science	3/ 8	✓		
Economics	4/ 8	✓		
Inquiry Skills	8/ 8			✓

WRITING TEST RESULTS:

CONTENT CLUSTERS	RAW SCORE/NUMBER OF ITEMS	BELOW AVERAGE	AVERAGE	ABOVE AVERAGE
SCIENCE	36/50		✓	
Physical Science	15/19		✓	
Biological Science	14/21		✓	
Inquiry Skills	7/10		✓	
USING INFORMATION	23/30		✓	

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See back for aids for interpretation.

THE PSYCHOLOGICAL CORPORATION
HARCOURT BRACE JOVANOVICH, INC.

Stanford TEST OF ACADEMIC SKILLS

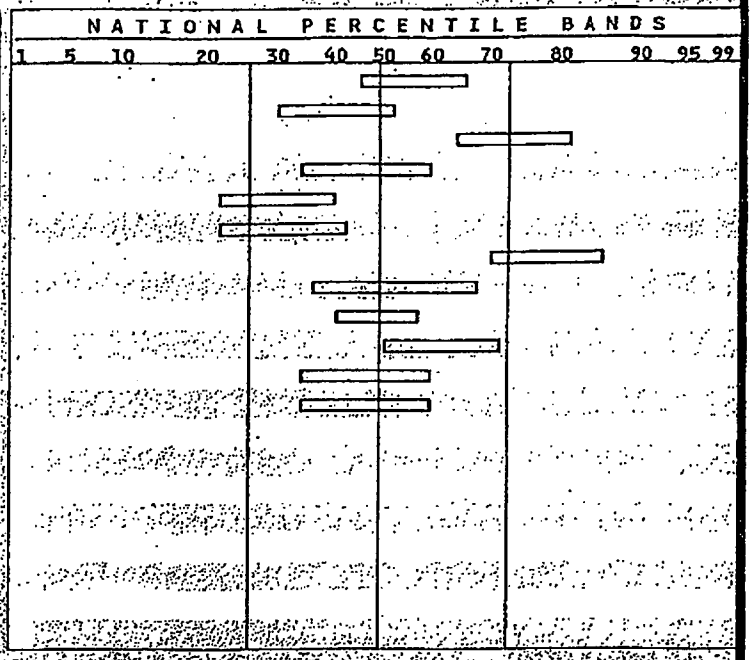
SKILLS ANALYSIS FOR KEN L BARR

CHER A

SCHOOL EMMANUEL BAPTIST GRADE 11 TEST DATE 3/17/86 COPY 2

SYSTEM A A C S SC STANFORD NORMS GR 11.8 LEVEL TASK 2 FORM E PROCESS NO 007468-000

TESTS / NUMBER OF ITEMS	RAW SCORE	NATL PR-S	LOCAL PR-S	GRADE EQUIV
READING COMPREHENSION 50	41	57-5	38-4	PHS
READING VOCABULARY 37	26	42-5	22-3	10.5
SPELLING 40	35	76-6	71-6	PHS
ENGLISH 54	37	48-5	29-4	11.4
MATHEMATICS 48	21	32-4	18-3	9.1
SOCIAL SCIENCE 50	34	32-4	21-3	9.4
SCIENCE 50	44	81-7	81-7	PHS
USING INFORMATION 30	21	54-5	27-4	12.3
READING 87	67	50-5	29-4	11.6
TOTAL ENGLISH 94	72	63-6	48-5	PHS
BASIC BATTERY TOTAL 229	160	48-5	29-4	11.4
COMPLETE BATTERY TOTAL 329	238	48-5	29-4	11.4



AGE 16 YRS 7 MOS

ING SKILLS GROUP: DEVELOPMENTAL

WRITING TEST RESULTS:

CONTENT CLUSTERS	RAW SCORE/NUMBER OF ITEMS	BELOW AVERAGE	AVERAGE	ABOVE AVERAGE
READING COMPREHENSION	41/50		✓	
Textual Reading	14/17		✓	
Functional Reading	16/17			✓
Recreational Reading	11/16		✓	
Literal Comprehension	22/25		✓	
Inferential Comprehension	19/25		✓	
READING VOCABULARY	26/37		✓	
SPELLING	35/40		✓	
Homophones	7/ 9		✓	
Phonetic Principles	15/16			✓
Structural Principles	13/15		✓	
ENGLISH	37/54		✓	
Conventions	16/21		✓	
Language Sensitivity	5/ 9		✓	
Reference Skills	6/12	✓		
Paragraph Arrangement	10/12		✓	
MATHEMATICS	21/48		✓	
Concepts of Number	5/12		✓	
Computation	9/18		✓	
Applications	7/18		✓	
SOCIAL SCIENCE	34/50		✓	
Geography	7/ 7			✓
History	5/ 7		✓	
Anthropology	3/ 5	✓		
Sociology	7/ 7			✓
Political Science	2/ 8	✓		
Economics	4/ 8	✓		
Inquiry Skills	6/ 8		✓	

CONTENT CLUSTERS	RAW SCORE/NUMBER OF ITEMS	BELOW AVERAGE	AVERAGE	ABOVE AVERAGE
SCIENCE	44/50			✓
Physical Science	16/19			✓
Biological Science	19/21			✓
Inquiry Skills	9/10		✓	
USING INFORMATION	21/30		✓	

See back for aids for interpretation.

THE PSYCHOLOGICAL CORPORATION
HARCOURT BRACE JOVANOVICH, INC.

Stanford TEST OF ACADEMIC SKILLS

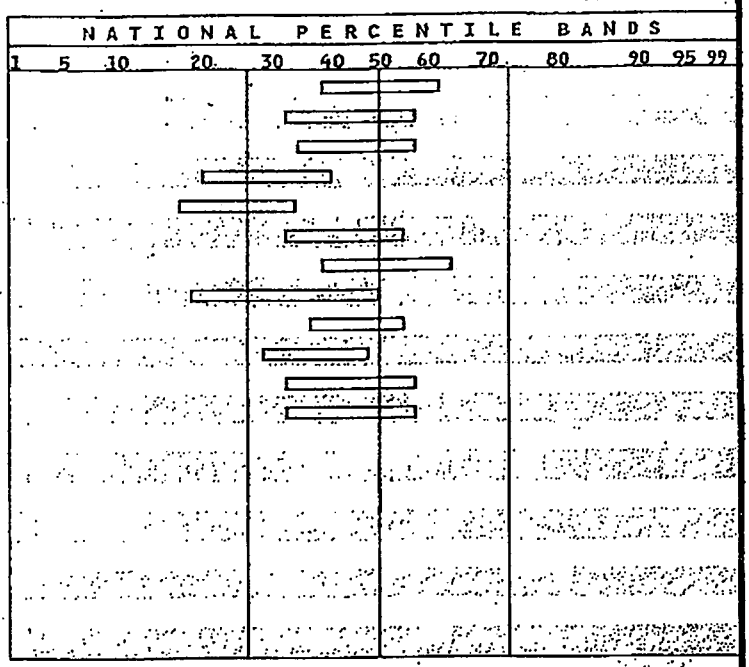
SKILLS ANALYSIS FOR KEN L BARR

ACHER

SCHOOL EMMANUEL BAPTIST 045 GRADE 10 TEST DATE 3/16/85 COPY 2

SYSTEM A A C S S STANFORD NORMS GR 10.8 LEVEL TASK 2 FORM E PROCESS NO 002015-000

TESTS / NUMBER OF ITEMS	RAW SCORE	NATL PR-S	LOCAL PR-S	GRADE EQUIV
READING COMPREHENSION 50	37	51-5	34-4	10.4
READING VOCABULARY 37	24	45-5	26-4	9.6
SPELLING 40	26	47-5	35-4	10.1
ENGLISH 54	28	30-4	12-3	7.5
MATHEMATICS 48	16	25-4	14-3	8.0
SOCIAL SCIENCE 50	35	45-5	34-4	9.7
SCIENCE 50	36	52-5	42-5	10.7
USING INFORMATION 30	16	33-4	15-3	8.3
READING 87	61	47-5	29-4	9.9
TOTAL ENGLISH 94	54	37-4	20-3	8.7
BASIC BATTERY TOTAL 229	131	45-5	26-4	9.6
COMPLETE BATTERY TOTAL 329	202	45-5	34-4	9.7



AGE 15 YRS 7 MOS

DING SKILLS GROUP: DEVELOPMENTAL

CONTENT CLUSTERS	RAW SCORE/NUMBER OF ITEMS	BELOW AVERAGE	AVERAGE	ABOVE AVERAGE
READING COMPREHENSION	37/50		✓	
Textual Reading	14/17		✓	
Functional Reading	12/17		✓	
Recreational Reading	11/16		✓	
Literal Comprehension	19/25		✓	
Inferential Comprehension	18/25		✓	
READING VOCABULARY	24/37		✓	
SPELLING	26/40		✓	
Homophones	6/ 9		✓	
Phonetic Principles	11/16		✓	
Structural Principles	9/15		✓	
ENGLISH	28/54		✓	
Conventions	10/21		✓	
Language Sensitivity	3/ 9	✓		
Reference Skills	3/12	✓		
Paragraph Arrangement	12/12			✓
MATHEMATICS	16/48		✓	
Concepts of Number	5/12		✓	
Computation	6/18	✓		
Applications	5/18		✓	
SOCIAL SCIENCE	35/50		✓	
Geography	7/ 7			✓
History	3/ 7		✓	
Anthropology	4/ 5		✓	
Sociology	4/ 7		✓	
Political Science	4/ 8		✓	
Economics	6/ 8		✓	
Inquiry Skills	7/ 8		✓	

WRITING TEST RESULTS:

CONTENT CLUSTERS	RAW SCORE/NUMBER OF ITEMS	BELOW AVERAGE	AVERAGE	ABOVE AVERAGE
SCIENCE	36/50		✓	
Physical Science	15/19		✓	
Biological Science	15/21		✓	
Inquiry Skills	6/10		✓	
USING INFORMATION	16/30		✓	

See back for aids for interpretation.

DATA SERVICES DIVISION THE PSYCHOLOGICAL CORPORATION HARCOURT BRACE JOVANOVICH, PUBLISHERS

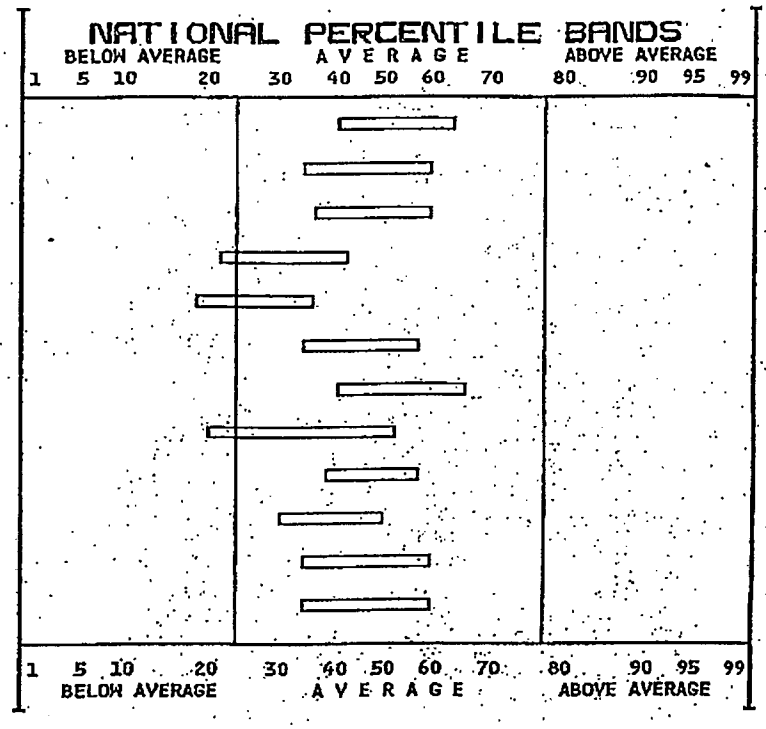
Stanford TEST OF ACADEMIC SKILLS

PUPIL PROFILE
KEN L BARR

TEACHER
SCHOOL EMMANUEL BAPTIST CODE 045
SYSTEM A A C S S

GRADE 10
TEST DATE 3/16/85
NORMS: GR 10.8 NATIONAL
AGE 15 YRS 7 MO

TESTS	NATIONAL PR	NATIONAL S
READING COMPREHENSION	51	5
READING VOCABULARY	45	5
SPELLING	47	5
ENGLISH	30	4
MATHEMATICS	25	4
SOCIAL SCIENCE	45	5
SCIENCE	52	5
USING INFORMATION	33	4
READING	47	5
TOTAL ENGLISH	37	4
BASIC BATTERY TOTAL	45	5
COMPLETE BATTERY TOTAL	45	5



HOW TO INTERPRET THESE SCORES:

The report above shows the Percentile Rank (PR) and Stanine (S) scores this student obtained on the Stanford Test of Academic Skills.

Stanine scores range from a low of 1 to a high of 9. Stanines 4, 5, and 6 are considered average; Stanines 1, 2, and 3 below average; and Stanines 7, 8, and 9 above average.

Percentile Ranks range from a low of 1 to a high of 99. If a student has a Percentile Rank of 70, for example, it means that this student obtained a score that is higher than 70 percent of the students in the comparison group.

The group with which the student is compared is shown above the PR and S heading. "National" means that the student is compared with a nationally representative sample of students in the same grade.

The Percentile Bands to the right show that scores are approximate dicators of achievement. By comparing the bands you can see whether the dent did better in some subjects than in others. If two bands do not overlap, may conclude that the difference between those two scores is indeed meaningful.

The skills measured by each of the tests are described on the back.

2/E PROCESS NO 002015-001

interpretation. DATA SERVICES DIVISION THE PSYCHOLOGICAL CORPORATION

3-8-09
9:45am

DARLINGTON COUNTY SCHOOL DISTRICT

CLASSIFIED EMPLOYMENT APPLICATION

Department of Operations/Maintenance
102 Park Street • Darlington, South Carolina 29532 • 843-398-2311

- ☐ Secretarial
- ☐ Clerical
- ☐ Bookkeeping
- ☐ Instructional Assistant
- ☑ Maintenance
- ☐ Custodial
- ☐ Food Services
- ☐ Substitute
- ☑ Other Painting

Date of Application		
4	8	09
Month	Day	Year

Date Available for Employment_____

I. CONTACT AND IDENTIFICATION INFORMATION

Please provide a permanent address (such as a parent's address) if a change in residence is anticipated within the next year. It is the applicant's responsibility to advise the DCSD Department of Human Resources of any change in name, address, or telephone number. Applications are retained on file for one year.

Name Barr (Last) Kenneth (First) Lee (Middle)

Present Address____ (Number Street City State Zip) Until____ Telephone____ (Area Code / Number)

Permanent Address____ (Number Street City State Zip) Telephone____ (Area Code / Number)

Social Security Number____ Telephone where we may leave a message____

Are you a resident of Darlington County? Yes ✓ No____

Have you applied to the Darlington County School District before? No____ Yes ✓ If yes, when 2008

II. PERSONAL INFORMATION

You are not obligated to discuss information about physical or mental limitations that you believe will not interfere with your capacity to do the job. However, if you want the district to consider special arrangements to accommodate a physical or mental impairment, you may identify that impairment in the space below and suggest the kind of accommodation that you believe would be appropriate.

Military: Years of service completed____ Please check: ☐ Veteran ☐ Active Reserve ☐ Retired ☐ Inactive Reserve

Branch of Service____

Employment: Have you ever been dismissed/non-renewed from any employment? ☐ Yes ☑ No

If yes, explain____

Convictions: Have you ever been convicted by Federal, State, or other law enforcement authorities or pleaded nolo contendere, for violation of any federal law, state law, county or municipal law, regulation, ordinance, including fraudulent checks? (Do not include any offense or minor traffic violations for which a fine of $30.00 or less was imposed.)
☐ Yes ☑ No If yes, complete below:

Conviction for the following:

Violations	Date	Law Enforcement Authority	Disposition

Through the **Family Independence Act of 1995**, state agencies are actively recruiting welfare and food stamp recipients. Are you currently receiving AFDC benefits or food stamp? (A yes answer will not disqualify you from employment with the Darlington County School District. We must ask this question pursuant to South Carolina Law solely for reporting purposes.) ☐ Yes ☐ No

AN EQUAL OPPORTUNITY EMPLOYER

The Darlington County School District will provide equal employment opportunities to otherwise qualified individuals without regard to race, color, religion, gender, age, disability, or national origin.

V. EMPLOYMENT HISTORY

Please account for all employment, including military, beginning with current or most recent employment. Insert extra sheet, if needed.

Position	Dates of Employment	Principal/Supervisor's Name
Painter	2-03' - ' Present	—
Principal/Employer Telephone No. Area Code/No	**Salary**	**School/Employer**
Self-employed	—	—
Reason for Leaving		**City / State / Zip**
looking for future and to support my family		

Position	Dates of Employment	Principal/Supervisor's Name
Lead Installer	7-93' - ' 2-03	Marion Outlaw
Principal/Employer Telephone No. Area Code/No	**Salary**	**School/Employer**
843-332-2211	$12.49 hr.	Suburban Propane
Reason for Leaving		**City / State / Zip**
		Hartsville S.C. 29550

Position	Dates of Employment	Principal/Supervisor's Name
Journeyman Painter	10-94 - ' 6-98	Ricky Hancock
Principal/Employer Telephone No. Area Code/No	**Salary**	**School/Employer**
no longer at Robinson	$12.50 hr.	Williams Power at #8 Robinson Nuclear Plant
Reason for Leaving		**City / State / Zip**
Reduction of Force		Hartsville S.C. 29550

Position	Dates of Employment	Principal/Supervisor's Name
Asst. manager/Sales	7-93 - 10-94	Lann Waldrop
Principal/Employer Telephone No. Area Code/No	**Salary**	**School/Employer**
no longer in business	don't remember	B.C. Moore's
Reason for Leaving		**City / State / Zip**
didn't like sales, like working with my hands		Hartsville S.C. 29550

Position	Dates of Employment	Principal/Supervisor's Name
Carpenter	1991' - ' 1993	Don Atkins Sr.
Principal/Employer Telephone No. Area Code/No	**Salary**	**School/Employer**
no longer in business	$10.00 hr.	Don Atkins Construction
Reason for Leaving		**City / State / Zip**
lay-off		Hartsville S.C. 29550

Position	Dates of Employment	Principal/Supervisor's Name
	/ /	
Principal/Employer Telephone No. Area Code/No	**Salary**	**School/Employer**
Reason for Leaving		**City / State / Zip**

Position	Dates of Employment	Principal/Supervisor's Name
	/ /	
Principal/Employer Telephone No. Area Code/No	**Salary**	**School/Employer**
Reason for Leaving		**City / State / Zip**

Please Note: We may contact your present and previous employers.

copied to Michelle 5/13/13

FILE COPY

RECEIVED MAY 10 2013

DISABILITY CERTIFICATE

HARTSVILLE ORTHOPEDICS & SPORTS MEDICINE
Terence W. Hassler, M.D.
Umesh S. Metkar, M.D.
Prashant P. Deshmane, M.D.
700 Medical Park Drive • Hartsville, SC 29550 • Telephone 383-3742

Date 5/2/13

This is to certify that Kenneth Barr has been under my professional care and was totally

Incapacitated from _____ to 5/16/13

As of this date he/she is

- ✓ Still unable to return to work/school
- ☐ Sufficiently recovered to resume a normal workload
- ☐ Sufficiently recovered to return to work/school with the following limitations.

Dr.

M Kenneth

has an appointment on

☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Bi

Date Day 16 at 10:00 a.m. p.m.

☒ TERENCE W. HASSLER, M.D.

☐ UMESH S. METKAR, M.D. ☐ PRASHANT P. DESHMANE, M.D.

Hartsville Orthopedics And Sports Medicine, P.A.

700 MEDICAL PARK DRIVE • HARTSVILLE, SC 29550

(843) 383-3742

If unable to keep appointment, kindly give 24 hrs. notice.

DARLINGTON COUNTY SCHOOL DISTRICT

EVALUATION/RECOMMENDATION FORM
PARA-PROFESSIONAL/SUPPORT PERSONNEL

Name Kenneth Barr

Position Maintenance/Painter School/Department: Operations

I. PERFORMANCE RATINGS

RATING SCALE: (For each rating category below, the Evaluator enters the best rating appropriate to the employee's performance.)	Exceeds	Meets Requirements	Poor/ Unsatisfactory
1. QUALITY (Thoroughness, accuracy, neatness)	(1)	2	3
2. QUANTITY (Speed, diligence, consistency in output)	1	(2)	3
3. LEARNING (Mastery of duties, comprehension and retention of knowledge)	(1)	2	3
4. COOPERATION (Harmonious, effective in relationships with others)	(1)	2	3
5. ATTITUDE (Interest, satisfaction, enthusiasm for job and organization)	(1)	2	3
6. COMMUNICATIONS (Tact, effective self-expression, courteous in dealing with others)	(1)	2	3
7. DEPENDABILITY (Flexible work is on time despite pressure, needs little check/supervision)	(1)	2	3
8. INITIATIVE/SELF RELIANCE (Acts when necessary, seeks responsibility and improvement in assigned tasks and general duties)	1	(2)	3
9. ATTENDANCE (Absenteeism) Enter days absent for evaluated period 75	1	2	(3)
10. PUNCTUALITY (Timely in reporting at beginning of work, after lunch, and breaks)	1	(2)	3
11. SAFETY (Awareness and practice of safe work habits)	1	(2)	3
12. OTHER (Specify) Injuries have prevented him from producing the quantity of work needed	(1)	2	3
OVERALL PERFORMANCE (Cumulative rating of all items above)	1.5	2	3

II. Employee has expressed desire to continue employment: ☑ Yes ☐ No (Attach Retirement/Resignation Form)

III. RECOMMENDED: ☑ Yes Commendation beyond strengths in Section I: _____

IV. RECOMMENDED WITH CONDITIONS:
Noted weaknesses of the employee are: (Use back of sheet for additional description, if needed.)

Weakness	Corrective Measures	Time Frame

V. NOT RECOMMENDED: ☐ Copies of supporting documentation are attached with the Personnel File Cover Sheet.

Clearance from Personnel and the Superintendent is required before informing an employee that he/she is not recommended for continued employment.

Evaluator Signature/Position [signature] Date 5/16/13

Employee Signature [signature] Date _____

THIS COMPLETED FORM AND THE PERSONNEL FILE COVER SHEET ARE TO BE RETURNED TO THE HUMAN RESOURCES OFFICE BY MAY 10, 2013

Darlington County School District

Request for Family and Medical Leave (FMLA)
Family and Medical Leave Act of 1993
Serious Health Condition

COPY to PR
RECEIVED OCT 24 2014

Returned to work 10/18/14
No letter written

Form B-100

The Darlington County School District requires this form be submitted for severe illnesses resulting in absences of 3 consecutive days or more. **DOCTOR'S STATEMENTS ARE REQUIRED FOR ALL ABSENCES AFTER 3 CONSECUTIVE DAYS and afterwards, updates must be provided to the Benefits Office every 30 days.**

EMPLOYEE'S NAME: Kenny Ball SSN: _____

ADDRESS: _____

PHONE: ( ) _____ Employee's Job Title: Painter

Type of Leave (check one) ☐Continuous ☑Intermittent STARTING DATE: 10-13-14 ENDING DATE: 10-17-14

I. TYPE OF LEAVE REQUESTED: ☑PAID SICK OR VACATION LEAVE* ☐ UNPAID LEAVE*
* Unaccrued days will be at full-deduct.

II. CHECK REASON FOR LEAVE:

A. ☐ **Birth of a child, or placement of a child with you for adoption or foster care** Note: If absence is due to maternity, newborn must be added to insurance within 31 days of birth or obtaining custody. Call 398-2308.

B. ☑ **Serious health condition of SELF**

C. ☐ **Serious health condition of a** ☐spouse ☐child ☐parent

D. ☐Other /Please briefly explain: _____

III. SHORT TERM DISABILITY PLAN

A. ☐ Yes, I am enrolled in the Short Term Disability Plan for the district and I wish to use this plan during my absence. Plan No._____ (elimination days for the plans are: Plan 1 = 14 day Plan 2 = 29 day Plan 3 = 45 day) Please call the Benefits Office to obtain a claim form or make an appointment to discuss this Plan.

B. ☐ No, I do not wish to use my Short Term Disability Plan.

C. ☐ I am not enrolled in the Short Term Disability Plan.

IV. CERTIFIED PERSONNEL: Please note, you must be paid by the district 152 days during an academic year to receive a full year's experience. Your Short Term Disability payment does not apply to the required 152 days.

V. It is my intention to return to work at the end of this leave period.

A. ☑ Yes

B. ☐ No. Please complete a Resignation Form.

Signature of Employee: K Ball DATE: 10-20-14 LOCATION: Hartsville Maintenance

---

To be completed by Benefits Office: Eligible for FMLA ☐ Yes ☐ No

Signature of Benefits Coordinator: _____ Date_____

To be completed by Leave Specialist: Medical Leave days earned up to date of absence: _____

Medical Leave days to apply: _____ Approximated days to be docked: _____

Note: If the number of days absent changes notify Teresa Segars, Leave Specialist immediately at 398-2276 or Michelle Reynolds, Kronos Bookkeeper at 398-2312.

Signature of Leave Specialist: _____ Date: _____

After the form is completed the effected employee will receive a copy of this form advising him/her of leave status. See the reverse side for worksheet.

(revised July 2009)

Copy to PR

The Medical Group

Certificate For Return to School or Work

DOB

Kenneth Barr

has been under my care from 10/14/14 to 10/17/14

Return date: 10/18/14

Limitations/Remarks Ø

Date: 10/17/14

Dr Mac Chapman / C. Blackwell

Dr. T. James Bell, Jr.
Dr. William Powell
Dr. R. Mac Chapman
Shari Carter, FNP

701 Medical Park Drive, Suite 305, Hartsville, SC 29550
Phone 843-339-3040 Fax 843-332-2240

Copy to Michelle 1/31/12

Darlington County School District

Request for Family and Medical Leave (FMLA)
Family and Medical Leave Act of 1993
Serious Health Condition

FILE COPY

RECEIVED JAN 30 2012 DARLINGTON COUNTY SCHOOL DISTRICT BENEFITS

Form B-100

The Darlington County School District requires this form be submitted for severe illnesses requiring absences of 3 consecutive days or more. **DOCTOR'S STATEMENTS ARE REQUIRED FOR ALL ABSENCES OF 3 CONSECUTIVE DAYS and afterwards, updates must be provided to the Benefits Office every 30 days.**

EMPLOYEE'S NAME: Kenneth Barr SSN: _____

ADDRESS: _____

PHONE: (___) _____ Employee's Job Title: Painter

Type of Leave (check one) ☑ Continuous ☐ Intermittent STARTING DATE: 1-26-12 ENDING DATE: TBD

I. TYPE OF LEAVE REQUESTED: ☐ PAID SICK OR VACATION LEAVE* ☐ UNPAID LEAVE*

* Unaccrued days will be at full-deduct

II. CHECK REASON FOR LEAVE:

A. ☐ **Birth of a child, or placement of a child with you for adoption or foster care** Note: If absence is due to maternity, **newborn must be added to insurance within 31 days of birth or obtaining custody.** Call 398-2308.

B. ☑ **Serious health condition of SELF**

C. ☐ **Serious health condition of a** ☐spouse ☐child ☐parent

D. ☐Other /Please briefly explain: _____

III. SHORT TERM DISABILITY PLAN

A. ☑ Yes, I am enrolled in the Short Term Disability Plan for the district and I wish to use this plan during my absence. Plan No.____ (elimination days for the plans are: Plan 1 = 14 day Plan 2 = 29 day Plan 3 = 45 day) Please call the Benefits Office to obtain a claim form or make an appointment to discuss this Plan.

B. ☐ No, I do not wish to use my Short Term Disability Plan.

C. ☐ I am not enrolled in the Short Term Disability Plan.

IV. CERTIFIED PERSONNEL: Please note, you must be paid by the district 152 days during an academic year to receive a full year's experience. Your Short Term Disability payment does not apply to the required 152 days.

V. It is my intention to return to work at the end of this leave period.

A. ☑ Yes

B. ☐ No. Please complete a Resignation Form.

Signature of Employee: unavailable (OJ) DATE: 1/30/12 LOCATION: Maintenance

---

To be completed by Benefits Office: Eligible for FMLA ☑ Yes ☐ No

Signature of Benefits Coordinator: Pearl Jeffords Date January 30, 2012

To be completed by Leave Specialist: Medical Leave days earned up to date of absence: _____

Medical Leave days to apply: _____ Approximated days to be docked: _____

Note: If the number of days absent changes notify Teresa Segars, Leave Specialist immediately at 398-2276 or Michelle Reynolds, Kronos Bookkeeper at 398-2312.

Signature of Leave Specialist: _____ Date: _____

After the form is completed the effected employee will receive a copy of this form advising him/her of leave status. See the reverse side for worksheet.

(revised July 2009)

FILE COPY

Forwarded to Michelle

RECEIVED MAY 30 2012

CAMDEN ORTHOPAEDIC ASSOCIATES

Joseph P. Jackson, Jr., M.D., F.A.C.S.
Orthopaedic Surgery
Surgery of the Hand

Telephone
(803) 432-9300

507 Walnut Street
Camden, S.C. 29020

Kenneth Barr has been under my care

from 11/25/12 to 6/4/12 and is able

to return school / work on 6/4/12. Limitations/

Remarks Return to work full duty. no restrictions

[redacted] Date: 5/30/12

Joseph P. Jackson, Jr., M.D.

498

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
803-737-5675 www.wcc.sc.gov

WCC File #: **1507304**
Carrier File #:
Carrier Code #:
Employer FEIN #:

Claimant's Name: Kenneth L. Barr SSN: ployer's Name: Darlington County School District
Address: Address: 120 East Smith Avenue
City: State: SC Zip: City: Darlington State: SC Zip: 29532
Home Phone: ( ) - Work Phone: ( ) - Insurance Carrier: SC School Boards Insurance Trust
Preparer's Name: Preston F. McDaniel Law Firm: McDaniel Law Firm Preparer's Phone #: (803) 771 - 7211

REQUEST FOR COMMISSION REVIEW

Request for Commission Review by ☒ Claimant ☐ Employer (check one) Date of Injury or Illness: 05/21/2015

The undersigned makes application for review of the findings of the Commissioner in the above-captioned case. The request for review is based on the following grounds: (State the grounds of your appeal in the form of questions presented. Each question presented must contain a concise statement of one proposition of law or fact. Refer to evidence by title and exhibit number. Use additional pages if necessary).

See Attachment.

(Check one) Oral argument ☒ is ☐ is not requested. Appellant's request for oral argument is waived if not indicated on this form.

☐ **Mediation**

☐ Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.

Questions regarding mediation may be submitted to **mediation@wcc.sc.gov.**

I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to SEE ATTACHED CERTIFICATE OF SERVICE on the ___day of ____20__, by ___ first class postage ____certified mail____ personal service.

Preparer's Signature | ATTORNEY FOR CLAIMANT (Title) | preston@pfmcdlaw.com (Email) | October 2, 2017 (Date)

Check this box if you are not represented by an attorney ☐

Questions about the use of this form should be directed to the Judicial Department at 803.737.5675 or appeals@wcc.sc.gov.

If the claimant appeals and is not represented by counsel, the Judicial Department will properly serve this form pursuant to Reg. 67-607 C. Pursuant to Reg. 67-205 and Reg. 701, the appeal must be postmarked no later than 14 days from the date of service of the Decision and Order of the Hearing Commissioner along with the filing fee. Attach a Form 32, if you are unable to pay the filing fee. Refer to Reg. 67-211 and Reg. 67-701 through 711.

ATTACHMENT TO FORM 30

Kenneth L. Barr v. Darlington County School District

WCC File No. 1507304

1. That pursuant to S.C. Code of Laws §42-17-40, the Claimant requests a review of all of the Findings of Fact, the Conclusions of Law, the Order and Award and of all Rulings and Decisions made by the Commissioner(s) at the hearing, as contained in the Record or as made at any unrecorded pre-hearing conference, and in any communications concerning the claim, Order, Award and Decision rendered by the Hearing Commissioner or assigned Commissioner in this matter.

2. That where the Defendants had sought to require the Claimant, who lives and worked for his employer in Darlington County to be evaluated not by a medical doctor but by a psychologist in Charleston, SC; and wherein the Claimant agreed to appear before a medical doctor for an independent medical evaluation pursuant to SC Code §42-15-80 by a local physician at reasonable times and places; and wherein an Order was issued without hearing granting the Defendant's Motion to Compel; and wherein the Claimant filed Writs of Mandamus and Prohibition before the Fourth Judicial Circuit Court alleging that the Defendants were not entitled to an evaluation by a psychologist but only by a qualified physician or surgeon at reasonable times and places, and wherein the Complaint sets forth that reasonable times and places has been interpreted by the SC Supreme Court to be in the Claimant's locality where he lives and works; and wherein the Circuit Court issued a temporary Restraining Order based on that verified complaint; and wherein after a telephone conference with the Defendants and the Commission, the Claimant agreed to dismiss the Writs of Mandamus and Prohibition (without an Order of the Circuit Court as requested by the Commission) and agreed to return jurisdiction to the Commission and file a Motion for Reconsideration which was filed on December 22, 2015; and wherein thereafter the Commission issued a specific Order December 22, 2015 denying the Defendants' right to the evaluation by a psychologist but reaffirmed the right of the Defendants to an independent medical evaluation by a, "properly qualified examiner **at reasonable time and place**"; and wherein the hearing set for January 7, 2016 was postponed and reset for February 24, 2016; and wherein the Defendants took no action and did not notify the Claimant of an independent medical evaluation until January 25, 2016 setting an independent medical evaluation with Dr. Paul Pritchard again in Charleston, South Carolina for

February 2, 2016 to which the Claimant renewed his objection on the basis that the examination was not at reasonable times and places as required by the Act to which Defendants filed another Motion to Compel without an Affidavit as to no qualified physician or surgeon being available in Darlington/Florence area for the SC Code §42-15-80; and wherein Commissioner Beck notified the parties that the Commissioner would grant the Motion; and wherein the examination was conducted on February 2, 2016; and wherein after formal written objections with supporting Memorandum of Law from Claimant were made as to numerous reports and documentary evidence offered by Defendants from out of area experts both prior to and at the February 24, 2016 scheduled hearing; and wherein on February 24, 2016 after those objections and at the time of the hearing, the Hearing Commissioner instead of excluding the evidence pursuant to Reg. 67-613 and SC Code §1-23-330 and proceeding with the hearing, continued the hearing to allow the Defendants time to take the deposition of Dr. Paul Pritchard and telling the Claimant he could exercise his due process right to cross-examine these out of the area alleged experts by taking their depositions at his expense, based on the above, the Commissioner(s) erred as a matter of law:

A. By allowing an examination which was not at reasonable times and places as is required by the Act and as was set forth in Commissioner Beck's Order as part of the agreement returning jurisdiction to the Commission, wherein the Commissioner's Order specifically noted that the examination was to be at, "**reasonable times and places**" and where such examination was not in accordance with the Supreme Court Decisions interpreting reasonable times and places;

B. By postponing the hearing set for February 24, 2016 where the Defendants had specifically violated the directives of the Commission as to the performance of an independent medical evaluation and where the Commission had granted the Defendants the right to an independent medical evaluation on December 22, 2015 but Defendants did not schedule it and give notice to the Claimant until January 24, 2016 and wherein knowing about the objection to the report and even though the examination was conducted on February 2nd, there is no evidence in the Record that there was any attempt to take the deposition prior to the February 24th hearing;

C. By postponing the hearing on February 24, 2016 without Motion as required by Rule 67-613 to allow the Defendants to take the deposition;

D. By postponing the hearing on February 24, 2016 and not proceeding with a hearing at that time excluding the documentary evidence as specifically objected to for numerous reasons including those as set forth in the Memorandum which was before the Commissioner, before and at, the Prehearing conference;

E. By not sustaining the objection to the submission of documentary evidence from several experts that had neither seen nor evaluated the Claimant and had no personal knowledge of the Claimant and/or which was not based on properly phrased hypotheticals and by continuing the hearing shifting the expense of cross-examination to the Claimant thus violating the Claimant's due process rights by requiring the Claimant to take the deposition of the Defendants' witnesses whose written reports the Defendants sought to submit into evidence, and which later and now serve as the very basis for the denial of the Claimant's right to benefits under the Act.

3. That the Commissioner erred as a matter of law by continuing the hearing set for February 24, 2016, and overruling objections to the documentary evidence sought to be admitted and specifically the documentary evidence from Dr. Paul Pritchard, M.D., Dr. Mark T. Wagner, Ph.D., Dr. L. Randolph Waid, Ph.D., and Dr. David H. Eagerton, Ph.D. and by the denying the Claimant due process of law by shifting the responsibility and expense of taking the depositions of these witnesses to the Claimant wherein this evidence was specifically and highly prejudicial to the Claimant in that these reports served as the very basis for a denial of benefits. It is improper to shift the burden of expense for any testimony or evidence sought to be admitted by any party to the opposing party. The right to cross-examination of your accusers and/or opposing witnesses is one of the most fundamental rights guaranteed by due process.

4. That the Commissioner erred as a matter of law by continuing the February 24, 2016 hearing and allowing the submission of reports from Dr. Mark Wagner, Ph.D., Dr. L. Randolph Waid, Ph.D., and Dr. David H. Eagerton, Ph.D. whose reports were dated February 12, 2016, February 12, 2016 and February 14, 2016 respectively wherein the reports of Dr. Wagner, Ph.D. and Dr. Waid, Ph.D. were submitted under cover letter dated February 13, 2016 (Saturday) but with an Affidavit of Service on February 12th and which was not received until February 16th, the day after a Federal holiday on Monday the 15th. The report of Dr. Eagerton, Ph.D. was not mailed and filed, allegedly in accordance with the Administrative Procedures Act

and the Rules of this Commission, until February 15th, again which was a Federal holiday, but was not received until February 16th for the February 24th hearing. Although an Order denying the right to send Mr. Barr to Dr. Wagner, Ph.D. was entered December 22, 2015 and Depositions were taken of Dr. White, November 23, 2015; Dr. Skinner, December 10, 2015 and Dr. Lind, Ph.D., February 19, 2016, the reports of Dr. Waid, Ph.D., Dr. Wagner, Ph.D. and Dr. Eagerton, Ph.D. were not provided to the Claimant until February 16th, eight (8) days before the hearing. Those untimely reports then served as the very basis for denial of the Claimant's entitlement to benefits. Thus, a continuance was highly prejudicial to the rights of the Claimant to due process of law. There is no provision under the Workers' Compensation Act for the submission of documentary evidence except by Subpoena (§42-3-150) and the only exception is contained with the Administrative Procedures Act which provides that documentary evidence may only be submitted where it will not substantially prejudice the interest of any party.

5. That the Commissioner erred as a matter of law by granting a Motion to Compel the Claimant and requiring the Claimant to sign a Release of Information Form wherein the Commission has no right under its statutory authority to require or compel the Claimant to sign such a form and wherein the Motion was granted without a hearing and wherein the Claimant forwarded an Authorization to Release Form directly to the medical group in question authorizing the specific release directly to Defense Counsel of all requested medical records. The Motion to Compel and Rule to Show Cause resulted in prejudice to the Claimant and a hearing not being held on his claim from May through August 31, 2016.

6. That the Commissioner erred as a matter of law by issuing the 2nd Amended Order submitted by the Defendants wherein the Commissioner had issued his directives for an Order on November 17, 2016; and the Claimant immediately thereafter brought to the attention of the Commissioner that he did not address the alternative basis for Claimant's claim; that being that his exposure to VOCs in the workplace had resulted in causing and/or aggravating and causing to become symptomatic his chronic headaches. Nowhere in his directives had the Commissioner addressed this proposition and upon wherein upon bringing this to the attention of Defense Counsel and without further directive of the Commissioner, Defense Counsel amended the Order and made her own unsupported Findings of Fact and Conclusions of Law addressing the alternative claim for benefits, which is in violation of SC Code §42-9-5 and §42-17-40 and the prior Decisions of the SC Supreme Court.

7. That based upon the reliable, probative and substantial evidence in the Record, the Hearing Commissioner erred by not awarding the Claimant benefits where there is absolutely no evidence in the Record, expert of otherwise, that the Claimant's problems with headaches, memory, fatigue and confusion and psychological functioning are not causally related to his exposure to VOCs in the workplace.

8. That the Hearing Commissioner erred as a matter of law by considering and basing his opinion on the medical report and deposition of Dr. Paul Pritchard wherein the Record establishes that in violation of SC Code §42-15-95 the Defendants submitted letters and extensive medical records to Dr. Pritchard, without notifying the Claimant and pursuant to statute, all such evidence should have been excluded.

9. That the Hearing Commissioner erred as a matter of law where there is absolutely no expert medical opinion other than that the Claimant's headaches, memory, fatigue, confusion, neurological, and psychological problems stem from his exposure to VOCs from his job as a painter with the School District. Even Dr. Pritchard who opined in his report that he did not find that the Claimant had suffered from an encephalopathy; opined: that he could not, "speak authoritatively on the potential for impairment from the various paints and other compounds to which he reports on-the-job exposure"; that he recommended that he should be, "evaluated by an occupational medicine physician who has training and experience in toxicology"; that VOC exposure would cause acute headaches; and also opined and agreed that by history that his headaches were consistent with chronic daily headache.

10. That the Hearing Commissioner erred as a matter of law in his Statement of the Case in that it is an inaccurate summary of the testimony and evidence submitted.

11. That the Hearing Commissioner erred as a matter of law by not amending his Statement of the Case to add and/or to amend the Statement to accurately reflect in the summary of the evidence, for example, after going to work for the School District as a painter using commercial paints, the Claimant did not continue to operate his painting business but only performed several side jobs. He also did not use commercial paints in his residential painting business.

12. That the Hearing Commissioner erred as a matter of law by considering the opinion of Dr. Eagerton, Ph.D. who as is admitted is not a medical doctor, but, yet who stated his opinion to a reasonable degree of scientific and "medical"

certainty. The Commissioner erred by considering this as a medical opinion for which the Ph.D. is not qualified.

13. That the Hearing Commissioner erred as a matter of law in making Finding of Fact #1 as written in that it misstates the position of the Claimant and does not represent an appropriate view of the evidence in the Record.

14. That the Hearing Commissioner erred as a matter of law by making Finding of Fact #2 which implies that the Claimant prior to his employment was diagnosed on a continual basis with conditions as outlined in that Finding of Fact. There is no evidence in the Record of a continuing diagnosis of or any treatment for any of those problems. The last medical report dated May 27, 2009 was for treatment of left arm pain; on September 19, 2008, upper respiratory infection with chest congestion; and on May 15, 2009, indigestion and prostrate.

15. That the Hearing Commissioner erred as a matter of law and fact in making Finding of Fact #4 in that it does not properly reflect the evidence and it ignores the initial opinion Dr. White expressed on May 21st of 2015 that the Claimant was suffering from, "fatigue, migraines and memory loss" due to exposure to VOCs in the commercial paints used by the Claimant.

16. That the Hearing Commissioner erred as a matter of law and fact in his Finding of Fact #5 in that it improperly states the psychological opinions and findings based on the neuropsychological testing conducted by Dr. Lind. Contrary to the Finding, it was Dr. Lind's opinions stated to a reasonable degree of psychological certainty that the test results were consistent with mild organic brain damage and he recommended repeat testing in one year as to whether or not that was progressive.

17. That the Hearing Commissioner erred as a matter of law and fact in referencing the testimony and opinions of Dr. Pritchard whose testimony and evidence should not have been admitted; however his testimony establishes that he found the Claimant's history to be consistent with chronic headaches; that he found the Claimant to be an accurate reporter; that he did not deny or dispute that the Claimant was having severe chronic headaches; that VOC exposure will cause acute headaches and that in reference to objective tests to confirm or deny headaches, Dr. Pritchard confirmed and stated the medical opinion that there were <u>no</u> objective medical tests which will either confirm or deny headaches and specifically stated, "I would say none at all."

18. That the Hearing Commissioner erred as a matter of law and fact in reference to Finding of Fact #7 for the reasons as stated in the other Exceptions but in addition thereto, there is no evidence that Dr. Mark Wagner, Ph.D. had any personal knowledge of the Claimant nor was his report based upon actual examination, nor is there any evidence that his reports are based upon properly phrased hypotheticals and in addition thereto, he expresses no opinion as to whether or not the Claimant is suffering from severe disabling headaches.

19. That the Hearing Commissioner erred as a matter of law, in addition to all the foregoing reasons in reference to the consideration of the report by Dr. Randolph Waid, by considering his report in that there is no evidence that he expressed any opinion concerning the Claimant's headaches nor did he make any statement that the Claimant was not factually and truthfully reporting and was not suffering from severe disabling headaches. In addition to the foregoing reasons for not finding this report to be not supportive of the denial of benefits based on severe chronic disabling headaches, and while it is true that the Claimant's primary complaint was and is one of disruptive headaches, Dr. Waid states that his headaches existed, "**prior to his engagement in employment with Darlington County School District**." There is absolutely no evidence in the Record that the Claimant was suffering from headaches or chronic headaches at all prior to him going to work for the School District.

20. That the Hearing Commissioner erred as a matter of law and fact in making Finding of Fact #9 in that in addition to the objections as set forth hereinabove and that this Commissioner should not have considered this evidence at all based on the violation of the Claimant's due process right to cross-examine this Ph.D., here again in this Finding the Commissioner notes specifically that Dr. Eagerton, Ph.D. who is admittedly not a medical doctor, states a medical opinion to a reasonable degree of medical certainty.

21. That the Hearing Commissioner erred as a matter of law and fact in that his decision does not address Dr. Bennett's toxicological findings in reference to the Claimant's exposure and Dr. Bennett's opinion that Mr. Barr's severe disabling headaches stem from his exposure to VOCs in the paints with which he worked with the School District. The finding of Dr. Bennett in reference to headaches and his supportive toxicological opinions are not even referenced in reference to headaches.

22. That the Hearing Commissioner erred as a matter of law by making Finding of Fact #11. In addition to the Finding as set out not being factually accurate as to Dr. Healy's testimony in his deposition, the Finding of Fact does not address Dr. Healy's opinion that the Claimant's disabling headaches were caused by his exposure to VOCs and that that opinion was reaffirmed under oath at his deposition.

23. That the Hearing Commissioner erred as a matter of law in making Finding of Fact #12 and particularly specifically committed an error of law in this Finding by referring to there being no unusual or extraordinary conditions to his employment as there was no claim being made for any type of stress related claim or claim unrelated to physical inhalation or absorption exposure injury.

24. That the Hearing Commissioner erred as a matter of law in making Finding of Fact #13 wherein the greater weight of the evidence clearly establishes that the Claimant was daily exposed to VOCs in the commercial paints with which he worked; that he had never had a problem prior to the time that he went to work with the School District in 2009 and first reported with headaches in 2010; and that his consistent complaint throughout and since 2010 has been severe chronic headaches; and wherein all of the lay and medical testimony and evidence supports that his chronic headaches are due to his exposure to VOCs.

25. That the Hearing Commissioner erred as a matter of law by making Conclusion of Law #1 wherein the Commissioner found that the evidence was not consistent with a Finding as a matter of Law that the Claimant had sustained injury by accident wherein the evidence specifically establishes that under subsection 42-1-160(f) combined with either in both §42-1-172 and §42-11-10, et. seq., that it is consistent with establishing that the Claimant sustained injury by accident in the nature of repetitive inhalation and absorption exposure. It also establishes that due to his inhalation exposure and absorption exposure to VOCs compounds in the workplace on a continual and consistent basis from the normal exposure to Claimant as a commercial painter to commercial paints as part of his job that he suffers from an occupational disease.

26. That the Hearing Commissioner erred as a matter of law by not finding that the Claimant has an occupational disease as defined under SC Code §42-11-10, et. seq. The Claimant is a commercial painter and was exposed to commercial paints on a continual and daily basis in his job and was exposed, according to the evidence, to VOCs as part of the commercial paints he used continually throughout the day. The Claimant's job was that

of a commercial painter and in that job and as part of that job, he was exposed to VOCs which are in excess of those hazards that are ordinarily incident to employment and which are peculiar to the employment in which he was engaged. His condition of severe chronic headaches stems directly from his exposure to VOCs in the workplace as part of the normal working conditions of his job due to his exposure to hazards peculiar to that particular employment as established by medical opinion evidence stated to a reasonable degree of medical certainty to which there is no contrary opinion in reference to the particular opinion that his chronic residual headaches are caused by his exposure to VOCs in the workplace.

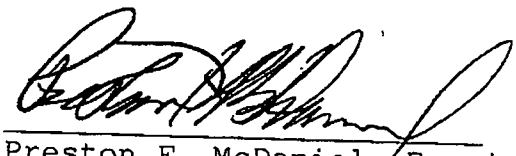
27. That the Hearing Commissioner erred as a matter of law by not finding that the Claimant had sustained a repetitive trauma injury as defined under §42-1-172 and by failing to find as a matter of law that the Claimant has sustained repetitive trauma. The Commissioner's Conclusion of Law ignores the evidence in that Dr. White stated the opinion to a reasonable degree of medical certainty that in his opinion the Claimant's headaches, memory problems and fatigue were caused by his exposure to VOCs in the workplace on a daily and repetitive basis. Dr. Healy also expresses the same opinion that the Claimant's severe chronic headaches were caused by his repetitive exposure to VOCs in the workplace. In fact, Dr. Pritchard also expressed the same opinion and the Commissioner's Conclusion of Law to the contrary is an inaccurate statement of the facts and evidence presented. Dr. Nicholas Lind, Ph.D., according to the neuropsychological testing performed by Dr. Lind, found and stated the opinion to a reasonable degree of psychological certainty that Mr. Barr's cognitive complaints were secondary to his exposure to organic compounds. He also stated the opinion to a reasonable degree of psychological certainty that the Claimant's psychological problems were causally related to his exposure to VOCs in the workplace. He stood by those opinions in his deposition.

28. That the Hearing Commissioner erred as a matter of law in Conclusion of Law #4 in that the evidence clearly establishes both from a psychological standpoint of Dr. Lind's treatment and evaluation and the opinions of Dr. Marshall White, and more importantly, of the opinions of Dr. Healy that the Claimant's psychological problems stemmed from his exposure to volatile organic compounds and the severe chronic headaches that he had sustained as a result of that repetitive exposure.

29. That the Hearing Commissioner erred as a matter of law in making Conclusions of Law #5, #6, #7 which are based on and are a restatement of his denial of benefits, wherein the

substantial evidence and all of the medical opinion evidence establishes that the Claimant has sustained a repetitive trauma injury and/or occupational disease resulting and arising out of his repetitive and continual exposure to VOCs in the workplace. He should be placed under the care of Dr. Healy, found to be not at maximum medical improvement, and allowed to treat for these residual severe problems in reference to his chronic severe headaches and fatigue and memory loss.

Respectfully submitted,



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October 2, 2017

BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

KENNETH L. BARR, Employee/Claimant, v. DARLINGTON COUNTY SCHOOL DISTRICT, as Employer, and S.C. SCHOOL BOARDS INSURANCE TRUST, Carrier/Defendants.	)	W.C.C. FILE No. 1507304 **APPELLANT'S BRIEF TO THE FULL COMMISSION**

STATEMENT OF THE CASE

This should have been a very simple straight-forward case.

It is agreed Mr. Barr started work with the School District on May 27, 2009 as a commercial painter using commercial paints (Cl. APA p. 207). [Commercial paints contain (requiring MSDS sheets) volatile organic compounds - VOCs; residential house paints do not]. Prior to going to work for the School District, Mr. Barr operated his own house painting business using, residential house paints without VOCs.

For the period 2005 to 2010, only Dr. Chapman his family doctor's records were put into evidence. They contain no history or treatment for chronic/repetitive headaches through May, 2010 (Def. APA p. 250-257).

ONE YEAR AND ½ MONTH AFTER MAY 27TH 2009 ON:

June 15, 2010, Mr. Barr saw Dr. Chapman for:

"H/A (headaches) (x) (off/on) for 2-3 weeks (2-3 wks.); fatigue; taking Tylenol every day."; And he returned

September 1, 2010 - persistent headaches (?) migraine.

September 13, 2010 -

"He stated the headache started about 4 weeks ago ... CT scan ...negative ... he was given a prescription ... unfortunately, the headache has persisted. He returned to work on 9/7/10 and worked through Thursday and was released from work ... because of dizziness, fatigue and balance issues ...
Goody Powders ... now offer no relief. It persists throughout the day."

September 16, 2010, Mr. Barr returned to Dr. Chapman stating:

"Follow-up of his headache and fatigue evaluation. Wife states that she took him to the ER a few nights ago and waited several hours and left without being seen. She stated he had a severe dizzy spell with facial pain and pressure and "looked like he was out of it." Denied any drug use or even OTC medications. He recently had an MRI which showed microvascular ischemic changes ..."

He was given medications and an out of work statement and then Dr. Chapman recorded, "*as young as this patient is with his abnormal brain MRI, I recommend Aspirin 81 mg daily for now in addition to further neurological evaluation ...*" (Cl. APA pp. 165-166).

[MSDS-Paints- VOCs, "Acute Symptoms of Overexposure": headache, fatigue, dizziness, concentration, memory, nausea.]

On September 23, 2010, Mr. Barr was seen by Dr. Roland Skinner, a neurologist who wrote a letter to Dr. Chapman that same day detailing a history of dizziness and headaches with severe headaches that had been continual for the last five weeks. He also noted problems with concentration. Dr. Skinner recorded a very limited social history recording that he had been a chronic smoker but had just quit smoking and that he worked for the school district as a, "handyman and painter." Dr. Skinner "because of his relative lack of other risk factors except for smoking, and because of the intractable nature of his headaches", ordered additional testing. (APA pp. 171-173).

October 22, 2010, Dr. Chapman noted Mr. Barr was being followed by a neurologist, Dr. Skinner; opined the headaches were likely, "tension" headaches; but, he also recorded Mr. Barr stated, "he was exposed to some lead paint in the Summer and wonders if this is a contributing factor". (APA p. 164).

Dr. Skinner saw him from 2010 through February 21, 2012. On November 15, 2011, he noted Mr. Barr was having, "headaches pretty much every day"; that he had good days and bad days in reference to how severe his headaches were; and Mr. Barr noted to him that, "certain smells will trigger the headaches." His diagnosis was chronic headaches and at that time (15 months later) it was his opinion, "a good bit of his problems may be analgesic rebound." (APA pp.190-191). Dr. Skinner last saw him on February 21, 2012 and continued to diagnose him with tension

headaches and as to causation he stated, "we really had not come up with any other reasons for his headaches at that point." (Dep. p. 29, l. 23 - p. 30, l. 15; l. 14-15). **Per Dr. Skinner he never considered his job (Dep. p65-67).**

From October of 2010 until the time he lost his health insurance in 2015, Mr. Barr continued to see Dr. Chapman for chronic intractable headaches and in addition to Dr. Skinner saw Dr. Chapman on a constant basis from 2010 to 2012, [11/16/10, 12/13/10, 3/30/11, 4/19/11, 5/2/11, 7/15/11, 8/22/11, 8/24/11, 10/5/11, 9/12/12, 10/10/12, 11/19/12].

October 10, 2012, Dr. Chapman recorded that:

> "I have discussed options as it related to neurological evaluation. He has an appointment to see Dr. White, a neurologist here, rather than traveling to Florence and hopefully this will be a little easier for him to accomplish as it relates to taking off of work." (APA p. 143).

Then his treatment jumped to mid-2013. Per Dr. Chapman's records, Mr. Barr was seeing him for, "chronic headaches, likely tension" and for fatigue.

October 17, 2012, Mr. Barr **first saw Dr. Marshall White** at his then Hartsville office and after taking a detailed history including his work history as a commercial painter for the School District, Dr. White issued a work restriction note:

> "No exposure to volatile organic compounds (including paint fumes). x 6 weeks" (the emphasis/underlining is on original work restriction statement). (APA p. 75A).

Mr. Barr continued to have severe chronic headaches and continued to see Dr. White and sporadically after he closed his Hartsville office, and then continued to mainly see Dr. Chapman for treatment.

In a note drafted on May 12, 2015, Mr. Larry Stagner, Mr. Barr's supervisor with the School District, noted that he had met with Mr. Barr both on March 28th and again on May 7th, 2015, because Mr. Barr was having trouble performing his work due to his headaches which on March 28th, his doctors had, "speculated" were related to his painting with the School District. Mr. Stagner recorded:

> "While no doctor's excuses have been provided to date to substantiate these issues and other than a doctor's excuse provided Oct. 17, 2012 by Dr. Marshall White stating "no exposure to volatile organic compounds (including paint fumes) for six weeks", we have nothing definitive in which to substantiate this assumption."

He noted that Mr. Barr was going to meet again with his doctors on May 22nd and noted that since the doctors had told him to stay out of the VOCs, Mr. Barr inquired about alternative employment and he and Mr. Stagner set up an appointment with vocational rehabilitation and discussed the idea of applying for Social Security Disability. Mr. Stagner then advised that,

> "our meeting closed with the fact that you need to find a way to be able to perform your job or to find a career that you are able to work without making you sick. ... on 5/22 ... I expect the release to return to work as a painter without restriction or to remove you from work permanently. I need for you to be able

to perform your job at 100% or I need a resignation." (APA p. 199).

In a May 26th note, Mr. Stagner noted Mr. Barr and his wife had presented a doctor's note taking him out of work until further notice and another note stating, "fatigue, migraines, and memory loss due to VOCs in paint from work". On May 29th, Mr. Stagner instructed a fellow employee to go to Sherwin Williams to get the MSDS sheets. (APA pp. 197-198).

On June 4th, after his initial statement on May 21, 2015, Dr. White again recorded Mr. Barr's headaches and memory loss were due to exposure to VOCs and that he had slow mental processing speed, headaches, memory loss due to his exposure to the VOCs in the paint at work.

June 15th, a claim was filed and June 30th Claimant was notified of representation by defense counsel.

Dr. White issued out of work statements on July 18th and again on September 10th, 2015 taking Mr. Barr out of work until further notice. On September 10, 2015, Dr. White confirmed his opinion stated to a reasonable degree of medical certainty. Mr. Barr's fatigue, headaches and memory loss were caused to volatile organic compounds in the paint at work.

HISTORY AFTER HEARING REQUEST

On September 29th having heard nothing and the Defendants having not accepted the claim, a hearing request was filed.

Between Dr. White's May 21st and September confirmational

opinions, and November 4th, aside of taking Mr. Barr's deposition in September, Defendants did nothing in reference to medical evaluation or medical opinion by any physician local or otherwise.

Dr. White confirmed at his November 23rd, 2015 deposition he had issued a referral to a local clinical psychologist, Dr. Avie Rainwater, Ph.D. in Florence, South Carolina on November 3, 2015 to perform neuropsychological testing; provided Nov. 3 to Defendants. (Dep. p. 36-37).

On November 4, Mr. Barr received a telephone call that an appointment had been set up for an evaluation at MUSC to which the Claimant initially objected on the basis that it was not at reasonable times and places and when informed, it was for an evaluation by a psychologist, Dr. Mark Wagner, Ph.D., the Claimant further objected that it was an evaluation that was not allowed for under the Act and there was no reason that that testing could not be performed as prescribed by Dr. White locally by Dr. Rainwater.

On November 6th, 2015, the Defendants filed a Motion to Compel the attendance at what they referred to as a, "medical evaluation" but which in fact was the evaluation by Dr. Wagner, Ph.D. in Charleston, South Carolina. A Reply was filed and the Motion to Compel was initially granted without hearing. After a Writ of Mandamus and a Writ of Prohibition and a temporary restraining order was issued by the Circuit Court restraining

any evaluation, based on a requested conference with the hearing Commissioner, the hearing Commissioner entertained a Motion for Reconsideration and the Motion to Compel was then denied by December 22nd Order on the basis that it was not with a medical doctor. The hearing Commissioner further held Defendants could request and had a right under the Act to have an independent medical evaluation performed by a licensed physician or surgeon but specifically noted it was to be at, "reasonable times and places". The hearing set for January 7th was continued and reset for February 24, 2016.

Not until and then by letter dated January 19, 2016, Defendants noticed an evaluation by Dr. Paul Pritchard, MD not in the Florence-Darlington area but again in Charleston, South Carolina for February 2, 2016. The Claimant objected to this as not being at reasonable times and places and a Motion to Compel was filed on January 27, 2016. In his Reply, Claimant reiterated that his objection had been on two bases back in November: one being that it was not set with a medical physician or surgeon and the second being that it was not at reasonable times and places. He again stated his position as he had back in November that he would attend any independent medical evaluation scheduled pursuant to the Act under §42-15-80 at reasonable times and places with a licensed physician or surgeon and that, as the Circuit Court had agreed, reasonable times and places meant the Florence-Darlington area.

The Claimant also noted that the hearing Commissioner back in December during the conference call and in his Order based on Claimant's position specifically highlighted in quotes that any evaluation was to be at reasonable times and places and that it had been over a month since that Order and that it was not until January 19th that any evaluation was scheduled and it was then scheduled for February 2; 22 days before the hearing.

By email the hearing Commissioner notified the parties he would grant the Motion to Compel the evaluation in Charleston. The Claimant, noting his objection, attended the evaluation.

On February 12, 2016, by regular mail the Defendants filed their first Pre-Hearing Brief noting that a deposition of Dr. Pritchard had been set for March 3 but also enclosing a report that had been issued by Dr. Pritchard on February 2, 2016. [It should be noted that the Notice of Deposition of Dr. Pritchard was not served on counsel for the Claimant until February 17.] Also included with the first Pre-Hearing Brief was a Notice of Deposition of Dr. Nicholas Lind via deposition that had been set for February 19, 2016 which had been noticed on February 5th. That Pre-Hearing Brief also included a report from Dr. Mark Wagner Ph.D. dated February 12, 2016.

Saturday, February 13th, Defendants by mail filed a first Amended Pre-Hearing Brief and added yet another report from Dr. L. Randolph Waid, Ph.D. also dated February 12, 2016. No

request was made to leave the Record open for either the deposition of Dr. Wagner Ph.D. nor Dr. Waid Ph.D.

Monday, February 15, (federal holiday), Defendants by mail added yet another report from Dr. David H. Eagerton, Ph.D. as an exhibit but again no request to leave the Record open for a deposition was included. Note, the deposition notice and cover letter filed February 17th specifically noted that the deposition of Dr. Pritchard was to be taken, "in lieu of your live testimony at a workers' compensation hearing in the above-referenced matter."

On February 18th, Claimant noting that February 13th was a Saturday, the 14th a Sunday and Monday, the 15th was a federal holiday and that none of this was received until February 16th, filed his objection to the submission of any of these records as being late filed and inappropriately served. In addition, he notified the Commission that he would be filing a formal notice of objection to the admission of any of this evidence at the hearing and would be filing a Memorandum in Support thereof which was filed with the Commission on February 19th. He also objected to the Record being left open for the submission of any of this late filed documentary evidence.

A pre-hearing conference was held on February 24th and the Commissioner continued the hearing to allow for the deposition of Dr. Pritchard; allowed the admission of these late filed reports; notified the Claimant that the Commissioner would not

subpoena these doctors to any hearing and that if he wanted to exercise his right to cross-examination of any of this documentary evidence that he would have to schedule, at his own expense, the depositions of these doctors.

The hearing was then reset without agreement for April 20, 2016 in Columbia, South Carolina. Note, after notice of the rescheduled hearing, counsel again objected to the late filed documentary evidence and that the Defendants could not bootstrap that evidence into being timely filed because the Commissioner had rescheduled the hearing.

Claimant, because of a conflict on April 20th and because the matter was not being reset in Hartsville, had to withdraw the Form 50 which was withdrawn by letter dated April 19th. Claimant also requested that a hearing go forward on motions before the hearing Commissioner which was not set and this entire matter was transferred to the next jurisdictional Commissioners.

Although the Regulations do not require refiling where there is no change in the request for hearing, another Form 50 per the direction of the Commission, was filed and a responsive Form 51 was filed.

Subsequently, this matter was set before Commissioner Campbell and APAs and Pre-Hearing Briefs were filed, all objections to evidence were renewed and this matter was then heard. Again, at the August 31st hearing the Record was left

open, this time for the deposition of Dr. R. Joseph Healy, MD. Commissioner Campbell issued his findings on November 17th, 2016. January 19th, 2017, Gerald Malloy filed for reconsideration in part because Commissioner Campbell had not addressed Mr. Barr's request for benefits based on his chronic headaches being caused by or caused to become symptomatic by the VOCs and requesting only temporary total disability, medical care and a finding he was not at maximum medical improvement. The first proposed Order was not filed until August 17, 2017, nine (9) months after his directives and one year (≤ 2 weeks) after the hearing.

ARGUMENTS

I. APPLYING A LIBERAL INTERPRETATION OF THE ACT IN FAVOR OF BENEFITS TO THE INJURED WORKER AND APPLYING HIS BURDEN OF PROOF BY A PROPONDERANCE OF THE EVIDENCE, THE HEARING COMMISSIONER ERRED BY NOT AWARDING MR. BARR BENENFITS.

Mr. Barr requested benefits on the basis that his severe chronic headaches and other problems stemmed from his exposure to paint fumes, volatile organic compounds (VOCs), from the commercial paints he was using. Both of his local treating neurologists stated the opinion that his chronic severe headaches were being caused by exposure to VOCs in the commercial paints he used as a commercial painter for the School District. The other neurologist that first treated him, Dr. Skinner agreed in the opinion that he suffered from chronic headaches which he last diagnosed in 2012 as chronic tension headaches and stated he had not determined the cause stating at

that time in 2012 they were possibly resulting from analgesic rebound, meaning from the other-the-counter and other medications that he had taken for two years trying to control his daily persistent headaches. In other words, all three treating neurologists agreed that he was suffering from chronic severe headaches. Dr. Marshall White was of the opinion that Mr. Barr suffered from severe headaches, fatigue and other problems resulting from an encephalopathic condition which had led to permanent brain damage stemming from his exposure to VOCs in the commercial paints he used. Dr. Healy, his current treating neurologist was of the opinion that the Claimant suffered from chronic headaches and fatigue that were causally related to his exposure to VOCs in the commercial paints he was using between 2009 and 2015 while a commercial painter with the School District. He was of the further opinion that the Claimant was not a maximum medical improvement and needed continuing care in reference to medications and other treatment in an effort to control those headaches. Again, Dr. Skinner expressed no opinion in reference to the cause of Mr. Barr's headaches initially or concerning whether or not the VOCs in the commercial paints Mr. Barr's used were the cause of the triggering of his chronic headaches.

It is axiomatic that the Act shall be liberally construed in favor of benefits to the injured worker and any reasonable doubts shall be resolved in his favor. The Claimant need only

prove he entitlement to benefits by the simple burden of proof of proving by a preponderance of the evidence his entitlement to those benefits. As a matter of law the burden of proof by a preponderance of the evidence simply means that if the scales of justice tip ever so slightly in favor of the Claimant, then the Commission must award benefits. Our Courts have held under that burden of proof that if there is any, "reasonable inference" from the evidence whether that be direct or circumstantial or otherwise, the Commission should award benefits.

There is a gross misunderstanding and confusion confusing the Claimant's preponderance of the evidence burden of proof with the substantial evidence rule. To meet his burden to be entitled to benefits, the Claimant must only prove or put forth evidence of sufficient substance, "to afford a reasonable basis for ..." an award of benefits under the Workers' Compensation Act. Hudson v. South Carolina State Ports Authority, 399 SC 381, 732 SE2d 500 (2012). The Commission must apply that preponderance of the evidence standard as to whether or not there is a reasonable basis for making an award and once the Commission has applied that standard and makes an award the legal standard on appeal completely flips and the reviewing courts must apply the substantial evidence rule to see if there is any substantial evidence in the Record to support the award. Lake v. Reader Construction Co., 332 SC 242, 498 SE2d 650 (SC App. 1998). It is beyond question that the Claimant put forward

sufficient evidence to tip the scales ever so slightly in his favor and there being a reasonable basis for an award, the hearing Commissioner did not as a matter of law apply the standard which this Commission must apply and award benefits to the Claimant.

While the burden of proof may be met by either circumstantial or direct evidence, where the circumstances lead, "an unprejudiced mind to reasonably infer the injury was caused by the accident", the Commission should award benefits. Tiller v. National Health Care Center of Sumter, 334 SC 333, 513 SE2d 843 (1999). The hearing Commissioner in this case simply took his eye inadvertently off of the Claimant's actual burden of proof and responsibility and the fact that Mr. Barr met that responsibility. The following facts both circumstantial and direct are uncontradicted in the Record.

1. There is no evidence in the Record for at least 10 years prior to 2009 of any treatment ever for chronic headaches and no more than one or two times that the Claimant was treated for a headache even as a symptom related to a common cold or a sinus infection.

2. There is no evidence of any exposure to commercial paints for a period of at least 10 years prior to 2009 when Mr. Barr went to work for the School District. Prior to 2009, he was using residential paints (latex) which under federal law do

not contain, the volatile organic compounds that are found in commercial paints and which require MSDS/OSHA sheets.

3. In 2010, one year after becoming a commercial painter and being exposed daily/constantly to the volatile organic compounds, Mr. Barr sought treatment specifically for chronic recurring headaches after August, was under and has remained under treatment ever since for severe headaches.

4. There is no dispute and this Commission may take judicial notice of the fact pursuant to the MSDS sheets, that the Commercial paints Mr. Barr was using as a painter for the District contain VOCs which cause on an acute basis and the symptoms from acute exposure to volatile organic compounds are MSDS sheets: "SIGNS AND SYMPTOMS OF OVER EXPOSURE headache, dizziness, nausea, and loss of coordination are indications of excessive exposure to vapors or spray mist." (APA p. 46, 49, 51-52, 59, 63, 66-67, 70).

5. **June 15, 2010**, Dr. Chapman recorded headaches, fatigue and occasional indigestion. (APA p. 170); **September 13th** - dizziness, fatigue, balance issues and headaches; **September 16th**- headache and fatigue. (APA p. 167). Dr. Skinner, on **September 23rd** - dizziness, headache, difficulty concentrating, some nausea. (APA p. 171).

6. After September, 2010, Mr. Barr has been under constant and continual treatment for severe chronic headaches ever since.

7. When Dr. Marshall White first saw him in 2012, that same day he removed him from exposure to the VOCs and his employer removed him for a period of six weeks. (APA p. 75A, pp. 197-199).

8. On March 28th, 2015, Dr. White was expressing to Mr. Barr and Mr. Barr was taelling his supervisor, Mr. Stagner, that his headaches were speculated to being related to his painting environment. (APA p. 199).

9. While unrepresented and at the request of his employer, on May 21st, 2015, Dr. White issued the opinion that his headaches, fatigue and memory problems were being caused by his exposure to VOCs from the commercial paints he was using and took him out of work. (APA pp. 7, 75A, 199).

10. Subsequently, both Dr. White, Dr. Healy and Dr. Skinner all concurred that the Claimant suffers from chronic and severe headaches and Dr. Healy and Dr. White both stated the opinion that those headaches were being caused by his exposure to the VOCs in the commercial paints at work. Even Dr. Pritchard agreed that the Claimant's history is consistent with the diagnosis of, "chronic daily headache" and recommended an evaluation by an, "occupational medicine physician".

Therefore, the undisputed evidence is there was no exposure to VOCs or commercial paints before 2009; one year later he reports with all of the classic symptoms and symptoms of acute over exposure and thereafter he has been treated for chronic

headaches ever since. Two doctors specifically opine that those headaches stem from his exposure to volatile organic compounds in the commercial paints he was using as a painter for the District. Clearly, the Claimant met his burden of proof that there is a reasonable inference both circumstantially and directly from his exposure to volatile organic compounds in the commercial paints he was using as a painter for the District. There is no question that he suffered from acute over exposure on a daily basis in 2010 based on the uncontradicted symptoms which he was reporting to the doctors.

There is not one other medical opinion contained in the Record as to the cause of his chronic headache condition which developed in 2010 other than the opinions of Dr. White and Dr. Healy that his chronic headaches that started in 2010 were caused by his exposure to VOCs in the commercial paints he used at work. The Commission cannot ignore the unanimous opinion of the medical experts on the cause of the chronic headaches. Herndon v. Morgan Mills, Inc., 246 SC 201, 143 SE2d 376 (1965).

This Commission should award benefits.

II. THE ASSIGNED HEARING COMMISSIONERS ERRED BY ADMITTING AND THE HEARING COMMISSIONER ERRED BY BASING HIS DECISION ON THE DOCUMENTARY EVIDENCE IN VIOLATION OF THE CLAIMANT'S DUE PROCESS RIGHTS IN THE APA SUBMISSIONS FROM DR. PRITCHARD, DR. WAID, PH.D., DR. WAGNER, PH.D. AND DR. EAGERTON, PH.D.

This matter was originally scheduled to be heard on the Form 50 filed by the Claimant requesting benefits on January 6, 2016 before Commissioner Beck. On December 22nd, Commissioner

Beck had issued an Order quashing the Defendant's Motion to Compel the Claimant to attend an evaluation in Charleston, South Carolina BY Dr. Wagner, Ph.D. but ordered that the Defendants were entitled to obtain an independent medical evaluation by a medical doctor emphasizing at reasonable times and places. Although filed on the Claimant's Form 50, the January hearing was continued and reset for February 24th.

For the first time on February 12th, the Defendants provided a copy of a report from Dr. Pritchard, MD which was submitted to the Commission under the Administrative Procedures Act. By Affidavit of Service by mail on Saturday, February 13, 2016, the Defendants served notice of reports from Dr. Mark Wagener, Ph.D. and Dr. Randolph Waid, Ph.D. both to be submitted at the upcoming hearing on February 24th as APA exhibits. By letter and Affidavit of Service on Monday, a federal holiday, February 15th, received February 16th, Defendants filed a report from Dr. David Eagerton, Ph.D. dated February 14, 2016 to be submitted at the upcoming hearing on February 24th as an APA submission.

By letter and then by Memorandum of Law dated February 18th and February 19th, respectively, the Claimant objected to all of this documentary evidence being submitted on the basis that it was being submitted in violation of the Administrative Procedures Act, the Rules of the Commission and in violation of his rights to due process of law and specifically violating his right to cross-examination of the evidence sought to be

admitted. The Claimant further requested under the Act that the Commission issue subpoenas for these doctors to attend the hearing set for February 24th.

A pre-hearing conference was held on February 24th and the Commissioner continued the hearing to allow the Defendants to take the deposition of Dr. Pritchard which was set after the hearing. He also admitted all of the APAs and shifted the burden to the Claimant to schedule and take the depositions of all of these medical doctors and Ph.D.s if he wanted to exercise his right to cross-examination. There is no evidence in the Record that there was any attempt to take the deposition of Dr. Pritchard prior to the February 24th hearing nor was there any effort by the Defendants to schedule and take the depositions prior to the February 24th hearing of the alleged experts so that this evidence could be properly admitted or at least the depositions of these experts could be properly admitted at the February 24th hearing.

Instead and again, although the hearing was based on the request for benefits by the Claimant, the hearing was continued a second time for these purposes and was not reset until April 20th.

After the Claimant had a conflict on April 20th and there being no effort to reschedule the hearing in Darlington County where the accident occurred, the Claimant pulled the Form 50, refiled the Form 50 and then the matter came on for hearing

before Commissioner Campbell. At that hearing and in the Pre-Hearing Brief, the Claimant reiterated and restated his objections to the submission of all of this documentary evidence under the Administrative Procedures Act and shifting the burden to him to pay the expense to cross-examine the experts who had issued these reports and at the same time, admitting those reports into evidence over objection. Commissioner Campbell then totally based his entire decision denying the Claimant benefits based on the reports of all of these doctors and Ph.D.s.

The Rules of this Commission refer to the requirements of the Administrative Procedures Act in the submission of written documentary evidence before the Commission and where there is a conflict between the requirements of the Administrative Procedures Act and the Rules of this Commission, the Administrative Procedures Act controls. Pringle v. Builders Transport, 298 SC 484, 381 SE2d 731 (1989).

Rule 67-612, is a regulation and not a statute. The documentary evidence sought to be admitted was not submitted pursuant to deposition de bene esse or by witness testimony, either of which preserves the Claimant's right to due process and cross-examination. Reg. 67-612 refers to the submission of experts reports into evidence pursuant to the Administrative Procedures Act, which is the controlling statutory authority for the submission of documents. All regulations must be based upon

and subject to statutory authority. A regulation cannot add to nor subtract from the authority granted to an agency. Under the SC Workers' Compensation Act, SC Code §42-3-10, et seq., the Commission is granted the authority to subpoena witnesses, to administer oaths and affirmations, take depositions, issue subpoenas to compel the attendance of witnesses, and for the production of books, papers, correspondence, memoranda, or other records deemed necessary in connection with any proceeding under this title, and specifically under SC Code §42-3-130, 140, 150 and 160. The authority of the Commission to receive documentary evidence at any time and in any fashion is not contained in the Workers' Compensation Act but is contained only under the statutory authority pursuant to the Administrative Procedures Act, SC Code §1-23-330.

Before listing the specific objections to each report and document sought to be admitted as documentary evidence at the hearing, as to the preservation of Claimant's fundamental due process right of cross-examination since the Defendants sought to submit this evidence in documentary form, the Claimant moved for its exclusion and requested the Commission issue subpoenas for the attendance of these witnesses at the hearing. Thus he specifically requested pursuant to Statute by subpoena the right to exercise his fundamental due process right of cross-examination of the witnesses who produced that hearsay evidence

and moved to exclude that evidence without such right being granted.

In Richardson v. Perales, 402 U.S. 389, 91 S.Ct. 1420, 28 Law. Ed.2d. 842 (1971), in a Social Security Administration hearing the United States Supreme Court applied the Federal Administrative Procedures Act and the fundamental right of cross-examination and held that documentary evidence may be received into evidence, but only where the Claimant did not exercise his right by requesting the witnesses be subpoenaed by the Administration to the hearing to exercise that right. Where the Claimant requests Subpoenas to exercise his right to cross-examination, such documentary evidence cannot be admitted nor can it be considered as substantial evidence in the case and is to be excluded. The Claimant would also note that in this case the Defendants did not seek to take the de bene esse depositions of the three Ph.D. reports.

Further, in reference to due process and the right of cross-examination, SC Code §1-23-330 provides that in an Administrative Proceeding documentary evidence may only be admitted where the, "hearing will be expedited and the interest of the parties **will not be prejudiced substantially**". That statute further preserves to the parties the right of cross-examination which is guaranteed to all parties under that statute and under SC Constitution, Article I, Sec. 3, which guarantees to all citizens in all proceedings due process of

law. Further, Article I, Sec. 22 of the SC Constitution requires that in an Administrative Procedures Action, that no person shall be finally bound by the quasi-judicial decision of an Administration Agency affecting private rights except on due notice and opportunity to be heard. In interpreting the requirements of due process and specifically the right to be heard, our Supreme Court has stated that at a minimum certain elements must be present in order to comply with the procedural requirements of due process including notice and **the right to confront and examine witnesses**; In Re: Vora, 354 S.C. 590, 582 S.E.2d 413 (2003). In multiple cases in administrative settings, our Supreme Court has upheld the right to cross-examination:

> "Where important decisions turn on questions of fact, **due process requires an opportunity to confront and cross-examine adverse witnesses.** Procedural due process often requires confrontation and cross-examination **of one whose word deprives a person of his or her livelihood.**" Brown v. State Bd. of Education., 301 S.C. 326, 391 S.E.2d 866 (1990).

Administrative agencies are required to meet minimum standards of due process and the Courts have applied this specifically to the SC Workers' Compensation Commission and required that the parties be given the required notice and an opportunity to present evidence and to, "cross-examine witnesses" regarding the merits of the case. Smith v. SC Dept. of Mental Health, 494 S.E.2d 630, 329 S.C. 485, reh. den., cert.

granted., affirmed, 335 S.C. 396, 517 S.E.2d 694 (1997). Citing Stono River Environmental Protection Assoc. v. SC Dept. of Health & Environmental Control, 305 S.C. 90, 406 S.E.2d, 340 (1991).

Again, in accordance with Richardson v. Perales, supra, the Claimant specifically objected to the submission of this documentary evidence and requested the witnesses be subpoenaed by the Commission so he could assert his right to cross-examine the witnesses at the hearing.

In support of this argument by way of history, prior to the advent of current Reg. 67-612 and under Reg. 67-612 **as it existed from 1992 until the 1998 amendment**, a party offering a written report had to move for its admission at the hearing and it was within the Commissioner's discretion whether to order the party submitting the written report to take the deposition of the expert before the report could be admitted. Prior to the 1992 amendment, Regulation 67-612, under the original recodification of the Commission's regulations, an expert's report could only be admitted with the consent of the opposing party and if not consented to, **the party seeking to have that report admitted had to take the deposition or procure the testimony of the expert**. Therefore, from 1936 until 1998, written documentary evidence could only be admitted by agreement and if not agreed to, the party seeking to admit that evidence had to ensure the opposing party's right to cross-examination by

taking the deposition as is done in every other civil case to preserve that party's right of cross-examination. The statute granting the authority to this Commission concerning depositions and the submission of evidence has still to this day never been changed and the same general contemplation is provided for under that statute; in other words, that a party seeking to submit evidence will either have the witness appear or will present the witness' testimony by de bene esse deposition.

Concerning the Claimant preservation of his right by requesting that Subpoenas be issued by the Commission requiring the attendance of the witnesses at the hearing so that he could exercise his right of cross-examination and barring that, that any documentation be disallowed into evidence, and in compliance with the reasoning in Richardson v. Perales, supra, the Court of Appeals' in Gadson v. Mikasa Corp., 368 S.C. 214, 628 S.E.2d 262 (SC App. 2006), specifically held that by giving notice of the submission of a report in written form, and by a party not requesting that the witness be subpoenaed to the hearing to exercise the right of cross-examination, that this allowed for the submission of the document into evidence.

Next, as a matter of general legal principle, there are only two bases upon which an expert can give expert opinion testimony and evidence; 1) the expert's opinion must be based on personal knowledge or 2) the expert's opinion must be based on a properly phrased hypothetical question.

First, in reference to personal knowledge, neither a lay nor expert witness may testify as to a matter unless evidence is introduced sufficient to support a finding that the witness has personal knowledge of the matter. In reference to personal knowledge as stated by Professors Thames and Dreher, "through question and answer at the trial or hearing and after it is established that the expert witness has personal knowledge of the facts about which he is supposed to testify and after a rendition of those facts by the witness, the expert witness may testify; such as in this case that he personally examined Mr. Barr and reviewed all of the objective testing results and information concerning him and can express opinions on his exposure and/or medical condition based on that personal knowledge.

The second way that an expert witness may testify is again through, "question and answer" at the hearing or trial where the witness is examined concerning his knowledge of and the underlying facts or data upon which his opinion is based and then after that, he states his opinion in reference to a properly phrased hypothetical question containing all of that data and information. "A Guide to Evidence Law in South Carolina" by Professor James F. Dreher, as revised by Professor Jon P. Thames, 1979 Ed. and SC Rules of Evidence, Rule 602, Rule 702, 703 and 705. SCRCP Rule 705 specifically provides in reference to the expert's testimony that the expert is required

to disclose the underlying facts and data upon which his opinion is based, "on cross-examination".

Two of the most precedential cases in reference to the submission of expert opinion testimony based on either personal knowledge or by properly phrased hypothetical questions are in fact workers' compensation cases. See: Chapman v. Foremost Dairies, Inc., 249 S.C. 438, 154 S.E.2d 845 (1967); Wright v. Graniteville Co. Vaucluse Div., 266 S.C. 88, 221 S.E.2d 777 (1976). Either way, but especially in reference to opinions based on data, it is blackletter law that the factual underlying basis for the expert's opinion must be set out in detail otherwise the opinion of the expert lacks probative value.

Next, as a general principle any finding of fact by the SC Workers' Compensation Commission will be and should be upheld if there is substantial evidence in the Record upon which it is founded but the decision and factual findings of the Commission cannot rest upon surmise, speculation or innuendo. Rudd v. Fair Forrest Finishing Co., 189 S.C. 189, 200 S.E.2d 727 (1939).

Finally, all evidence must be relevant and material and the relevancy and materiality of evidence cannot be outweighed by its prejudicial effect.

Based on those general provisions, none of the documentary evidence should have been submitted into evidence:

1. Documentary evidence submitted from David H. Eagerton, Ph.D., F.ABFT - first, this group of documents was not served on

the Claimant until February 15, 2016 and were thus not timely submitted and must be excluded pursuant to WCC Reg. 67-612.

Further, the submission of this alleged expert opinion into evidence in documentary form would deny the Claimant due process of law by denying him his right, which he requested, to cross-examine the expert.

Next, the documentation provided that was admitted into evidence sets forth that his opinions are based upon a review of records with no personal knowledge of Mr. Barr or his job, job duties or exposure and there is no properly phrased hypothetical question in reference to or as a background for the provision of his opinions as expressed in the documentation. Therefore, his opinions were neither based on personal knowledge nor based on a properly phrased hypothetical question. [Legal note: It would be noted as to both personal knowledge and particularly as to a properly phrased hypothetical question that the hypothetical questions in both Chapman and Wright were presented either at a hearing or at a deposition for consideration and answer by the expert and presented to the Commission in person or by deposition.]

Next, in the actual statement of the opinion the alleged expert stated that "it is my opinion that, within a reasonable degree of scientific **and medical certainty** . . ." there is nothing in the documentation that would establish Dr. Eagerton, Ph.D. is also a medical doctor or that he has any

background or experience or credentials or training as a medical doctor that would allow him to express a medical opinion.

Next, there is no specific attachment to the opinion with all records "allegedly" reviewed by the expert in preparation for submitting this summary report. In addition, the summary is inaccurate as to the history available from the evidence that was presented at the hearing.

2. Documentary evidence L. Randolph Waid, Ph.D., dated February 12, 2016 - This document starts with "per your request, I reviewed records concerning Mr. Kenneth L. Barr . . .". Further, the report states he is, "concurring" with the opinions expressed by Dr. Mark Wagner, Ph.D.

First, the submission of this documentary evidence would deny the Claimant due process of law because of his inability to cross-examine this expert who conducted only a, "records review."

Next, this documentary report clearly indicates that there is no personal knowledge on behalf of Dr. Waid, PhD nor is there any properly phrased hypothetical question(s). The documents alleged to have been reviewed are not attached and therefore there is no evidence of the data reviewed or personal knowledge nor is there a properly phrased hypothetical question and/or opinions expressed in response to that or those hypothetical questions and thus there is no basis for the submission of this expert's opinions into evidence.

There is no evidence that Dr. Waid, Ph.D. is a medical doctor but yet he tends to set forth medical opinions in reference to the documents reviewed.

This being a records review and there being absolutely no evidence of the specific records reviewed and/or credentials of the alleged expert, the documents should not be admitted.

Finally, the documents are hearsay and contain hearsay within hearsay. It is not based upon a review of objective tests results but is in fact based upon numerous statements made within other documents allegedly reviewed that are hearsay in nature and thus again constitute hearsay on hearsay and not based on personal knowledge. Further, as noted in expressing his findings, there is clear-cut reference to and reliance upon another records review by Dr. Mark Wagner, which clearly indicates that this expert's opinion is based on hearsay based on hearsay based on hearsay, is biased and prejudicial and is based upon the opinion of another alleged expert, Dr. Wagner, PhD.

3. Documents from Dr. Mark T. Wagner, Ph.D. - The submission of these documents would deny the Claimant the right of cross-examination and should not be admitted.

The document clearly states that it is a, "records review" and that Dr. Wagner, Ph.D. does not have any personal knowledge of Mr. Barr. The records allegedly reviewed by Dr. Wagner, Ph.D. are not attached and there is no way of verifying

what records were specifically reviewed and again the Claimant's right of cross-examination to test the credibility, veracity, bias and prejudice of this report is denied to the Claimant. This is particularly the case here wherein the Defendants attempted to obtain a direct referral to Dr. Mark Wagner, Ph.D. in lieu of a medical examination, which the Commission ruled was improper. The need to test the credibility, veracity, bias and prejudice of Dr. Wagner is evident and paramount.

The documents clearly establish that they are based on a records review and that Dr. Wagner, Ph.D. had no personal knowledge of Mr. Barr, nor are his opinions based upon any properly phrased hypothetical questions, nor are the documents that he allegedly reviewed attached to this report with any certification as to his review of those documents and/or that he reviewed a complete set of documents from each source. Further, a review of the documents reveals that this Ph.D. did not have copies of the MSDS sheets.

4. Dr. Paul B. Pritchard, M.D. - The submission of these documents at the February hearing denied the Claimant the right of cross-examination as to Dr. Pritchard's examination and opinions. While Dr. Pritchard personally examined the Claimant, there are no attached documents to his report verifying and certifying as to the specific documents that he reviewed during or after the evaluation. As provided for in Rule 704, the Claimant through cross-examination may require specific

explanatory and detailed documentation of the documents and data referred to and used in expressing opinions.

Further, this document should not have been submitted into evidence for the reasons previously submitted to the Commission concerning the evaluation. As previously noted as a basis for objection, on December 22, 2015, the Hearing Commissioner granted the Claimant's Motion for Reconsideration and the Claimant was supposed to be only compelled to attend an evaluation by a properly qualified medical doctor at, "reasonable times and places". Almost a month later on January 19th, the Claimant received a letter without any accompanying records or anything else addressed to Dr. Paul Pritchard setting up an appointment for the Claimant in Charleston, South Carolina (the Claimant lives in Hartsville) on February 2, 2016. Because no records were attached to that notification subsequent thereto the Claimant pursuant to SC Code §42-15-95 specifically requested a copy of all records, if any, submitted to Dr. Pritchard as part of his examination. In response, on February 4th, two (2) days after the examination, Claimant's Counsel received a stack of documentation purportedly to have been submitted to Dr. Pritchard **on December 8, 2015**. Those documents contained a cover letter sent to Dr. Pritchard dated December 8, 2015 requesting an independent medical evaluation to be scheduled for Mr. Barr. Attached to that letter, Claimant's Counsel was advised for the first time on February 4th, that an

almost three (3) inch stack of records had been forwarded to Dr. Pritchard for review and evaluation. Based on this communication without the knowledge of Counsel for the Claimant and also based on the submission of all of these records without the knowledge of the Claimant, Claimant's Counsel objected to the submission of those records into evidence as being in violation of §42-15-95. SC Code §42-15-80 specifically gives the employer and its insurance carrier the right to have an "independent" medical examination conducted by a qualified physician or surgeon as designated and paid for by the employer or the Commission. SC Code §42-15-95(B) provides that a health care provider who provides examination or treatment for any injury, disease or condition for which compensation is sought under the provisions of this Title, may communicate on various listed items/issues such as medical history, diagnosis, and causation with the insurance carrier or the employer without the employee's consent. However, in order to comply with the statute concerning a physician who performed an examination, "the employee **must** be:" notified that the discussion or communication **is going to take place** and this notification **"must occur prior to the actual discussion or communication"** or advised of the nature of the discussion or communication, **"prior to the discussion or communication"** and the employee must be "provided with a copy of the written questions **at the same time the questions are submitted to the healthcare provider**." An employee must also be

provided with the response of the healthcare provider and the report of Dr. Pritchard dated February 2, 2016 was not received until February 16th when it was submitted as part of the APA Submissions by the Defendants. More importantly, the statute further provides that any discussion or communication, medical reports or opinions obtained,

> "in accordance with this section will not constitute a breach of the physician's duty of confidentiality **but** any discussions, communications, **medical reports, or opinions** obtained in violation of this section **must be excluded from any proceeding** under the provisions of this Title."

You cannot bootstrap compliance by taking a deposition after you have violated the statute.

5. Medical records submitted from various providers prior to the employment of the Claimant in 2009 - As a general objection, the Claimant objected to the submission of all of these because it denied him the right of cross-examination as to these medical records. Prior to 1998, any records that were submitted into evidence were agreed upon and if the parties could not agree upon their submission, the party that wanted those records into evidence, or used in any way, would have to take the deposition necessary for their submission. The Claimant requested the Commission take judicial notice that medical records are notorious for containing inaccurate hearsay statements outside of the objective part (e.g. examination, x-rays, etc.) of the records. The Supreme Court of South Carolina

has specifically ruled in reference to the submission of medical records under the Business Records Act that while the objective parts of such records are admissible under the Business Records Act, any hearsay statements in those records should be redacted. See: State v. Key, 277 S.C. 214, 284 S.E.2d 781 (1981). Up until 1998 (and the problem with the current procedure) is that all of this type hearsay evidence would be redacted by agreement of the parties before being submitted to any expert for use. If the hearsay statements were thought to be necessary by either party and the parties could not agree on their submission, then the party wanting that hearsay into evidence or to determine its truth and accuracy would take the deposition of the appropriate doctor or medical provider, or the person involved with making the Record initially. For example, there is a tremendous amount of difference between the terms two weeks, two months and two years and there are many times that medical records are wrong on contradictory as to time periods. This is the basic reason that all hearsay statements are not admitted into evidence.

Based on this, the Claimant objected to their submission based on the fact that these items are all hearsay, are not subject to verification as to their truth and accuracy and that they are irrelevant and immaterial and/or that their prejudicial value far exceeds any probative value. In addition, Mr. Barr's inability to conduct cross-examination denied him due process of law but also makes the experts' opinions and the Commission

decision based on those records or the opinions based on those surmise, speculation and innuendo.

Further, while there are specific exceptions under the HIPPA statute and Regulations that allows for medical doctors to release and for insurance carriers and employers to obtain the medical records of a claimant in reference to a workers' compensation proceeding, that exception does not extend to the entire medical history of the Claimant. The HIPPA statute and statute §42-15-95 apply only to the records following the accident.

III. COMMISSIONER BECK, ORIGINALLY AS SIGNED TO HEAR THIS CASE, ERRED AS A MATTER OF LAW BY ALLOWING THE DEFENDANTS TO SEND THE CLAIMANT FOR EVALUATION TO DR. PRITCHARD IN VIOLATION OF SC CODE §42-15-80.

In November of 2015, the Defendants scheduled an evaluation with Dr. Mark Wagener, Ph.D. to which the Claimant objected as being not with a medical doctor and also not being at reasonable times and places to where he lived in Hartsville, South Carolina. The Defendants filed a Motion to Compel attendance (although there is no right under the statutory authority of the Commission to compel anything) which was initially granted. The Claimant filed a Writ of Mandamus and Writ of Prohibition in the Circuit Court which resulted in a temporary restraining order restraining the Defendants from sending the Claimant to any evaluation on the preliminary basis that such evaluation was in violation of the Commission's statutory authority. A telephone

conference was then held with Commission Beck at his request and Commissioner Beck granted a Motion for Reconsideration; denied the Defendants the right to send the Claimant directly to a neuropsychologist; but found that the Defendants had the right to schedule an evaluation with a licensed medical doctor or surgeon, and Commissioner Beck put this in quotes and in bold in his Order, that, "such evaluation was to be at reasonable times and places".

Thereafter, the Defendants, although the Order was issued on December 22nd, did not schedule or notify the Claimant of any evaluation until January 19th and then notified the Claimant of an evaluation to be performed by Dr. Pritchard in Charleston, South Carolina on February 2nd just twenty-two days(22) prior to the rescheduled Hearing on February 24, 2016. The Claimant again objected on the basis that the evaluation was in violation of SC Code §42-15-80 and specifically in violation of the provision that the evaluation must be at "reasonable times and places;" which has been interpreted by the Supreme Court to mean the county or the area in which the Claimant lives unless there is a showing of just cause.

The Defendants again filed a Motion to Compel and that Motion to Compel set forth no reason or justification as to why there was not a licensed medical physician or surgeon within the Florence-Darlington-Hartsville area that could perform the independent medical evaluation sought to be performed by the

Defendants. Commissioner Beck by email then advised the parties he would order that the evaluation take place and the Claimant, over his objection, attended the evaluation with Dr. Pritchard. The problem with allowing this examination was further compounded by the fact that the Claimant's requested hearing for benefits in February was then continued to allow the Defendants the opportunity to take the deposition of Dr. Pritchard. Although the evaluation was performed on February 2nd and his report is dated February 2nd, the report was not submitted to the Claimant for review until February 12th as part of the Defendants' APA Submissions at that time. Although the defendants had known about Dr. White's opinion since May 21st, 2015; Defense counsel had been involved since June 30th, 2015; and a Hearing had been set for January 7th which was continued once to February 24th they did not schedule an evaluation until February 2nd. Because of the continuance over objection in violation of Rule 67-613 and the claimant's right to speedy benefits no hearing was held until August 2016. Subsequent thereto, Commissioner Campbell based his decision almost entirely on the opinion of Dr. Pritchard.

The Claimant does not question the right of the Defendants to obtain an examination under SC Code §42-15-80 as long as that examination is in accordance with the provisions of that Code section and is requested in a timely manner. That Code section specifically provides that the Claimant shall submit himself to,

"examination, at **reasonable times and places**, by a qualified physician or surgeon designated and paid for by the employer or the Commission". The Supreme Court has specifically held that generally reasonable times and places means the county or the area wherein the Claimant resides. In Singleton v. Young Lumber Co., 236 SC 454, 114 SE2d 837 (1960), where the Claimant lived in Georgetown and the Defendants sought an examination by an orthopedic surgeon in Charleston, South Carolina and where the Commission found that there were qualified physicians or surgeons in the Georgetown area to perform the evaluation, the Court held the Commission should not order and the Claimant was justified in not attending such examination. In this case in addition to the over eight month delay in requesting IME, both in the original Motion to Compel and the the subsequent Motion to Compel, the Claimant took the position that there were qualified physicians and surgeons in the Florence-Darlington-Hartsville area that could perform the evaluation requested by the Defendants. The Defendants made no showing that there were no qualified physicians or surgeons or even that there were no qualified physicians or surgeons in the specific specialty from which the Defendants wanted the Claimant to be examined. There was no just cause as is required by Rule 67-613 for the postponement. The Commission erred by ordering the Claimant to attend the evaluation by Dr. Pritchard and then basing its decision on that evaluation especially where there was no

showing by the Defendants that there were no qualified physicians or surgeons to conduct the evaluation in the Florence-Darlington-Hartsville area or just cause for the delay in requesting it or for postponement of the Hearing.

The Claimant has the burden of proof to prove his entitlement to benefits and the Defendants have a very limited right and the Claimant would reiterate a very limited right, to have an evaluation performed. That right is limited in two regards; it is limited to an examination by a qualified physician or surgeon and it must be at reasonable times and places which has been interpreted to mean in the area in which the Claimant lives unless there is a showing of just cause.

IV. THE HEARING COMMISSIONER ERRED AS A MATTER OF LAW BY CONSIDERING THE REPORT AND OPINION OF DR. EAGERTON, PH.D.

In his report, Dr. Eagerton specifically states that his opinion is stated to a reasonable degree of, "medical" and professional certainty. Dr. Eagerton is a Ph.D. not a licensed physician or surgeon in the state of South Carolina. It was the unauthorized practice of medicine, totally improper and beyond his credentials as an expert (as stated in the documentary evidence concerning his credentials) for Dr. Eagerton to state a medical opinion. There is no evidence in the Record that he is qualified by background, experience or training to express a medical opinion. Since the decision of the hearing Commissioner is in part, based upon the opinion of Dr. Eagerton, the decision

must be reversed and remanded for a de novo hearing at a minimum.

V. THE HEARING COMMISSIONER ERRED AS A MATTER OF LAW IN HIS ORDER BY ISSUNG AN ORDER ON AN ESSENTIAL ISSUE UPON WHICH HE MADE NO DETAILED FINDINGS OF FACT AS IS REQUIRED BY THE STATUTE AND CASELAW.

Commissioner Campbell issued his notes for decision including his findings of fact based on a review of the evidence on November 17, 2016. Subsequent thereto, the Claimant pointed out and asked for reconsideration specifically on the basis that Commissioner Campbell had not addressed in his findings of fact for decision one of the bases upon which the Claimant was requesting benefits. The Claimant had specifically requested benefits based on the opinion of Dr. Healy that the Claimant suffered from chronic headaches that were caused by his exposure to VOCs in the commercial paints which he used as a painter for the District, but that the Claimant was not at maximum medical improvement in his opinion. The essential issue the request for temporary total disability benefits and the provision of medical care until the Claimant reached maximum medical improvement based on Mr. Barr's chronic headaches is nowhere addressed in Commissioner Campbell's notes for decision.

After this had been brought to the attention of the Commissioner in January 2017 and after the first proposed Order was submitted to the Commissioner in August 2017 which the proposed Order also did not address this essential issue, and

this issue was again raised. The Defendants then submitted a second proposed Order without any further findings by the Commissioner and in that second proposed Order made additional findings of fact and conclusions of law on that essential issue but again outside of those that had originally been made by Commissioner Campbell. There is absolutely nothing in the Record to indicate that these are the findings of fact of Commissioner Campbell in reference to that specific issue and that specific request for benefits. These findings of fact in the Order are simply nothing more and nothing less than findings of fact that were made by defense counsel addressing these issues that had not been addressed by Commissioner Campbell.

Under law, the Commission is required under SC Code §42-9-5 and under the prior decisions of the South Carolina Supreme Court and specifically in reference to such decisions as Drake v. Reybestos-Manhattan, Inc., 241 SC 116, 127 SE2nd 288 (1962)to make detailed findings of fact and conclusion of law. It is the, "*duty of the Commission to make specific findings of fact upon which a Claimant's entitlement of compensation may rest and upon which the amount of compensation due to him may be calculated by one of the statutory formulas*". Those findings of fact and conclusions of law on the essential factual issues before the Commission for decision must be, "***sufficiently definite and detailed to enable the appellate court properly to determine whether the findings of fact are supported by evidence***

and that the law has been properly applied to them." (emp. added). Where the Commission itself, not defense counsel, does not make detailed findings of fact and conclusions of law on an essential issue for decision by the Commission, it is reversible error and the case must be remanded for a hearing on those issues. Hill v. Jones, 255 SC 219, 178 SE2d 142 (1970).

Commissioner Campbell simply did not make detailed findings of fact and conclusions of law on the specific request for benefits based on his chronic headaches caused by VOCS for temporary total disability benefits and medical care until he reached maximum medical improvement from his chronic headaches and having not done so, the defense lawyer cannot be allowed to simply fill in the blanks.

VI. THAT THE HEARING COMMISSIONER ERRED BY DENYING THE CLAIMANT BENEFITS AS SET FORTH IN REQUESTS FOR REVIEW NOs. 4,5,9,13-17,19-23,25-29 AS SET FORTH IN THE REQUEST FOR COMMISSION REVIEW.

The Claimant would request review of but will not make further argument on the other separate grounds for review set forth in his Requests for Commission Review as set forth hereinafter:

4. That the Commissioner erred as a matter of law by continuing the February 24, 2016 hearing and allowing the submission of reports from Dr. Mark Wagner, Ph.D., Dr. L. Randolph Waid, Ph.D., and Dr. David H. Eagerton, Ph.D. whose reports were dated February 12, 2016, February 12, 2016 and February 14, 2016 respectively wherein the reports of Dr. Wagner, Ph.D. and Dr. Waid, Ph.D. were submitted under cover letter dated February 13, 2016 (Saturday) but with an Affidavit of Service on February 12th and which was not received until February 16th, the day after a Federal holiday on Monday the 15th.

The report of Dr. Eagerton, Ph.D. was not mailed and filed, allegedly in accordance with the Administrative Procedures Act and the Rules of this Commission, until February 15th, again which was a Federal holiday, but was not received until February 16th for the February 24th hearing. Although an Order denying the right to send Mr. Barr to Dr. Wagner, Ph.D. was entered December 22, 2015 and Depositions were taken of Dr. White, November 23, 2015; Dr. Skinner, December 10, 2015 and Dr. Lind, Ph.D., February 19, 2016, the reports of Dr. Waid, Ph.D., Dr. Wagner, Ph.D. and Dr. Eagerton, Ph.D. were not provided to the Claimant until February 16th, eight (8) days before the hearing. Those untimely reports then served as the very basis for denial of the Claimant's entitlement to benefits. Thus, a continuance was highly prejudicial to the rights of the Claimant to due process of law. There is no provision under the Workers' Compensation Act for the submission of documentary evidence except by Subpoena (§42-3-150) and the only exception is contained with the Administrative Procedures Act which provides that documentary evidence may only be submitted where it will not substantially prejudice the interest of any party.

5. That Commissioner Wilkerson erred as a matter of law by granting a Motion to Compel requiring the Claimant to sign a Release of Information Form wherein the Commission has no statutory authority to require or compel the Claimant to sign such a form and wherein the Motion was granted without a hearing and wherein the Claimant forwarded an Authorization to Release Form directly to the medical group in question authorizing the specific release directly to Defense Counsel of all requested medical records. The Motion to Compel and Rule to Show Cause resulted in prejudice to the Claimant and a hearing not being held on his claim from May through August 31, 2016.

9. That the Hearing Commissioner erred as a matter of law where there is absolutely no expert medical opinion other than that the Claimant's headaches, memory, fatigue, confusion, neurological, and psychological problems stem from his exposure to VOCs from his job as a painter with the School District. Even Dr. Pritchard who opined in his report that he did not find that the Claimant had suffered from an encephalopathy; opined: that he could not, "speak authoritatively on the potential for impairment from the various paints and other compounds to which he reports on-the-job exposure"; that he recommended that he should be, "evaluated by an occupational medicine physician who has training and experience in toxicology"; that VOC exposure would cause acute headaches; and also opined and agreed that by history that his headaches were consistent with chronic daily headache.

13. That the Hearing Commissioner erred as a matter of law in making Finding of Fact #1 as written in that it misstates the position of the Claimant and does not represent an appropriate view of the evidence in the Record.

14. That the Hearing Commissioner erred as a matter of law by making Finding of Fact #2 which implies that the Claimant prior to his employment was diagnosed on a continual basis with conditions as outlined in that Finding of Fact. There is no evidence in the Record of a continuing diagnosis of or any treatment for any of those problems. The last medical report dated May 27, 2009 was for treatment of left arm pain; on September 19, 2008, upper respiratory infection with chest congestion; and on May 15, 2009, indigestion and prostrate.

15. That the Hearing Commissioner erred as a matter of law and fact in making Finding of Fact #4 in that it does not properly reflect the evidence and it ignores the initial opinion Dr. White expressed on May 21st of 2015 that the Claimant was suffering from, "fatigue, migraines and memory loss" due to exposure to VOCs in the commercial paints used by the Claimant.

16. That the Hearing Commissioner erred as a matter of law and fact in his Finding of Fact #5 in that it improperly states the psychological opinions and findings based on the neuropsychological testing conducted by Dr. Lind. Contrary to the Finding, it was Dr. Lind's opinions stated to a reasonable degree of psychological certainty that the test results were consistent with mild organic brain damage and he recommended repeat testing in one year as to whether or not that was progressive.

17. That the Hearing Commissioner erred as a matter of law and fact in referencing the testimony and opinions of Dr. Pritchard whose testimony and evidence should not have been admitted; however his testimony establishes that he found the Claimant's history to be consistent with chronic headaches; that he found the Claimant to be an accurate reporter; that he did not deny or dispute that the Claimant was having severe chronic headaches; that VOC exposure will cause acute headaches and that in reference to objective tests to confirm or deny headaches, Dr. Pritchard confirmed and stated the medical opinion that there were <u>no</u> objective medical tests which will either confirm or deny headaches and specifically stated as to whether there are any: "I would say none at all."

19. That the Hearing Commissioner erred as a matter of law, in addition to all the foregoing reasons in reference to the consideration of the report by Dr. Randolph Waid, by

considering his report in that there is no evidence that he expressed any opinion concerning the Claimant's headaches nor did he make any statement that the Claimant was not factually and truthfully reporting and was not suffering from severe disabling headaches. In addition to the foregoing reasons for not finding this report to be not supportive of the denial of benefits based on severe chronic disabling headaches, and while it is true that the Claimant's primary complaint was and is one of disruptive headaches, Dr. Waid states that his headaches existed, "**prior to his engagement in employment with Darlington County School District**." There is absolutely no evidence in the Record that the Claimant was suffering from headaches or chronic headaches at all prior to him going to work for the School District.

20. That the Hearing Commissioner erred as a matter of law and fact in making Finding of Fact #9 in that in addition to the objections as set forth hereinabove and that this Commissioner should not have considered this evidence at all based on the violation of the Claimant's due process right to cross-examine this Ph.D., here again in this Finding the Commissioner notes specifically that Dr. Eagerton, Ph.D. who is admittedly not a medical doctor, states a medical opinion to a reasonable degree of medical certainty.

21. That the Hearing Commissioner erred as a matter of law and fact in that his decision does not address Dr. Bennett's toxicological findings in reference to the Claimant's exposure and Dr. Bennett's opinion that Mr. Barr's severe disabling headaches stem from his exposure to VOCs in the paints with which he worked with the School District. The finding of Dr. Bennett in reference to headaches and his supportive toxicological opinions are not even referenced in reference to headaches.

22. That the Hearing Commissioner erred as a matter of law by making Finding of Fact #11. In addition to the Finding as set out not being factually accurate as to Dr. Healy's testimony in his deposition, the Finding of Fact does not address Dr. Healy's opinion that the Claimant's disabling headaches were caused by his exposure to VOCs and that that opinion was reaffirmed under oath at his deposition.

23. That the Hearing Commissioner erred as a matter of law in making Finding of Fact #12 and particularly specifically committed an error of law in this Finding by referring to there being no unusual or extraordinary conditions to his employment as there was no claim being made for any type of stress related

claim or claim unrelated to physical inhalation or absorption exposure injury.

25. That the Hearing Commissioner erred as a matter of law by making Conclusion of Law #1 wherein the Commissioner found that the evidence was not consistent with a Finding as a matter of Law that the Claimant had sustained injury by accident wherein the evidence specifically establishes that under subsection 42-1-160(f) combined with either or both §42-1-172 and §42-11-10, et. seq., that it is consistent with establishing that the Claimant sustained injury by accident in the nature of repetitive inhalation and absorption exposure. It also establishes that due to his inhalation exposure and absorption exposure to VOCs compounds in the workplace on a continual and consistent basis from the normal exposure to Claimant as a commercial painter to commercial paints as part of his job that he suffers from an occupational disease.

26. That the Hearing Commissioner erred as a matter of law by not finding that the Claimant has an occupational disease as defined under SC Code §42-11-10, et. seq. The Claimant is a commercial painter and was exposed to commercial paints on a continual and daily basis in his job and was exposed, according to the evidence, to VOCs as part of the commercial paints he used continually throughout the day. The Claimant's job was that of a commercial painter and in that job and as part of that job, he was exposed to VOCs which are in excess of those hazards that are ordinarily incident to employment and which are peculiar to the employment in which he was engaged. His condition of severe chronic headaches stems directly from his exposure to VOCs in the workplace as part of the normal working conditions of his job due to his exposure to hazards peculiar to that particular employment as established by medical opinion evidence stated to a reasonable degree of medical certainty to which there is no contrary opinion in reference to the particular opinion that his chronic residual headaches are caused by his exposure to VOCs in the workplace.

27. That the Hearing Commissioner erred as a matter of law by not finding that the Claimant had sustained a repetitive trauma injury as defined under §42-1-172 and by failing to find as a matter of law that the Claimant has sustained repetitive trauma. The Commissioner's Conclusion of Law ignores the evidence in that Dr. White stated the opinion to a reasonable degree of medical certainty that in his opinion the Claimant's headaches, memory problems and fatigue were caused by his exposure to VOCs in the workplace on a daily and repetitive basis. Dr. Healy also expresses the same opinion that the Claimant's severe chronic headaches were caused by his

repetitive exposure to VOCs in the workplace. The Commissioner's Conclusion of Law to the contrary is an inaccurate statement of the facts and evidence presented. Dr. Nicholas Lind, Ph.D., according to the neuropsychological testing performed by Dr. Lind, found and stated the opinion to a reasonable degree of psychological certainty that Mr. Barr's cognitive complaints were secondary to his exposure to organic compounds. He also stated the opinion to a reasonable degree of psychological certainty that the Claimant's psychological problems were causally related to his exposure to VOCs in the workplace. He stood by those opinions in his deposition.

28. That the Hearing Commissioner erred as a matter of law in Conclusion of Law #4 in that the evidence clearly establishes both from a psychological standpoint of Dr. Lind's treatment and evaluation and the opinions of Dr. Marshall White, and more importantly, the opinions of Dr. Healy that the Claimant's psychological problems stemmed from his exposure to volatile organic compounds and the severe chronic headaches that he had sustained as a result of that repetitive exposure.

29. That the Hearing Commissioner erred as a matter of law in making Conclusions of Law #5, #6, #7 which are based on and are a restatement of his denial of benefits, wherein the substantial evidence and all of the medical opinion evidence establishes that the Claimant has sustained a repetitive trauma injury and/or occupational disease resulting and arising out of his repetitive and continual exposure to VOCs in the workplace.

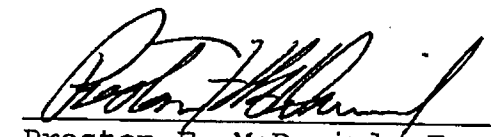
CONCLUSION

For all of the foregoing reasons and the Claimant having met his burden of proof proving by a preponderance of the evidence, or in other words that there is a reasonable inference from the circumstantial and direct evidence, that the Claimant's chronic headaches caused by his exposure to volatile organic compounds contained within the commercial paints which he used as a painter for the School District he should be awarded temporary total disability benefits and medical care pursuant to

the direction of Dr. Joseph Healy, his treating neurologist until he reaches maximum medical improvement.

In the alternative, this Commission should reverse the decision and remand the case for a de novo hearing based on the numerous errors of law committed in a submission and consideration of evidence presented in this matter.

Respectfully submitted,



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November 10, 2017

BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

KENNETH L. BARR, Claimant/Appellant, v. DARLINGTON COUNTY SCHOOL DISTRICT, Employer, and S.C. SCHOOL BOARDS INSURANCE TRUST, Carrier, Respondents.	)	W.C.C. FILE No. 1507304 **BRIEF OF THE RESPONDENTS**

Statement of the Case

This matter came before Hearing Commissioner Campbell for a hearing on August 31, 2016 in Florence, South Carolina, pursuant to the Forms 50 and 51. The Claimant alleged that he sustained injuries, described as "Encephalopathy, Brain (headaches, memory, fatigue, confusion), neurological/central nervous system, psychological functioning," as a result of either an accident, repetitive trauma, or occupational disease on May 21, 2015. At the hearing, the Claimant alleged that he was entitled to benefits for permanent and total disability as a result of alleged brain damage; however, he has now abandoned his claims for encephalopathy, brain damage, memory loss, fatigue, confusion, and his claim for injuries to the "neurological/central nervous system" on appeal. Apparently, the Claimant now alleges that he is entitled to past and future temporary disability compensation and medical treatment for headaches only.

The Respondents have consistently denied that the Claimant sustained any injury or disease arising out of or in the course of his employment, whether by accident, repetitive trauma, or occupational disease, and deny that his headaches are causally-related to his employment. The Respondents further deny that the Claimant's working conditions were either repetitive or traumatic and deny the Claimant has satisfied the mandatory elements of the Occupational Disease statute.

Evidence Summary

The Claimant

The Claimant, Ken Barr, testified on his own behalf. The Claimant has been married for 25 years and has 3 children. He attended Emmanuel Baptist High School in Hartsville and described himself as an average student. After school, the Claimant worked as a furniture delivery driver, in addition to roofing and carpentry work for his father. The Claimant also worked for a year or a year and a half as a clothing salesman. Later, he worked doing rough carpentry for a construction company for a couple of years. The Claimant then went to work as a painter at a nuclear plant. Next, the Claimant delivered propane tanks to houses and then did installation of gas appliances for 4 or 5 years. After that, the Claimant started his own painting business for 4 or 5 years before coming to work at the School District. The Claimant continued to operate his own business, Kenny's Painting, after he began working at the School District.

The Claimant testified that he began working at the School District in 2009. He worked 5 days a week, 8 hours per day during the school year and in the summer, he worked 4 days a week, 10 hours per day. The Claimant testified that he did not paint with oil-based paints during the school year and when he painted in the summer, he

could leave the doors open because sometimes the air conditioning was not on in the school rooms. The Claimant testified that he primarily worked on interior painting, but did do some painting outside. According to the Claimant, he "rarely" used a sprayer to apply paint at the School District, though he did use a sprayer when doing his own jobs with Kenny's Painting because he had a sprayer at his disposal. (Hrg. T. p.138, lines 13-16).

For protection, the Claimant initially testified that he "regularly" wore latex gloves and a respirator with particulate and fume filters. Upon persistent questioning from his attorney, the Claimant subsequently testified that

> "I didn't wear 'em regularly. I wear – I wore 'em sometimes. I mean, I don't know – I mean, this week, I might not wear 'em. It depends on what I'm using and where I'm at." (Hrg. T. p. 91, lines 4—7).

Regarding the respirator, the Claimant testified that if he could not ventilate a room by opening doors and windows and using fans, he would wear his respirator. The Claimant then testified that he would

> "put it on no matter if I had the doors open, the windows open or whatever. So, therefore, I would wear it." (Hrg. T. p.92, lines 1—10).

Apparently, the respirator did not cover his eyes; however, the Claimant wears eyeglasses and was always wearing his eyeglasses while painting at the School District, sometimes with goggles. (Hrg. T. p.138, line 20 – p.139, line 4).

On cross-examination, the Claimant admitted that he "[m]ostly always" used a respirator indoors. (Hrg. T. p. 125, lines 16—23). When confronted with his sworn deposition testimony, the Claimant admitted that he had previously testified, under oath, that he had used a respirator ever since he started work at the School District and could not remember an instance when he ever pained inside without a respirator.

The Claimant was asked about his treatment with his family physician, Dr. Chapman. The Claimant sought treatment for headaches in June 2010 that he described as "fairly bad" and "severe." His headaches became progressively worse and he also complained of dizziness, fatigue, and vertigo. The Claimant admits that he was first diagnosed and treated for vertigo in 2005, prior to his employment with the School District. Dr. Chapman referred the Claimant to Dr. Skinner, who treated him for over a year. The Claimant testified that his headaches were severe when he was seeing Dr. Skinner, but not as severe as they have been in the last few years. According to the Claimant, Dr. Skinner was only giving him medicine and he wanted a second opinion.

The Claimant then sought treatment with Dr. White in 2012, who took him out of work, during which time he claims his headaches improved. However, the records of Dr. White indicate that after being out of work for 6 weeks, the Claimant was still having headaches, which Dr. White diagnosed as migraines. (APA p. 34). In fact, the medical records reflect that even after being out of work for a period of approximately 4 months due to an arm injury in 2012, the Claimant was still seeking treatment for "severe" headaches. (APA p. 342).

The Claimant testified that on Monday, March 16, 2015 he reported to Carolina Elementary School for approximately 10 minutes and talked to Ms. Barrett, the principal. The principal told him they were going to have a drill of some kind, so he

went to Lowe's to buy supplies. The Claimant did not do any painting that day. According to the Claimant, when he left the school, he went down Marlboro Avenue and took a left on Carolina Avenue and the next thing he knew he was sitting a block from the school behind the chiropractor's office, feeling confused. He testified he was having a headache, but does not remember how bad it was. (Hrg. T. p.107). The Claimant called his wife and she called the Claimant's supervisor. The Claimant then took his work vehicle back to the shop a few miles away and his wife picked him up there to take him to the Emergency Room, where he was given pain medicine. The Claimant sought treatment at the Emergency Room and records from the March 16, 2015 visit document complaints of dizziness, confusion, and headache that "occurred at home." (APA p. 88).

The Claimant later saw Dr. White who told him to get out of painting, so he spoke to his supervisor, Mr. Stegner, to see what jobs were available to him. According to the Claimant, Mr. Stegner had some job options for him that didn't involve painting, but they would have involved a pay cut so the Claimant refused.

The Claimant was asked about his condition when he saw Dr. White on May 21, 2015 and the Claimant testified that he had a

> "[t]ypical every day headache, every day, hard. It wasn't a secluded area of my head. It was my entire head like it always is. And it's – I mean, I don't – I mean, nothing – nothing really changed." (Hrg. T. p. 112, lines 10—16).

At the time of the hearing, the Claimant was receiving treatment with a new family physician, Jennifer Lynch at CareSouth, and a neurologist, Dr. Healy, and was

taking Lorcet, Methiamazole, Nexium, Valium, Aspirin, and Lisinopril. By that time, he had not seen Dr. White in over a year.

The Claimant has not worked anywhere since May 2015. He testified that he gets confused and disoriented and has bouts of sudden fatigue. He was asked about headaches and responded that he has them every day. According to the Claimant he cannot work because of his headaches and fatigue. The Claimant admitted that he wakes up in the morning with headaches, as recorded in Dr. White's records, and his headaches even wake him up from his sleep, as noted by Dr. Healy. (APA p. 4, p. 231).

He testified that Dr. Healy is treating him with medications and a CPAP machine after performing a sleep study that showed the Claimant to have severe sleep apnea. In addition, Dr. Healy has diagnosed the Claimant with restless leg syndrome, for which he was prescribed Depakote and Requip, which the Claimant is apparently not taking.

On cross-examination, the Claimant was confronted with the medical records of his family physician, Dr. Chapman, indicating that he had recommended a sleep study for possible sleep apnea after the Claimant began complaining of fatigue in 2006, prior to his work at the School District. (Hrg. T. p. 130, APA p. 250—252). By 2008, Dr. Chapman began prescribing Volataren for the Claimant's complaints of headaches, which was also prior to his work at the School District. The Claimant admits that in addition to the fatigue, vertigo, and headaches, he was also treated for anxiety and panic attacks prior to his employment at the School District. The Claimant has also smoked cigarettes for a long time, smoking a pack and a half at most, though he has since cut back.

Dr. Paul Pritchard

The Claimant was evaluated by Dr. Paul Pritchard, a board-certified neurologist and clinical neurophysiologist at the Medical University of South Carolina, on February 2, 2016, at which time Dr. Pritchard also reviewed the Claimant's medical records. Dr. Pritchard's report is contained in the Record as APA #18. After review of the Claimant's medical records, meeting with the Claimant, and performing an examination, Dr. Pritchard offered the following opinion to a "reasonable degree of medical certainty":

> "Although he has been diagnosed as having an encephalopathy [by Dr. White], the neurological exam today was normal, including normal scores for orientation, memory, calculations, and language function on exam and the Montreal Cognitive Assessment. [The Claimant] did not have findings to support a diagnosis of encephalopathy on today's exam." (APA p.407).

In addition, Dr. Pritchard testified by way of deposition that he reviewed the CT and MRI of the Claimant's brain and found it to reveal "unidentified bright objects," or nonspecific changes related to small vessels, which are not uncommon in a person of the Claimant's age and are seen in people who have chronic migraines, diabetes, and hypertension. Dr. Pritchard did not believe these changes were relevant to the Claimant's cognitive complaints.

In addition to reviewing the medical records (including the reports of the neuropsychologists) and other documents provided by the Claimant, as well as meeting with the Claimant and his wife, and performing a physical exam, Dr. Pritchard testified that he administered the Montreal Cognitive Assessment Exam, which showed the

Claimant to have normal comprehension, naming, and fluency. Dr. Pritchard testified that

> "[a]ll components of his language were normal as were calculations and, in fact, memory. We tested that as well." (Pritchard T. p.12, lines 13—19).

The Claimant actually made a perfect score on the Montreal Cognitive Assessment Exam. The Claimant's score on the Weschler Memory Scale was also normal. In fact, nothing about the Claimant's neurological examination was abnormal according to Dr. Pritchard. Therefore, Dr. Pritchard testified that, to a reasonable degree of medical certainty, the Claimant did not have encephalopathy, or any evidence of memory problems, or any evidence of any neurological impairment or injury. Dr. Pritchard further testified that, to a reasonable degree of medical certainty, the Claimant does <u>not</u> have physical brain damage as a result of his alleged exposure to volatile organic compounds at the School District. (Pritchard T. p.27, lines 8-15).

Dr. Pritchard's assessment was that the Claimant has simple chronic daily headaches, which could be migraines or muscle tension headaches. Dr. Pritchard testified that if the Claimant was taking up to three Goody's Powders per day (as the Claimant has admitted), that could cause rebound headaches, as could overuse of caffeine. Cigarette smoking can also play a role in headaches because it triggers changes in the small blood vessels and complicates treatment.

On cross-examination, Dr. Pritchard was asked to describe different types of headaches. He was also asked about types of things that could cause brain damage. The Claimant's attorney also asked him about litigation over lead poisoning and heavy

metals. Dr. Pritchard was asked about his recommendation that the Claimant see an occupational medicine physician who has training in toxicology. The Claimant's attorney also asked Dr. Pritchard to explain the different types and degrees of encephalopathy. He then asked Dr. Pritchard about a Mr. Mundy who was apparently electrocuted. Dr. Pritchard was then asked to read certain medical records and recite from MSDS provided by the Claimant's attorney.

Dr. Pritchard next explained that migraine headaches can cause dizziness and can occur first thing in the morning. Dr. Pritchard also testified that, based upon what the Claimant had reported, he has a chronic headache problem and there is nothing that can prove or disprove the cause of that headache. (Pritchard T. p.83). According to Dr. Pritchard, the number one reason for doctor visits in the United States is headache.

When Dr. Pritchard was asked about whether objective testing could confirm whether volatile organic compound exposure had caused brain damage, Dr. Pritchard was quick to remark that the very concept of volatile organic compounds as a cause of chronic encephalopathy is "highly controversial." Dr. Pritchard further testified that the Claimant

> "didn't have encephalopathy. His neurological exam was normal. His memory was normal. His language, his calculation, all the things we do on a neurological exam were normal."

Dr. Pritchard was next asked about lead poisoning and whether it could progress. The Claimant's attorney then asked Dr. Pritchard about epilepsy and white matter

changes and dementia. Later, Dr. Pritchard was asked when the IME was scheduled and when his deposition was scheduled.

On re-direct examination, Dr. Pritchard confirmed his opinion that – to a reasonable degree of medical certainty -- there is no objective evidence that the Claimant has dementia and that there is no objective evidence that the Claimant has any permanent impairment of his brain or neurological system from any cause. Finally, Dr. Pritchard testified, again to a reasonable degree of medical certainty, that the Claimant's current complaints of headaches have no causal relationship to his employment at the School District.

Dr. Roland Skinner

Dr. Roland Skinner testified at a deposition on December 10, 2015 and his medical records are contained at APA #5. Dr. Skinner is a neurologist in private practice and first evaluated the Claimant in September 2010. At that time, the Claimant's presenting complaints were primarily headache, with some dizziness, which had been constant over a five-week period. Apparently, the Claimant experienced nausea with the headache, felt off-balance when he looked down, and had both trouble concentrating and fatigue. The Claimant also gave a history of chronic anxiety, for which he was taking several medications. According to Dr. Skinner, his neurological examination "really was pretty normal." (Skinner T. p.8, lines 11-12). Dr. Skinner's diagnosis was tension type headache, based upon the Claimant's description of the pain and the lack of other findings and symptoms.

Dr. Skinner testified that he prescribed Nortriptyline for the Claimant's tension type headaches; however, when the Claimant returned to Dr. Skinner in December

2010, but the Claimant had stopped taking the Nortriptyline and Dr. Skinner could not determine its efficacy. At that time, Dr. Skinner still believed the Claimant's headaches were due to tension and he again prescribed Nortriptyline. Dr. Skinner wanted to avoid prescribing narcotics as they are habit forming. In addition, Dr. Skinner explained a phenomenon called "analgesic rebound," in which people who take analgesics frequently get temporary relief from headaches only to have them come back progressively more frequently.

When the Claimant returned to Dr. Skinner in February 2011, Dr. Skinner still believed the Claimant's headaches were tension-type and that there was a component of depression. Dr. Skinner testified that the Claimant

> "was very focused on somatic things and even asked...if I thought he had a tumor in his spinal cord." (Skinner T. p. 18, lines 3—8).

At that time, Dr. Skinner counseled the Claimant about analgesic rebound because he was taking Aspirin, Goody Powders, Tylenol, and Aleve ... "a whole lot of short acting analgesic medications" that could be causing his headaches. (Skinner T. p.19, lines 2—10).

Dr. Skinner next evaluated the Claimant on May 18, 2011, at which time the Claimant was doing better, but his headaches were still not resolved. Nevertheless, the Claimant demonstrated no objective physical or neurological abnormalities and Dr. Skinner's diagnosis remained tension type headaches. The Claimant did not return to Dr. Skinner until August 2011, at which time he was still having daily headaches and "still taking a lot of over-the-counter analgesic medications." (Skinner T. p.22, lines 11—

12). However, there were still no physical or neurological abnormalities on exam in August 2011 and Dr. Skinner still felt that the most likely diagnosis was tension headaches. Nevertheless, Dr. Skinner prescribed Depakote in hopes it would decrease the frequency of his headaches.

On November 15, 2011, the Claimant returned to Dr. Skinner and was still complaining of daily headaches, which were allegedly worse with changes in barometric pressure or with certain smells, which the Claimant did not describe. Unfortunately, the Claimant was still taking three Goody Powders daily about four days per week, which Dr. Skinner testified could alone trigger rebound headaches. Because the Claimant was also taking Tylenol, Aspirin, and Ibuprofen, Dr. Skinner was still concerned about analgesic rebound headaches.

Dr. Skinner evaluated the Claimant on one final occasion in February 2012 and the Claimant "seemed to be about as he always had been." (Skinner T. p.29, lines 17–18). The Claimant was stable at that time and Dr. Skinner felt that there were psychological factors (anxiety) were playing a part in his headaches, so Dr. Skinner recommended counseling. However, the underlying diagnosis remained tension-type headaches.

According to Dr. Skinner, his opinion – to a reasonable degree of medical certainty -- remains that the Claimant's headaches were tension-type headaches complicated by analgesic rebound. When asked what causes tension-type headaches, Dr. Skinner responded that this was the proverbial "$64,000 question." Nevertheless, at the time Dr. Skinner last evaluated the Claimant, he did not believe him to have any evidence of physical brain damage. Dr. Skinner further testified that at no time during

his treatment of the Claimant did he ever complain of his work environment impacting his headaches.

On cross-examination, the Claimant's attorney asked Dr. Skinner about his awareness of lead paint regulation, lead poisoning, and mercury toxicity in the brain. Dr. Skinner was also asked about arsenic poisoning. Dr. Skinner was subsequently asked about his understanding of the Claimant's job duties and was also asked to review MSDS provided by the Claimant's attorney. Dr. Skinner was asked to read from the MSDS and agreed that they list routes of exposure may be inhalation or eye or skin contact and suggest that repeated overexposure can cause brain and nervous system damage. Subsequently, Dr. Skinner was asked what types of headaches affect attention, memory, concentration, and fatigue and Dr. Skinner testified that any type of headaches could affect those things. Dr. Skinner was then asked to describe all of the types of headaches.

Dr. Nicholas Lind

Nicholas Lind is a psychologist in private practice in Columbia who evaluated the Claimant at the request of his attorney on December 16, 2015 after the Claimant refused to see the psychologist selected by the Respondents (Dr. Wagner). Dr. Lind's report of his one-time evaluation is contained in the record as APA # 2 and he was deposed by the parties prior to the hearing. According to Dr. Lind's deposition testimony, he reviewed the records of Dr. White, but did not review any of the Claimant's other medical records. Dr. Lind administered neuropsychological testing. The results of these tests were considered valid, but demonstrated that the Claimant could be affected by a somatoform disorder, which could in turn affect his test results. The tests also revealed a severe level

of depression, which Dr. Lind believed was a long-standing problem for the Claimant. Dr. Lind explained that depression and anxiety (which the Claimant also has) affect the results of neuropsychological testing by way of inattention.

Dr. Lind also tested the Claimant's intelligence and found it to be average. Dr. Lind did not believe there had been any change in the Claimant's intellectual functioning. Dr. Lind explained that the Claimant's processing speed was also within the low average range, but could be affected by stress, pain, and depression. The Claimant reportedly performed "very well" on the Weschler Memory Scale and average to above average on the Rey Complex Figure Test and the Hopkins Verbal Learning Test. According to Dr. Lind "all the tests of memory, there was no compromise." (Lind T. p.13, lines 4—5). Therefore, Dr. Lind was asked:

> Q. Is there any objective evidence of any memory loss or memory impairment in Mr. Barr's case?
>
> A. No. Not from this testing.
>
> Q. Would his memory testing be consistent with dementia or severe cognitive impairment?
>
> A. No. (Lind T. p.14, lines 7—12).

Dr. Lind discussed the Exide battery factory and studies of toxic lead exposure in Korea, neither of which were "relevant for this case." Dr. Lind also admitted that he only has an "assumption" that the Claimant was exposed to anything. (Lind T. p.16, p.17). Dr. Lind further acknowledged that any abnormalities revealed on his testing for be explained by things other than the Claimant's alleged exposure at work.

Regarding the test of executive functioning, Dr. Lind was forced to concede that the Claimant's performance was only "abnormal" on a single sub-test, which had not been validated by retest. Dr. Lind was also forced to concede that while testing suggested disinhibition, neither the Claimant, nor his wife complained of any symptoms of disinhibition or impulse control, and the Claimant demonstrated good impulse control in his interview with Dr. Lind. With respect to impaired motor control, Dr. Lind acknowledged that there are multiple possible explanations unrelated to any alleged chemical exposure and that, not only did the Claimant not complain about any problem with coordination, the Claimant had been treated for a complex tendon laceration in his dominate hand, of which Dr. Lind was not previously aware. In addition, Dr. Lind admitted that "disinhibition" and "impaired dexterity" were the only parameters he measured that are even potentially consistent with an alleged brain injury, and he further admitted that he can't specifically relate these issues to any toxic exposure -- they may, in fact, simply represent a constellation of unrelated symptoms. Lastly, Dr. Lind testified that the Claimant's cognitive function is not preventing him from working or earning wages. (Lind T. p.39, lines 10—19).

On cross-examination, the Claimant's attorney asked Dr. Lind about his participation in the Exide battery cases and his "exposure with [sic] people with toxic problems." (Lind T. pp.40—41). Dr. Lind was also asked to clarify that he was "not professing to express medical opinions concerning whether or not what caused his actual problem." (Lind T.p.42, lines 7—10). Dr. Lind was then asked to explain depression and anxiety and the degrees of brain damage. Dr. Lind also stated he would defer to a neurologist regarding the Claimant's complaints of headaches.

On redirect, Dr. Lind admitted that his tests results were no consistent with a diagnosis of memory impairment.

Dr. Marshall Allyn White

Dr. White was deposed on November 23, 2015. Dr. White is a neurologist who first evaluated the Claimant on October 17, 2012, at which time the Claimant complained of a two and a half year history of headaches and back pain. While Dr. White was aware that the Claimant was previously treated by Dr. Skinner for headaches, Dr. White did not review those records. According to the new patient questionnaire the Claimant completed for Dr. White, the Claimant was actually waking up in the morning with his headache. The Claimant also admitted to being a cigarette smoker, which Dr. White admitted can cause or exacerbate headaches. According to Dr. White, after his initial evaluation of the Claimant,

> "...he just complained of headache. I mean, I wasn't that concerned about it." (White T. p.9, lines 7—9).

The Claimant apparently complained about paint fumes, so Dr. White recommended that he stay away from paint fumes for six weeks to see if his headaches went away. Despite staying out of work for 6 weeks, the Claimant's headaches were unchanged when he returned to Dr. White in November 2012, so Dr. White prescribed medication used to treat migraines. When the Claimant returned to Dr. White in January 2013, the Claimant's headaches had improved with the use of Topomax and Dr. White added Clonazepam to treat the Claimant's anxiety. When Dr. White prescribed these

medications, he was unaware of the Claimant's use of other prescribed medications, including Klonopin and narcotic pain medications. In addition, Dr. White did not place the Claimant on any work restrictions.

The Claimant did not return to Dr. White until April 2015, after an absence of over two years. Dr. White testified that the Claimant returned because he was continuing to have headaches, in addition to complaints of memory loss, fatigue, disorientation, and confusion. When pressed to explain the nature of the Claimant's headaches, Dr. White admitted that he didn't even know how frequently the Claimant was experiencing headaches, he couldn't describe the headaches at all, and he "didn't document" any symptoms associated with the Claimant's headaches. (White T. p.19). Dr. White admitted that did not review any of the Claimant's prior medical records and had no idea about why the Claimant was taking Lorcet, Tramadol, Meloxicam, and Tizanidine in 2015 or who was prescribing them, nor did he inquire about the Claimant's use of over-the-counter analgesics.

Dr. White then prescribed Klonopin and Topirimate for the Claimant, as well as a steroid dose pack. On follow up in May 2015, the Claimant's headaches were apparently unchanged; however, the Claimant was complaining of more memory loss and fatigue and he discussed the Claimant's workplace exposures, which the Claimant felt were "making him sick."

According to Dr. White, it is his opinion that the Claimant's "symptomatology and his syndrome is the result of VOC exposure." (White T. p.26, lines 17—21). When asked if he had any objective evidence to support his opinion, Dr. White testified that he "used [his] experience and the pattern of illness" to reach his conclusion. Dr. White then suggested that the Claimant's headaches were not be due to muscle contraction

headaches, because muscle contraction headaches are not associated with memory loss. Dr. White also suggested that the Claimant's headaches weren't due to analgesic rebound, because *the Claimant* believed they were work-related and because analgesic rebound does not cause memory loss. Dr. White further suggested that the Claimant's cigarette smoking was not a cause of his headaches because smoking doesn't cause memory loss. Of course, even though all of Dr. White's opinions were based on his assumption that the Claimant had memory loss, all of the objective testing showed the Claimant to have absolutely no evidence of any memory loss. (*See* Lind T. p.13, lines 4–5; Pritchard T. p.12, lines 13–19).

Dr. White was also forced to admit that he knows nothing about the personal protective equipment used by the Claimant at work; however, this did not stop him from speculating that the Claimant has been exposed to volatile organic compounds on a near daily basis for years. Dr. White further admits that there is no evidence of the alleged dose or duration of any exposure, but believed that his opinion as to cause was more important than evidence of exposure. In fact, when confronted with the fact that the Claimant testified to wearing a respirator and asked how the Claimant could be exposed to volatile organic compounds while wearing a respirator, Dr. White testified,

> "I'm not going to make a comment in that regard. That's not, that's not within the purview of my testimony. My opinion is that there was an exposure, and how that exposure took place is not for me to determine." (White T. p.31, liens 19–25).

Dr. White further testified that he diagnosed the Claimant with encephalopathy based upon Dr. White's personal opinion that the Claimant has memory deficits and slow processing speeds. In fact, Dr. White testified that he ordered neuropsychological testing to objectively evaluate the Claimant's memory and processing speed. Of course, neuropsychological testing done by the Claimant's own psychiatrist, Dr. Lind, revealed average processing speeds and normal memory. According to Dr. Lind:

> "Q. Is there any objective evidence of any memory loss or memory impairment in Mr. Barr's case?
>
> A. No. Not from this testing.
>
> Q. Would his memory testing be consistent with dementia or severe cognitive impairment?
>
> A. No." (Lind T. p.14, lines 7—12).

Dr. White did not have benefit of Dr. Lind's testing or testimony at the time he rendered his speculative opinions about the Claimant's neuropsychological functioning. However, he was specifically asked whether any objective evidence supported his opinions at the time:

> "Q. Because at this point there's no objective evidence he has neuropsychiatric or neuropsychological or memory deficits?
>
> A. You're here today to hear my opinions and, you know, as an expert, I'm free to opine, and I would assume that's true." (White T. p.32, line 22 – p.33, line 2).

Instead of providing evidence to support his opinion about alleged exposure and alleged memory loss, Dr. White continued to deflect by stating that he didn't believe the Claimant "is sophisticated enough to carry on a charade like this." (White T. p.33, lines 13-14). According to Dr. White, "his story and the evolution of his symptoms over the years is entirely consistent with exposure to a toxin." (White T. p.33, lines 17—19). Dr. White was then questioned as follows:

> "Q. Well, tell me what else other than the subjective statements of [the Claimant] have you based your opinions on?
>
> A. It's based upon the pattern of the illness. I think I've answered those questions.
>
> Q. All right. So what evidence is there that he has suffered any memory loss or currently has any memory problems?
>
> A. My observations." (White T. p.34, lines 8—14).

According to Dr. White, he was disadvantaged because he gave these opinions regarding a diagnosis and causation "before [he] finished working him up." (White T. p.34, lines 24—25). Dr. White then suggested that he was still "working him up" and had ordered neuropsychological testing to provide objective evidence: "If there are signs of dementia, then that's going to show up. If there's signs of encephalopathy or dementia, that's going to show up." (White T. p.40, lines 14—18). Dr. White believed that neuropsychological testing would "validate" his opinions; however, it did not, despite Dr. White's claim that

"...I really can't recall but on rare occasion the neuropsychiatric testing or the neuropsychological testing was substantially different from what my opinions are. So my opinions are typically right on target with respect to neuropsych testing." (White T. p.44, lines 12—17).

Dr. White last saw the Claimant on July 16, 2015. At that time, Dr. White prescribed Topomax, on top of the Prozac and Tramadol and Adderall the Claimant was already taking, which Dr. White admits put the Claimant at risk of developing Seratonin Syndrome, which causes headaches, confusion, elevated blood pressure, potentially seizures and even death. (White T. p.47--49). Dr. White does not know why the Claimant never returned to him and has no knowledge of his condition after July 2015. Despite prescribing a six month supply of Topomax, he never followed-up with the Claimant.

Dr. White was then asked,

"Q. Is there any objective evidence that he has brain damage at all of any degree?

A. Well, there hopefully will be after neuropsychology testing." (White T. p.53, lines 16—19).

Dr. White further volunteered that "neuropsych testing is the best objective measure we have for evaluating patients with encephalopathic conditions." (White T. p.54, lines 10-12).

Dr. L. Randolph Waid

Dr. Waid is a private-practice neuropsychologist who reviewed and evaluated the Claimant's neuropsychological test data and medical records. Dr. Waid opined that the Claimant's neuropsychological evaluation by Dr. Lind

> "revealed [the Claimant] to perform well, particularly on tests assessing anterograde memory. Indeed, [the Claimant's] performance of a battery of neuropsychological tests failed to reveal evidence of severe impairment affecting brain behavior functioning. Some of the test performances that were in the low average range would be considered as being consistent with [the Claimant's] premorbid intellectual abilities." (APA p.446).

In fact, Dr. Waid specifically disagreed with the speculative opinions offered by Dr. White. According to Dr. Waid:

> "Review of the records including previous reports of evaluations conducted by multiple practitioners as well as Dr. Lind's neuropsychological test results simply do not support Dr. Marshall White's opinion that [the Claimant] suffers from an encephalopathic condition that has led to severe permanent brain damage with severe compromise in brain behavior functions. As noted above, [the Claimant's] performance on objective tests assessing anterograde memory was in the average to above average range. Review of records failed to reveal any biological markers to support that [the Claimant] is suffering from a neurobehavioral

syndrome consistent with VOC exposure. [The Claimant] is not suffering from a dementing disorder as that would involve evidence of severe cognitive impairments via conduction of neuropsychological testing...Indeed, [the Claimant's] primary complaint is one of disruptive headaches that existed prior to his engagement in employment with Darlington County School District." (APA p. 446).

In summation, Dr. Waid concluded,

> "there is no evidence to indicate that [the Claimant] suffered physical brain injury as a direct result of his employment...Nor is there any compelling evidence that [the Claimant] currently suffers from an encephalopathic condition that has resulted in severe brain damage." (APA p.446).

Dr. Mark T. Wagner

Dr. Wagner is a neuropsychiatrist at the MUSC Department of Neurology. The Respondents attempted to have the Claimant tested and evaluated by Dr. Wagner; however, the Claimant refused. Therefore, Dr. Wagner reviewed the Claimant's medical records and Dr. Lind's neuropsychological test data and offered his opinions regarding the claim. According to Dr. Wagner, the Claimant's

> "neuropsychologic test scores are highly consistent with his prior academics, and more importantly his standardized test scores, all obtained

well before any alleged exposure...While it is my opinion that [the Claimant's] neuropsychological test scores are primarily related to below average intellect and poor academic standing, one can not ignore other confounding factors, notably the abnormal MRI with hyperintensities mostly in the frontal white matter bilaterally and chronic noncompliance with smoking cessation. This area of the brain is responsible for deficits in disinhibition and other executive function. Likewise, slow processing speed is a cardinal symptom of clinical depression and would result in slow performance on fine motor and psychomotor tasks." (APA pp.418–419).

With regard to the speculative opinions of Dr. White, Dr. Wagner offered the following:

"With the exception of Dr. White's opinions, all objective basic neurologic exams with associated mental status examination by numerous physicians that have examined [the Claimant] have been unremarkable from a neuropsychiatric perspective. Even Dr. White's examination failed to demonstrate any objective neurological findings and his documentation is so limited that his nots do not allow for peer-review of his opinions. Additionally, his documentation does not allow for any other doctors to replicate abnormal findings to confirm or refute his opinions...To the extent that Dr. White relied on the neuropsychological test results to form his opinions, those findings were also normal...Indeed, [the Claimant's] objective memory performance was exceptionally strong and exceeded

that of most neurologically intact people in the US reference population." (APA p.419)

Dr. Wagner ultimately concluded that there

> "was no objective evidence in the examinations or reports that [he] reviewed that would support a neurobehavioral syndrome consistent with VOC exposure. There were not biological markers to support exposure. There is no document of any other organ system involvement to support exposure. Additionally, not only is there no objective evidence of any distinctive neuropsychiatric assessment there is no evidence to support that [the Claimant] has dementia related to severe encephalopathy as opined by Dr. White. Dementia requires **severe** [emphasis original] cognitive impairment (not documented in any of the objective cognitive testing by Lind, Pritchard, White)..." (APA pp. 419—420).

Dr. Wagner went on to explain that the episodic memory loss the Claimant' described as having with his headaches "is a common complaint with anyone that experiences severe headaches." (APA p. 420).

Dr. William Woodbury

The Claimant was evaluated by Dr. William Woodbury in April 2005 – years prior to his employment with the School District. Even at that time, the Claimant complained of a four year history of Vertigo. (APA p.247). Apparently, the Claimant

was experiencing dizziness, imbalance, trouble walking and nausea, for which he was treated with the prescription medical Anitvert.

Robert Bennett

The first witness called by the Claimant at the August 31, 2016 hearing was a Dr. Robert Bennett. Dr. Bennett has a pharmacy degree from the Medical University of South Carolina and a doctorate in pharmaceutical sciences. According to Dr. Bennett, he practices as a forensic toxicologist. However, Dr. Bennett admitted that he is not a medical doctor and has no professional licenses whatsoever, as his pharmacy license has expired. Dr. Bennett also admitted that the South Carolina Department of Labor has issued a "Cease and Desist" Order against him, prohibiting Dr. Bennett from holding himself out as a pharmacist. Apparently, the bulk of his work is in drug, alcohol, and DNA testing. No organization has certified Dr. Bennett as a specialist in toxicology. Over the objection of the Respondents, Dr. Bennett was permitted to testify at the hearing.

According to Dr. Bennett, he was given documents by the Claimant's attorney to review, including medical records, material safety data sheets ("MSDS"), and the Claimant's job description. Dr. Bennett believed that the Claimant worked as a commercial painter "and used chemicals that are required in performing those duties." (Hrg. T. p.33, liens 18—20). Dr. Bennett testified that the Claimant primarily used brushes and rollers to paint, as opposed to aerosol spray tools, and worked both inside and outside. Dr. Bennett further testified that the Claimant used a respirator while working inside buildings, which were also ventilated.

Dr. Bennett opined that based upon his review of the Claimant's job description and the MSDS sheets, he believes the Claimant was exposed to volatile organic compounds. Dr. Bennett described volatile organic compounds as being fat soluble and suggested that fat soluble compounds can cross the blood/brain barrier and affect the brain. Dr. Bennett believes that the most important factor "is what quantity does get into the brain." (Hrg. T. p.37, lines 9—10). Apparently, the Claimant could have his blood or urine or hair tested to check for the presence of volatile organic compounds, but he did not.

Dr. Bennett suggested that one could be exposed to volatile organic compounds through inhalation, absorption through the skin or eyes, or by swallowing. Dr. Bennett testified that even if a person uses protective gear, one could still be exposed to volatile organic compounds because "no device is perfect." (Hrg. T. p.46, lines 10—11). Dr. Bennett testified that acute exposure to volatile organic compounds can cause disorientation, dizziness, nausea, headaches, and sometimes vomiting, but these effects are "short lived" and "go away and the patient returns to normal" once the person is removed from the environment. (Hrg. T. p.48, lines 4-10). However, Dr. Bennett testified that if there is repeated exposure to volatile organic compounds, the toxic effects can be cumulative – it's "a dose-related response." (Hrg. T. p. 56, lines 16—25). Dr. Bennett believes it is important to have CT and MRI scans and neuropsychological testing to determine if there is any permanent disability.

Ultimately, Dr. Bennett testified that he believes the Claimant was exposed to volatile organic compounds "to some degree or extent" and subsequently exhibited symptoms consistent with exposure to volatile organic compounds. (Hrg. T. p.61, lines 4—9). Dr. Bennett went on to describe at length different types of headaches and the

medications used to treat them. Dr. Bennett also gave testimony regarding terms used on the MSDS, including "percent by weight" and "evaporation rate."

On cross-examination, Dr. Bennett admitted that he cannot objectively quantify the degree or extent to which the Claimant may have been exposed to volatile organic compounds at the School District, or in his work as a private painter. Dr. Bennett conceded that "dose" is the most relevant factor in determining whether an alleged exposure was toxic, but he cannot quantify "dose" in this claim.

Dr. David H. Eagerton

Dr. David Eagerton is an Assistant Professor of Pharmacology at Presbyterian College and former Chief Toxicologist for the South Carolina Law Enforcement Division. Dr. Eagerton reviewed voluminous records in this claim, including the MSDS for the product the Claimant used most often at work – DTM and Pre-catalyzed epoxy. According to Dr. Eagerton, these products

> "contain compounds that have a relatively low vapor pressure and are not considered by some sources to be a VOC." (APA p.448).

Dr. Eagerton noted that the Claimant's professed to using a respirator on inside jobs and that "[u]tilization of a properly fitted air-purifying respirator (APR) eliminates the exposure to VOCs."

After reviewing and summarizing the Claimant's medical and vocational records, Dr. Eagerton issued the following statement:

"It is my opinion that, within a reasonable degree of scientific and medical certainty, [the Claimant's] symptoms are not likely due to exposure of VOCs while he was employed by the Darlington County School District. This is based on the fact that 1) there is no toxicological evidence of exposure; 2) there is no definitive medical evidence that VOC exposure occurred; 3) there is no definitive medical evidence that [the Claimant's] symptoms are caused by exposure to VOCs; 4) the products that were used most frequently by [the Claimant] did not contain highly volatile VOCs; 5) when [the Claimant] was painting inside, he used an APR and the area was ventilated; 6) [the Claimant's] headaches are not associated with exposure to pain fumes; 7) [the Claimant's] medications can cause impairment of neurologic functions; 8) [the Claimant] suffered no ill effects that are commonly seen with acute exposure to VOCs; 9) [the Claimant] has no renal or hepatic injury which can be attributed to VOC exposure; and 10) even if [the Claimant] had an exposure to VOCs, it is more likely that it occurred at a previous job or while he was moonlighting as a self-employed painter..." (APA p. 449).

Carolina Pines Regional Medical Center

Records from Carolina Pines are contained in the record at APA #3. According to a report dated March 16, 2015, the Claimant reported to the Emergency Room with complaints of dizziness, confusion, hand pain, and headache on that date, which "[o]curred at home." (APA p.88).

Hartsville Medical Group

Records from Hartsville Medical Group (Dr. Raymond Chapman) are contained in the record at APA #4 and APA #11. These detail the Claimant's history of anxiety, depression, right arm pain, stomach problems, sinus issues, neck pain, back pain, and chest pain, as well as his tobacco dependence. Regarding his headaches, Dr. Chapman noted on April 14, 2015 that the Claimant

> "Has seen 4 neurologists...didn't like any. They told him they had nothing to offer him. Will start decreasing meds as he has had no real improvement clinically when any meds were increased." (APA p.105).

In addition, Dr. Chapman's records detail the Claimant's health problems prior to his work at the School District. As early as May 12, 2006, Dr. Chapman believed that the Claimant's complaints of fatigue were due to sleep apnea and a sleep study was recommended on February 2, 2007. (APA p. 250). Apparently, the Claimant never obtained this sleep study or treatment for sleep apnea until he started seeing Dr. Healy in 2016. (APA p.224). Dr. Chapman treated the Claimant for vertigo in 2007 and by 2008 Dr. Chapman had prescribed Voltaren for the Claimant's headaches. (APA p.252). According to Dr. Chapman's May 2, 2011 office note, he had diagnosed the Claimant with tension headaches which "occur for no reason." (APA p.260). Dr. Chapman referred the Claimant to Dr. Skinner for treatment of his tension headaches.

Dr. Joseph Healy

Records of Dr. Joseph Healy are contained in the Record at APA #8 and Dr. Healy gave deposition testimony on September 27, 2016. According to Dr. Healy's records, the Claimant has been diagnosed with "severe" Obstructive Sleep Apnea. (APA p.223). In fact, the Claimant's sleep apnea is so severe, he required an emergency CPAP during his sleep study. (APA p.223, 224). In addition to obstructive sleep apnea, Dr. Healy's records reveal that the Claimant's analgesic rebound headaches were being treated in April 2016, at which time the Claimant was also referred to a pulmonologist for possible Chronic Obstructive Pulmonary Disease secondary to his cigarette abuse. (APA p.225).

At his deposition, Dr. Healy testified that he initially evaluated the Claimant on March 31, 2016 for complaints of headache and fatigue. Dr. Healy explained that the Claimant's smoking addiction could be affecting the both the headache and fatigue symptoms the Claimant described. (Healy T. pp.8--9). At the time he came to Dr. Healy, the Claimant was taking prescription medications for Hyperthyroidism, high blood pressure, and the prescription pain-killer Hydrocodone. (Healy T. pp.9—10). It was unclear who was prescribing the Hydrocodone, or for what purpose, but Dr. Healy explained that chronic daily headaches can be related to too much medication, whether prescribed or over-the-counter. (Healy T. p.10). Dr. Healy testified that he performed a mini-mental exam, on which the Claimant obtained a perfect score, meaning he had normal cognition. (Healy T. pp.11—12). According to Dr. Healy, he didn't see any evidence of dementia or cognitive impairment. (Healy T. p.12, lines 14—18).

Dr. Healy saw the Claimant on follow-up on April 19, 2016, at which time the Claimant was apparently taking "[a] lot of over-the-counter medications." (Healy T. p.

13, lines 1—6). Dr. Healy felt that the Claimant may have "chronic daily headaches," which are also known as rebound or "medication overuse" headaches. (Healy T. p.13). Dr. Healy noted that the Claimant often woke in the morning with headaches and, as a result, testified that:

> "...the whole time I'm thinking, you know, this fellow's breathing is bad. He's got a lot of reasons to be relatively hypoxic, which leads to stress, fatigue and that might be what causes his headache." (Healy T. p.15, lines 20—24).

As a result, Dr. Healy ordered a sleep study on April 27, 2016, which showed two different sleep disorders :

> "...he had severe sleep apnea, and so, I mean, in anybody that has headaches, you got to correct your sleep, you got to correct your breathing and then, too, it showed that he was a kicker...He kicks all night long which is a pattern that means you have a periodic leg movements of sleep...then I put him on Requip at bedtime..." (Healy T. p.17 lines 4—14).

Dr. Healy was testified that with sleep apnea, "you stop breathing," which can cause headaches and fatigue and lead to mental effects, including confusion, and problems with concentration. (Healy T. p.18). Dr. Healy noted that the symptoms of sleep apnea often mimic dementia or Alzheimer's. (Healy T. p.18, lines 22—25).

When the Claimant returned to Dr. Healy on May 4, 2016, Dr. Healy prescribed Requip for the restless leg issues and a CPAP machine for his sleep apnea. In addition, Dr. Healy diagnosed the Claimant abnormal arterial blood gas, which is due to structural lung disease. (Healy T. pp.19—20). Dr. Healy was asked about this abnormal arterial blood gas due to lung disease and its relationship with the Claimant's complaints of headache and fatigue:

> "Q...As so could that be playing a role in his headaches and fatigue as well?
> A. Oh, I think it definitely is."

(Healy T. p.20, lines 11—16). As a result, Dr. Healy referred the Claimant to a Pulmonologist.

In addition to the sleep apnea, the restless leg, and the low arterial blood gas, Dr. Healy also found the Claimant to have problems with his vision, which he described as "very poor and getting worse." (Healy T. p.21, lines 6—7). Poor vision, in turn, can contribute to headaches, and; therefore, Dr. Healy referred the Claimant to an eye doctor. Dr. Healy also prescribed an iron supplement because his iron level was borderline. (Healy T. p.21, lines 21—22).

On June 28, 2016, the Claimant

> "was having [heart] palpitations. He was having episodes where he would get palpitations. He would get chest discomfort. He would start to and then get disoriented and have his headache worsening. He'd had two

episodes the day before and then I started wondering since he was such a heavy smoker and whether or not he had any cardiac issue."

(Healy T. p.22, lines 10—16). Dr. Healy believed he may have Coronary Artery Disease and he told the Claimant he needed to see a Cardiologist.

Apparently, the last time the Claimant saw Dr. Healy was July 21, 2016. At that time, the Claimant was still smoking and had not seen a Pulmonologist as recommended. (Healy T. p.24--25). Dr. Healy testified that the Claimant did not ever take the Requip he prescribed for the Claimant's restless leg syndrome (also known as Periodic Limb Movement Syndrome, or PLMS) and it is unclear whether he ever took his prescribed iron supplement. Apparently, the Claimant had seen an eye doctor and was diagnosed with bilateral retinal hemorrhages, the cause of which he left to the opthamologists. (Healy T. p.38, lines 7—10).

According to Dr. Healy, he believes that the Claimant has primarily a pulmonary problem, which has led to his other problems, including fatigue and headaches. Dr. Healy acknowledged that pulmonary disease not uncommon for heavy smokers and that he could not say with any certainty what portion of any pulmonary problems are caused by smoking, as opposed to other alleged exposures: "that would be a question for the pulmonologist." (Healy T. p.28, lines 23--24).

While Dr. Healy endorsed a questionnaire prepared by the Claimant's attorney indicating that the Claimant's headaches and fatigue was causally-related to the alleged exposure to volatile organic compounds, he admitted on direct examination that alleged VOC exposure was merely "contributory" and given the smoking history, he would defer

to a pulmonologist as to "which is felt to be the larger issue." (Healy T. p.30, lines 16—21).

On cross-examination, Dr. Healy was asked if anything other than medication excess could cause the Claimant's chronic daily headaches. Dr. Healy responded:

> "Well, I'm sure there's a lot of... I think this fellow walks around relatively hypoxic. He retains carbon dioxide. The blood chemistry isn't exactly ideal for a properly functioning [sic] in any organ system you can name."

(Healy T. p.36, lines 4—11). Dr. Healy also explained that the Claimant's elevated carbon dioxide levels

> "doesn't produce a milieu for the brain to exactly work properly and from a metabolic standpoint, headache is the end result. So that, that's my reason for thinking that his breathing is contributory to his headaches. But what's to his breathing beyond smoking, **again I would defer to a pulmonologist...**"

(Healy T. p.38, lines 17—25; emphasis added).

Dr. Healy was also asked about the Claimant's "spells" of dizziness and headache. Dr. Healy testified that:

> "...he was having these episodes where he would get headache. He would then get anxious, palpitations, and they he would stutter and have trouble

> talking. And so it was almost like a TIA, which he's at risk of because of his vascular...You do see people with underlying lung disease who will get an area of mucus...and that's enough to kick him over into being hypoxic...so **I was curious about what was causing these spells, although didn't' turn up a neurologic cause.**

(Healy T. p.42, lines 4—20; emphasis added).

Dr. Healy was also asked on cross-examination whether he had treated painters in the past with chronic headaches, to which he responded, "you don't see it a lot." (Healy T. p.43, line 4).

Arguments

I. The Claimant has abandoned his claims for encephalopathy, brain damage, memory loss, fatigue, confusion, and alleged injuries to the "neurological/central nervous system."

The Claimant's appellate brief makes no argument with respect to the alleged injuries for which he initially brought the May 21, 2015 claim: encephalopathy, brain damage, memory loss, fatigue, confusion, and alleged injuries to the "neurological/central nervous system." Therefore, the Claimant has abandoned these issues on appeal. Wright v. Craft, 372 S.C. 1, 20, 640 S.E.2d 486, 497 (Ct. App. 2006) ("An issue raised on appeal but not argued in the brief is deemed abandoned and will not be considered by the appellate court." (internal quotation omitted)). Of course, an unappealed issue, right or wrong, is the law of the case. ML-Lee Acquisition Fund, L.P. v. Deloitte & Touche, 327 S.C. 238, 489 S.E.2d 470 (1997) (unappealed ruling is law of the case); Buckner v. Preferred Mut. Ins. Co., 255 S.C. 159,161, 177 S.E.2d 544, 544

(1970) (an unchallenged ruling, "right or wrong, is the law of this case and requires affirmance."). As such, the Appellate Panel is without jurisdiction or authority to disturb the Hearing Commissioner's findings of fact and conclusions of law with respect to these alleged injuries on appeal and his Decision and Order should be affirmed.

II. The Claimant has abandoned his occupational disease claim, as well as his claim for medical and compensation benefits.

The Claimant's brief to the Appellate Panel makes no argument with respect to his prior occupational disease claim, the Hearing Commissioner's findings of fact or rulings of law denying this claim, or with respect to S.C. Code Ann. § 42-11-10 generally. The Claimant's brief similarly makes no mention of the Hearing Commissioner's findings of fact or rulings of law denying his claim for medical and compensation benefits, or with respect to S.C. Code Ann. § 42-15-60, §42-9-260, § 42-9-10, § 42-9-20, or § 42-9-30. Therefore, his claims for an occupational disease, for medical benefits, and for compensation benefits have been abandoned on appeal and are the law of the case. "An issue is deemed abandoned and will not be considered on appeal if the argument is raised in a brief but not supported by authority." Bryson v. Bryson, 378 S.C. 502, 510, 662 S.E.2d 611, 615 (Ct. App. 2008). "[S]hort, conclusory statements made without supporting authority are deemed abandoned on appeal and therefore not presented for review." Glasscock, Inc. v. U.S. Fid. & Guar. Co., 348 S.C. 76, 81, 557 S.E.2d 689, 691 (Ct. App. 2001). When an appellant provides no legal authority regarding a particular argument, the argument is abandoned. State v. Lindsey, 394 S.C. 354, 363, 714 S.E.2d 554, 558 (Ct. App. 2011). Therefore, the Hearing Commissioner's findings and

conclusions denying the Claimant's occupational disease, medical, and compensation claims are the law of the case and cannot be disturbed on appeal.

III. The Hearing Commissioner's finding and conclusion that the Claimant's headaches were not caused by an accident or repetitive trauma on May 21, 2015 is supported by the greater weight of the evidence and the applicable law and should be affirmed.

The Claimant previously alleged that he sustained injuries to his brain, central nervous system, and psyche as a result of repetitive exposure to volatile organic compounds (VOCs) arising out of and the course of his employment on May 21, 2015. He now claims that he only has headaches as a result of his employment; however, it remains unclear – even on appeal – whether he brings his claim under S.C. Code Ann. § 42-1-160 or § 42-1-172, as his appellate brief references neither statute. Nevertheless, the fact remains that the greater weight of the evidence in the record reveals that the Claimant's headaches are not causally-related to any alleged workplace exposure and the Hearing Commissioner's Decision and Order should be affirmed.

The Claimant relies, primarily, on the specious and unsubstantiated opinion of Dr. Marty White, despite the fact that Dr. White has not evaluated the Claimant since July 2015. The Hearing Commissioner properly discounted the opinions of Dr. White because he was forced to admit that he had no expertise in toxicology and no direct knowledge of any alleged VOC exposure, but only *assumed* that there had been such an exposure in rendering his opinions as to causation. (White T. p.31, liens 19—25). Dr. White was also forced to admit that he didn't know how frequently the Claimant was experiencing headaches, he couldn't describe the headaches, and he "didn't document"

any symptoms associated with the Claimant's headaches. (White T. p.19). According to Dr. White, he discounted all of the other possible causes of the Claimant's headaches because he *assumed* that the Claimant's headaches were accompanied by objective memory loss and that neuropsychological testing would "validate" his opinions ((White T. p.53, lines 16—19).

However, the neuropsychological testing showed no evidence of any memory loss or memory impairment and no evidence of dementia or cognitive impairment. (Lind T. p.14, lines 7—12). Instead, the Claimant's memory was normal. Therefore, Dr. White's opinions as to the cause of the Claimant's headaches (as well as his opinion that he has encephalopathy, dementia, and/or brain damage) are based upon hypothetical facts that have been disproven with neuropsychological testing according to three neuropsychologists (Dr. Lind, Dr. Waid, and Dr. Wagner) and more recent neurological examinations by two neurologists, Dr. Pritchard and Dr. Healy, both of whom disagreed with Dr. White's opinions. Because Dr. White's opinions are speculative, based upon disproven hypotheticals, uncorroborated, and are otherwise without objective basis, the statements and opinions of Dr. White were properly discounted by the Hearing Commissioner and do not support an award of benefits for headaches.

Furthermore, while Dr. R. Joseph Healy endorsed an opinion on a questionnaire proffered by the Claimant's attorney that the Claimant's chronic daily headaches were causally-related to his alleged exposure to VOCs between 2009 and 2015, Dr. Healy retreated from this opinion in his deposition testimony. Therefore, the Hearing Commissioner properly gave greater weight to the actual testimony of Dr. Healy, than to the questionnaire he endorsed. According to Dr. Healy's testimony, he believed that any alleged VOC exposure was merely "contributory" and he could not state with any

certainty what was causing the Claimant's headaches. (Healy T. p.30; p.38, lines 17—25). In fact, Dr. Healy testified that he could not find any neurological cause for the Claimant's symptoms. (Healy T. p.42, lines 4—20).

Instead, Dr. Healy believed the Claimant to have pulmonary problems for which he referred him to a Pulmonologist, cardiac problems for which he referred him to a Cardiologist, severe vision problems for which he referred him to an Opthamologist, all in addition to the severe sleep disorders (Obstructive Sleep Apnea and Periodic Limb Movement Syndrome) and abnormal arterial blood gas he had diagnosed. Dr. Healy admitted that the Claimant's severe sleep disorders, in combination with the Claimant's abuse of cigarettes, could be causing or contributing to his symptoms of headache, fatigue, and even confusion. (Healy T. pp.8—9; Healy T. p.18; p.20).

Dr. Healy further explained that:

> "...the whole time I'm thinking, you know, this fellow's breathing is bad. He's got a lot of reasons to be relatively hypoxic, which leads to stress, fatigue and that might be what causes his headache." (Healy T. p.15, lines 20—24).

Dr. Healy was asked about this abnormal arterial blood gas due to lung disease and its relationship with the Claimant's complaints of headache and fatigue that prompted his referral to a pulmonlogist:

> "Q... so could that be playing a role in his headaches and fatigue as well?
> A. Oh, I think it definitely is."

(Healy T. p.20, lines 11—16). Dr. Healy also explained that the Claimant's elevated carbon dioxide levels

> "doesn't produce a milieu for the brain to exactly work properly and from a metabolic standpoint, headache is the end result. So that, that's my reason for thinking that his breathing is contributory to his headaches. But what's to his breathing beyond smoking, **again I would defer to a pulmonologist...**"

With regard to the Claimant's cardiac issues and their relationship to his headaches, Dr. Healy testified that the Claimant

> "was having [heart] palpitations. He was having episodes where he would get palpitations. He would get chest discomfort. He would start to and then get disoriented and have his headache worsening. He'd had two episodes the day before and then I started wondering since he was such a heavy smoker and whether or not he had any cardiac issue."

(Healy T. p.22, lines 10—16). Dr. Healy believed he may have Coronary Artery Disease and he told the Claimant he needed to see a Cardiologist.

The role of the Claimant's severe sleep disorders, including sleep apnea and restless leg syndrome – both of which remained untreated – and the Claimant's headaches was also explained by Dr. Healy's testimony:

"...the whole time I'm thinking, you know, this fellow's breathing is bad. He's got a lot of reasons to be relatively hypoxic, which leads to stress, fatigue and that might be what causes his headache." (Healy T. p.15, lines 20—24).

When asked by the Claimant's attorney whether he had treated painters in the past with chronic headaches, Dr. Healy responded, "you don't see it a lot." (Healy T. p.43, line 4). Therefore, the opinions of Dr. Healy do not support a finding that the Claimant's headaches are compensable under the Act, as Dr. Healy opined that there were multiple, objectively-documented causes for the Claimant's headaches unrelated to his employment.

In addition, the Claimant's personal neurologist, Dr. Skinner, testified to a reasonable degree of medical certainty that the Claimant's headaches are tension-type headaches complicated by analgesic rebound, which he did not relate in any way to alleged workplace exposures of any kind. In addition, Dr. Skinner testified that at no time during his treatment of the Claimant did he ever complain of his work environment impacting his headaches. Similarly, neurologist Dr. Paul Pritchard of MUSC evaluated the Claimant on February 2, 2016 and testified, to a reasonable degree of medical certainty, that the Claimant's current complaints of headaches have no causal relationship to his employment at the School District.

Therefore, the Respondents respectfully contend that, based upon the greater weight of the evidence in the record the Claimant's headaches were not caused by accident or repetitive trauma arising out of or in the course of his employment, as alleged, and request that the Hearing Commissioner's Decision and Order be affirmed.

IV. The Claimant's allegations regarding the admissibility of documentary evidence are without merit.

The Claimant's brief contains a lengthy diatribe about the documentary evidence submitted by the Respondents pursuant to the Administrative Procedures Act and the Workers' Compensation Regulations; however, his various complaints are without merit and the Hearing Commissioner committed no legal error in admitting the reports of Dr. Eagerton, Dr. Waid, Dr. Wagner, and Dr. Pritchard. For example, the Claimant alleges that the report of Dr. Eagerton should be excluded as untimely because it was noticed by the Respondents on February 15, 2016 – six and a half months prior to the hearing on August 31, 2016 (199 days in advance). However, S.C. Code Reg. 67-612 requires only 10 days notice.

Similarly, the Claimant alleges that his right to "due process" was violated by the admission of this documentary evidence because he was allegedly "unable" to cross-examine the Respondents' experts. However, his umbrage is misplaced. The Claimant was not prevented from cross-examining the Respondents' experts, he simply chose not to exercise this right, as he never even attempted to schedule a single deposition. Having failed to exercise his rights, the Claimant cannot now be heard to complain of some constitutional deprivation.

The Claimant goes on to argue that the reports of the Respondents' experts should also be excluded because the experts allegedly rely on hearsay and lack personal knowledge. This alleged "hearsay" consists of the Claimant's own medical records, which were submitted into evidence and of course, the Rules of Evidence do not apply in administrative proceedings under the Workers' Compensation Act. S.C.R.E. 81, S.C. Code Ann. §1-23-33. Even so, these medical records are corroborated by the Claimant's

own testimony regarding his medical records and constitute business records and; therefore, fall within the general exceptions to the hearsay rule.

Furthermore, the experts' review of these medical records allowed them to gain personal knowledge of the Claimant's medical history, which formed the basis of their opinions. Had the Claimant wished to challenge the Respondents' experts' knowledge of the Claimant's medical history and condition, he could have exercised his right to cross-examine them by way of deposition, which again, he failed to do. More importantly, this documentary evidence was properly submitted in accordance with S.C. Code Reg. 67-611 and 67-612. *See* Gadson v. Mikasa Corp., 628 S.E.2d 262 (Ct. App. 2006) (upholding the admissibility of documentary evidence under S.C. Code Reg. 67-611 and 67-612 where the party failed to exercise his right of cross-examination).

Therefore, the Claimant's arguments regarding the admissibility of the Respondents' APA submissions are without merit. Furthermore, as our courts have explained:

> "The utilitarian efficacy of admissibility under Workers' Compensation regulations is salutary and salubrious. Historically, the regulations allow for written reports and documentation in lieu of live testimony, concomitantly saving time and expense in the presentation of testimony before the single commissioner." (Id.)

Respectfully, the Claimant's arguments regarding the admissibility of documentary evidence serve to undermine the utility of our Workers' Compensation system.

V. The Claimant's allegation regarding the propriety of Dr. Pritchard's neurological evaluation is moot and otherwise without merit.

The Claimant argues that the neurological evaluation performed by Dr. Paul Pritchard at the Medical University of South Carolina on February 2, 2016 was not at "a reasonable time or place" and that; therefore, the Hearing Commissioner somehow erred in considering Dr. Pritchard's opinions in deciding this case. Because the Claimant actually attended the appointment, his arguments regarding the propriety of the time and place of that appointment are now moot and of no consequence. In fact, the Claimant cited no statute or case law that would impact the weight accorded medical evidence based on the time or location of the medical evaluation.

The Claimant further alleges that Dr. Prichard's opinions were inadmissible because the Respondents provided Dr. Pritchard with medical records prior the IME being scheduled. The Claimant was provided all of the medical records reviewed by Dr. Pritchard and even had the opportunity to cross-examine Dr. Pritchard prior to the hearing. The Respondents did not violate the terms of S.C. Code Ann. § 42-15-95, as that statute deals with the confidentiality of doctor-patient relations, which quite simply had not attached prior to Dr. Pritchard's appointment with the Claimant, and Dr. Pritchard's medical reports and opinions were not obtained in violation of that statute.

VI. The Hearing Commissioner made detailed findings of fact and conclusions of law.

The Claimant inexplicably argues that the Hearing Commissioner's forty-eight (48) page Decision and Order was somehow not sufficiently detailed with respect to the

Claimant's headache allegations. However, the Hearing Commissioner's Decision and Order is replete with detailed and specific findings of fact regarding the weight of the evidence on the headache issue and legal rulings applying the law to those findings:

1. *Pursuant to S.C. Code Ann. § 42-1-160, the Claimant did not sustain any injury to his brain, central nervous system, or psyche by accident arising out of or in the course of his employment on May 21, 2015 (or any other time) and his complaints of* ***headaches****, memory loss, fatigue, and confusion are otherwise not causally-related to any accident at work based upon the greater weight of the evidence. The Claimant describes no event or work conditions on May 21, 2015, or any other time, that could have caused or aggravated his condition. More importantly, the Claimant alleges that his condition was gradual in onset and due to repeated alleged exposures over time; therefore, his alleged injuries cannot be considered injuries by "accident" pursuant to the plain terms of S.C. Code Ann. § 42-1-160(F). Furthermore, the overwhelming weight of the evidence, including the opinions of Dr. Paul Pritchard, Dr. Joseph Healy, Dr. Mark Wagner, Dr. Nicholas Lind, and Dr. Randolph Waid, do not support a finding that the Claimant has any injury to his brain or nervous system, or that his* ***headaches****, fatigue, or confusion are causally-related to his employment generally, or any alleged accident on May 21, 2015 specifically. Regarding the Claimant's allegation of an accidental injury to his "memory," the objective evidence in the record shows that the Claimant has no loss or impairment of his memory from any cause.*

2. *Pursuant to S.C. Code Ann. § 42-11-10, the Claimant's alleged injuries to the brain, central nervous system, and psyche (including his alleged **headaches**, memory loss, fatigue, and confusion) do not qualify as an "occupational disease." Specifically, the greater weight of the evidence indicates that the conditions for which the Claimant seeks benefits do not "result directly and naturally from exposure... to the hazards peculiar to the particular employment." Furthermore, the greater weight of the evidence, including the opinions of Dr. Paul Pritchard, Dr. Joseph Healy, Dr. Mark Wagner, Dr. Nicholas Lind, and Dr. Randolph Waid, indicates that the Claimant does not suffer from any disease of his brain or nervous system (or psyche) and that his complaints of **headaches** were not caused or aggravated by any alleged workplace disease. To the extent that the Claimant's condition, specifically his complaints of **headaches** and fatigue, could be attributed to some pulmonary or cardiac disease (as suggested by Dr. Healy), the Claimant has made no claim for any pulmonary or cardiac disease and any such disease would otherwise not be compensable as an "occupational disease" pursuant to S.C. Code Ann. § 42-11-10(B)(5). Furthermore, there is no evidence that **headaches** are peculiar to the Claimant's occupation and when asked whether he had treated painters in the past with chronic **headaches**, Dr. Healy responded, "you don't see it a lot." (Healy T. p.43, line 4).*

3. *Pursuant to S.C. Code Ann. § 42-1-172, the Claimant's alleged injuries to the brain, central nervous system, and psyche (including his alleged **headaches**, memory loss, fatigue, and confusion) were not caused by a*

compensable "repetitive trauma." Specifically, the preponderance of the medical evidence, including the opinions of Dr. Paul Pritchard, Dr. Joseph Healy, Dr. Mark Wagner, Dr. Nicholas Lind, and Dr. Randolph Waid, indicate that the Claimant does not have any injury to his brain, nervous system, or psyche from any cause. Furthermore, there is no credible evidence of a "direct causal relationship" between the Claimant's work conditions and his alleged injuries, specifically including his complaints of ***headaches****. While Dr. White has opined as to the existence of such a relationship, the opinions of Dr. White are given little weight, as they have no objective basis and they are otherwise contradicted by the overwhelming weight of the credible evidence in the record, including the opinions of the other neurologists who evaluated the Claimant and found him to have no evidence of any brain or other neurologic injury and do not believe that the Claimant's* ***headaches*** *were caused by any alleged workplace exposures. In addition, the greater weight of the evidence, including the opinions of Dr. Eagerton, indicate that the Claimant's alleged workplace exposures were neither repetitive, nor traumatic.*

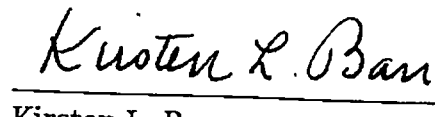
(emphasis added). Therefore, the Claimant's argument with regard to the sufficiency of the Hearing Commissioner's Decision and Order are without merit.

Conclusion

Based upon the foregoing arguments, the Respondents respectfully request that the Decision and Order of the Hearing Commissioner be affirmed in its entirety in accordance with the greater weight of the evidence and the applicable law.

Respectfully submitted,

November 22, 2017



Kirsten L. Barr
Trask & Howell, LLC
Attorneys for the Respondents

In The Matter Of:

Kenneth L. Barr v.
Darlington County School District

Marshall Allyn White, MD
November 23, 2015

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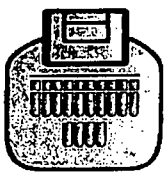

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BEFORE THE

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

Kenneth L. Barr, Employee/Claimant, -vs- Darlington County School District, Employer. -and- SC School Boards Insurance Trust, Carrier.	W.C.C. File No. 1507304 **DEPOSITION OF:** **MARSHALL ALLYN WHITE, M.D.**

DATE: Monday, November 23, 2015

TIME: 2:30 p.m

LOCATION: Trask & Howell, LLC
763 Johnnie Dodds Boulevard
Mt. Pleasant, SC 29465

REPORTER: Cheryl Foults Milligan

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5

6 A P P E A R A N C E S

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Columbia, SC 29201

9

10 For the Defendant: Trask & Howell, LLC
Kirsten L. Barr, Esquire
11 763 Johnnie Dodds Boulevard
Mt. Pleasant, SC 29464

12

13 I N D E X

14 WITNESS PAGE

15 MARSHALL ALLYN WHITE, M.D.

16 Examination by MS. BARR 3

17 Examination by MR. MCDANIEL 60

18 Examination by MS. BARR 70

19 E X H I B I T S

20 Exhibit No. Exhibit Description Page

21 1 Email dated May 12, 2015 71

22

23

24

25

1 P R O C E E D I N G S

2 Thereupon, **MARSHALL ALLYN WHITE, M.D.**, the
3 Deponent called for examination by Counsel for the
4 Employer and, after having been duly sworn by the
5 notary, was examined and testified as follows:

6 **EXAMINATION BY COUNSEL FOR THE EMPLOYER**

7 **BY MS. BARR:**

8 Q Thank you, Dr. White. We met briefly before we
9 went on the record; but, again, my name is Kirsten Barr, and
10 I represent the Darlington County School District in a
11 workers' compensation claim filed by your patient, Mr.
12 Kenneth Barr. We are no relation as far as anyone knows,
13 although it may be distant. Thank you for being here today.
14 The purpose of your deposition is to ask you about
15 your treatment and medical records pertaining to Mr. Barr.
16 The questions I'm going to ask you are intended to be
17 straightforward. So if I ask you something that's unclear
18 or doesn't make sense, which is quite possible, please ask
19 me to repeat or rephrase my question. Otherwise, I expect
20 that if you answer my questions that No. 1, you understood
21 them; and No. 2, you're just answering truthful and to the
22 best of your ability.
23 I assume you've had your deposition taken before?
24 A Yes, ma'am.
25 Q All right. If you would start with your full name

1 for the record?
2 A Marshall Allyn, A-L-L-Y-N, White.
3 Q And could you give us a brief overview of your
4 medical education and training?
5 A Yes, ma'am. I graduated from the Citadel in 1982,
6 followed by the University of South Carolina School of
7 Medicine in 1986. I did an internship in psychiatry at the
8 William S. Hall Psychiatric Institute, followed by an
9 internship in internal medicine at the Medical University of
10 South Carolina, followed by a residency in neurology at the
11 Medical University of South Carolina.
12 I've been in private practice in the Charleston
13 area and in other places around South Carolina in satellite
14 offices for approximately 25 years, and I'm board certified
15 by the American Board of Psychiatry and Neurology in General
16 Neurology.
17 Q Dr. White, it was in your private practice that you
18 came to first meet Mr. Barr?
19 A Yes, ma'am.
20 Q When did he first present to your practice?
21 A 10/17/2012.
22 Q And what were his presenting complaints at that
23 time?
24 A He was complaining of severe headache and back pain
25 for two and a half years.

1 Q Did you take -- was there any sort of medical
2 history questionnaire or medical history taken from Mr. Barr
3 at that time?
4 A Yes, ma'am.
5 Q What sort of medical history did he give to you?
6 A He was sent to me, he said he was sent to me by Dr.
7 Chapman to get a second opinion about his headaches and back
8 pain. His headaches principally. He had been seen early by
9 another neurologist in Florence. And that's the history he
10 gave, severe headaches for two and a half years.
11 Q And did he -- was he accompanied by any records
12 from either Dr. Chapman or Dr. Skinner?
13 A I don't recall that he was at the time; no, ma'am.
14 Q Have you had, since that time, any opportunity to
15 review his records from Dr. Chapman or Dr. Skinner or any of
16 his other treating physicians?
17 A I have got some records from Dr. Chapman's office,
18 but I don't believe I have a copy of Dr. Skinner's records.
19 Q Okay. Were the other medical records contained in
20 your file that you've reviewed be records perhaps from other
21 clinicians that you had referred him to?
22 A I don't believe so, no.
23 Q Okay. All right. So when he comes in he said two
24 and a half years of headaches. So that would date them to
25 approximately 2009; is that your understanding of how long

1 he had been having headaches?
2 A That was my understanding.
3 Q How did he describe his headaches?
4 A He described them as severe. My recollection was
5 that they had been throbbing in nature. Not typically
6 lateralizing. More holocephalic, all over his head. Not
7 really typical of any specific type of headache other than
8 perhaps a migrainous type headache, which most of them are.
9 Q Did he complain of any other associated symptoms
10 along with the headaches?
11 A His review of systems was positive for memory loss
12 -- let me make sure I'm looking at the right date, I'm
13 sorry.
14 Q Yes, we're back on October 17th, 2012.
15 A Right. His review of systems was positive for
16 nausea, diarrhea, constipation, chest pain, leg pain, arm
17 pain, loss of appetite, difficulty sleeping, drowsiness,
18 headaches, back pain, neck pain, memory difficulties, and
19 dizzy spells and blurred vision.
20 Q Were those just general complaints, or were any of
21 those in particular associated with the onset of headaches?
22 A My understanding were they were just general
23 complaints.
24 Q Okay. Is this a medical history form that he
25 completed in October of 2012?

1 A He completed it -- it looks like he completed parts
2 of it. It looks like maybe my nurse's handwriting is on
3 other parts. Either he or his wife completed it probably.
4 Q Would it be possible, I don't believe I have a copy
5 of that initial intake form. I know I've got one from 2015.
6 Would it be possible for us to copy that, and I can make a
7 copy for Mr. McDaniel?
8 A Sure.
9 Q That way we're on the same page.
10 A Here's everything from 2012 from that first visit.
11 Q Okay, perfect.
12 (Whereupon there was a pause in the proceedings.)
13 Q Back on the record. You were kind enough to give
14 us the new patient questionnaire that Mr. Barr completed on
15 October 17, 2012, and it looks like he was complaining that
16 he was waking up in the morning with headaches; is that
17 right?
18 A Right.
19 Q Is that of any clinical significance to you when
20 trying to determine maybe the cause or the type of headaches
21 the patient might be dealing with?
22 A It's possible, you know, in patients who are having
23 increased intracranial pressure a morning headache is
24 typically described.
25 Q And he listed a number of medications that he was

1 taking at that time?
2 A Correct.
3 Q And he also admitted to being a cigarette smoker?
4 A Correct.
5 Q Smoking cigarettes can cause or exacerbate
6 headaches in patients; is that true?
7 A True.
8 Q Did you go through the medications he was taking
9 and the purpose of these medications?
10 A Well, I know what the medicines are so I know the
11 purpose. I don't know -- I don't recall specifically going
12 over each of them.
13 Q All right. Did Mr. Barr, other than just
14 complaining generally of these headaches, did he give you
15 any other history or information regarding the timing, the
16 onset, or any sort of triggers for his headaches?
17 A No, not that I recall.
18 Q Okay. So part of what we can do, as you know
19 you're a doctor and you've got bad handwriting, so if you
20 could help us. I'm looking at the office assessment note
21 from 10/17/2012. You did a physical examination?
22 A Right.
23 Q Anything significant about or abnormal about your
24 physical examination?
25 A No, ma'am, not really.

1 Q What about the neurological evaluation?
2 A No, ma'am, there's nothing specific there.
3 Q And the handwriting I think, if I'm reading it
4 right, nonfocal, nonlateral; is that right?
5 A Nonlateral, right. That was generally on the
6 neurologic exam.
7 Q What was your impression after evaluating him on
8 October 17, 2012?
9 A Well, he just complained of headache. I mean, I
10 wasn't that concerned about it. Apparently some history
11 came out at that visit that he was -- and I believe he may
12 have indicated that he felt this way; that his headaches
13 were being made worse by his exposure to paint fumes, which
14 is something that can happen. And so instead of treating
15 him, my recommendation on that day was to keep him out of
16 work for six weeks and see if his headaches went away.
17 Q Did you have any more detailed understanding of
18 what the nature of his exposure to paint fumes was?
19 A Not at that time.
20 Q So you recommended he be excused from work, and I
21 believe that happened; is that right?
22 A To my knowledge, yes.
23 Q And he was seen in follow-up November 28th of 2012;
24 is that right?
25 A Correct.

1 Q Any change in his medical history as it was
2 reported to you?
3 A Not that I documented, no.
4 Q Okay. Any change in his headaches when you saw him
5 in November of 2012?
6 A Not to my knowledge, no.
7 Q Okay. Any change in his physical or neurological
8 evaluation?
9 A No, ma'am.
10 Q And just down at the neurological -- bottom of the
11 page of that office assessment if you could help us
12 interpret your handwriting.
13 A Under impression?
14 Q Yes, sir.
15 A Migraine question mark. Time to try meds. Topamax
16 trial, six week follow-up.
17 Q Had you discussed with him the different treatment
18 regimens or medications he had tried in the past for his
19 headaches?
20 A My understanding, and this is based upon a cryptic
21 notation before, was that he was on Topamax. I was not sure
22 whether he had been placed on the appropriated dosage. A
23 lot of times I see patients who have been tried on Topamax,
24 and they will not have been placed on a therapeutic dosage.
25 They are placed on a sub-therapeutic dosage. So I'll go

1 back and try that medicine anyway because it is the most
2 effective.
3 Q Now, obviously you hope that the Topamax would be
4 therapeutic. Is there any diagnostic value to prescribing
5 the Topamax. I mean, would it signal to you if it's
6 effective or ineffective what type of headaches or what
7 might be causing them?
8 A There is a diagnostic value. Topamax is probably
9 90 percent effective in terms of stopping garden variety
10 idiopathic migraine headaches. So I've told patients for
11 years that if Topamax doesn't fix your headaches, there's
12 only a 50/50 chance that I'll be able to because it's that
13 effective.
14 Q Would it have any affect on a tension type
15 headache?
16 A No.
17 Q Would that be the differential for a headache
18 patient generally a migraine versus a tension headache?
19 A There are lots of different types of headaches. I
20 mean, that's one of the differential diagnostic
21 possibilities. A tension headache though is typically
22 characterized by a pattern where a patient will awaken in
23 the morning, and there's no headache at all. And then the
24 headache becomes worse throughout the course of the day as
25 the patient becomes more stressed and perhaps fatigued in

1 terms of muscular stability in the neck and so forth. So
2 that headache is typically described as non-throbbing, more
3 of a low grade headache. Not as severe as a migraine
4 headache. They are usually not described as severe
5 headaches, and they're described as band like bilateral,
6 both sides, frontal, frontal squeezing, halo like. As
7 opposed to a migraine headache, which is usually
8 lateralizing on one side of the head associated with
9 throbbing, nausea, vomiting, visual changes, and other
10 symptoms.
11 Q So you're still questioning migraine. Couldn't
12 rule it in; couldn't rule it out as of the November 28, 2012
13 appointment?
14 A That's correct.
15 Q Now, according to his family medical records, he
16 had been diagnosed with a sinus infection and fever and was
17 being treated with antibiotics approximately nine days
18 before his office visit with you on November 28th of 2012.
19 Could an acute sinus infection impact somebody's
20 symptomatology in somebody who is complaining of headaches?
21 A They can cause headaches. Sinus headaches can
22 occur. Typically facial or frontal and they are associated
23 with sinus symptoms. Nasal discharge or bleeding, fever,
24 and so forth. You know, typically someone with a sinus
25 infection is treated for their sinus infection. If the

1 headache persists, then it's typically not thought to be
2 sinus related.
3 Q If you have a chronic sinus problem, could that
4 lead to chronic headaches?
5 A It's possible. It's entirely possible, but usually
6 patients that are having sinus -- sinus headache is pretty
7 uncomfortable. And if you're aware of the fact that you've
8 got sinus problems, you're typically going to pursue the
9 sinus problem and the symptom of headache related to the
10 sinus problem until it's resolved.
11 So in my experience there are many patients with a
12 history of chronic sinus diseases. In fact, you know, in
13 these parts of the country where seasonal allergies are so
14 prevalent, I would say the majority of people have evidence
15 radiographically of chronic sinus disease and almost none of
16 them have headaches. So I don't see chronic sinus headache
17 as a very prevalent problem at all. But to answer your
18 question, it's possible.
19 Q I mean it certainly could have been a variable when
20 he's complaining of headaches in November of 2012?
21 A It's a variable. I'm not exactly sure what you
22 mean by variable. Maybe you could define that a little bit
23 better so I'm not surprised if we --
24 Q If you have a patient complaining of headaches and
25 he has an acute sinus infection, could you rule out the

1 sinus infection being the cause of the headache as opposed
2 to some other factor such as his employment?
3 A You mentioned acute sinus injection. I would say
4 yes, certainly for an acute sinus infection, but I would be
5 somewhat suspicious about a chronic sinus infection. There
6 would be a much, much, much lower probability.
7 Q But as of November 2012 when you're questioning
8 whether he has migraine symptoms, it might have been
9 important to know that he had an acute sinus infection at
10 that time?
11 A Yes, if he were being -- and he was being treated
12 for it obviously.
13 Q So the next follow-up appears to be January 16th of
14 2013; is that right?
15 A It looks that way.
16 Q Any change in his presenting complaints?
17 A He was having headaches three to four times per
18 week.
19 Q Was that a change for him?
20 A I don't recall whether it was. I thought he was
21 having very frequent headaches. So I would guess that
22 that's not much of a change. If anything, maybe some
23 reduction. He was reporting that the Topamax may reduce
24 some of his headaches and severity of his headaches. He was
25 also absent from the practice for kind of a protracted

1 period of time, and I'm not exactly sure why that was the
2 case.
3 Q That was following the January 16, 2013?
4 A Right. 16 January '13 -- well, it's not too bad.
5 Q It was after that appointment.
6 A It was after that appointment. I knew there was a
7 gap somewhere. I'm getting ahead of myself, sorry.
8 Q That's all right. And, again, just to try to
9 interpret your handwriting, to the right on the January 16,
10 2013 office assessment there's kind of in the right-hand
11 side if you could read your notes for us?
12 A I questioned possibly a tension headache and
13 anxiety as he was, you know, reporting anxiety and appeared
14 to be anxious. And I added Clonazepam, which is a sedative
15 muscle relaxer in an attempt to treat along with the
16 Topamax. So I was adding medications on to try to bring his
17 headaches under control.
18 Q So the Klonopin was for the anxiety component?
19 A Well, it would be for both, anxiety and tension
20 headache.
21 Q Did you discuss with him at all his prior use of
22 Klonopin?
23 A I don't recall that I did.
24 Q Were you aware that he had actually taken Klonopin
25 for several years from 2009 to 2011?

1 A I may have been, but I don't know.
2 Q Okay. Now, on his past medical history, it appears
3 that it was reportedly unchanged at that time. Was that
4 your understanding?
5 A Yes.
6 Q All right. So did he report to you that he had
7 sustained a complex meniscal tear a month earlier prior to
8 the January 16, 2013 report?
9 A I don't think I discussed that with him, but that
10 wouldn't have impacted my decision making in any way.
11 Q Somebody who has chronic pain, could that not
12 impact headaches in other somatic symptoms?
13 A Meniscal tears don't cause headaches.
14 Q What about analgesic rebound from taking
15 medications for a complex meniscal tear?
16 A I don't buy that.
17 Q You don't buy what?
18 A I don't buy the notion that he was having headaches
19 related to rebound effects of narcotics.
20 Q Why not?
21 A Because the chronicity of the headaches was much
22 longer than his use of narcotics for his meniscal tear.
23 Q So what do you know about his narcotics use?
24 A I don't think he was on chronic narcotics because
25 he indicated early on in his intake several months before

1 that he wasn't on narcotics. So my assumption at the time
2 was based upon what he told me on 10/17 was that he wasn't
3 on narcotics. He didn't list narcotics at least. So I
4 would assume that he wasn't on narcotics at that time.
5 Q Well, if medical records indeed reveal that he had
6 been taking chronic narcotics and was told by his
7 orthopedists that they believed he was addicted to Lorcet,
8 would that perhaps change your opinion on the possibility
9 that analgesic rebound or narcotics use could be playing a
10 role in his headaches?
11 A I'd have to review the records.
12 Q So you haven't reviewed any of these records
13 regarding his narcotics use that started in about 2008?
14 A No.
15 Q So did he ever follow-up with you to discuss the
16 change or any impact that Klonopin may have had on his
17 headaches?
18 A No. No, ma'am.
19 Q And as of that January 16, 2013 evaluation, your
20 impression was his headaches were being caused by muscle
21 tension and/or anxiety?
22 A That was one of the potential differential
23 diagnoses. I hadn't ruled out the possibility of migraine
24 or some other cause at that point.
25 Q But you didn't further restrict him from his work

1 environment?
2 A No, ma'am, not at that point.
3 Q Okay. Did you have any contact with Mr. Barr
4 between January of 2013 and April of 2015?
5 A No, ma'am.
6 Q All right. And why did -- go ahead.
7 A I mean, there may have been some phone calls early
8 on through that period. We closed our office in Hartsville
9 in the first quarter of 2013, and so my recollection is he
10 didn't want to drive to see me in Sumter, which is over an
11 hour away or an hour away about.
12 Q Is the Sumter office where he's been seeing you
13 most recently?
14 A Yes, ma'am.
15 Q So why did he return to you in April of 2015?
16 A Because he was continuing to have problems. He was
17 reporting continued severe headaches, memory loss, fatigue,
18 confusion, and disorientation. He reported that he had been
19 having severe headaches for almost five years, and that they
20 had gotten better under my care a few years ago. And he
21 stated in his intake that now the doctor can't find anything
22 wrong. Having severe headaches again. Health has gone
23 downhill. Job performance and attendance has decreased.
24 Doctor wanted me to follow-up with a neurologist.
25 Q Any change in the nature of his headaches when you

1 saw him in April 2015 as opposed to your earlier evaluation?
2 A I didn't really document anything. He continued to
3 have a review of systems that was positive for nausea,
4 blurred vision, dizzy spells, memory loss. He was now
5 complaining of numbness and tingling particularly in right
6 arm. He was continuing to complain of headaches, neck pain,
7 drowsiness, difficulty sleeping, loss of appetite.
8 Q How frequently was he experiencing headaches when
9 you saw him in April of 2015?
10 A I don't know that I necessarily documented it.
11 Q Did he describe the headaches to you when he saw
12 you on April 23rd, 2015?
13 A He may have, but I didn't write it down, which
14 meant that there was probably very little change.
15 Q Did he complain of any symptoms associated with the
16 onset of headaches?
17 A Not that I documented although there are some
18 things documented in the review of systems.
19 Q But no photophobia or phonophobia or anything like
20 that?
21 A I didn't document any of that; no, ma'am.
22 Q And did you discuss with him at all these right arm
23 symptoms, the numbness and tingling that he listed on the
24 review of symptoms?
25 A Not at that time.

1 Q Did you review any medical records from that
2 interim period between January 2013 and April 2015?
3 A I don't believe so.
4 Q Have you since that time?
5 A I don't believe so.
6 Q You also went over the medications he was taking as
7 of April 23rd, 2013; is that right?
8 A That's right.
9 Q Do you know who prescribed those medications?
10 A I would assume it was Dr. Chapman.
11 Q All right. Do you know why he was taking things
12 like Tizanidine and Tramadol or Lorcet?
13 A Tizanidine is a muscle relaxer. Lorcet is a pain
14 killer. So, you know, I presume he's taking those things
15 because of pain.
16 Q Pain. Do you know where he was having pain that
17 would require Lorcet, Tramadol, and Tizanidine?
18 A Well, I didn't prescribe them, but he was
19 complaining of back pain, leg pain, chest pain primarily, as
20 well as headaches. So it would have been for one of those,
21 any one of those three things. He was also on Tramadol,
22 which is a pain killer as well.
23 Q And his -- go ahead.
24 A And Meloxicam, which is an anti-inflammatory pain
25 killer as well.

1 Q So a significant amount of pain medication?
2 A Well, that's all relative. I wouldn't consider
3 this to be a significant amount of pain medicine, at least
4 in my pain management population.
5 Q All right. Well, did you go over with him any of
6 the over-the-counter analgesics he was using in addition to
7 these prescribed medications?
8 A No.
9 Q Taking over-the-counter analgesics in conjunction
10 with the narcotic and muscle relaxors he was taking could
11 contribute to headaches or an analgesic rebound syndrome,
12 correct?
13 A Potentially, yes.
14 Q And he was continuing to smoke cigarettes when you
15 saw him in April 2015?
16 A Yes.
17 Q All right. Somebody who is complaining of chronic,
18 severe headaches, would smoking cessation be an important
19 recommendation for them?
20 A It might be.
21 Q So if he were to stop smoking, he could see an
22 improvement; or you'd expect to see him have an improvement
23 in his headache symptoms?
24 A Possibly.
25 Q So what was your assessment when you saw him in

1 April of 2013?
2 A Well, obviously he was still having headaches, and
3 I told him since he had indicated that I had helped him in
4 the past, and what I had largely done for him was place him
5 on Topiramate, and he continued to be taking the Klonopin
6 that I prescribed for him, my first course of action was to
7 put him back on his Topiramate.
8 Q Did you do a physical evaluation or a physical
9 examination on April 23rd, 2013?
10 A I checked his vital signs. Not that I documented.
11 Q And did you discuss at all the neck pain he had
12 been complaining about and its potential role with his
13 headache symptoms?
14 A Not that I recall.
15 Q Somebody who has neck problems, orthopedic in
16 nature, could that impact or cause headaches?
17 A Not directly but it could cause headaches
18 indirectly.
19 Q It's not uncommon to see people with neck problems
20 who also complain of headaches secondarily as a result?
21 A That's correct.
22 Q All right. Any other treatment recommendations or
23 diagnostic recommendations as of April 23rd of 2015 other
24 than the Topamax?
25 A I put him on a Medrol Dosepak as an

1 anti-inflammatory.
2 Q What were you hoping to achieve with the
3 anti-inflammatory?
4 A I was hoping that we would help his headaches by
5 reducing inflammation.
6 Q Inflammation of his neck?
7 A Any type of inflammation. It's nonspecific.
8 Steroids can serve to reduce inflammation in the neck. They
9 could also serve to abort migraine headaches. So it's used
10 in both circumstances.
11 Q All right. And it looks like you also had some
12 drug testing done on Mr. Barr; is that right?
13 A I know that I have.
14 Q Okay. Why would you order the drug test?
15 A May I see a copy of that?
16 Q Certainly.
17 A I just want to look at it.
18 Q Yes, and I can make a copy.
19 A That's okay. Well, I do a fair amount of pain
20 management. When I see patients on controlled medications,
21 I have an obligation to routinely and randomly drug test
22 them.
23 Q All right. The narcotic medications themselves can
24 have side effects; is that correct?
25 A Yes, ma'am.

1 Q Could the side effects of narcotic medications
2 result in headaches or dizziness or the lack of
3 concentration like Mr. Barr was complaining about?
4 A It's possible.
5 Q Did you have any concerns about the amount of
6 medications, narcotic medications Mr. Barr was taking?
7 A No, ma'am.
8 Q Even after his drug screen?
9 A The drug screen was just to confirm that he was
10 compliant. Make sure he didn't have illicits in his system,
11 or to make sure that there were no medications that I was
12 unaware of. I didn't -- I don't view Mr. Barr as taking
13 huge quantities of pain medications.
14 Q Well, isn't that relative. I mean, wouldn't you
15 want to know what the --
16 A That's my opinion. I'm sorry to cut you off, but
17 you asked the question, and I answered it.
18 Q Certainly. But it's relative in the sense that
19 somebody who does not need narcotic pain medications, might
20 need to be taking them in such quantities?
21 A Well, that's not my question to answer. I didn't
22 prescribe them for him. Dr. Chapman would have to answer
23 that question.
24 Q All right. Well, when somebody comes to you
25 because they have chronic headaches, it wouldn't be

1 important for you to know whether or not say they've had a
2 history of secondary gain or narcotics abuse?
3 A It might be important, yes.
4 Q When did you see Mr. Barr next? May 21st of 2015;
5 is that right?
6 A That's correct.
7 Q Any change in his somatic complaints at that point
8 in time?
9 A Not really. He was noting more memory loss or
10 noting to me at least to me for the first time fatigue and
11 memory loss. I don't know that these are new complaints,
12 but it's perhaps more prominently documented at that time.
13 And so I think this notion that he was being exposed to
14 chemicals at work became more prominent, and I remember
15 having discussions with he and his wife.
16 He felt very clearly that the exposure to these
17 chemicals was making him sick. And I told him that there
18 was no way that I thought that he could get better or even
19 improve or stop the progression of perhaps the neurologic
20 syndrome unless he got out of the environment that he was
21 in. And so I told him that I felt he couldn't work around
22 VOCs. And so, you know, on examination, he appeared to be
23 really really depressed. He had slow mental processing
24 speeds, and I believed Mr. Barr that he was being made sick
25 by his exposure to these chemicals.

1 Q Why did you believe him?
2 A Because I've seen people who have been exposed to
3 these kind of chemicals, and these are the types of problems
4 that they develop.
5 Q What kind of chemicals are you speaking of?
6 A I'm speaking of volatile organic compounds. I have
7 a list of the things that he's been exposed to, although I
8 don't hold myself out as an expert in toxicology, you know,
9 I'm well aware that VOCs can cause a variety of syndromes
10 and medical problems, including those that have been
11 observed in Mr. Barr.
12 Q There's certainly other potential etiologies for
13 the myriad of symptoms that Mr. Barr complains of; wouldn't
14 you agree?
15 A Not in my opinion.
16 Q Not in your opinion.
17 A I'm the neurologist. So, you know, I'm here, and I
18 hope to be qualified if I have to go to court to opine.
19 Whether the jury would decide to reject my opinions or not,
20 it's my opinion that his symptomatology and his syndrome is
21 the result of VOC exposure and not related to these other
22 theories that you're trying to put up like cigarette smoking
23 or narcotic withdrawal or rebound effect from
24 over-the-counter analgesics. Well, which one is it. Who is
25 going to make that decision. Are you in a better position

1 to make that decision or am I. I would assert that I am.
2 Q Okay. Well, we'd like to know how you reached the
3 decision. Did you use actual objective evidence?
4 A I used my experience and the pattern of illness,
5 the fact that the illness is made worse by exposure. All
6 the things --
7 Q How do you know that the illness isn't made
8 worse --
9 A I'm not finished answering the question. I was in
10 the middle of answering the question if I might. Could you
11 go back and tell me the question again so I can make sure
12 that I give an exact answer.
13 (Whereupon the question was read back.)
14 A First I want to say you have mentioned a number of
15 different conditions that could potentially explain Mr.
16 Barr's symptomatology, and I'd like to take them one at a
17 time and explain to you why they don't fit with this pattern
18 of illness if I may.
19 The first one that you mentioned is the potential
20 for muscle contraction headache. Muscle contraction
21 headache is not associated with cognitive change. It's not
22 associated with symptoms of depression, memory loss, fatigue
23 typically, or neuropsychiatric symptomatology, and the
24 pattern of headache is atypical for muscle contraction
25 headache.

1 The pattern for rebound headache is that of a
2 chronic, and it depends on which analgesic you're taking.
3 Analgesic headaches are typically associated with a low
4 volume of headaches that gradually increase as you increase
5 the use of certain medications. And so you start off with
6 infrequent headaches, and it's followed by an escalating
7 pattern of headache.
8 Again, his headache frequency and severity has
9 remained relatively stable, and in his estimation is related
10 to exposure to a known circumstance, which is going to work,
11 painting, and smelling fumes for hours and hours on end.
12 Again, muscle contraction headache and medication
13 overuse headache is unassociated with neurocognitive
14 symptoms, memory loss, and in most cases fatigue.
15 Now there are some other things you've thrown in
16 there. Some other conditions that you've mentioned that are
17 potentially involved like chronic sinus infection. Chronic
18 sinus infection is not associated with the type, the pattern
19 of headache. The cranial headache that he's experienced.
20 It's not associated with dysthymia, poor concentration, poor
21 memory, and fatigue.
22 So we've got a constellation of symptoms, which
23 include chronic headaches and encephalopathy that cannot be
24 explained by anything other than toxic exposure in my
25 opinion.

1 So I'm sure there's some other potential causes of
2 headache that you want to explore. Let's take cigarette
3 smoking for instance. Cigarette smoking in a 45 year old
4 man is typically not associated with neuropsychiatric
5 symptoms or memory loss.
6 You know, later on in life, a patient develops a
7 multi-infarct dementia or some type of alcohol or tobacco
8 induced ecephalopathy you can see memory problems. But the
9 history is just not there in Mr. Barr.
10 So looking at all the potential causes for his
11 headaches and his encephalopathic condition, the one thing
12 that stands out, and thing that he relates it to the most is
13 his exposure to these chemicals. And in my opinion the
14 pattern of illness is corroborated by that exposure.
15 Q What exposure?
16 A To the VOCs.
17 Q What do you know about his alleged exposure to
18 volatile organic compounds?
19 A My understanding is that he's been exposed at work
20 on a near daily basis for the number of years that he's been
21 painting.
22 Q Do you know about the personal protective equipment
23 that he uses while he's painting or the ventilation of the
24 environment?
25 A I don't know anything about that.

1 Q Okay. Wouldn't that be important to know before
2 you ascribe exposure to volatile organic compounds as the
3 cause of his headache symptoms?
4 A Not necessarily.
5 Q All right. So you know nothing about what he was
6 exposed to, the durations, the amounts, or any other
7 particulars regarding this alleged exposure other than what
8 Mr. Barr said was I am a painter?
9 A You know what, I'm sure OSHA is not in the
10 classroom that he's painting, and I'm sure the levels of VOC
11 exposure are not known. So, I mean, you could ask that
12 question to the contrary. No one really is going to be able
13 to answer those questions, certainly not me or anyone else
14 because there's no record of it.
15 Q Are you aware -- go ahead.
16 A I've seen patients with VOC exposure related
17 abnormalities where they have been in facilities, they've
18 worked in facilities where OSHA has been there, and they
19 have very well documented levels of elevation in VOCs.
20 Q And you have no such evidence in this case?
21 A Because it doesn't exist. OSHA is not required to
22 go into the Darling District II classroom where he's
23 painting and monitor levels of VOCs. So that data doesn't
24 exist anywhere for anyone. So it becomes a matter of expert
25 opinion as to what the cause is.

1 Q Right. And you're not an expert toxicologist or
2 know nothing about the volatile organic compound exposure he
3 may have experienced given the fact that he wore a
4 respirator every single day he painted at the Darlington
5 County School District?
6 A That's not the history that I got from him.
7 Q All right. So you don't have a history from Mr.
8 Barr that he wore a respirator at all times while painting
9 at the Darlington County School District?
10 A No.
11 Q That's in consistent with your understanding?
12 A Yes.
13 Q All right. So would that perhaps change your
14 opinion or the certainty of your opinion if you were to
15 learn that he actually could not think of an instance where
16 he had not used a respirator that had both a particulate and
17 a fume filter?
18 A No.
19 Q How do you suggest he was exposed to volatile
20 organic compounds while wearing a respirator that had a
21 particulate and a fume filter?
22 A I'm not going to make a comment in that regard.
23 That's not, that's not within the purview of my testimony.
24 My opinion is that there was an exposure, and how that
25 exposure took place is not for me to determine. The

1 symptoms that he has of encephalopathy and headaches in my
2 opinion cannot be explained in any other way.
3 Q Any other way but what?
4 A Exposure to VOCs.
5 Q So headaches, his headaches could only be caused by
6 VOCs; is that what you're saying?
7 A When you take it in combination with the fact that
8 he's developed neuropsychologic symptoms and an
9 encephalopathy and mild neurocognitive deficits, there's no
10 other explanation for it other than a toxic exposure in my
11 opinion.
12 Q Well, let's take this one at a time. What do you
13 mean by encephalopathy? How have you diagnosed
14 encephalopathy in Mr. Barr's case?
15 A It's based upon his history of memory deficits.
16 The fact that I've observed him to be forgetful. I've
17 observed him to have slow processing speeds. And in fact as
18 a way to better characterize that on the 3rd of November
19 2015, I ordered formal neuropsychiatric testing to evaluate
20 him so that we can further delineate the nature of his
21 neuropsychiatric and neurocognitive problems.
22 Q Because at this point there's no objective evidence
23 that he has neuropsychiatric or neuropsychological or memory
24 deficits?
25 A You're here today to hear my opinions and, you

1 know, as an expert, I'm free to opine, and I would assume
2 that's true.
3 Q Oh, you're free to opine. I just am free to ask
4 the basis of your opinions because it sounds like a whole
5 lot of speculation to me so that's why I'm asking do you
6 have any objective evidence that he has memory loss?
7 A It's not speculative evidence that people exposed
8 to elevated levels of VOCs develop these types of
9 neurological problems.
10 Q Why do you think he was exposed to elevated levels
11 of VOC's? You have no evidence of that, do you?
12 A I have the history from him that he was. And so I
13 don't think that Mr. Barr is sophisticated enough to carry
14 on a charade like this that occurs progressively over a
15 number of years with the possibility that he might get some
16 sort of compensation. I don't think he's that calculating
17 of a person. I think his story and the evolution of his
18 symptoms over the years is entirely consistent with exposure
19 to a toxin, and that's my opinion.
20 And, you know, I'm not going to be able to go back
21 and give you the parts per million readouts of the VOCs in
22 his classroom. I'm not going to be able to tell you the
23 type of mask that he may have worn some of the time. I will
24 tell you this, Mr. Barr was not wearing a mask all of the
25 time, and I know --

1 Q Well, he's given sworn testimony to the contrary.
2 A Well, that's not what he told me.
3 Q All right. So you've based your opinions entirely
4 on the history given to you by Mr. Barr, which you now
5 recognize may have been less than truthful?
6 A Well, I'm not going to go there. That's your
7 interpretation of what's been said.
8 Q Well, tell me what else other than the subjective
9 statements of Mr. Barr have you based this opinion on?
10 A It's based upon the pattern of the illness. I
11 think I've answered those questions.
12 Q All right. So what evidence is there that he has
13 suffered any memory loss or currently has any memory loss?
14 A My observations.
15 Q And what have you observed to determine that he has
16 memory loss. He told you he is forgetting things?
17 A Yes. His wife tells me he's very forgetful.
18 Q Okay. So that's subjective; would you agree?
19 A I would agree that that's subjective, but I also
20 observed him to have very very slow processing speeds.
21 You'll ask him a question, and he'll forget the question
22 that you've asked him, and he'll ask the same question over
23 again. To me that indicates memory loss.
24 Mr. Barr is -- you've deposed me before I finished
25 working him up. I'm still working him up. I've ordered the

1 neuropsych testing. That's going to be part of my
2 evaluation. If the neuropsychologist comes back and tells
3 me he's a malinger, then I'll take that into consideration,
4 but I'll be profoundly surprised if that turns out to be the
5 case.
6 Q So without neuropsych testing, you can't determine
7 whether or to what extent he has any neuropsychological
8 deficits?
9 A It's going to provide objective, more objective
10 evidence about his problem.
11 Q More objective evidence. Again, I've been asking
12 you for quite some time is there any objective evidence that
13 he has any problem at this time?
14 A It depends on if you consider my observations and
15 opinions to be objective or not. I mean, people argue all
16 the time whether examining a patient or whether an
17 observation from a physician is objective or subjective, and
18 I'm not here to argue that point. You know, you can decide
19 whether or not you think that my information is obviously
20 some of it is subjective. Whatever the patient tells me is
21 subjective. But my observations are those subjective or
22 objective. That's not for me to decide.
23 Q Well, what observations have you made that you
24 believe are indicative of an encephalic or
25 neuropsychological deficit?

1 A He appears to be depressed. He exhibits a flat
2 affect. He exhibits signs of forgetfulness and slow
3 processing speeds. He appears to be really dysthymic. He
4 does appear to have a deficit. And he presents himself like
5 someone who has diffuse neurologic injury, almost like a
6 traumatic brain injury patient.
7 Q Is there any objective evidence that he has a
8 diffuse neurologic injury?
9 A Just the things that I've told you by way of my
10 observation. We're in the process of gathering that data.
11 So, you know, once he's seen by the neuropsychologist I hope
12 to have that objective evidence for you.
13 Q Okay. I noted that you wrote the order for
14 neuropsychological testing for someone who is not a
15 neuropsychologist; why is that?
16 A My understanding is he's a neuropsychologist. He's
17 a PhD psychologist, isn't he, Dr. Rainwater?
18 Q Dr. Rainwater does not hold himself out as a
19 neuropsychologist.
20 A This is somebody that's been identified as somebody
21 close to Mr. Barr. I've seen his neuropsychological testing
22 before.
23 Q So you recommended Dr. Rainwater because you
24 believe he's close to Mr. Barr?
25 A Yes. Mr. Barr lives up in Hartsville, Darlington

1 area.
2 Q Oh, proximity is what you're speaking of?
3 A Yes, yes.
4 Q But you know nothing about his credentials or
5 training as a neuropsychologist or his ability to properly
6 administer --
7 MR. MCDANIEL: Objection to training as a
8 neuropsychologist versus a clinical psychologist.
9 MS. BARR: Well, we were talking about
10 neuropsychological testing.
11 MR. MCDANIEL: Exactly. You're talking
12 neuropsychological testing. That's two different
13 things. Neuropsychological testing versus -- most
14 people --
15 A PhD clinical psychologists perform neuropsychiatric
16 testing or neuropsychological testing. Those are the people
17 that perform that so.
18 Q Okay. And some people actually specialize in it,
19 correct?
20 A Well, I don't --
21 MR. MCDANIEL: Object to specialize.
22 A -- I don't know how people hold themselves out, and
23 I'm unfamiliar with the criteria that this community of
24 practitioners, if you'll call them that, monitor themselves
25 or credential themselves. I'm not familiar with that. I

1 know this man's reputation. I've seen his work for, you
2 know, a decade or more. He's one of the ones in that area
3 who performs this type of work. There's a lady up there
4 that I'm familiar with. I'm blanking on her name.
5 MR. MCDANIEL: Windsorova.
6 A Windsorova, Dora Windsorova I think is her name.
7 So I'm familiar with this name and the name of Windsorova
8 that practice in the Florence area.
9 Q There are other people who practice as
10 neuropsychologists in South Carolina, Randy Waid, Mark
11 Wagner; are you familiar with them?
12 A Yes. I've worked with all of them. I refer
13 patients to all of them.
14 Q Okay. So you don't have an issue with the
15 neuropsychological testing that's traditionally performed by
16 Dr. Wagner or Dr. Waid?
17 A No.
18 Q Okay. All right. So May 21st of 2015, depression,
19 slow processing speed, flat affect, and complaints of memory
20 loss. Any other, any other abnormalities you noted at that
21 time?
22 A Not that I documented.
23 Q Okay.
24 A Fatigue.
25 Q All right.

1 A I guess that's a subjective complaint. He appears
2 to be fatigued though.
3 Q Do you know anything about Mr. Barr's history of
4 depression, or how long he's been clinically depressed?
5 A No. I know that it predates my first visit with
6 him in 2012. I'll also represent to you that there was a
7 change in his condition from 2012 to 2015, and his condition
8 was appalling to me to see the difference in him that
9 occurred from the last time that I saw him in early 2013
10 until the time that I saw him I believe in 2015.
11 Q What specifically was this difference?
12 A He appeared to be much flatter. He appeared to be
13 far more dysthymic or depressed, and his mental processes
14 were badly slowed.
15 Q And do you know anything about his intervening
16 medical history in those years between 2013 and 2015?
17 A I don't know other than the fact that he was
18 followed by Dr. Chapman, and the medications that had been
19 prescribed for him. There seemed to be an indication that
20 he was getting progressively worse.
21 Q So you know nothing about his orthopedic or pain
22 management treatment that he had in those years between 2013
23 and 2015?
24 A Other than the medications that he was prescribed.
25 Q How have you excluded other possible causes of

1 fatigue or memory loss or depression in Mr. Barr's case?
2 A Based on his history and the fact that I feel that
3 the constellation of symptoms is most consistent with a
4 toxic exposure. Again, as I've said, you've deposed me
5 prior to completing my work up. So I'm still waiting on the
6 neuropsychological testing, which I think is going to give
7 us a lot more information.
8 Q Depression can be caused by things other than toxic
9 exposure; is that true?
10 A That's true.
11 Q And have you ruled out every other possible cause
12 of depression in Mr. Barr's case?
13 A Well, I think what you're going to have to do is
14 you're going to have to look at the neuropsychological
15 aspect of his testing and oppose it against the cognitive
16 portion of the test. If there are signs of dementia, then
17 that's going to show up. If there's signs of encephalopathy
18 or dementia, that's going to show up.
19 If his neurocognitive deficits are more the effect
20 of depression, then that will also show up on the test. So
21 I think that, I think that the test is going to be very
22 important and potentially helpful in terms of validating
23 what my clinical observations have been of Mr. Barr and help
24 in validating my opinions regarding his care and case.
25 Q All right. You're speculating that it will

1 validate because right now you have no evidence other than
2 your observations and the subjective complaints made to you
3 by Mr. Barr; is that correct?
4 A How would you define speculation? What percentage
5 of correctness would I have to assume myself to be to not be
6 speculating?
7 Q Well, Doctor, --
8 A You used the word.
9 Q Doctor, you have given opinions to a reasonable
10 degree of medical certainty which indicates --
11 A Which means more likely than not.
12 Q And I am asking you on what basis you have reached
13 that degree of certainty given the fact that you just
14 acknowledge you need further testing to prove your
15 hypothesis?
16 MR. MCDANIEL: Objection. It's been asked and
17 answered on several occasions.
18 MS. BARR: I'm not sure that it has.
19 A I don't, I don't need any additional testing to
20 state my opinions to a reasonable degree of medical
21 certainty. But this is a case of litigation. And so you're
22 asking for objectification of my opinions, and I'm going to
23 provide that to you. So my opinions are stated to a
24 reasonable degree of medical certainty based upon my
25 education, training, and 25 years of experience as a board

1 certified neurologist and based upon the patterns of disease
2 that I've explained to you earlier in the deposition. And
3 based upon the fact that the constellation of symptoms and
4 signs that I've observed in Mr. Barr are to a reasonable
5 degree of medical certainty can only be explained by toxic
6 exposure. And that would be the only thing that I could
7 find in his history that would explain that constellation of
8 symptoms in its entirety.
9 Q All right. It's possible that it's a
10 multi-factoral cause, headaches, fatigue, memory loss,
11 flatness. Why do you believe there's only one syndrome and
12 one potential cause for all these somatic complaints?
13 MR. MCDANIEL: Again, I'm just going to
14 object. Asked and answered.
15 A You know, typically in medicine we try to find a
16 unifying diagnosis. And if there's a unifying diagnosis,
17 then that's the most likely cause. It doesn't mean that
18 there aren't other factors that don't go into play. For
19 example, you know, the fact that he's a cigarette smoker.
20 Is it ideal that he is and he has headaches; no, it's not.
21 Is that an exacerbating factor; yes. Is it the primary
22 cause of his syndrome; the answer in my opinion is no.
23 So I'm not saying that there aren't other risk
24 factors or there aren't other factors that go into making
25 his syndrome somewhat more significant; but, again, I think

1 the overriding diagnostic etiology or causation for his
2 current syndrome is VOC exposure.
3 Q So you would agree there's other possible causes of
4 his constellation of subjective complaints?
5 A No.
6 Q You don't believe there's any -- you just
7 acknowledged that cigarette smoking may be impacting his
8 headache complaints?
9 A I said there are other risk factors, and there are
10 other lesser issues in play that could exacerbate the
11 syndrome. I didn't say that they were causative. For
12 example, if he continued to smoke and had no VOC exposure,
13 then I would say he would have not developed this syndrome.
14 Would his cigarette smoking exacerbate the syndrome; yes,
15 it's possible that it would, but it's not causative.
16 Q But you know nothing of the VOC exposure that
17 you've ascribed as the cause; is that correct?
18 A It's my understanding that there's been significant
19 VOC exposure.
20 Q And that's what you learned from somebody with a
21 high school education who came to you for the purpose of
22 litigation?
23 MR. MCDANIEL: Objection to the form of the
24 question. Purpose of litigation.
25 A I think Erin Brockovich had a high school

1 education. I'm not going to cast stones at people just
2 because they had a high school education. I believe in Mr.
3 and Mrs. Barr, and I think that they're -- I believe in
4 their veracity. There are validity measures built into
5 these tests, and if he's not --
6 Q In what tests?
7 A Into the neuropsych testing. If he's not telling
8 the truth, then the neuropsychologist will be able to say
9 that as well. He's trying to exacerbate his symptoms or
10 make up his symptoms. But it's my experience that he's not.
11 You know, I would say that it's -- I order
12 neuropsychological testing at least once a week, and I
13 really can't recall but on rare occasion the
14 neuropsychiatric testing or the neuropsychological testing
15 was substantially different from what my opinions were. So
16 my opinions are typically right on target with respect to
17 neuropsych testing.
18 Q Neuropsych testing is going to say nothing about
19 exposure to volatile organic compounds, will it?
20 A Yes. They know and they will know that he's been
21 exposed to VOCs, then they're going to be able to tell you
22 whether or not there's an encephalopathic process at work.
23 Q Why would they know if he was exposed to volatile
24 organic compounds when you don't know this?
25 A Well, it's going to be part of the history. And so

1 the testing will be able to -- it won't be specific to
2 exposure to volatile organic compounds, but it will be
3 specific with respect to whether or not he has what would
4 equate to a toxic induced degenerative brain condition. So
5 that will became apparent.
6 Q Okay. That would necessitate an accurate history
7 on the part of Mr. Barr, which seems to be inconsistent with
8 his sworn testimony?
9 MR. MCDANIEL: Objection.
10 MS. BARR: No, Dr. White has already said he
11 was not lead to believe he ever wore a respirator,
12 and we know what Kenny said.
13 A Well, you're dealing with somebody who is demented.
14 I mean, I don't think that you're --
15 Q Oh, he is?
16 A Well, that's what an encephalopathy implies is that
17 he's got cognitive dysfunction.
18 Q But you have no objective evidence that he has any
19 cognitive dysfunction, do you?
20 A As I've told you now and for the fourth time --
21 Q Yeah, you haven't tested him yet.
22 A -- I'm still in the middle of my work up.
23 Q But you're still in the middle of your work up, but
24 that didn't stop you from writing a letter to Mr. McDaniel
25 on October 21st, 2015, did it?

1 A Those are my opinions, and they are my opinions
2 today.
3 Q Okay. So if you're certain enough to make these
4 opinions, I don't think it's unfair to ask you the questions
5 now since you seem to have the requisite certainty to issue
6 this letter.
7 MR. MCDANIEL: And they have been asked and
8 answered.
9 MS. BARR: Preston, thank you. I don't know
10 that they have. Again, I still can't for the life
11 of me see what other than just Kenny says that he's
12 demented that we have working here for us.
13 BY MS. BARR:
14 Q You prescribed Topamax July 16th of 2015?
15 A Yes.
16 Q Why?
17 A For headaches.
18 Q Were you concerned at all about the interaction
19 with Topamax and the other medications he was taking?
20 A No.
21 Q Why?
22 A I just wasn't. You know, all medications have
23 varying degrees of interactions, and we prescribe
24 medications that interact with other medications every day.
25 Q All right. You have no concern about the possible

1 interaction between the Prozac and Tramadol he was taking
2 with this Adderall that you added in July of 2015?
3 A I probably told him to stop Tramadol. That's one
4 that I despise, and I would almost guarantee that I told him
5 to stop that because of the problem with serotonin syndrome
6 and the metabolism through the P450 system. So I take every
7 patient off of Tramadol that I see.
8 Q Do you know if he stopped taking Tramadol because
9 he's taken it for about five years now?
10 A If he's still taking it, I told him not to.
11 Q So Tramadol combined with the Adderall, does that
12 put him at a risk for serotonin syndrome?
13 A In combination with Prozac, it certainly does. I
14 mean, he's on a number of medicines that will exacerbate
15 serotonin levels.
16 Q Let's talk about the symptoms of serotonin
17 syndrome. What are they?
18 A Confusion, headaches, elevated blood pressure,
19 potentially seizures, and death.
20 Q All right. So can you rule out, given the
21 medications you know Mr. Barr to have taken, can you rule
22 out serotonin syndrome as a cause of his constellation of
23 subjective symptoms?
24 A Yes. Serotonin syndrome is typically not a chronic
25 condition. It's one that occurs in the acute setting and

1 becomes progressive and exacerbated. And I don't believe
2 that Mr. Barr would have continued to take Topamax (sic)
3 when I asked him not to. Pharmacy records would certainly
4 reveal that information.
5 Q He was taking Tramadol and Prozac and other
6 medications prior to coming to see you. Could he have not
7 had serotonin syndrome when he first presented to you in
8 April 2015?
9 A I don't believe so, no.
10 Q You can't rule it out, can you?
11 A Serotonin syndrome is extremely rare. Not
12 everybody on that constellation of medications develops it.
13 The few times that I've seen it it's been a rather severe
14 syndrome and quite obvious. Blood pressure elevations are
15 noted to be quite severe. And if you look at his record,
16 his blood pressure was 122 over 80 that day, which is
17 completely normal. He had no tachycardia. Pulse was 70.
18 So if he had serotonin syndrome, he certainly had no
19 physiologic evidence of it.
20 Q You would not recommend that he continue taking the
21 Tramadol that was being prescribed by other providers and
22 the Prozac along with the Adderall that you had chose to add
23 to his prescription regimen in July?
24 A I certainly would not.
25 Q What could happen if he was taking Adderall with

1 Prozac and Tramadol?
2 A He'll develop serotonin syndrome.
3 Q And the symptoms of serotonin syndrome are very
4 similar to the symptoms he's complained to you about?
5 A Not in the absence of physiologic signs of
6 serotonin syndrome, which he hasn't displayed.
7 Q But he has displayed symptoms of serotonin
8 syndrome, fatigue, memory loss, confusion, dizziness?
9 A Some of the symptoms are overlapping. He has not
10 displayed signs of serotonin syndrome.
11 Q Only the symptoms?
12 A He has symptoms that overlap with VOC toxicity and
13 serotonin syndrome, but he has not displayed signs of
14 serotonin syndrome, nor have I made that diagnosis.
15 Q Have you seen him at all since July of 2015?
16 A I don't know whether I saw him in November or not
17 for neuropsychological testing. I kind of think that I
18 didn't.
19 Q I mean, have you done neuropsych testing, or you
20 just ordered it?
21 A I've ordered it. I don't know that -- I don't
22 think it's been done at this point. I may have seen him in
23 October when I dictated this note to Mr. McDaniel, but I
24 can't be sure of that.
25 Q Are there any medical records other than the note

1 you wrote or dictated to Mr. McDaniel?
2 A No.
3 Q All right. So do you have any way of knowing what
4 his current status is or whether or not he has any problems
5 at this point in time?
6 A I don't. He's kind of been in some respect MIA,
7 and I'm not sure why that is except that he's kind of
8 disorganized.
9 Q Have you written any prescriptions for him since
10 July 16th, 2015 when you added the Adderall?
11 A I have not.
12 Q Were there any other prescriptions written at that
13 point in time, just the Adderall?
14 A I don't see that there were.
15 Q Did you keep him on, what was it, Klonopin and --
16 or rewrite the other prescriptions that you had written
17 in the past. Was it Topamax and Klonopin?
18 A I didn't. It may be that some of these things are
19 being taken care of by his family physician. For example, I
20 had written him Topamax for six refills in April.
21 Q Okay.
22 A So in July he should have been on that medicine.
23 His follow-up was in four weeks. Again, I think Mr. Barr
24 has some issues with traveling to Sumter still even though I
25 think Dr. Chapman and certainly I feel it is in his best

1 interest to continued to be followed at my practice.
2 Q So just so I can be clear, when you saw him on July
3 16th of 2015, you intended him to continue taking the
4 Topamax along with the Adderall?
5 A Correct.
6 Q Were there any other medications that you intended
7 him to continue; was the Klonopin still a recommendation or
8 no?
9 A At that point I was not prescribing Klonopin. Dr.
10 Chapman would have been prescribing.
11 Q Okay. Looking at this letter you wrote to Mr.
12 McDaniel on October 21st of 2015, you mentioned that his
13 review of symptoms was positive for numbness and tingling in
14 the right arm. Is that just an incidental complaint, or are
15 you suggesting that that's somehow related to his alleged
16 work place exposure?
17 A I'm not alleging that. I haven't fully elucidated
18 the cause for that. My primary focus has been on his
19 encephalopathic condition and trying to treat his headaches.
20 Q Do you know anything about the history of his arm
21 problems?
22 A And to try to establish some type of longitudinal
23 rapport. I'm unaware of his -- I have not adequately worked
24 up his arm problem.
25 Q So at this time you're not suggesting that the

1 numbness and other symptoms he complains about in his right
2 arm are related to his what you call encephalpathic
3 condition?
4 A Not at this time.
5 Q If Mr. Barr has a history of RSD affecting his
6 right arm, would that be important for you to know in
7 working up the cause or etiology for his right arm
8 complaints?
9 A Probably not. Paresthesias are not typically a
10 symptom of RSD, and I never noticed any symptoms of Complex
11 Regional Pain Syndrome. Did you call it RSD?
12 Q I did. Well, that's what his orthopedist had
13 called it.
14 A That's the old terminology, but the new terminology
15 is Complex Regional Pain Syndrome. I never observed
16 clinical symptoms of Complex Regional Pain Syndrome in Mr.
17 Barr, which are very obvious in most patients. And so that
18 history I would want to know, but it would not necessarily
19 lead me to a specific diagnosis. I wouldn't say aha, well,
20 that's what's causing the numbness and tingling in his right
21 arm. I'd have to look for another cause because those are
22 not symptoms of CRPS.
23 Q Other potential causes could be his ongoing
24 complaints of neck pain?
25 A Could be.

1 Q And he also had complex tendon arm damage when he
2 put his arm through a glass window, his right arm?
3 A Could be, yes, ma'am. Could have carpal tunnel.
4 We just don't know.
5 Q So these right arm symptoms may very well have
6 nothing to do with the other symptoms he's complained of to
7 you?
8 A I would say they most likely don't. That would be
9 in fact a completely separate problem in most -- and almost
10 certainly from a medical standpoint.
11 Q In this letter of October 21st, 2015 you said to a
12 reasonable degree of medical certainty Mr. Barr has severe
13 permanent brain damage. On what basis do you make that
14 statement?
15 A Based upon my clinical observations of him.
16 Q Is there any objective evidence that he has brain
17 damage at all of any degree?
18 A Well, there hopefully will be after neuropsychology
19 testing. You know, when Junior Seau was alive there was no
20 evidence of physical brain damage in him until the brain got
21 sent to the NIH and got chopped up and looked at under the
22 microscope and tau protein was seen all throughout the
23 brain. Not everything that we can evaluate or see in
24 neurology can be assessed in the living patient.
25 And I would equate this type of exposure of these

1 VOCs to -- or analogous to traumatic encephalopathy, chronic
2 traumatic encephalopathy because what you're doing is you're
3 inducing changes biochemically in the brain that will be
4 observable from a pathological standpoint, but you can't
5 observe these things on any type of imaging. You can only
6 observe the symptomatology and the signs of encephalopathy
7 in these patients.
8 And since so many people are wanting objective
9 evidence of problems where there's scant objective evidence,
10 unfortunately at this time neuropsych testing is the best
11 objective measure we have for evaluating patients with
12 encephalopathic conditions.
13 Q And you have not pursued or reviewed any of the
14 diagnostic studies, the CT scans or MRIs of his brain?
15 A That's just, ma'am, not going to show anything.
16 There's no VOC exposed encephalopathic patient who is going
17 to show signs of imaging abnormality on CT or MRI unless
18 it's some type of atrophic process, but that's going to be a
19 lagging indicator and would show up in all likelihood
20 further down the road as you see in patients who have other
21 exposure related neurodegenerative problems.
22 Q So in the case of Mr. Barr, it's crucial that he
23 have the neuropsych testing to determine whether or not he
24 truly does have an encephalic condition -- enceph -- you
25 know what I mean.

1 A Encephalopathic condition.
2 Q Encephalopathic condition or any brain damage. I
3 mean, can you really make that determination without the
4 neuropsych testing?
5 A Yes, ma'am. So I don't view it to be crucial. I
6 feel confident in my ability to make that diagnosis without
7 it; but, you know, we're in a different venue now, and we're
8 in a medical legal arena, and I think people want objective
9 testing so I've ordered it.
10 Q Okay. So you feel certain simply because he says
11 he is forgetful and has headaches, and he's slow?
12 A Well, I've said a number of things. I think
13 overlapping constellation of signs and symptoms and given
14 the fact that I've ruled out other potential causes for his
15 problem based upon the things that I've testified to earlier
16 indicates to a reasonable degree of medical certainty that
17 his problems are related to a VOC exposure of a chronic
18 nature.
19 Q How do you differentiate the exposure to VOCs that
20 he had at Darlington County School District versus the
21 painting he's done in his own private business?
22 A I can't.
23 Q All right. So if he's exposed to VOCs and paint
24 fumes, painting in his own private business both before and
25 after his employment at Darlington County School District,

1 could that potentially be the cause of his current syndrome?
2 MR. MCDANIEL: Object to the form of the
3 question in reference to after his exposure at.
4 There's no. . .
5 MS. BARR: There's no what?
6 MR. MCDANIEL: No evidence that he's worked
7 after he left. After the doctor took him out of
8 work. I only object to the word after.
9 MS. BARR: I mean, he's got that painting
10 truck out in his yard and everything.
11 BY MS. BARR:
12 Q If he's painting in his own private practice, can
13 you differentiate his exposure in his private painting
14 business versus his exposure at the School District?
15 A I'm not an expert in making that determination.
16 I'm sure there's someone that could look at the amount of
17 work that he's done for the School District versus the
18 amount of work that he's done in the private sector and come
19 up with some sort of calculation to approximate that
20 exposure, but I'm not an expert in that regard. So to
21 answer your question, I'm not capable of making that
22 determination.
23 Q If you assume for the sake of this question that
24 Mr. Barr was provided and used a respirator at all times
25 while painting at the Darlington County School District, yet

1 didn't use similar protective equipment while painting in
2 his own private business, would you agree that his exposure
3 to volatile organic compounds would be more significant in
4 his private painting business than it would be when using a
5 respirator at the School District?
6 MR. MCDANIEL: I'm going to object to the form
7 of the question because --
8 MS. BARR: All right. Well, that's all you
9 need to do.
10 MR. MCDANIEL: No.
11 A I don't know the specifications for the respirator,
12 so I can't answer that question. You know, there are things
13 that people wear from Lowe's called respirators that allow
14 VOCs to slip right through. I don't know, I don't know what
15 kind of respirator it was.
16 Q If Mr. Barr testified under oath that he was using
17 a VOC fume filter and a particulate filter in the respirator
18 that he used at all times while painting at Darlington
19 County School District, would you believe him?
20 A No, because he told me that he wasn't.
21 Q Okay. So the history that you've based your
22 opinions on is inconsistent with what I've represented to be
23 his sworn testimony?
24 A That's correct.
25 Q Okay. The dizziness that Mr. Barr has complained

1 to you, is it substantially different in any way than the
2 dizziness he was treated for beginning in 2005?
3 A I don't know anything about the dizziness he was
4 treated for in 2005.
5 Q In determining the possible cause of complaints
6 like dizziness, would a thorough medical history be helpful
7 to you?
8 A Any piece of medical history is potentially
9 helpful.
10 Q If Mr. Barr had dizziness and vertigo -- and these
11 are his family doctor records from 2005 -- starting in 2005,
12 which was approximately four years before his employment
13 began at Darlington County School District, isn't it
14 possible that those symptoms are wholly unrelated to his
15 employment?
16 A It's conceivable, but I don't know, I don't know
17 the nature of his 2005 dizziness. So I could answer that
18 question with some greater certainty if I had the
19 opportunity to review those records.
20 Q And I guess the same would be true for the records
21 of his treatment for headaches prior to his employment at
22 the Darlington County School District?
23 A No, I think his -- whether he had headaches before,
24 I think his headaches are clearly worse now.
25 Q On what basis?

1 A Based upon the history from him and the severity of
2 the headaches. And the fact that he felt that they came on
3 as a result of direct exposure to the fumes, and that he
4 felt sick when he was exposed to the fumes.
5 Q All right. Excuse me, but I believe you testified
6 before that the severity and frequency of his headaches has
7 been stable over time?
8 A Since I was seeing him, yes. I mean, there's
9 little evidence that there's been -- there was a great deal
10 of improvement in his condition. Although when I saw him
11 for the first time in 2015, he said that there had been some
12 improvement while on Topamax, which is why I put him back on
13 Topamax. So I don't mean to represent that there hasn't
14 been any treatment related improvement in his condition, but
15 I just haven't been impressed that we've been able to
16 adequately treat his headaches. And I would attribute that
17 to the fact that he has been unable to, for whatever reason,
18 reliably come to my practice for treatment.
19 Q Were you aware that he had been treating for
20 headaches with other practitioners?
21 A That's right.
22 Q So you're not stating that there's been a change in
23 the frequency or severity of his headaches over the course
24 of his employment with the School District?
25 A No. I think his headaches have been worse as a

1 result of his exposure to the VOCs that thus necessitating
2 the referral to me, you know, by Dr. Chapman in 2012. And
3 it was mentioned from the very start that he felt that his
4 headaches were worse as a result of his exposure to the VOC.
5 That's why the first course of action in terms of treatment
6 was to take him out of the fumes for six weeks.
7 Q And there was no change, correct?
8 A Not at six weeks, no.
9 Q And you haven't seen him since he last worked so
10 you can't know if there's been any change since he left
11 their employ?
12 A I'm not sure the last time, I'm not sure about the
13 last time he worked.
14 Q That's all the questions I have for you, Dr. White.
15 EXAMINATION BY COUNSEL FOR THE CLAIMANT
16 BY MR. MCDANIEL:
17 Q Just a moment. Dr. White, first off, when he came
18 to you, he was working for, for in better terms, in
19 commercial painting in reference to the School District; is
20 that correct, when he first came to treat by you in 2009?
21 MS. BARR: Objection. I don't think the
22 doctor has a foundation to testify.
23 BY MR. MCDANIEL:
24 Q Where was he working as far as you know when he
25 first came to see you?

1 A For the school system.
2 Q All right. And you've looked at the MSDS Sheets
3 from the paints he was exposed to?
4 A Yes, sir.
5 Q And in reference to those, do some of those cause
6 brain damage?
7 A Yes, sir.
8 Q All right. And have you been shown any MSDS Sheets
9 for any household painting he may have done in work prior to
10 the time he went to work full time at the School District?
11 A Not that I recall.
12 Q Okay.
13 A If I have, I haven't delineated between the two.
14 Q So have you been shown any information today that
15 would show whether or not there's any difference between
16 water based paints, and the types of paints that he was
17 using at the School District?
18 A There is a difference.
19 Q Have you been shown any MSDS Sheets of any -- if he
20 was a house -- assume that he was a house painter before he
21 went to work for the School District. Have you been shown
22 any MSDS Sheets from any household type paints, water base
23 paints that were used versus the epoxy type paints that he
24 was using at the School District?
25 A No, sir.

1 Q That would show that they can cause any type of
2 physical brain damage?
3 A No, sir.
4 Q He was employed, according to your knowledge, full
5 time at the School District as a painter. And I would
6 assume -- did he ever tell you that he worked during the
7 summers four tens, and then during the fall eight five or in
8 other words eight fives, eight hours a day, five days.
9 During the summer, four tens; did he tell you that?
10 A No, sir, I was just aware that he was working full
11 time.
12 Q Okay. In reference to the use of the respirator,
13 do you know whether or not he was provided with the
14 particular types of filters on a consistent regular basis;
15 do you have any knowledge of that?
16 A No, sir.
17 Q Basically your knowledge is that he was exposed to
18 VOCs on the job?
19 MS. BARR: Objection. There's no foundation
20 for that.
21 BY MR. MCDANIEL:
22 Q Based on the MSDS Sheets that you've observed,
23 reviewed, and based on your knowledge given to you by your
24 patient that he was a painter for the School District and
25 based on that knowledge, is it your understanding that he

1 was exposed to VOCs, volatile organic compounds, on the job
2 per the use of those MSDS Sheets or those chemicals that he
3 was exposed to -- the paint that he was exposed to on the
4 job?
5 MS. BARR: Objection. There's no foundation
6 for him to answer that question.
7 A Yes.
8 Q Now, --
9 MS. BARR: Calls for speculation.
10 BY MR. MCDANIEL:
11 Q We were hired as his attorney, I'd ask you to
12 assume this to be a fact, on May 29th of 2015. You actually
13 wrote him out of work due to -- and told him not to be
14 exposed on May 21st; is that correct?
15 A That's correct.
16 Q And you had discussions with him about this in
17 April; is that correct?
18 A Yes.
19 Q And I believe he had -- after your discussion with
20 him in April is when he went to his district, and they
21 discussed that he had to get out of the chemicals, out of
22 the paints; is that right; is that your understanding?
23 A That's my understanding.
24 Q And then that's why you gave him -- you gave him
25 two statements on May 21st. One taking him out of work, and

1 one saying that his problems, memory loss, fatigue were all
2 due to his exposure to VOCs in your opinion?
3 A Yes.
4 Q So do you have -- have you heard anything today,
5 Counsel at one point used the term for purposes of
6 litigation. Had he ever had an attorney, or was there any
7 intent in litigation from the time that he first came to see
8 you and until May 21st when you wrote him out of work, did
9 he have a lawyer; was he anticipating any litigation?
10 A Not that I knew of.
11 Q Do you know whether or not --
12 MS. BARR: Emails here that were provided.
13 BY MR. MCDANIEL:
14 Q Let me ask you this: Did he -- did you have
15 discussions with him as to -- when this became -- I believe
16 you described his condition as a lot worse in April of 2015;
17 is that right?
18 A Yes.
19 Q And that's when you really made the decision that
20 this is where his problem is coming from. It was actually
21 the cause of his problem; is that correct?
22 A Yes, sir.
23 Q Now, did you have discussions with him at that time
24 or do you remember whether or not you had any discussions
25 with whether or not he needed to contact somebody about

1 this; do you know; do you remember?
2 A I thought I told him he needed to talk to his
3 employer about it.
4 Q All right. I mainly want to clear up -- I got no
5 problem with that, all right. Now, let's go back. I want
6 to clarify a few of your records. If you would flip back to
7 the record of -- one of your first office visits. As a
8 matter of fact, even on October 17, 2012 and then under
9 November 28, 2012. In reference to extremities, is that,
10 under extremities, is that LLE, left lower extremity?
11 A No, that's without cyanosis, clubbing, or edema.
12 Q Oh, okay. All right. Thank you for clearing up
13 the reading. Look at your, if you would, look at your, just
14 very briefly I'd like you to look at your report in
15 reference to your findings and observations in reference to
16 November 2012, January 16th of 2012, as compared to your
17 findings on May 21st, 2015. I see you're reporting -- I
18 don't see any specific record of where you found it
19 appropriate to note back in January or November to record
20 fatigue and memory loss as part of your examination.
21 A I didn't.
22 Q Okay. Also under --
23 A The only thing that I recorded in January 2013
24 would have been the anxiety.
25 Q So and then in reference to, again, May 21st, you

1 found it to note that, made a specific notation of flat
2 affect and also slow processing speed?
3 A That's correct.
4 Q Did you make any such notation in reference to
5 January of 2013 and 2012?
6 A No, sir.
7 Q If those would have been -- why did you make those
8 on May 21st of 2015 and also back in April, why did you make
9 those then as compared to 2012, those specific findings?
10 A Because they were there.
11 Q Were they prominent, I mean, were they more
12 prominent?
13 A Far more prominent. I think I've already mentioned
14 that.
15 Q I believe you had too. I just wanted to clarify
16 that just to make in specific reference to those various
17 things. And so you followed this man. You saw him back in
18 2012, and then you saw him and you continued to see him, but
19 then you literally saw him in January 2013 and then again in
20 2015. His condition in your words was it much worse in 2015
21 than it was in 2012 and 2013?
22 A Yes.
23 Q Now, pretty much the type of damage to the brain
24 that we're talking about, just for the Commissioner's
25 understanding, are we talking about something like a

1 subdural hematoma that's observable on MRI or something. At
2 what level is this damage being done?
3 A You're talking about loss of cells due to toxicity.
4 So it's a cellular fall out and gradual loss of proper
5 connections and number of neurons. So it's a toxic
6 exposure, and it's a diffuse toxic exposure.
7 Q Is this much like, for example, if somebody is
8 exposed to lead encephalopathy or some type of -- I'm really
9 familiar with lead encephalopathy. So, in other words, an
10 MRI is not just going to show that up. This cellular
11 damage, it's not going to show that type of damage up, is
12 it?
13 A No, sir.
14 Q And there really, for example, if those heavy
15 metals chelate out, there's very little to show them other
16 than -- except if you do, as you referred to earlier, if you
17 do a biopsy of the brain. So we can't literally do a biopsy
18 of the brain while the person is living, can you?
19 A No, sir.
20 Q Back in 2012 you did have the benefit of reviewing,
21 I believe, some negative test results that had been done by
22 Dr. Skinner. I'm referring to these are the records you
23 provided Counsel, and you provided me a copy of.
24 A Okay.
25 Q I think, am I correct in reading those, that

1 they're negative, basically negative?
2 A This isn't really looking at his brain. It's a CT
3 angiography looking at the circulatory system.
4 Q Okay.
5 A So, yeah, it just says that the circulation of the
6 brain appears to be normal.
7 Q So the test result -- going back again.
8 A There's a lumbar puncture in here where they would
9 get spinal fluid, which is found to be normal. There's a CT
10 scan of the sinuses, which show minimal chronic sinus
11 disease and no acute infection. And I don't see any other
12 specific imaging of his brain.
13 Q Okay.
14 A At least in that general area of the chart that
15 you've handed to me.
16 Q Okay. All right. Do you know if you were made
17 aware, Counsel referred to several orthopedists. Do you
18 know if you were aware that he had surgery on the knee at
19 one point in time, then had surgery again in like 2013?
20 A I was. . .
21 Q He had a right knee scope on April 23rd of 2013.
22 A Okay. That was made clear to me; that he had knee
23 surgery when he came in to see me in 2015. But obviously
24 not in 2012 because he hadn't had it yet so. He indicated
25 in his surgical history that he had surgery -- hand surgery

1 times two in 2012 and a right knee surgery in 2003.
2 Q And I believe in reference to the two hand
3 surgeries in 2012, it was in the right hand and arm that you
4 found some problems that you said were probably not related
5 to his encephalopathy?
6 A Correct.
7 (Pause in the proceedings.)
8 Q I'm just about through. Doctor, according to my
9 client, Mr. Barr, Mr. Barr said that he did not use a
10 respirator outside when he was painting anywhere outside,
11 outside a closed classroom. He also said that he used a
12 respirator when he was inside the classroom painting. And
13 also he said that there were two types of respirators
14 involved. In other words, a particulate and/or fumes.
15 Do you know whether or not those respirators --
16 first off, we haven't given you a specific type that he was
17 using. I see no testimony -- well, there is some testimony
18 about one of the types he used. But do you know whether or
19 not those are supposed to completely irradicate the intake
20 of fumes or if they are simply supposed to cut down on the
21 exposure levels?
22 A I'm not an expert in respiratory or respirator
23 technology.
24 Q And out of everything you've heard here today and
25 your knowledge of the MSDS Sheets and what his job was, is

1 it still your opinion that his exposure to volatile organic
2 compounds in the work place as a painter for the School
3 District is the cause of his problems?
4 A Yes.
5 Q Okay. Nothing further.
6 RE-EXAMINATION BY COUNSEL FOR THE EMPLOYER
7 BY MS. BARR:
8 Q I promise I'll be brief. Back to that 4/23/15,
9 which was the first time he had seen you after the absence.
10 A Yes, ma'am.
11 Q And y'all kind of went through the more detailed
12 history, and I think that presenting complaint, would that
13 be on the first page, the first page that has the review of
14 symptoms to check off, is this something that Mr. Barr would
15 have completed or?
16 A Yes, ma'am.
17 Q Anywhere on this form or in the other documents
18 that were produced as a result of the April 23rd, 2015
19 appointment that mentioned any complaint about paint or
20 fumes or VOCs?
21 A That's probably a rhetorical question. Not that I
22 see.
23 Q Well, I just wanted to make sure that there wasn't.
24 We weren't missing a page or we misinterpreted your
25 handwriting. But it doesn't appear that was a discussion

1 that y'all had April 23rd of 2015?
2 A No, ma'am.
3 Q And, again, maybe rhetorical. It does not appear
4 that you restricted him from work or restricted his
5 exposures in any way at that 4/23/15 appointment?
6 A That's correct.
7 Q Okay. So when he came back to you this second
8 round in 2015, the first work excuse would have been that
9 May 21st of 2015?
10 A Yes, ma'am.
11 Q And then just, again just some clarification. This
12 was part of the records that we got from you, and I might
13 just mark this as Defendant's Exhibit 1.
14 **(Exhibit No. 1, Email dated May 12, 2015**
15 **was marked for identification)**
16 Q Who is -- and you might not know. Who is Jennifer
17 Amram?
18 A That was my -- that's my estranged wife.
19 Q Okay. And John Myers is part of your practice?
20 A He's our office administrator.
21 Q Okay. So they both would be copied on emails
22 potentially as a part of your practice; is that how this
23 email?
24 A They would have received them.
25 Q All right. So we've marked this as 1. This is an

1 email --

2 MR. MCDANIEL: Got no objection.

3 MS. BARR: Thanks, Preston.

4 BY MS. BARR:

5 Q From Anna Barr on May 12 of 2015. I'll just give

6 you a chance to look at that. You've had a chance to review

7 this email. But this email that we've marked as Defendant's

8 Exhibit 1, does that indicate an inclination on the part of

9 the Barrs to potentially pursue litigation for VOC exposure?

10 A This is from Anna Barr?

11 Q Yes.

12 A Is that your wife?

13 MR. MCDANIEL: No, that's his wife.

14 Q Kenny's wife.

15 A Oh, oh, wait a minute.

16 Q I know there's too many Barrs.

17 A All right. Anna Barr, I'm sorry.

18 Q Sorry.

19 A Just talked to Gretta at the lawyers office and she

20 said that since they are not representing us. Email you --

21 MR. MCDANIEL: No objection. The document

22 speaks for itself. That they contacted my

23 co-counsel, Gerald Malloy's office at that time.

24 A That's what it seemed to indicate.

25 Q So it was after that email on May 21st, 2015, that

1 you indicated the possibility of his symptoms being related
2 to volatile organic compounds and restricted him?
3 A That looks like a record, that looks like a record
4 request. So emails like that don't come to my attention.
5 Q But this was part of his medical file if it came to
6 me?
7 A Could have been, yes.
8 Q All right. That's all I have. Thank you.
9 (The deposition concluded at 4:20 p.m.,
10 and the deponent waived signature.)
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1 STATE OF SOUTH CAROLINA)
2 COUNTY OF CHARLESTON) : C-E-R-T-I-F-I-C-A-T-E
3 I, Cheryl Foults Milligan, Notary Public, certify
4 that I did have MARSHALL ALLYN WHITE, M.D. to appear before
5 me at 2:30 o'clock, p.m. on Monday, November the 23rd, 2015,
6 in the Law Offices of Trask & Howell, LLC, 763 Johnnie Dodds
7 Boulevard, Mt. Pleasant, South Carolina; that the witness
8 was duly sworn and cautioned to tell the truth, the whole
9 truth and nothing but the truth; that the foregoing pages
10 constitute a true and accurate transcript of his testimony
11 given at that time and place.
12 I further certify that I am not of counsel or
13 kin to any of the parties to this cause of action, nor am I
14 interested in any manner in its outcome.
15 IN WITNESS WHEREOF I have hereunto set my
16 hand and seal this the 3rd day of December, 2015.
17
18
19
20
21 Notary Public for South Carolina.
22 My Commission Expires July 9, 2017.
23
24
25

Before the South Carolina
Workers' Compensation Commission

Kenneth L. Barr,
Employee,
Claimant,

Vs. WCC File # 1507304

Darlington County School District,
Employer,
and
SC Boards Insurance Trust,
Carrier,
Defendants.

Deposition of: Roland L. Skinner, III, M.D.

Location: 800 West Cheves Street, Suite 300
Florence, South Carolina

Date: Thursday, December 10, 2015

Time: 3:05 p.m. - 4:44 p.m.

Court Reporter: Roger Williamson

The deposition is taken pursuant to notice and/or agreement, in the above-entitled cause pending in the above-named court and pursuant to the South Carolina rules of civil procedure.

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11 I N D E X

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Further Examination by Mr. McDaniel 76
14 Further Examination by Ms. Barr 77
15

E X H I B I T S

16

Claimant's

17 Pg/Ln	Ex.	Description
45/20	1	Material Data Safety Sheet
18 47/13	2	Material Data Safety Sheet
48/8	3	Material Data Safety Sheet
19 49/4	4	Material Data Safety Sheet
49/19	5	Material Data Safety Sheet

20
21
22
23
24
** Uh-huh = Affirmative
25 Huh-uh = Negative

1 S T I P U L A T I O N S

2 It is stipulated between Counsel that
3 this deposition is being taken pursuant to the
4 South Carolina rules of civil procedure; and that
5 all objections, except as to the form of the
6 question, are reserved until the time of trial.
7 It is also stipulated between Counsel for the
8 respective parties and the deponent that the
9 deponent will waive the right to read and sign this
10 transcript.
11 Thereupon,
12 Roland L. Skinner, III, M.D.,
13 being first duly sworn by the Court Reporter, as
14 hereinafter certified, testified as follows:
15 E X A M I N A T I O N
16 BY MS. BARR:
17 Q Good afternoon, Dr. Skinner. My name
18 is Kirsten Barr and I represent the Darlington
19 County School District in a workers' compensation
20 claim that Mr. Kenneth Barr has filed. And
21 because his current claim is for symptoms that are
22 similar to those you had treated in the past I
23 just wanted to ask you some questions about your
24 evaluation and treatment and opinions that you had
25 given during your treatment of -- of Mr. Barr. If

1 you would, could you give us a brief overview of
2 your medical education and training before we get
3 started?
4 A Sure. I -- I went to Clemson
5 University. I graduated in '75 with a degree in
6 psychology and went to medical school in '76,
7 graduated in '80 with a medical degree. And I did
8 a year of internship in internal medicine also in
9 Charleston and then a three -- a three year
10 residency in neurology at -- at the Medical
11 University as well. I then went to Knoxville,
12 Tennessee where I practiced for three years in
13 private practice and then returned to Florence and
14 I have been in Florence since 1987.
15 Q Okay. And it was in the context of
16 your private neurology practice that you first
17 came to see Mr. Kenneth Barr?
18 A Yes.
19 Q All right. From the records that
20 y'all were kind enough to provide it looks like
21 your -- your first encounter with Mr. Barr would
22 have been September 23rd of 2010. Does that
23 appear right based on your records?
24 A September 23rd of 2010 is the first.
25 Q Okay. What were his presenting

1 complaints to you at that time?
2 A Primarily headache, but he also had
3 some dizziness. And he gave me a history that he
4 had, had rather constant or regular headaches for
5 a period of about five weeks at that time.
6 Q Okay. And -- and did he give you any
7 more descriptors as far as his headaches or
8 associated symptoms that -- that were significant
9 to you?
10 A He did. He said that he had some
11 nausea with the headache. He also said that if he
12 -- if he looked downward he would feel kind of off
13 balance and had dizziness with that. The headache
14 was described as squeezing like someone was
15 squeezing his head. Along with that he had some
16 trouble concentrating. He was experiencing some
17 fatigue and a loss of interest in activities that
18 he had previously found pleasurable. He said that
19 he had some trouble with work, but he -- he wasn't
20 really specific about that. He denied feeling
21 depressed, but he was taking anti-depressant
22 medications at that time.
23 Q Did he give you any -- well, first,
24 did -- was he accompanied by any medical records,
25 to your knowledge, when you first evaluate him? I

1 think he was sent by his personal physician,
2 Dr. Chapman?
3 A Yes.
4 Q Okay.
5 A There were some office notes from
6 Dr. Chapman.
7 Q Okay. Did he give you either from the
8 office notes or from the history you obtained from
9 Mr. Barr himself, did you -- were you aware of his
10 ongoing problems with vertigo when the anxiety and
11 the medications he had been prescribed in the
12 years prior to him presenting to your practice?
13 A He did give me a history of -- there
14 was a history of anxiety that was chronic, yes.
15 Q Okay. And he was taking a number of
16 medications including some for that anxiety. Is
17 that right?
18 A Yes.
19 Q Okay. You -- and you list them there.
20 The Biaxin, was that for sinus problems or ---
21 A It's an antibiotic, I believe.
22 Q Okay. And the Loratadine?
23 A That is antihistamine usually used for
24 allergy problems.
25 Q Okay. And then he also indicated

1 taking the Aspirin and Celexa?
2 A Yes.
3 Q Okay. And those were being
4 prescribed, I assume by Dr. Chapman, to your
5 knowledge?
6 A Yes.
7 Q Okay. Looks like you did a medical
8 review of symptoms on page two of your September
9 23rd, 2010 report. And he noted that he had
10 rhinitis and seasonal allergy symptoms. Is that
11 right?
12 A Yes.
13 Q Why might that be significant in the
14 context of a patient presenting with headache
15 complaints?
16 A I wouldn't consider it that, that
17 significant. I don't believe in sinus headaches,
18 so I wouldn't have considered -- I would have
19 considered that a separate issue.
20 Q Okay. So, what -- what sort of things
21 -- well, next thing on your social history you
22 noted, he was a chronic smoker. Could that be a
23 differential in your workup of his headache
24 symptoms?
25 A I -- I mean, I think it -- it would be

1 very non-specific. And nicotine use has been said
2 to make headaches worse and also to make them
3 better. So --
4 Q Okay.
5 A -- so -- so, I mean...
6 Q Okay. Well, so, you did a physical
7 examination after interviewing, I assume?
8 A Yes.
9 Q And anything significant or your
10 physical or neurological examination that day?
11 A No. His -- his examination really was
12 pretty normal.
13 Q Okay. So, any -- any subjective
14 evidence, any sort of deficit on your physical or
15 neurological evaluation?
16 A No.
17 Q Okay. It looks like you also reviewed
18 an M.R.I. of his brain?
19 A Yes.
20 Q All right. Anything significant in
21 your mind about that brain M.R.I.?
22 A Well, he did have some -- some mucal
23 inflammatory change in his sinuses, which might or
24 might not have been significant as far as the
25 sinus -- reported sinus problems. He had some

1 areas of what we call increased T2 signal in his
2 frontal white matter. These appear to be very
3 non-specific. And there wasn't anything obvious
4 about his presentation that really correlated with
5 -- with those findings.
6 Q Okay. With the -- I mean, did you
7 just -- was there any reason to -- to -- to look
8 into those, the increased T2 signal findings
9 further or did it become relevant in your
10 evaluation at any point?
11 A Well, eventually we sort of did in
12 that we decided to because -- because he wasn't
13 responded to treatments that we initiated on his
14 initial visit and subsequent visits we decided to
15 pursue that by doing a spinal tap. And we did
16 several tests on his spinal fluid sort of to -- to
17 try to assess the significance of that in -- in
18 the context of his headaches. And those tests, as
19 I recall, were unrevealing of anything.
20 Q Okay.
21 A Any significant abnormality.
22 Q So, after your initial evaluation and
23 review of that M.R.I. scan in September of 2010,
24 what -- what was your impression with regard to
25 Mr. Barr's complaints of headaches?

1 A I thought that they sounded like
2 tension type headaches. The character of the
3 headache, the character of the pain or discomfort
4 itself, and the -- the lack of other associated
5 symptoms with it suggested to me that they were
6 tension type headaches.
7 Q Is there -- to rule in or out that
8 diagnosis of -- of the tension headaches or that
9 -- or the characterization of the headaches as
10 being tension type, was there any further workup
11 that you needed to do or is there anything
12 objectively that you test or is it based on your
13 knowledge and experience and --
14 A It -- it's really --
15 Q -- evaluation?
16 A -- based on the description of the --
17 of the pain and the lack of other findings on
18 examination that might suggest some other sort of
19 intracranial abnormality, and the lack of other
20 symptoms that would push it towards a diagnosis of
21 migraine.
22 Q Okay. So, is that really the
23 differential then, tension versus migraine
24 headaches?
25 A Versus intracranial pathology like a

1 brain tumor or something like that. But that had
2 pretty much already been ruled out --
3 Q Okay.
4 A -- by the scan that he had.
5 Q Okay. And is there any way then to
6 rule out the migraine potential?
7 A No, there are particular clinical
8 criteria for diagnosing migraine. The headaches
9 generally have to be more commonly on one side or
10 beginning on one side more commonly associated
11 with a combination of nausea, vomiting,
12 sensitivity to light and sensitivity to noise.
13 There have to be -- and relieved by rest or sleep.
14 There have to be at least three of those things in
15 there to make a diagnosis of migraine.
16 Q All right.
17 A And he didn't have -- he had a little
18 bit of nausea with his headaches, but otherwise
19 really didn't have other symptoms that would
20 suggest that they were migraines.
21 Q Okay. So, from a neurological
22 perspective any -- you've ruled out a migraine as
23 the source of his headaches?
24 A We did. We -- we were concerned about
25 the sort of new onset of the headaches and the

1 fact that they were -- he had all of a sudden
2 started to have headaches he had not really had
3 problems with before. And I think because of that
4 and because of these little T2 abnormalities on
5 the M.R.I. we did some intracranial vascular
6 imaging at that time and -- and found that he had
7 a very small aneurism. We eventually had him
8 evaluated by neurosurgery and they felt like the
9 aneurism was very small and probably asymptomatic
10 and did not require anything, but sort of routine
11 serial follow-up at that time.
12 Q Okay. And so you ruled out this
13 aneurism as being a source of his somatic
14 complaints?
15 A I did not feel that -- that it was
16 related.
17 Q Okay. Did the brain imaging you did,
18 whether the -- the vascular imaging, the M.R.I.,
19 the lumbar functioning, those other testing you
20 did, did anything reveal -- any of those tests
21 reveal any objective evidence or findings that
22 could explain his symptomatology?
23 A No.
24 Q Okay. And with the tension headaches,
25 how do you go about treating those? It looks like

1 you recommended Nortriptyline. Is that right?
2 A Yes.
3 Q Okay.
4 A It's for patients who have very
5 frequent tension type headaches. We usually will
6 put them on something to try to decrease the
7 frequency and severity of their headache. And
8 Nortriptyline is one of a group of medications
9 called tricyclic anti-depressants. They're also
10 called tricyclic analgesic anti-depressants. And
11 they are very commonly used to treat tension
12 headaches.
13 Q Okay. So, he returns to you on
14 December 20th of 2010 and it looks like perhaps he
15 didn't continue on the Nortriptyline. Is that
16 right?
17 A Yeah, he -- he had stopped it already
18 or he had -- he had run out of it. It hadn't
19 provided immediately relief and he had stopped.
20 He had not refilled the --
21 Q Okay.
22 A -- prescription.
23 Q So, I guess at that point, at that
24 December 20, 2010, appointment you couldn't really
25 assess the efficacy of the Nortriptyline?

1 A I -- yeah, I believe I did not think I
2 -- he -- he had given it a sufficient trial to
3 know whether it was going to be effective.
4 Q Okay. Anything different in his
5 presenting complaints or either his physical or
6 neurological evaluation at that December 20th,
7 2010 appointment?
8 A No.
9 Q Okay. It looks like perhaps his
10 family physician had changed some of his
11 medications. It looks like Celexa to Zoloft and
12 then adding Nucynta?
13 A Yes.
14 Q All right. What is the Nucynta?
15 A It's a narcotic analgesic.
16 Q Do you know why that was being
17 prescribed?
18 A I think just as a pain medicine.
19 Q Okay. Anything about his presentation
20 or any other new evidence when you saw him on
21 December 20, 2010, that changed your opinion that
22 his headaches were a tension type headache?
23 A No.
24 Q Okay. So, it looks like you placed
25 him back on Nortriptyline and gave him some

1 counseling about the Nucynta. Is that right?
2 A Yes.
3 Q What were your concerns about the
4 Nucynta?
5 A Well, the narcotics are habit forming.
6 And generally we feel they are to be avoided in
7 patients with chronic and particularly very
8 frequent headaches. We try to -- we try to avoid
9 their use.
10 Q Do you avoid their use to avoid
11 dependency issues or their other potential
12 problems?
13 A Well, both that and the fact that very
14 frequent use of any sort of short acting analgesic
15 a lot of times leads to what we call analgesic
16 rebound, which actually makes the headache worse
17 and also has a negative effect on the ability of
18 the medication we're trying to use for prophylaxis
19 to be effective.
20 Q All right. So, taking the Nucynta
21 would have affected the efficacy of the
22 Nortriptyline you believe?
23 A It could have.
24 Q Okay. And help us understand
25 analgesic rebound a little bit. I know it's

1 mentioned in some of your notes, but what -- what
2 is that?
3 A Well, what's been found is that people
4 who take -- who have headaches who take analgesics
5 on a frequent enough basis, usually on a daily
6 basis develop actual worsening or increase in the
7 frequency of their headaches such that they get
8 temporary relief from the analgesic, but as it
9 wears off the headache always comes back and
10 actually becomes more frequent, progressively more
11 frequent. And that phenomenon is called analgesic
12 rebound.
13 Q Okay. And to avoid that what -- what
14 sort of frequency, if any, would you recommend
15 something like Nucynta or another narcotic?
16 A Well, I -- I would probably recommend
17 against using narcotics at all --
18 Q Okay.
19 A -- for headache.
20 Q Okay.
21 A Except in extreme situations. But we
22 would want it to be used as infrequently as
23 possible, hopefully not on a daily basis and --
24 and really hopefully on no more than maybe a
25 couple of times a week at the most, if -- if

1 absolutely necessary.
2 Q Okay. Looks like Mr. Barr came back
3 to February 22nd of 2011 and he was still using
4 the Nucynta. Is that right?
5 A Yes.
6 Q All right. Looks like he was also
7 taking the Nortriptyline. Was that beneficial, in
8 your opinion?
9 A He reported some improvement, but he
10 was still having symptoms and also reported that
11 he was -- sometimes felt confused and disoriented,
12 sort of absent minded.
13 Q All right. Could the -- the use of
14 narcotics like Nucynta, could that lead to
15 symptoms of confusion or disorientation?
16 A I really wouldn't expect it to. It
17 would -- it would depend on how often he was using
18 it, I guess. But if he was using it according to,
19 you know, the way his physician had likely
20 prescribed it, I -- I really wouldn't expect him
21 to have those symptoms from --
22 Q Okay.
23 A -- Nucynta.
24 Q Okay. Did you have any explanation or
25 feel like additional workup was -- was needed for

1 those subjective complaints of confusion and
2 disorientation?
3 A Well, I -- I still felt that -- that
4 this was probably tension type headaches. And I
5 -- I thought that perhaps he was experiencing some
6 depression. He was very focused on somatic things
7 and even asked me if he -- if I thought he had a
8 tumor in his spinal cord. And -- but I felt like
9 because he was having all of these other symptoms
10 that perhaps we should consider having him have a
11 spinal tap.
12 Q Okay. And that eventually came back
13 as unrevealing?
14 A Right.
15 Q Okay. Any other recommendations that
16 you made for him?
17 A We did some blood work to -- to rule
18 out connective disease or thyroid disease. So, a
19 screening test for that.
20 Q Okay.
21 A And they were -- they were negative.
22 Q All right. Now, it looks like in
23 addition to continuing on the Nucynta he reported
24 that he was also taking Aspirin. Did you counsel
25 him again about the concerns of analgesic rebound

1 and the narcotics use?
2 A Well, we talked to him about nar---
3 about analgesic rebound in general because he was
4 taking a lot of things. I mean, he was taking
5 Goody powders. He was taking Aspirin. He was
6 taking Tylenol. He was taking Ibuprofen, Aleve.
7 And he was just taking a whole lot of short acting
8 analgesic medications and we had concerns about
9 that. That might be causing his headaches to be
10 continuing.
11 Q Okay. All right. Anything about his
12 presentation or the information you had as of
13 February 22nd, 2011, that caused you any doubt on
14 your assessment as this being a tension type
15 headache?
16 A I -- I felt like that was the most
17 likely diagnosis at the --
18 Q Okay.
19 A -- time.
20 Q Okay. Then we -- the next note I have
21 is May 18 of 2011. Is that right?
22 A Yeah, of May 18?
23 Q Yes.
24 A Yes.
25 Q Okay. Any change in his presenting

1 complaints at that time?
2 A He felt like he was perhaps doing a
3 little bit better. But his headaches weren't --
4 still weren't resolved completely.
5 Q Okay. It looks like his medications
6 had changed somewhat?
7 A Yes. He was taking Tramadol and his
8 Nortriptyline, we had I guess increased his
9 Nortriptyline up to 100 milligrams a day.
10 Q Okay. The Tramadol, would the concern
11 with Tramadol be any different than the concerns
12 you had with Nucynta as far as rebound or -- or
13 chronicity?
14 A There would be some concern with that.
15 It would depend. But sometimes Tramadol has a
16 little bit of a different mode of action in that
17 it sort of acts very similarly to serotonin
18 stimulating drugs or serotonin reuptake inhibitor
19 medications and -- but also has sort of a -- a
20 mild activity at the same receptor sites, what are
21 called new receptors in the brain that are where
22 Morphine acts and other narcotic analgesics act.
23 So, it -- it had sort of -- it sometimes is used
24 for chronic pain even though it's a relatively
25 short acting drug, rightly or wrongly. It -- it

1 probably also can cause some analgesic rebound.
2 Q Okay. Is -- is that dosage of
3 Tramadol, the 50 to 100 milligrams three times a
4 day, would there be side effects that you should
5 be concerned about that may impact say your
6 ability to work or operate -- drive a car --
7 A I wouldn't --
8 Q -- or anything?
9 A I would not expect so. I --
10 generally, Tramadol is a fairly benign medication
11 as far as its side effect profile. It usually
12 works or it doesn't, but it doesn't really cause
13 us a lot of problems most of the time.
14 Q Could it potentially cause problems
15 when interacting with other medications though?
16 A It can cause what's called serotonin
17 syndrome, but there was not any evidence of that
18 in his case.
19 Q Okay.
20 A And in that dosing I would not expect
21 it to cause it.
22 Q Okay. Any objective abnormalities on
23 his physical or neurological evaluation in May of
24 2011?
25 A No.

1 Q Okay. And, again, it appears from
2 page two of that report it was still your belief
3 that his headaches are primarily tension type
4 headaches?
5 A Yes.
6 Q Okay. The next note I have was August
7 18th of 2011. Any changes, presenting complaints
8 between May and November of 2011 -- or May and
9 August of 2011?
10 A Well, he was still having headaches
11 daily. And he was still taking a lot of
12 over-the-counter analgesic medications. He didn't
13 really have any other new symptoms that he
14 expressed to me at that time.
15 Q Okay. Again, any change on the
16 physical or neurological examination to reveal any
17 objective abnormalities?
18 A No.
19 Q Anything about your evaluation on
20 August 18, 2011, that -- that caused you any doubt
21 in your opinion that these were tension type
22 headaches?
23 A I still felt like that was the most
24 likely diagnosis. Although because he was having
25 the headaches on a chronic daily basis we decided

1 to try treating him with some Depakote seeing if
2 that would help with the Nortriptyline. The
3 Nortriptyline didn't seem to be working. I felt
4 like we needed to add something else to it.
5 Q And so what is the Depakote hoping to
6 do or what do you hope the Depakote to do?
7 A We were hoping that it would decrease
8 the frequency of his headaches.
9 Q Okay. What type of medication is
10 Depakote?
11 A Depakote is a -- is a -- a medicine
12 that is used most commonly for migraine and for
13 cluster headaches. We've sometimes used it in
14 patients who had chronic daily headaches.
15 Q All right. So, you add Depakote and
16 he followed up it looks like November 15th of
17 2011. At that time did he report any improvement
18 in his symptoms with the Depakote added to his
19 regimen?
20 A He still was having headaches
21 everyday. And he noted then that changes in the
22 temperature or changes in barometric pressure and
23 certain smells would make his headaches worse.
24 Didn't really elaborate what smells those were,
25 but certain odors could -- or at least I didn't

1 document that he elaborated on what smells and I
2 don't remember now.
3 Q Okay. Did you feel like the Depakote
4 had been beneficial at all?
5 A I wasn't really sure whether it had
6 been very helpful or not.
7 Q Okay.
8 A I thought there was still -- there was
9 complicating use of a lot of analgesic
10 medications.
11 Q Okay. He reported that he was taking
12 Goody powders -- three Goody powders daily about
13 four days a week?
14 A Yeah.
15 Q Okay. Could that alone trigger
16 rebound headaches?
17 A Yes.
18 Q Okay. And then in addition to that he
19 was taking the Tylenol and Aspirin and Ibuprofen
20 and Aleve?
21 A Right.
22 Q So, all -- could all of those
23 medications --
24 A I don't know --
25 Q -- potentially --

1 A -- that he was taking all of those
2 everyday. But he was taking those at some point
3 for -- to try to relieve himself of the pain that
4 he was having.
5 Q A significant enough use of analgesics
6 that you were concerned for rebound as late as
7 November 15th of 2011?
8 A Yes.
9 Q Okay. It looks like you recommended
10 that he try some additional medications or
11 different medications when you saw him November
12 15th, 2011?
13 A Right.
14 Q And what did you -- what did you add
15 at that point?
16 A We put him on Nabumetone, which is a
17 non steroidal anti-inflammatory analgesic
18 medication that's in the same class as Aleve and
19 is a long acting medication. And we also decided
20 to try him on some Gabapentin.
21 Q Okay. And what kind of medication is
22 Gabapentin?
23 A It's -- it's a medicine that's used
24 for a lot of different types of pain problems.
25 And it's used sometimes in both muscle tension

1 headaches and migraine headaches. It's sort of an
2 off label use for it, but it's used for a good
3 many pain type problems including fibromyalgia and
4 other --
5 Q Okay.
6 A -- pain problems.
7 Q At one point you even indicated that
8 fibromyalgia could be part of his problem perhaps?
9 A I thought that it was possible
10 although I'm not really an expert on fibromyalgia.
11 Q Okay. And when you saw him on that
12 date, November 15th of 2011, what was then your
13 impression as to the type of headache he was
14 describing or the type of headaches --
15 A I -- I still thought that there --
16 that analgesic rebound was possibly playing a part
17 in -- in his headache, in causing his headaches to
18 be continuing without improvement.
19 Q Okay. Did you -- what was your
20 opinion on the -- the migraine versus tension type
21 category?
22 A I -- I don't -- I don't think I really
23 said. But I still -- I think all along I felt
24 like tension type headache was still the most
25 likely.

1 Q Okay. Does that remain your opinion
2 having revisited the records today?
3 A Well, I think at the time that I
4 treated him that was -- that was the working --
5 MR. MCDANIEL: Object to the form.
6 THE DEPONENT: -- diagnosis.
7 BY MS. BARR:
8 Q That was ca--- tension type headaches
9 was what --
10 A That was the working diagnosis at the
11 time, yes.
12 Q Okay. And do you stand by that
13 opinion as of the time you last -- as you
14 revisited your records, I mean, that's your
15 opinion that his condition --
16 A Well, that --
17 Q -- was at that --
18 A -- was --
19 Q -- time?
20 A -- my -- that was my opinion at the
21 time.
22 Q Okay. All right. And do you have any
23 reason to doubt that opinion or --
24 A Not based on my knowledge of his case
25 at the time.