No. 325784

COURT OF APPEALS, DIVISION III

OF THE STATE OF WASHINGTON

DIANE CHRISTIAN and CASEY CHRISTIAN, ***Appellants,***

v.

ANTOINE TOHMEH, M.D. and MIRNA TOHMEH; and ORTHOPAEDIC SPECIALTY CLINIC OF SPOKANE, et al.,
Respondents.

APPELLANT'S AMENDED APPEAL BRIEF

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I. INTRODUCTION

This matter consists of: 1) a medical negligence\loss of chance claim arising from orthopedic surgeon Dr. Antoine Tohmeh's post surgical/hospital in-patient care and treatment of his patient, Diane Christian; and 2) an intentional infliction of emotional distress claim due to Tohmeh's acts, omissions, and misrepresentations in consultation, communication, diagnosis, and treatment of the Ms. Christian's new, post surgical symptoms and conditions.

The Christians allege that Dr. Tohmeh, breached the applicable standard of care in failing to act on new neurological deficits which began to be symptomatic almost immediately after surgery. These symptoms were progressive during Ms. Christian's 4 days of post surgical hospitalization, leaving Ms. Christian with permanent severe neurological injury and deficits. These include, but are not limited to: loss of natural ability to urinate and defecate (bladder and stool retention); lower extremity pain, tingling, and numbness and weakness (primarily left leg and foot); perianal (saddle area) numbness/loss of sensation; and vaginal numbness/loss of sensation. The Christians' expert medical testimony addresses a the degree and nature of physical injury, and states that Dr. Tohmeh breached the standard of care in failing to timely and appropriately act on the new symptoms, causing Diane Christian a 40 percent loss of chance of a better outcome.

The record also provides evidence which Appellants believe firmly supports a claim of an intentional infliction of emotional distress against Dr. Tohmeh. Further, that this evidence allows for a reasonable conclusion that Dr. Tohmeh: attempted to dissuade the Christians from believing Mrs. Christian had neurological symptoms or deficits; attempted to dissuade Mrs. Christian from seeking appropriate and indicated medical diagnosis, care , and treatment; misrepresented the medical record contents, conclusions, and findings of other medical providers Dr. Tohmeh referred Ms. Christian to; attempted to cause the Christians to believe Ms. Christian's neurological symptoms and deficits were psychosomatic in nature, and due to obesity, lethargy, and lack of effort at rehabilitation; verbally abused and berated Ms. Christian in the presence of Mr. Christian; and made an effort to dissuade Mrs. Christian's subsequent medical provider, a physiatrist, from diagnosis and treatment of Ms. Christian's surgery related neurological deficits and injuries.

Procedurally, Dr. Tohmeh moved the trial court for a partial summary judgment on the loss of chance claim. However, the trial court, sua sponte, granted complete summary judgment. Thereafter, the trial denied the Christians' Motion for Reconsideration, resulting in this appeal.

II. ASSIGNMENT OF ERROR

No. 1

The trial court erred in dismissing the Christian's' claims.

No. 2

The trial court erred in denying the Christian's Motion for Reconsideration.

Issues Pertaining to Assignments of Error

(1) Whether competent medical testimony that states Dr. Tohmeh breached the standard of care in treatment of Ms Christian, which caused her at least a 40% loss of chance of a better outcome, is sufficient (if not necessary) to create issues of fact for a loss of chance claim to survive summary judgment.

(2) Whether claims for intentional infliction of emotional distress fall within the ambit of the medical malpractice statute (RCW 7.70, et seq);

(3) Whether there is sufficient admissible evidence contained in the record to create issues of fact for claims of intentional infliction of emotional distress to survive summary judgment.

III. STATEMENT OF THE CASE

A. CAUSE OF ACTION/PROCEDURE BELOW.

This matter arises from and relates to claims of injury and damages

resulting from a low back spinal column surgery performed on plaintiff Diane Christian by Antoine Tohmeh, M.D. at Holy Family Hospital in Spokane, on December 5, 2005. (CP 5). Plaintiff Diane Christian is claiming severe and permanent neurological injuries and other special and general damages and Plaintiff Casey Christian is claiming loss of consortium. (CP 7)

Further, the Christians claim the intentional infliction of emotional distress caused by Dr. Tohmeh. (CP 6). More specifically, it is claimed that Dr. Tohmeh's post surgical care: (1) breached the applicable standard of care; and (2) constituted intentional infliction of emotional distress. (CP 6-7).

As claimed in a preoperative assessment, Diane Christian, age 49 at surgery, had a history of bilateral leg pain and numbness, primarily of the anterior thighs and difficulty standing for long periods, with climbing stairs. ***No associated bowel or bladder disturbances or dysfunctions were noted.*** (CP 99 and CP 103). During the surgery, the spinal cord dura (enclosure) was punctured [and repaired by stitching]. (CP 184).

Pertinent hospital nursing notes indicate the following (CP 105-115).

12/5/05

10:07 a.m. Surgical procedure, with: partial L-2, complete L-3, complete L-4, and partial L-5 laminectomies; bilateral partial fasciectomies and foraminotomies of L-2, L-3 and L-4 nerve roots. (CP 101).

12/6/05

8:00 a.m. New (non-historic) symptom: "Slight tingling in toes, bilaterally." (CP 106).

12/7/05

1:00 a.m. New (non-historic) symptom: "Strong tingling to feet bilaterally." (CP 107).

8:00 a.m. New (non-historic) symptom: Additional ***complaints of severe pain in thighs and buttocks bilaterally (rated at "7")*** due to muscle spasms. Administered a laxative due to lack of bowel movement for three days. (CP 107).

10:00 a.m. New (non-historic) symptoms: In addition to tingling feet, cool sensation reported bilaterally to thighs, down anterior portion of legs. A nurse entered a specific note in the chart that Dr. Tohmeh was there and was aware of patient's complaints. *(Id.)*

10:55 a.m. Physical therapy note – "complaint of tingling, numb feet." (CP 114)

1:45 p.m. Physical therapy: tingling, numbness. *(Id.)*

4:00 p.m. 15 mg morphine administered.

4:30 p.m. Patient reports feet feel slightly numb, but getting better. However, Diane also requested that Foley Catheter be left in until the next day. (CP 108)

9:40 p.m. Feet remained somewhat numb, morphine continued. (*Id.*)

12/8/05

12:53 a.m. Bowel tones noted. Patient complained of bilateral toe numbness. "Doctor aware of complaints." *(Id.)*

6:15 a.m. Patient wants urinary catheter to remain (catheter apparently removed). *(Id.)*

10:05 a.m. Physical therapy – "Feet are still tingling." (CP 114).

3:00 p.m. New (non-historic) symptom: Vaginal and perineal (saddle area) numbness, unable to void, at this time. (CP 108).

3:00 p.m. Bladder scan reveals 400 cc. Nurse will monitor. (CP 109).

4:05 p.m. New (non-historic) symptom: Physical therapy – Loss of sensation in perineum, and unable to urinate. (CP 114).

4:40 p.m. Patient unsuccessful at attempts at voiding bladder and bowel movement. Patient complains of numbness to perineal area. (CP 109).

4:50 p.m. Bladder scan reports 545 ml retained. Reported to Dr. Tohmeh and PAC. Orders to re-catheterize if next attempt at voiding is unsuccessful, and to remove catheter following a.m. *(Id.)*

5:15 p.m. Patient voids 260 ml. Nurses continue to observe bladder function. *(Id.)*

12/9/05

12:00 A.M. (Midnight) Continued complaints of numbness to vaginal

area, tingling to ankles and feet, bilaterally. *(Id.)*

8:30 a.m. Continued complaints of numbness to both feet and vaginal area. *(Id.)*

9:30 a.m. Dr. Tohmeh visits and advises patient that in-home nursing will be necessary to monitor urinary output and writes prescription for same. *(Id.)*

10:20 a.m. Physical therapy – feet numb. (CP 115).

11:50 a.m. Patient voids approximately 100 ml from bladder, retaining approximately 400 ml. (CP 109).

11:52 a.m. Dr. Tohmeh authorizes patient release to home with orders for a Foley catheter and home nursing. (CP 110).

12:00 p.m. Catheter reinserted, and approximately additional 500 ml voided. *(Id.)*

12:30 p.m. Patient discharged to home care with catheter. *(Id.)*

1/5/06

Hospital Discharge Summary - PAC Schindele, Dr. Tohmeh - reference to difficulty emptying bladder and patient home with catheter. No mention of neurogenic symptoms. (Note: surgery 12/5/05, dictated 1/5/06 digitally authenticated by Dr. Tohmeh 2/2/06.) (CP 103-104).

B. POST-HOSPITALIZATION CARE AND TREATMENT

Dr. Tohmeh had Ms. Christian's bladder concerns assessed by

Spokane Urologist Dr. Olefin, during December 2005 and early January 2006. ***Dr. Olefin diagnosed a neurogenic bladder***, but found that certain drugs such as "flomax" used to assist patients in voiding their bladders helped with Ms. Christian's bladder retention issues. (CP 196).

The first sentence of Dr. Oefelein's clinical notes of 1/4/2006, a copy of which was sent to Dr. Tohmeh states:

> "Follow up ***neurogenic bladder with urinary retention*** status post multilevel lumbar laminectomy 12/05/05."
>
> (CP 197).

According to the online Medical Dictionary, "MedlinePlus," which is a service of the U.S. National Library of Medicine, and the National Institutes of Health, a neurogenic bladder is defined as follows:

> **Neurogenic bladder**
>
> "Neurogenic bladder is a problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition."
>
> **Causes**
>
> "Several muscles and nerves must work together for your bladder to hold urine until you are ready to empty it. Nerve messages go back and forth between the brain and the muscles that control bladder emptying. If these nerves are damaged by illness or injury, the muscles may not be able to tighten or relax at the right time.
>
> Disorders of the central nervous system commonly cause neurogenic bladder. These can include:
>
> ...

- Spinal cord injury

Damage or disorders of the nerves that supply the bladder can also cause this condition. These can include:

- Nerve damage (neuropathy)

..."

MedlinePlus, *Neurogenic Bladder,* found at:
http://www.nlm.nih.gov/medlineplus/ency/article/000754.htm

According to its Internet Website, The Urology Care Foundation is the official foundation of the American Urological Association. The Foundation provides support and a worldwide arena for new developments and progress in urologic care. The Foundation discusses neurogenic bladder, in part, as follows:

"WHAT GOES WRONG?

Several muscles and nerves must work together for your bladder to hold urine until you are ready to empty it. Nerve messages go back and forth between the brain and the muscles that control bladder emptying. ***If these nerves are damaged*** by illness or injury, the muscles may not be able to tighten or relax at the right time. In people with neurogenic bladder, the nerves and muscles don't work together well. ***The bladder may not fill or empty in the right way."***

(Bold + Italicized emphasis added), Urology Care Foundation, the official foundation of the American Urological Association, *Neurogenic Bladder /When Nerve Damage Causes Bladder Problems*, found at:
http://www.urologyhealth.org/_media/_pdf/BH_NeurogenicBladder_FactSheet_2014.pdf

The hospital discharge summary was authored by Dr. Tohmeh and

his PAC, Schindle, on January 5, 2006, fully one month after the surgery. (CP 103-104). In that discharge note, it was stated only that Ms. Christian was sent home with some bowel and bladder difficulty, with a catheter inserted. *(Id.)*

On March 2, 2006, Dr. Tohmeh wrote a letter to Ms. Christian addressing the fact that Ms. Christian had discussed several concerns with Dr. Tohmeh's assistant. (CP 116). As is thoroughly discussed in Ms. Christian's return letter to Dr. Tohmeh dated March 16, 2006, Ms. Christian had been doing research on line and found that her symptoms coincided with a constellation of neurological deficits known in the medical community as Cauda Equina Syndrome. (CP 117-120). Ms. Christian reported issues with sexual function, also. *(Id.)* The type of information that was readily available on the Internet from authoritative sources to lay persons or professionals, alike, are exemplified by the following:

> **Symptoms of Cauda Equina Syndrome**
>
> It may be hard to diagnose cauda equina syndrome. Symptoms vary and may come on slowly. They also mimic other conditions. If you have any of these symptoms, see your doctor right away:
>
> ...
>
> - ***Pain, numbness, or weakness in one or both legs*** that causes you to stumble or have trouble getting up from a chair.
> - ***Loss of or altered sensations in your legs, buttocks, inner thighs, backs of your legs, or feet that is severe or gets worse and worse.***

You may experience this as trouble feeling anything in the areas of your body that would sit in a saddle (called saddle anesthesia).

- ***Recent problem with bladder or bowel function, such as trouble eliminating urine or waste (retention) or trouble holding it (incontinence).***

- ***Sexual dysfunction that has come on suddenly.***

WebMD, an advertising funded commercial Internet enterprise providing medical information and articles from board certified M.D.'s and M.D. editorial staff, ***Cauda Equina Syndrome Overview, found at:*** http://www.webmd.com/back-pain/guide/cauda-equina-syndrome-overview

However, in his March 2, 2006 letter, Dr. Tohmeh stated: (1) that an EMG done by Dr. Lamb, at Dr. Tohmeh's request, ***tested the L4, L5, S1 and S2 nerve roots and that it was non-revealing and does not explain her current symptoms of the saddle area numbness and vaginal area numbness; and (2) that Dr. Olefin's urological consult concluded that she had a normal bladder function.*** (CP 116). In that same letter, Dr. Tohmeh denies any inference of any knowledge as to the cause of her symptoms. (*Id.*) This letter in context with the preceding various visits between the Christians and Dr. Tohmeh and Ms. Christian's simple lay research on the internet caused Ms. Christian to write her March 16, 2006 letter :

> "... I do not even know where (sic) to begin. ***You mentioned my frustration in your letter ... my emotions and [sic] have run the gamut and fluctuate depending on the degree of symptoms I may be experiencing on a particular day.*** Some days are better than others. I have felt ignored and granted a [sic] little validation. ... I am

> disappointed in the outcome and the process to try to get answers and correct treatment after the fact. ***Prior to surgery, I had limited mobility, thigh weakness and pain. Now I still have limited mobility due to the left leg and foot numbness, bowel/bladder issues, and saddle numbness. I can only stand or walk for limited amounts of time. It feels as if there is a turnicate [sic] around my left ankle that tightens the longer I am on that foot. It appears I traded one issue for four. I have lost more than I gained in terms of quality of life ... what I have wanted was a chance for healing with proper treatment, which requires acknowledgment of the problems and a proper diagnosis to pursue correct treatment.*** Three months seems unreasonable with no resolution in terms of diagnosis or treatment. ***I seriously believe I possibly have a spinal injury that I mentioned previous. I do not know where or how to proceed. My frustration is way up there. I can understand why patients drop off the radar dealing with these types of experiences. You lose the fight emotionally, especially when you are trying to recover physically.*** I find it almost impossible to ignore or forget about my symptoms. I would if I could, and believe me, that would be much more convenient for us all, especially for me since I am living with this.
>
> (CP 117-120).

Ms. Christian also addresses Dr. Tohmeh "yelling" at her and her husband, and his presumption there is nothing neurologically wrong with her, leaving the converse (psychosomatic) as the inference of choice. (CP 182-183, CP 185-187).

Ms. Christian was then referred to Physiatrist Vivian Moise, M.D., by her primary care physician. Dr. Moise, Spinal Cord Program Medical Director of Spokane's St. Luke's Rehabilitation Institute, diagnosed Diane as suffering from post surgical Cauda Equina Syndrome. The Diagnosis was based upon objective and subjective symptoms, clinical observations, and

testing. (CP 121-124) ***This included an abnormal test finding from the Continence Center at Providence Sacred Heart Medical Center, which, according to Dr. Moise, showed definitive objective findings of S3, S4 and S5 nerve root impairment.*** (CP 126). Recall that ***the EMG test requested by Dr. Tohmeh and performed by Dr. Lamb did not test the S3, S4 and S5 nerve roots.*** (CP 116)

Dr. Moise testified in her discovery deposition, recalling her interaction with Dr. Tohmeh after she diagnosed Diane with cauda equine syndrome, and that Dr. Tohmeh telephoned her. Her testimony follows:

> "Q. (BY MR. RICCELLI) Can you give us, in a narrative fashion, the interaction you have had with Dr. Tohmeh on this matter, on this case?
>
> A. Yes. We've talked just one time, when I first saw Ms. Christian, I had a copy of my evaluation, sent to her back in 2006, and then I got a phone call from Dr. Tohmeh.
>
> Q. I just want to make sure for the record, had you talked to Dr. Tohmeh about Ms. Christian prior to your written evaluation?
>
> A. No.
>
> Q. All right.
>
> A. ***Dr. Tohmeh was upset and angry and objected strongly to me saying I thought that it sounded like she had a caudaequina-type of a problem. He indicated that he thought this patient had some significant emotional or psychologic issues,*** and it made her history less valid to him. ***My interpretation was, I don't know that he ever used these words, but that, you know, psychosomatic kind of problems, might have been all psychosomatic.*** And then he also talked

to me about Dr. McNevin's test proving in his mind that there was nothing wrong with the cauda equina nerves. That's what I recall of that discussion.

Q. ***Do you have an impression as to whether Dr. Tohmeh was suggesting you change your opinion?***

MR. KING: Objection, speculation.

Q. (BY MR. RICCELLI) ***Based on your interaction with medical professionals on consultations on prior claims, do you have an impression?***

A. ***Seemed to be trying very hard to convince me there was no nerve damage.***

Q. Okay. ***And how often in your practice do you have an encounter like that with another treating physician when you've made your diagnosis?***

A. ***Only once in the last 27 besides this one time.***

Q. ***That's with literally thousands of patients, right?***

A. ***Yes."***

(CP 130)

C. EXPERT MEDICAL TESTIMONY

STANLEY BIGOS, M.D.

Expert for the Christians, Stanley Bigos, M.D, is an orthopedic surgeon formerly with the University of Washington School of Medicine faculty, and now residing in the Puget Sound area and in San Diego, California. (CP 140). Dr. Bigos testified, more probably than not, in his June 24, 2013 deposition that: ***Ms. Christian suffered permanent physical***

injury resulting from the surgery performed by Dr. Tohmeh; Dr. Tohmeh breached the standard of care in post-surgical treatment of Ms. Christian; and that this breach was causal of at least a 40% loss of chance or opportunity for a better outcome for Ms. Christian. (CP 135-136).

Further, Dr. Bigos' declaration in this matter states, in part:

"...

2. Unless otherwise stated, all observations, opinions, or conclusions herein are made with reasonable medical certainty, based upon my education, training, and background and experience that includes training medical students, residents and spine fellows, and on a more probable than not basis.

...

4. With respect to my deposition taken on June 24,2013, and the transcription of it, I believe the testimony I gave in response to Mr. Riccelli's questions beginning at page 80, line 7 through page 82, line 25, constitutes testimony by me that it was my opinion that Dr. Tohmeh breached the standard of care of a physician and surgeon in the State of Washington at the time of his post-surgical treatment of Ms. Christian in December of 2005. Dr. Tohmeh breached the standard of care by failing to explicitly acknowledge, explicitly discern, and act promptly to investigate and attempt to reverse or minimize new neurological symptoms Ms. Christian began to complain of and/or identify beginning December 5, 2005 post surgery, and thereafter, while hospitalized at Holy Family Hospital in Spokane, Washington. If for whatever reason it is not clear from the transcription of my testimony of June 24, 2013, then I confirm that the foregoing statement of breach of the applicable standard of care by Dr. Tohmeh contained in this declaration was then, is now, and remains as my opinion.

5. I believe that my deposition testimony on June 23, 2013, as transcribed, correctly represented my opinions regarding the fact that Dr. Tohmeh breached the applicable standard of care as to

Ms. Christian in December of 2005, as he failed to timely and adequately investigate, assess and act on new neurological symptoms which arose from and relate to the December 5, 2005 surgery performed on Ms. Christian by Dr. Tohmeh. According to available literature, Dr. Tohmeh's breach of the applicable standard of care did not afford Ms. Christian what has long been considered a 40 percent chance of a better recovery or outcome than she has ultimately experienced. These new symptoms progressively appeared and worsened during the time of her post-surgical hospitalization, such as: bladder and bowel retention; perianal and vaginal numbness and resulting sexual dysfunction; and left sided lower extremity and foot paresthesia (numbness); and weakness. Concerns about these symptoms have been confirmed by multiple clinicians.

6. My deposition testimony was based upon my general knowledge of the literature as of that time, and coupled with the experience I had with similar situations during my practice. I understand there may be concern about the meaning of my testimony as contained on pages 83 and 84 of my deposition, but I believe careful reading of the transcript should dispel any confusion. I believe I set out the medical profession's understanding of the literature, and basic medical knowledge of human anatomy and physiology, collectively upon which physicians routinely rely to guide their daily practice. This results in an approximate 40 percent likelihood or probability of a better outcome. It was this 40 percent chance of improvement and related urgency that was the basis for requiring Cauda Equina symptoms to be a "Red Flag" emergency, to be explicitly ruled out, before returning Ms. Christian to ordinary post-surgical care for back problems. This is, according to AHCPR Guide #14, comprised of the systematic review of the literature with 23 national consultants and 7 international experts from 19 different disciplines. This follows on the next page. Note the symptoms referenced under Cauda Equina.

"Clinical Practice Guideline Number 14

Acute Low Back Problems in Adults

U.S. Department of Health and Human Services \
Public Health Service Agency
for Health Care Policy and Research

Published December 4, 1994

"RED FLAGS"		
Fracture	Tumor/Infection	**Cauda Equina Syndrome**
Major trauma Minor trauma in elderly or potentially osteopenic	Age: Over age 50 Under age 20 Constitutional symptoms: fever, chills, Unexplained weight loss History of: Urinary tract infection IV drug abuse Immune suppression pain: worse supine worse at night	**Saddle Anesthesia** **Recent bladder dysfunction:** **Retention, frequency, Overflow** **Severe or progressive lower extremity neurologic deficit** **PE:** **Unexpected anal sphincter laxity** **Peri-anal/perineal sensory loss** **Major motor weakness:** **Quadriceps or drop foot**

(emphasis added)

I have found no more recent data that would alter those recommendations since. I found no record of Dr. Tohmeh to justify not considering Cauda Equina Syndrome in his post operative records on Ms. Christian with new neurological complaints and symptoms. I found no justification for not repeating spinal MRI; and, explicitly alerting others about the potential progressive and persistence nature of new neurological symptoms, to aid him in considering taking Ms. Christian to surgery, to explore potential causes of the new symptoms."

(CP 236-241).

RICHARD E. SEROUSSI, M.D.

The Christian's physical medicine expert, Richard E. Seroussi, M.D is a Seattle based physiatrist. (CP 149). Dr. Seroussi testified in his June 26,

2013, deposition that: ***Ms. Christian suffered permanent physical injury resulting from the surgery performed by Dr. Tohmeh and Dr. Tohmeh breached the standard of care in post-surgical treatment of Ms. Christian.*** (CP 82, CP 158-159).

Further, Dr. Seroussi reported:

"ASSESSMENT (On a more probable than not basis related to the surgery of 12/5/05, unless otherwise stated.)

1. Cauda equina syndrome, with left worse than right-sided neurological findings.

2. Multilevel bilateral lumbar radiculopathy, with the following:

a. Pre-existing clinical indication for the surgery of 12/5/05, with right worse than left sided neurologic findings preoperatively.

b. Significant worsening due to complications from the surgery of 12/5/05, with new onset of left worse than right sided neurologic findings postoperatively.

c. Lower thoracic spinal stenosis, gradually worsening over several years, resulting in decompressive laminectomy at the T10-T12 levels by John Demakas, MD on 8/29/12, without complication, overall without change in neurologic status by history.

3. Neurogenic bladder dysfunction, with probable lower motor neuron dysfunction, secondary to #1.

4. Neurogenic bowel dysfunction, with probable lower motor neuron dysfunction, secondary to #1.

5. Mobility deficits, impaired balance, and history of falling secondary to #1.

6. Impaired activities of daily living secondary to #1.

7. Probable reactive and appropriate dysphoria, secondary to chronic pain and loss of function.

8. Decreased vocational potential and community participation, with partial disability, secondary to the above.

9. Pre-existing history of obesity, significantly worsened due to complications from the surgery of 12/5/05, likely partly due to loss of mobility and community participation."

(CP 158-159)

ROD STROM, P.T.

The Christians' physical capacities expert, Rod Strom, is a Spokane based physical therapist who performed a physical capacities examination on Ms. Christian which report details that Ms. Christian has limited physical capacities and abilities to maintain her activities of daily living. (CP 178-179).

ROBERT H. PEARLMAN, M.D.

The Christian's medical ethics expert, Robert H. Pearlman, M.D. is a physician licensed to practice in Washington. (CP 243, para 1). He is a professor at the University of Washington School of Medicine, Division of Gerontology and Geriatric Medicine. He is also the Chief of Ethics Evaluation for the National Center for Ethics in Healthcare. *(Id.)* The National Center for Ethics in Healthcare has been established by the U.S.

Department of Veteran Affairs and serves as the Veterans Administration's authoritative resource for addressing complex ethical issues that arise in patient care, health management, and research. The Center oversees nationwide programs and quality improvement projects to help healthcare practitioners and administrators to understand and apply healthcare ethics and standards. *(Id.)* The Center provides information, education, and consultation to professionals and patients, and their families, regarding ethical issues that relate to healthcare and treatment. *(Id.)* Dr. Pearlman has performed studies and published professional peer reviewed publications including medical ethics, on numerous occasions. He has also written book chapters on medical ethical issues and has authored numerous other books, software applications, and internet information sources concerning medical ethics. He consults and lectures on various issues including medical ethics. *(Id.)*

Dr. Pearlman opined the medical records of Ms. Christian's post-surgical treatment include symptoms of potential complications from the type of surgery she underwent, in the form of various neurological deficits. (CP 246, para 8). Specifically when Ms. Christian progressively complained of, and apparently, clinical evidence developed that she was suffering from post-surgical neurological deficits, while hospitalized at Holy Family Hospital in December of 2005, Dr. Tohmeh had an obligation to timely address these

symptoms and deal with them appropriately (including documenting his efforts), or refer Ms. Christian to another physician. *(Id.)* There is no documentation to suggest that Dr. Tohmeh addressed the concerns. *(Id.)* Specifically, there is no documentation to evidence that Dr. Tohmeh specifically addressed or evaluated these concerns and either concluded that they did not merit further attention, or that further attention should be attempted either through his efforts, or the efforts of other healthcare professionals. *(Id.)*

Dr. Pearlman also addressed Dr. Tohmeh's post-discharge assessment, diagnosis and treatment of Ms. Christian with respect to the newly developed neurological deficits. (CP 247-248, para 9).

> 9. Finally, there is the issue of the post-discharge assessment, diagnosis and treatment of Ms. Christian as to the purported newly developed neurological deficits, by Dr. Tohmeh. Again, there is no adequate documentation in Dr. Tohmeh's files to evidence that he fully addressed the potential of the reported symptoms as potential complications of surgery resulting in true and significant neurological deficits. The chart notes and communications between Dr. Tohmeh and Ms. Christian, including mutual correspondence, are problematic, and if there is adequate evidence and proof, under the law, to conclude that Dr. Tohmeh, for untoward reasons:
>
> a. Delayed completion of a Discharge Summary for several weeks, in which not all of Mrs. Christian's new onset neurological deficits were noted or discussed; and/or

b. Attempted to dissuade Ms. Christian from obtaining appropriate medical treatment or follow-up on new onset neurological deficits; and/or

c. Did not thoroughly follow-up on diagnostic and treatment opportunities consistent with the nature and severity of new onset neurological deficits; and/or

d. Made an effort to dissuade Dr. Moise from providing treatment based upon Dr. Moise's diagnosis of Cauda Equine Syndrome or other similar neurological deficit(s); and/or

e. Attempted to dissuade Ms. Christian from believing that she had any true neurological symptom or deficit that might constitute a post-surgical complication or a symptom of Cauda Equina Syndrome or other such neurological deficits.

Then these acts or omissions, individually, and/or collectively, constitute a breach of medical ethics. Dr. Tohmeh has an ethical and fiduciary Responsibility to his patient, Ms. Christian, and to her physical, emotional, and mental wellbeing. Indeed, if it is concluded that Dr. Tohmeh acted intentionally, as alleged by Ms. Christian, then it is a patent breach of applicable and pertinent ethical codes and standards that are specifically designed to prohibit such activity, in order to maintain the health and wellbeing of patients, and the trust and confidence of the public at large in the medical profession.

(Id.)

STEVEN WANG, M.D.

Defense surgical expert Steven Wang, M.D. was deposed on April 11, 2014.

Pertinent portions of Dr. Wang's deposition testimony are found beginning on page 53, line 1 through the end of his deposition transcript. Dr. Wang's testimony, there, can be summarized in part, as follows:

a. Dr. Wang considers the total clinical presentation of the patient for evaluation of potential Cauda equina Syndrome (CES).

b. Post-surgically, ***Dr. Wang relies on severe pain as a primary indicator of potential CES.***

c. Dr. Wang, ***for his own practice, x-rays every back surgery patient after surgery to check if there might be some condition such as a*** potential ***accumulation of blood causing a hematoma which could put pressure on nerves, causing neurological deficits, including possible CES.***

d. ***When patients have symptoms that may be consistent with CES, and*** severe ***pain, he will perform a clinical evaluation and also have an MRI performed, and return them to surgery if appropriate.***

e. ***These types of cases occur with Dr. Wang approximately one to two times a year, and have already occurred twice in 2014.***

f. In such cases, ***Dr. Wang usually finds that a post-operative hematoma is present, and in most cases, Dr. Wang can surgically improve the patient's clinical symptoms and outcome. It is only "sometimes" that surgical intervention fails to improve the patient's symptoms, and ultimate outcome.***

g. Dr. Wang believes that ***Dr. Tohmeh did not violate the standard of care as*** ***he does not believe Ms. Christian reported pain significant enough for Dr. Tohmeh's index of concern for nerve***

compression or CES to be raised to a level of further investigation.

h. *Dr. Wang believes that any medical doctor who commands knowledge of* basic *anatomy would know that EMG testing such as performed by Dr. Larry Lamb (at the behest of Dr. Tohmeh) which only extended to the S-2level, would not be reliable to rule in or rule out the type of symptoms normally considered to be CES.*

i. *Dr. Wang doesn't address the fact that, according to nursing notes, Ms. Christian reported pain, at a level of 7 (out of 10),* on December 7, 2005, at 8:00A.M., less than 2days after surgery, and while on significant central nervous system depressants and scheduled pain medication.

(CP 111)

IV. SUMMARY OF ARGUMENT

The Christians contend admissible evidence exists in the record that Dr. Tohmeh breached the applicable standard of care which caused Mrs. Christian to lose chance of a better outcome following low-back surgery. Further, although not necessary, testimony that this loss of chance has an associated 40% value is certainly sufficient to establish issues of fact that defeat summary judgment. The Christians also maintain claims for intentional infliction of emotional distress are factually supported in the record; create sufficient issues of fact to defeat summary judgment; and that

the standard of proof is consistent with ordinary tort law, not requiring standard of care testimony pursuant to RCW Chapter 7.70.

Further, that emotional distress related to the injuries due to medical negligence are different in character, degree, and nature, than the separate distress caused by Dr. Tohmeh's alleged actions: dismissing Ms. Christian's symptoms; raising inference of psychosomatic disorder; and attempting to dissuade a colleague form proper diagnosis and treatment of Ms. Christian. Finally, that these actions were (unlikely) due to Dr. Tohmeh's ignorance of medical science, supporting simple negligence, or (most likely) his effort to cover up his medical negligence for failing to timely treat Ms. Christian's new and progressive post-surgical neurological symptoms.

V. ARGUMENT

A. Standard of Review.

The Court of Appeals reviews a summary judgment *de novo*, engaging in the same inquiry as the trial court. *Keck v. Collins*, 181 Wn. App. 67, 78, 325 P.3d 306 (2014). Summary judgment is proper if the records on file with the trial court show there is no genuine issue as to any material fact and the moving party is entitled to a judgment as a matter of law. *Id.* at 78-79. Like the trial court, the Court of Appeals construes all evidence and reasonable inferences in the light most favorable to the non-moving party, here the Christians. *Id.* at 79. The object and function of

summary judgment is to avoid a useless trial. A trial is not useless, but is absolutely necessary where there is a genuine issue as to any material fact. *Id.* at 87. A denial of a motion for reconsideration is reviewed for an abuse of discretion. *August v. US Bancorp*, 146 Wn. App. 328, 339, 190 P.3d 86 (2008).

For the following reasons, the court should reverse the trial court's entry of summary judgment dismissal and denial of the Christians' motion for reconsideration and remand the case for trial.

B. Intentional Tort Claims Are Not Statutory Medical Malpractice Claims.

Washington courts analyze medical malpractice claims separate and apart from common law intentional tort claims; even when those torts arise under "health care." *Young v. Savidge*, 155 Wn. App. 806, 821; 230 P.3d 222 (2010). The Washington Supreme Court distinguished a malpractice action from a common law action of outrage: "Doe's action for malpractice centers around Dr. Finch's alleged unprofessional and unethical sexual relationship with Doe's wife while Dr. Finch was providing therapy to Doe." *John Doe v. Finch*, 133 Wn. 2nd 96, 100; 942 P. 2d 359 (1997).

Chapter 7.70 RCW claims must "fit within one of the three statutorily prescribed causes of action - negligence, contract, or lack or informed consent." *Wright v. Jeckle,* 104 Wn. App. 478, 480; 16 P. 3d 1268 (2001).

Conspicuously absent from the prescribed causes of action is intentional tort. *(Id.)*

C. The Trial Court Erred When it Dismissed the Christians' Intentional Negligence Claim

To prove intentional infliction of emotional distress, the plaintiff must prove each of the following elements:

1. The defendant engaged in extreme and outrageous conduct;

2. The defendant caused severe emotional distress to the plaintiff;

3. The defendant intentionally or recklessly caused the emotional distress; and

4. The plaintiff was a direct recipient of the extreme and outrageous conduct or was an immediate family member of a direct recipient of the conduct and was present at the time the conduct occurred.

WPI 14.03.01 Outrage – Burden of Proof.

With respect to element number 1, extreme and outrageous conduct is:

> "... conduct of the defendant must be outrageous and extreme ... it is not enough that a defendant has acted with an intent which is tortuous or even criminal, or that he has intended to inflict emotional distress, or even that his conduct has been characterized by malice or a degree of aggravation which would entitle the plaintiff to punitive damages for another tort. Liability exists only where the conduct has been so outrageous in character, and so extreme in degree, that it goes beyond all possible bounds of decency, and is to be regarded as atrocious, and utterly intolerable in a civilized community. ... Liability in the tort of outrage does not extend to mere insults, indignities, threats, annoyances, petty oppressions, or other trivialities. In this area,

> plaintiffs must necessarily be hardened to a certain degree of rough language, unkindness, and lack of consideration."
>
> *Grimsby v. Samson*, 85 Wn.2d 52, 55, 530 P.2d 291 (1975), (citing Restatement (Second) Torts, § 46, comment D.

In *Grimsby*, the plaintiff asserted his wife's physician, Dr. Samson, negligently, reckless, wantonly and outrageously abandoned her and failed to provide her with proper medical care. *Id.* at 54. The defendant physician and co-defendant hospital moved to dismiss and the trial court granted their motions. *(Id.)* The Washington Supreme Court reversed.

Similar to *Grimsby,* the Christians allege Dr. Tohmeh engaged in a pattern of intentional behavior to obfuscate diagnosis of Mrs. Christian's neurological deficits, and, therefore, treatment diagnoses in an attempt to avoid legal liability; and that his acts, errors or omissions were in reckless disregard of known medical science and constitute extreme and outrageous conduct, which resulted in physical injury and severe emotional distress to the plaintiffs.

Toward that end, the Christians have presented admissible evidence with respect to all four elements of the intentional tort. As to elements one and three, they submitted the following evidence: post-operatively, because of Mrs. Christian's continued neurological symptoms, Dr. Tohmeh referred to Dr. Olefein, a urologist, and her to Larry Lamb, MD (physiatrist). Dr. Olefein reported a neurogenic bladder from which some relief of urinary

retention symptoms was observed with medication. However, Dr. Tohmeh reported to the Christians that Dr. Olefein didn't find any neurologically bladder issues. Dr. Lamb's requested nerve conduction study, which didn't include the S3 nerve root level or below, was reported by Dr. Tohmeh to the Christians as ruling out Diane's suspicions of cauda equina, or similar neurogenic complaints that might be traceable to Dr. Tohmeh's surgery. Treating physician Moise, the Christian's surgical expert Dr. Bigos, and Dr. Tohmeh's surgical expert Wang agree that an EMG that doesn't test the S3, S4, and S5 nerve root levels is not valid for testing for cauda equina type symptoms. Further, Dr. Tohmeh's expert Wang went so far as to say this is basic medical knowledge for any physician.

Moreover, in what was to be their final post-operative office visit, Mr. and Mrs. Christian met with Dr. Tohmeh in March of 2006. (CP 81, CP 182-183, CP 185 and CP 193). They informed Dr. Tohmeh they were concerned she had Cauda Equina Syndrome. *(Id.)* Dr. Tohmeh reacted angrily by yelling and shouting. *(Id.)* He asserted (inconsistently): (a) there was nothing neurologically wrong with Mrs. Christian; (b) it was all in her head; (c) it was not possible she had anything wrong; but (d) whatever was wrong with her would have happened anyway, and was not related to his surgery. (CP 183-187).

Subsequently, Mrs. Christian obtained care and treatment from Vivian Moise, M.D. (CP 121-127, CP 136). Dr. Moise is a physiatrist who diagnosed Mrs. Christian with Cauda Equina Syndrome. (*Id.*) Dr. Moise received a telephone call from Dr. Tohmeh. He was upset, angry and objected strongly to her diagnosis of Cauda Equina Syndrome. He thought Mrs. Christian had some significant emotional or psychological issues making her history less valid to him. Dr. Moise believed Dr. Tohmeh was trying very hard to convince her there was no nerve damage. (CP 130). This was only the second time in Dr. Moise's 27 years of practice that a physician had attempted to interfere with Dr. Moise's diagnosis and treatment of a patient.

In summary, Dr. Tohmeh's acts and omissions were extreme and outrageous. He intentionally or recklessly:

- Referred Ms. Christian to Urologist Dr. Olefein, who found a neurogenic bladder, yet Dr. Tohmeh told the Christians Dr. Olefein's findings were normal
- Referred Mrs. Christian to Dr. Lamb with instructions to check nerve root levels above the critical S3-S5 levels;
- Tried to dissuade Mrs. Christian from seeking appropriate medical care by denying any physiological isssues, but implied she was lazy, obese, and psychosomatic regarding her symptoms.

- Tried to dissuade Mrs. Christian's physician, Dr. Moise, from diagnosing and treating Diane for Cauda Equina Syndrome. While not evidence of direct action against the claimant, Dr. Tohmeh's actions visa-vis Dr. Moise are strong corroborating evidence of his knowledge, self awareness, and intent of covering his tracks with the Christians.

With respect to element number four of the Tort of Outrage, there is no question the Christians were the direct recipients of Dr. Tohmeh's extreme and outrageous conduct. Specifically, both Mr. and Mrs. Christian were present at the final office visit with Dr. Tohmeh. (CP 182, CP 193). This is when he made his various inconsistent assertions with respect to Mrs. Christian's neurological condition. The fact they were the direct recipients of his conduct is undisputed and the trial court should not have dismissed this claim.

Finally with respect to element number two of the Tort of Outrage, the Christians presented evidence that Dr. Tohmeh's conduct caused severe emotional distress to Mrs. Christian. With respect to Mrs. Christian's neuropathic pain and depression, Dr. Moise recommended she take Cymbalta. (CP 124). Mrs. Christian was tearful and depressed when she presented to Dr. Moise. (CP 122). Dr. Moise observed in her June 6, 2006 office note that Mrs. Christian remained tearful and frustrated as they

discussed her clinical course from surgery to the present time. (CP 127). Finally, in response to Dr. Tohmeh's March 2, 2006 letter, Mrs. Christian described the emotional distress she had incurred, in her responsive letter to Dr. Tohmeh of March 16, 2006.

The Christians' contend these actions were intentionally made in an attempt to obfuscate the truth and avoid legal liability for medical negligence. The Christian's medical ethics expert issued a scathing review of Dr. Tohmeh's conduct, legally presumed for the purpose of summary judgment. Clearly, Dr. Tohmeh knew or should have known of the ethical implications and ramifications of his self aware conduct. It should be patent, if not endemic, that this court should find that a jury in our relatively civilized society could readily conclude Dr. Tohmeh's conduct to fit well within the required finding for the intentional tort, especially considering the high moral and ethical position society places physicians in. ***First, do no harm.***

As demonstrated above, the Christians have presented admissible *prima facie* evidence of all four elements of the intentional tort. The jury should be allowed to evaluate the evidence and draw its own conclusion. The trial court erred in dismissing the claim and this court is requested to reverse that ruling and remand the case for trial.

D. The Loss of Chance Claims in Washington Require Traditional Standard of Proof – Statistical Testimony Sufficient, Not Necessary

Washington first recognized a claim for loss of a chance in *Herskovits v. Group Health Cooperative of Puget Sound*, 99 Wn.2d 609, 664 P.2d 474 (1983), where six justices concluded that the plaintiff had established a prima facie claim based upon a decrease in the statistical chance of survival. *Herskovits* involved a wrongful death and survival action based on a healthcare provider's failure to diagnose and treat. See *Id.* at 611 (lead opinion). There, the plaintiffs claimed the decedent had a loss of chance of survival. There defendants moved for summary judgment, and the plaintiff responded with evidence that the alleged negligence left the decedent with a decreased five year survival probability, from 39 percent to 25 percent. See *Id.* at 610-11. There was no dispute that the decedent's five year survivability never exceeded 50%. The decedent passed on approximately three years after the alleged negligence. See *Id.* at 611. The trial court granted summary judgment that the alleged negligence more likely than not caused the decedent's death. See *Herskovits, Id.* at 611-612.

The Supreme Court reversed and remanded the matter for trial. The lead opinion by Justice Dore, representing two justices; and the concurring opinion by Justice Pearson, representing four justices; conclude as a matter of

public policy, negligent healthcare providers should be at risk if they cause a loss of chance, which has put recovery of health beyond the possibility of realization. In the concurrence, Justice Pearson justifies this policy choice, explaining that failure to recognize loss of chance:

> "subverts the deterrence objectives of tort law by denying recovery for the effects of conduct that causes statistically demonstrable **losses** ... A failure to allocate the cost of these losses to their tortuous sources ... strikes at the integrity of the torts system of loss allocation."
>
> *Herskovits, Id.* at 634 (quoting King, *supra*, at 1377; ellipses in original).

Justice Dore notes, in the lead opinion, that "[t]o decide otherwise would be a blanket release from liability for doctors and hospitals anytime there was less than a 50 percent chance of survival, regardless of how flagrant the negligence." *Id.* at 614. See *Herskovits* at 614 (Dore, J., lead opinion stating "[t]he underlying reason is that it is not for the wrongdoer, who put the possibility of recovery beyond realization, to say afterward that the result was inevitable."); *Id.* at 634 (Pearson, 1, concurring, stating "the all or nothing approach gives certain defendants the benefit of an uncertainty which, were it not for their tortuous conduct, would not exist."); see also *Id.* at 642-43 (Dolliver, 1, dissenting, recognizing "the court is called upon to make a policy decision."); see generally Joseph H. King, Causation, Valuation, and Chance in Personal Injury Torts Involving Pre-Existing

Conditions and Future Judgment Based Upon the Estate's Failure to Produce Evidence Consequences, 90 Yale L. 11353, 1378 (1981) (explaining that "[d]estruction of a chance should also be compensated for reasons of fairness").

In Justice Pearson's plurality opinion, he carefully reviews other jurisdictions loss of chance cases. He then states.

> ***"O'Brien v. Stover*, the decedent's 30 percent chance of survival was reduced by an indeterminate amount**; in *McBride v. United States* the decedent was deprived of the probability of survival; in *Kallenberg v. Beth Israel Hosp.* the decedent was deprived of a 20 percent to 40 percent chance of survival; in *Hamil v. Bashline* the decedent was deprived of a 75 percent chance of survival; **and in *James v. United States* the decedent was deprived of an indeterminate chance of survival, no matter how small.**
>
> *Herskovits v. Group Health Coop.*, 99 Wn.2d 609, 630, 664 P.2d *474* (Wash.1983) (emphasis added)
>
> **My review of these cases persuades me that the preferable approach to the problem before us is that taken (at least** implicitly**) in *Jeanes, O'Brien*, and *James*.** I acknowledge that the principal predicate for these cases is the passage of obiter dictum in *Hicks*, a case which more directly supports the defendant's position. I am nevertheless convinced that these cases reflect a trend to the most rational, least arbitrary, rule by which to regulate cases of this kind.
>
> Herskovits *v. Group Health Coop.*, 99 Wn.2d 609, 633, 664 P.2d *474* (Wash.1983) (emphasis added)

Justice Pearson then concludes his opinion:

> These reasons persuade me that the best resolution of the issue before us is to recognize the loss of a less than even chance as an actionable injury. **Therefore, I would hold that plaintiff has *established* a prima facie issue of proximate cause by producing testimony that**

defendant probably caused a substantial reduction in Mr. Herskovits' chance of survival.

The decedent's personal action for loss of this chance will survive to his personal representatives as provided by *RCW 4.20.046*. The family of the decedent should also be allowed to maintain an action for the lost chance of recovery by the decedent. I would interpret the wrongful death statute, *RCW 4.20.010*, to apply to cases of this type. Under this interpretation, a person will "cause" the death of another person (within the meaning of *RCW 4.20.010*) whenever he causes a substantial reduction in that person's chance of survival. [1]

Finally, it is necessary to consider the amount of damages recoverable in the event that a loss of a chance of recovery is established. Once again, King's discussion provides a useful illustration of the principles which should be applied.

To illustrate, consider a patient who suffers a heart attack and dies as a result. Assume that the defendant-physician negligently misdiagnosed the patient's condition, but that the patient would have had only a **40**% chance of survival even with a timely diagnosis and proper care. Regardless of whether it could be said that the defendant caused the decedent's death, he caused the loss of a chance, and that chance-interest should be completely redressed in its own right. Under the proposed rule, the plaintiff's compensation for the loss of the victim's chance of surviving the heart attack would be 40% of the compensable value of the victim's life had he survived (including what his earning capacity would otherwise have been in the years following death). The value placed on the patient's life would reflect such factors as his age, health, and earning potential, including the fact that he had suffered the heart attack and the assumption that he had survived it. The 40% computation would be applied to that base figure.

(Footnote omitted.) 90 Yale L.J. at 1382 (emphasis added)

(*footnote*)1. **The wrongful death statute is probably the principal reason the parties focused on the death of Mr. Herskovits rather than his diminished chance of survival.** As I have endeavored to demonstrate, this approach leads either to harsh and arbitrary results, or to distortions of existing tort principles and

the potential for confusion. **A liberal construction of the statute appears a more effective method of achieving the most desirable end. The word "cause" has a notoriously elusive meaning (as the writings on legal causation all agree) and it is certainly sufficiently flexible to bear the interpretation I give it in the context of *RCW 4.20.010.***

(*footnote*)2. **In effect, this approach conforms to the suggestion of** Justice **Brachtenbach in his dissent at page 640, footnote 3.The statistical data relating to the extent of the decedent's chance of survival are considered to show the amount of damages, rather than to establish proximate cause.**

Herskovits v. Group Health Coop., 99 Wn.2d 609, 634-635,664 .2d 474 (Wash.1983) (emphasis and explanation added)

In *Mohr v. Grantham*, 172 Wn.2d 844,262 P.3d 490,2011 Wash. LEXIS 821(Wash.2011), the Supreme Court squarely adopts Justice Pearson's plurality decision in *Herskovits*, *supra*.

> We hold that *Herskovits* applies to lost chance claims where the ultimate harm is some serious injury short of death. We also formally adopt the reasoning of the *Herskovits* plurality. Under this formulation, a plaintiff bears the burden to prove duty, breach, and that such breach of duty proximately caused a loss of chance of a better outcome. This reasoning of the *Herskovits* plurality has largely withstood many of the concerns about the doctrine, particularly because it does not prescribe the specific manner of proving causation in lost chance cases. Rather, it relies on established tort theories of causation, without applying a particular causation test to *all* lost chance cases. Instead, the loss of a chance is the compensable injury.
>
> *Mohr v. Grantham*, 172 Wn.2d 844,262 P.3d 490,2011 Wash. LEXIS 821(Wash.2011)
>
> In *Herskovits*, both the lead and concurring opinions discussed limiting damages. *99 Wn.2d at 619* (Dore, J., lead opinion), *635* (Pearson, J., plurality opinion). This is a common approach in lost

> chance cases, responsive in part to the criticism of holding individuals or organizations liable on the basis of uncertain probabilities. *Restatement (Third) of Torts: Liability for Physical and Emotional Harm § 26 cmt. n* at 356 ("Rather than full damages for the adverse outcome, the plaintiff is only compensated for the lost opportunity. The lost opportunity may be thought of as the adverse outcome discounted by the difference between the ex ante probability of the outcome in light of the defendant's negligence and the probability of the outcome absent the defendant's negligence."). Treating the loss of a chance as the cognizable injury "permits plaintiffs to recover for the loss of an opportunity for a better outcome, an interest that we agree should be compensable, while providing for the proper valuation of such an interest." *Lord v. Lovett, 146 N.H. 232, 236, 770 A.2d 1103 (2001).* In particular, the *Herskovits* plurality adopted a proportional damages approach, holding that, if the loss was a 40 percent chance of survival, the plaintiff could recover only 40 percent of what would be compensable under the ultimate harm of death or disability (i.e., 40 percent of traditional tort recovery), such as lost earnings. *Herskovits, 99 Wn.2d at 635* (Pearson, J., plurality opinion) (citing King *supra*, 90 Yale L.J. at 1382). **This percentage of loss is a question of fact for the jury and will relate to the scientific measures available, likely as presented through experts.** Where appropriate, it may otherwise be discounted for margins of error to further reflect the uncertainty of outcome even with a nonnegligent standard of care. *See* King, *supra, 28 U. Mem. L. Rev. at 554-57* ("conjunction principle").
>
> *Mohr v. Grantham,* 172 Wn.2d 844,858,262 P.3d 490, 2011 Wash. LEXIS 821(Wash.2011) (emphasis added)

Accordingly, Washington law allows for testimony that medical or other healthcare negligence probably caused a substantial loss of a chance of a better outcome and/or survival. Further, that statistical information and/or percentages of effect of loss of chance may be utilized by a jury in determining damages if available. If not, their task is no different from allocation of comparative and contributory fault as in other tort actions.

However, statistics or percentages may be offered or used as part of sufficient testimony for the purposes of both establishing causation, and in aiding the jury in assessing damages, but in neither case are statistics or percentages necessary. To determine otherwise is rule out any anomalous medical occurrence which has no peer review study, double blind statistical study of a medical population or cohort study, where median, mean, and standard deviation from which a statistic or percentage may be derived, to be excluded from consideration as a loss of chance case. This would also deny consideration of loss of chance where, although a medical practitioner cannot refer to such a study, anecdotally, and based upon the practitioner's knowledge of his own practice or the practices of others, a relative statement of experience may be sufficient for jury consideration. This type of testimony is often developed during the course of many medical malpractice cases. The important consideration is whether there is sufficient evidence from which a jury can determine a reasonable allocation of damages. To determine otherwise, is to reward form over substance.

E. The Christians Presented Competent Evidence Creating Issues of Fact as to Loss Of Chance.

Review of Dr. Bigos' testimony, supra, leaves no doubt as to competent testimony in this matter to defeat summary judgment as to loss of chance. He firmly states Dr. Tohmeh breached the applicable standard of

care, which caused Diane Christian to suffer a 40% loss of chance for a better surgical outcome. This provides sufficient testimony under the strictest of application of Washington law.

Paragraph 5 contains Dr. Bigos' opinion that Dr. Tohmeh breached the applicable standard of care (CP 237, lines 19-22) and that the breach caused Ms. Christians' loss of a chance of a better recovery or outcome (CP 237, lines 22-24). Note, Dr. Bigos' opinions are made on a more probable than not basis with reasonable medical certainty based upon his education, training and experience. (CP 236, paragraph 2).

This raises an issue of fact for the jury to consider. Specifically, whether Mrs. Christian's pain level was "severe" enough to have raised a red flag. It is also a jury question to consider if or how this information affects Dr. Wang's opinion, and why or why not.

Additionally, Dr. Wang's own practice differs from his testimony. He x-rays every back patient after surgery to determine if there might be some condition such as a potential accumulation of blood causing a hematoma which could put pressure on the nerves causing neurological deficits such as CES. Yet, he opines the fact Dr. Tohmeh took or ordered no images of Mrs. Christian's spine post surgery in the hospital was not a violation of the standard of care. The jury should consider the discrepancy between Dr. Wang's practice and his opinion. The discrepancy affects his credibility.

Therefore, while it is true that Dr. Wang did not testify Dr. Tohmeh breached the applicable standard of care, Dr. Wang did not address Mrs. Christian's reported pain level at 7 out of 10 in his deposition testimony. His practice of x-raying patients differs from his deposition testimony. Accordingly, the jury is entitled to consider these questions as they bear on the issue of Dr. Wang's opinion of Dr. Tohmeh's negligence.

Finally, Dr. Tohmeh implies Dr. Wang is a consulting expert protected under CR 26(b)(4). This is incorrect. Dr. Tohmeh never designated Dr. Wang a consulting expert prior to the Christians' taking his deposition.

When viewed in the light most favorable to the non-moving party, Dr. Wang's testimony creates a genuine issue of material fact as to Dr. Tohmeh's breach of the applicable standard of care, as to interpretation of severity of pain.. Similarly, Dr. Bigos' May 16, 2014 declaration raises genuine issues of material fact as to Dr. Tohmeh's breach of the standard of care and causation of Mrs. Christian's loss of a chance claim. Accordingly, the trial court erred in denying the plaintiffs' motion for reconsideration. The Court of Appeals is requested to reverse and remand the case for trial.

VI. CONCLUSION

The trial court erred in granting Dr. Tohmeh's Motion for Partial Summary Judgment and denying the Christians' Motion for Reconsideration.

The Christians presented admissible evidence raising genuine issues of material fact as to Dr. Tohmeh's breach of the applicable standard of care and causation of Mrs. Christian's 40% loss of a chance for a better outcome. Similarly, the Christians presented admissible evidence raising a genuine issue of material fact as to the intentional infliction of emotional distress. The court is requested to reverse the trial court and remand the case for trial.

RESPECTFULLY SUBMITTED this 16 day of June, 2015.

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CERTIFICATE OF SERVICE

I hereby certify that on the 16 day of June, 2015, I caused a true and correct copy of the Brief of Appellant to be served on the following in the manner indicated below:

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