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 REPLY TO RESPONDENTS' CORRECTED BRIEF

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RULES

RAP 13.4(d) 1

To the extent the defendants/respondents (hereinafter referred to as "Dr. Tohmeh") seek review of an issue not raised in the appellants' Petition for Review, plaintiffs/appellants (hereinafter "The Christians") respectfully submit the following reply pursuant to RAP 13.4(d).

I. RESPONDENT TOHMEH'S COUNTERSTATEMENT OF THE CASE IS REPLETE WITH ERRONEOUS AND INCOMPLETE REFERENCES TO THE RECORD.

A. In part "C" of his brief, on page three, Dr. Tohmeh writes:

> "... while Ms. Christian was still in the hospital, she, at various times, voiced subjective complaints of numbness and/or tingling in her feet, as well as vaginal and perianal numbness."
>
> (CP 395, 396, 397, 398)

This is correct, but incomplete. According to the nursing notes, she also complained of a "cool sensation anterior thigh down to lower leg. Dr. Tohmeh here and aware." (CP 396). In addition, she experienced tingling and numbness in her toes. (CP 395, 397).

B. In part "C" of his brief, on page three, Dr. Tohmeh asserts neurologic and strength assessments were performed on multiple occasions by nursing staff, including the day of discharge, and were normal. (CP 391, 395, 396, 397, 398, 418). Reference to CP 391 lacks foundation as it is an ambiguous chart which requires medical interpretation. CP 395 is a partial nursing note of December 6, 2005, the day after Ms. Christian's surgery, in

which she does report tingling in her toes, bilaterally. CP 396 also references Ms. Christian reporting numbness and tingling in her feet, bilaterally, and a cool sensation to her anterior (backside) thighs. Reference to CP 397 is also in error. On December 7, 2005, two days after surgery, Ms. Christian continues with complaints of numbness, which complaints continue in CP 397, on December 8, 2005, three days after surgery. Ms. Christian also complains of vaginal and perineal (saddle area) numbness on December 8, 2005, as found in CP 397. These complaints continued on December 9, 2006, as found in CP 398. None of these nursing notes indicates the nurses ever performed a neurological assessment on the areas of Ms. Christian's complaints of numbness. Finally, CP 418 also lacks foundation as it is a testing chart, which requires medical interpretation. Regardless, no reference is made to neurological testing for sensation (numbness) in CP 418.

Dr. Tohmeh also argues he attended to Ms. Christian on each post-operative day, finding her to be neurologically intact with respect to both strength and sensation. (CP 378-381; CP 679-681). These references, too, are inaccurate and lack foundation. These "progress notes" do not clearly identify who made the entries, and apparently Dr. Tohmeh or different members of his staff saw Ms. Christian on different days. Further CP 378 and CP 381 reveal nothing to a lay person's review. CP 379 and 380 do, in fact, reference Ms. Christian's symptoms and continuing complaints of

numbness. CP 380 specifically references "? pudendal nerve" in relation to Ms. Christian's symptoms. According to WebMD:

> "**Pudendal neuralgia** is a rare problem with the pudendal nerve that can affect both men and women. **The pudendal nerve runs through your pelvic region, including your genitals, urethra, anus, and perineum.**"
>
> WebMD, Pudendal Neuralgia, http://www.webmd.com/a-to-z-guides/pudendal-neuralgia-overview (emphasis added)

Further, according to "Health Organization for Pudendal Education" (HOPE), in discussing similarities between CES and pudendal neuralgia:

> "**Cauda Equina Syndrome**
>
> This is a similar condition to arachnoiditis that involves damage to the nerves coming off of the spinal cord, sometimes called the horse's tail or cauda equina. **Some of the symptoms can be similar to pudendal neuralgia although typically there is involvement to a wider area than that innervated by the pudendal nerve.**"
>
> HOPE, *Related Topics*, http://www.pudendalhope.info/node/14 (**emphasis** added)

This "? Pudendal" entry was apparently made by Dr. Tohmeh, as the signature is consistent with the physicians signature found on CP 346, 349, and 363-366. Clearly, the "? pudendal" reference on CP 380 contradicts Dr. Tohmeh's arguments that Ms. Christian was neurologically intact while hospitalized and his later argument that Ms. Christian never had any symptoms consistent with CES.

Dr. Tohmeh's reference to CP 679 – 681 is an excerpt from his expert, Jeffrey Larson, M.D. In that excerpt, Dr. Larson testifies "somebody" tested Ms. Christian's motor functions, and Dr. Tohmeh's attorney, Mr. King, volunteers that Dr. Tohmeh or his PA wrote the subject progress notes. (CP 679).

C. In part "C" of his brief, at the top of page four, Dr. Tohmeh writes: "During her hospitalization, she never complained of significant back pain (CP 391, 394-399). On serial checking by the nursing staff and Dr. Tohmeh, Ms. Christian had intact reflexes and motor strength, as well as sensation in the lower extremities, except for the perineal area." *Id.* (CP 378-81; CP 679-681).

Again, these conclusionary statements are made without foundation. They are also inaccurate because Ms. Christian complained of back pain at a **"7"** (out of 10 as in the standard practice). (CP 396). The pain was apparently severe enough for Dr. Tohmeh to have allowed the nursing staff to medicate Ms. Christian with morphine, which was continued. (CP 397). In addition, sensation in her lower extremities was not "intact". To the contrary, she reported numbness in both feet and in her vaginal area (CP 398).

D. In part "D" of his brief, on page five, Dr. Tohmeh cites CP 671; 676-681 for the assertion that Dr. Larson testified Ms. Christian did not have CES because she never had muscle or motor weakness in her lower

extremities; and these are hallmark signs of CES. This testimony conflicts with the Christians' expert testimony and substantiates issues of fact making summary judgment improper.

II. RESPONDENT TOHMEH'S COUNTER STATEMENT OF THE CASE AND ARGUMENT SIMPLY ESTABLISHES ISSUES OF FACT AS TO BREACH, CAUSATION AND DAMAGES.

A. When reviewing expert testimony for The Christians and Dr. Tohmeh, issues of fact are evident. Dr. Tohmeh's brief refers to his expert medical witness Larson who opines that Ms. Christian did not suffer post-surgical Cauda Equina Syndrome (hereinafter "CES"). (Respondents' Brief p. 5). Thus, Dr. Tohmeh argues he did not breach the applicable standard of care. (Respondents' Brief pp. 10-11). Dr. Tohmeh's reference to a lack of CES diagnosis by Drs. Oefelien and Whiting is spurious. There is no foundation provided to argue these physicians either were asked to diagnose Ms. Christian's neurological deficits or whether they had appropriate medical training, background or experience to do so. Dr. Tohmeh's argument, and the testimony it is based on, merely establishes an issue of diagnostic fact as Ms. Christian's treating physician, Dr. Moise, diagnosed Ms. Christian with post-surgical neurological deficits consistent with CES and the Christians' medical experts, Drs. Bigos and Seroussi, also

conclude that Ms. Christian suffers from post-surgical CES. (CP 143, 159, 237, 238).

Finally, as discussed below, regardless of the specific diagnostic moniker used by any expert, all of the parties' expert medical witnesses agree that Ms. Christian suffered post-surgical neurological deficits.

B. The issue of fact regarding the standard of care is not found in the surgical procedure performed by Dr. Tohmeh (as argued by Dr. Tohmeh), but in the after-surgery care and treatment of Ms. Christian by Dr. Tohmeh. Dr. Bigos, the Christians' expert, has testified that it is Dr. Tohmeh's failure to follow-up on Ms. Christian's new, post-surgical neurological symptoms that constitute a breach of the standard of care. (CP 143, 237-238). The failure to follow-up on these symptoms forms the basis of Dr. Bigos' testimony that in not doing so, Dr. Tohmeh caused Ms. Christian a 40 percent loss of chance of a better outcome. (CP 143-147, 237-241). This better outcome ranges from a decrease in symptoms to full recovery from symptoms.

C. The testimony of Dr. Tohmeh's expert medical witness Dr. Wang establishes an extremely limited defense for Dr. Tohmeh, one which also creates an issue of fact. Dr. Tohmeh's medical expert Dr. Wang states that when post-surgical complaints such as those evidenced in Ms. Christian's chart appear, coupled with out-of-proportion pain, the

standard of care is to perform diagnostic imaging and/or emergency surgical exploration of the recent surgical site. (CP 264). Dr. Wang further states that when this occurs, he most often finds a post-surgical hematoma at fault and it is his experience that a majority of such patients improve after emergency surgical intervention. (CP 264).

Recall that Ms. Christian did report post-surgical low back pain in an order of magnitude of 7 (out of 10) which required her to be medicated with morphine. (CP 107-108). For the purposes of summary judgment, it is an issue of fact as to whether Ms. Christian's subjective report of pain falls within or outside a call for medical action such as described by Dr. Wang, above. Viewed in a light most favorable to the Christians, a trier of fact could reasonably determine it did, and that Dr. Tohmeh breached the standard of care by inaction. Further, Dr. Wang, by his testimony, arguably confirms, for purposes of summary judgment, a loss of chance of a better outcome. Dr. Wang's testimony is that, based on his (Dr. Wang's) own clinical experience, had Dr. Tohmeh acted he probably would have found a post-surgical hematoma (blood clot) causing the new symptoms. Further, it is likely that Ms. Christian would have improved, medically. (CP 264)

D. The Christians are not relying solely on a diagnosis of CES. The Christians are claiming that Ms. Christian suffered post-surgical and surgically related new neurological symptoms and deficits including, but not

limited to, bladder and bowel dysfunction, lack of vaginal sensation, and other sensory deprivation. (CP 136, 156-159) Dr. Tohmeh's argument is based on the semantics of medical terminology. In this instance, the treating physician Dr. Moise found that Ms. Christian suffered surgically related neurological deficits that are consistent with a diagnosis of CES and the Christians' experts, Drs. Bigos and Seroussi, agree. (CP 125-126, 135-136, 143, 238-240). These diagnoses create an issue of fact as to CES. Indeed, Dr. Tohmeh's expert, Dr. Wang, agrees that Ms. Christian suffers from post-surgical neurological deficits. Dr. Wang believes the array of deficits more closely fall within the diagnosis of Conus Medullaris Syndrome. Clearly, then, Dr. Tohmeh's argument rests solely on form (diagnostic classification) rather than substance (neurological deficits). (CP 266).

III. DR. BIGOS' TESTIMONY ESTABLISHES A 40% LOSS OF CHANCE OF A BETTER OUTCOME RANGING FROM SOME IMPROVEMENT TO FULL RECOVERY FROM SYMPTOMS.

Contrary to Dr. Tohmeh's assertion at pages 12-13 of his brief, the loss of a chance doctrine does not require the Christians to provide evidence defining the specific degree and nature of the better outcome.

As briefed previously, the Christians medical expert, Dr. Bigos, testified that Dr. Tohmeh breached the standard of care which caused a 40

percent loss of chance of a better outcome.

"EXAMINATION BY MR. RICCELLI:

Q. Just real quickly. Can you summarize your opinion about standard of care of Dr. Tohmeh.

A. Well, the only thing I can do is review the facts. One, we've got a cauda equina syndrome. We've got a patient who has significant difficulties related to the S2-3-4 nerves, okay, if you want to be specific. They came on during the postoperative care after her surgery. We saw the progression I already mentioned about going from tingling, DEFCON 1, to 2, 3, 4 and 5. And she was sent home with a Foley catheter, without an MRI, and she has a bad result. Bottom line is that I -- that's below the standard of care.

Q. And so do you believe there was a breach of standard of care that caused harm?

MR. KING: Objection. Lacks foundation.
BY MR. RICCELLI:

Q. Do you believe there was a breach of standard of by care Dr. Tohmeh in the exercise of his obligation as a surgeon with Ms. Christian?

A. I believe, from the facts that I have available to me, that that does not meet the standard of care that people expect when they come to the hospital.

Q. Based on your education, training, background and experience?

A. Yes.

Q. And is that more probable than not your opinion?

A. That's more probable than not my opinion.

Q. Do you believe that had Dr. Tohmeh taken her back into surgery to decompress or to explore that she would have an opportunity or chance at a better outcome?

MR. KING: Objection. Foundation.

THE WITNESS: Bottom line is that it may have done nothing. It may have improved her a little bit. Or it may have totally alleviated it. That's the experience in the literature, and that's all we really have to go on.

BY MR. RICCELLI:

Q. So by failing to do that did she lose the opportunity or chance to have a better outcome?

A. Well, according to the literature, it's about 40 percent chance of being improved."

Discovery Deposition of Stanley Bigos, M.D., P. 80, Line 1 - Page 81, Line 24 (CP 256-257; CP 236-241)

As the foregoing was taken from a discovery deposition, Dr. Bigos provided a declaration for review by the trial court which clarified any question about his opinions in this matter. Dr. Bigos clearly concludes Dr. Tohmeh breached the standard of care which resulted in a 40 percent loss of chance of a better outcome for Ms. Christian. (CP 236-242). Therefore, based on this testimony in the instant case, the jury may evaluate the

Christians' damages based on the testimony at trial, in the same manner jurors assess general and special damages in any personal injury action.

Neither *Mohr* nor *Herskovits v. Group Health Coop.*, 99 Wn. 2d 609, 664 P.2d 474 (1983), nor any other Washington case, requires a loss of a chance plaintiff to provide specific, conclusory testimony of the degree and nature of the better outcome. *Mohr* and *Herskovits* simply require testimony that a breach of the standard of care caused a loss of chance, which loss is a distinct and separate harm from the ultimate outcome. Dr. Tohmeh further engages in incomplete references on the issue of calculation of damages in a loss of chance case, *vis a vi, Mohr* and *Herskovits*. (See Respondents Brief, p. 12). Dr. Tohmeh's references should be considered in the context of the *Mohr* discussions, and deference given to the holding of the case, rather than *dicta*.

> "The significant remaining concern about considering the loss of chance as the compensable injury, applying established tort causation, is whether the harm is too speculative. We do not find this concern to be dissuasive because the nature of tort law involves complex considerations of many experiences that are difficult to calculate or reduce to specific sums; yet juries and courts manage to do so. We agree that:
>
> > [s]uch difficulties are not confined to loss of chance claims. A wide range of medical malpractice cases, as well as numerous other tort actions, are complex and involve actuarial or other probabilistic estimates.

Matsuyama, 452 Mass. at 18. Moreover, calculation of a loss of chance for a better outcome is based on expert testimony, which in turn is based on significant practical experience and "on data obtained and analyzed scientifically ... as part of the repertoire of diagnosis and treatment, as applied to the specific facts of the plaintiff's case." Id. at 17. Finally, discounting damages responds, to some degree, to this concern.

In Herskovits, both the lead and concurring opinions discussed limiting damages. 99 Wn.2d at 619 (Dore, J., lead opinion), (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 were 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 non-negligent standard of care.** See King, supra, 28 U. Mem. L.

Rev. at 554-57 ("conjunction principle")."

Mohr v. Grantham, 172 Wn.2d 844, 857-58, 262 P.3d 490, (2011) (emphasis added)

The Christians submit that the foregoing bold, emphasized text is the primary holding of *Mohr*, *Id.* The Washington Supreme Court's reference to New Hampshire's *Lord v. Lovett* (underlined for emphasis) is also supportive of the Christians' argument.

> "In affirming the trial court, without making any reference to the loss of opportunity doctrine, we held that "the plaintiff must produce evidence sufficient to warrant a reasonable juror's conclusion that the causal link between the negligence and the injury probably existed." Bronson, 140 N.H. at 801. The defendants argue that this language precludes the plaintiff's claim. We disagree. Having alleged as her injury the loss of opportunity, the plaintiff is not relieved of her burden to prove that the defendants' negligence "probably" caused it.
>
> *Finally, defendant Lovett argues that we should not recognize the plaintiff's loss of opportunity injury because it is intangible and, thus, is not amenable to damages calculation.* **We disagree.**
>
> First, **we fail to see the logic in denying an injured plaintiff recovery against a physician for the lost opportunity of a better outcome on the basis that the alleged injury is too difficult to calculate, when the physician's own conduct has caused the difficulty.** See Hicks v. United States, 368 F.2d 626, 632 (4th Cir. 1966). Second, **"we have long held that difficulty in calculating damages is not a sufficient reason to deny recovery to an injured party."** Smith v. Cote, 128 N.H. 231, 242, 513 A.2d 341 (1986). Third, loss of opportunity is not inherently unquantifiable. **A loss of opportunity plaintiff must provide the jury with a basis upon which to distinguish that portion of her injury caused by the defendant's negligence from the portion**

> **resulting from the underlying injury.** See Valliere v. Filfalt, 110 N.H. 331, 332-33, 266 A.2d 843 (1970); King, Causation, Valuation, and Chance, supra at 1360. **This can be done through expert testimony just as it is in aggravation of pre-existing injury cases."**
>
> *Lord v.* Lovett, 146 N.H. 232, 239, 770 A.2d 1103 (N.H. 2001) (emphasis added)

In *Mohr*, the Washington court discusses damages which can be **"discounted for margins of error to further reflect the uncertainty of outcome**." *Mohr*, 172 Wn.2d at 858 (emphasis added). *Mohr* clearly contemplates use of expert testimony in this regard. The New Hampshire court discusses expert testimony which can be used to clarify damage assessment by the jury "**just as it is in aggravation of pre-existing injury cases**." *Lord,* 146 NH at 239 (emphasis added). **In both cases, the courts are not requiring the jury to adopt the specific testimony of experts. Given the context of their holdings, they are simply stating that, as in any other personal injury tort case, the jury will consider expert testimony from both parties, assign weight and credibility to that testimony, and determine a final degree of loss of chance (opportunity for a better outcome), just as it does with other issues of fact.**

This Court's recent opinion in *Grove v. PeaceHealth St. Joseph Hosp., 182* Wn. 2d 136, 341 P3d 261 (2014), also supports the Christians' argument. In that case, two experts testified for the plaintiff during a medical

malpractice trial. Neither expert testified as to a percentage or range of percentage reduction in the chance of survival. Dr. Ghidella opined that Grove would not have suffered permanent injuries or would have had a better outcome if the standard of care had been met. *Id.* at 140-141. Dr. Adams testified that if the hospital employees had not breached the standard of care, Grove would have had a better chance of avoiding injury or would have suffered a less severe injury. *Id.* at 142. Although the primary issue decided by the court was whether the trial court properly granted defendants' motion for judgment as a matter of law, *Id.* at 138, the experts' testimony as to loss of a chance, absent specific percentages and specific outcomes, strongly supports the Christians' argument in the case at bar.

When considering Dr. Bigos' testimony most favorably to the Christians, the non-moving party at summary judgment, issues of fact exists as to loss of chance of a better outcome. Dr. Bigos testimony is that the medical literature supports a 40 percent loss of chance of a better outcome ranging from some improvement to total recovery from post-surgical neurological deficits. This clearly fits in *Mohr's* "margin of error to further reflect the uncertainty of outcome" and *Lovett's* reference to the jury's ability to assess damages in murky "aggravation of pre-existing injury cases."

IV. DR. BIGOS' TESTIMONY, SEPARATELY, AND IN CONJUNCTION WITH THAT OF DRS. MOISE AND SEROUSSI, ESTABLISHES ISSUES OF FACT AS TO BREACH, PROXIMATE CAUSE AND DAMAGES.

Treating physician Moise, and expert witnesses Drs. Bigos and Seroussi, all conclude that Ms. Christian suffered new and significant neurological deficits including, but not limited to, loss of bowel and bladder functions, loss of vaginal sensitivity, and other losses of sensation as a result of Dr. Tohmeh's surgery. They diagnosed CES. (See section II para. D above) (CP 125-126, 135-136, 236-240). Further, Dr. Bigos clearly testified that Dr. Tohmeh breached the standard of care, which caused Ms. Christian to lose a 40 percent chance of a better outcome in a range from improvement to complete reversal of these neurological deficits and symptoms. (CP 125-126, 135-136, 143, 238-240). Finally, Dr. Seroussi is also prepared to testify about Dr. Tohmeh's breach of the standard of care. (CP 166-167). This testimony creates material issues of fact as to breach of the standard of care, proximate cause of loss and chance, and damages.

V. ADEQUATE TESTIMONY EXISTS TO ESTABLISH ISSUES OF FACT REGARDING THE TORT OF OUTRAGE/ INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS.

No expert for Dr. Tohmeh has concluded Ms. Christian did not suffer new post-surgical neurological injury and deficits. Yet Dr. Tohmeh clearly

tried to dissuade Ms. Christian from obtaining a competent diagnosis. In fact, Dr. Tohmeh's expert, Dr. Wang concludes that she does suffer from new, post surgical neurological injury and deficits, including bowel and bladder dysfunction. (CP 264-266). Treating physician Moise has diagnosed post-surgical CES, causally related to Dr. Tohmeh's surgical procedure performed on Ms. Christian (CP 125-126), as did Dr. Bigos (CP 237-238) and Dr. Seroussi (CP 158). There is no expert testimony to support Dr. Tohmeh's steadfast denial of Ms. Christian's new, post surgical neurological injury and deficits. In a post-surgical letter from Dr. Tohmeh to Ms. Christian, Dr. Tohmeh states:

> **"I do not have an explanation for your vaginal numbness based on anatomy nor based on the surgery that you just had."**
>
> CP116 (emphasis added)

Clearly, this contradicts with both parties experts who agree Ms. Christian has surgically related neurological deficits. Consider also the CP 380 "? pudendal" entry, as pudendal neurologia, along with CES, is anatomically consistent with Ms. Christian's vaginal numbness. (See discussion in section I para. B above.)

In addition, Dr. Pearlman substantiates issues of fact as to the ethics of Dr. Tohmeh, and substantial public interest concerns. This depends on jury assessment of the various facts alleged regarding this claim, and

Dr. Tohmeh's credibility at trial when compared to that of the Christians, and Dr. Moise, primarily. (CP 246-248). According to Dr. Pearlman:

> "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 Ms. 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 well being. Indeed, if it is concluded that Dr. Tohmeh acted intentionally, as alleged by Ms. Christian, then it is a patent violation of applicable and pertinent ethical codes and standards that are specifically designed to prohibit such activity, in order to maintain the health and well being of patients, and the trust and confidence of the public at large."
>
> (Decl. Robert Pearlman, MD, MPH)(CP 247, 248)

The facts, when favorably viewed toward the Christians, the non-moving party, clearly support the occurrence of each of paragraphs 9(a) through (e) above. It is an issue of fact as to whether Dr. Tohmeh performed these acts or omissions for "untoward reasons," as the Christians claim. Dr. Tohmeh's dismissal of post-surgical neurological deficits, and efforts to dissuade Dr. Moise from a CES diagnosis, are strong circumstantial evidence of such. This has been established by: the testimony of the Christians, Dr. Moise, Dr. Bigos and Dr. Seroussi; Dr. Tohmeh's records; and Dr. Tohmeh's correspondence, as thoroughly briefed in the Christians' opening brief, pages 27 through 33. Certainly, the body of the evidence is strong, circumstantially, to meet the civil burden of proof, and allow a jury to conclude Dr. Tohmeh committed the tort of outrage/intentional infliction of emotional distress.

VI. CONCLUSION

In conclusion, the Christians establish issues of fact through lay and expert testimony, and the records of Dr. Tohmeh and of Ms. Christian's

hospitalization, as to all issues on appeal. Dr. Tohmeh's arguments to the contrary are spurious. His arguments which contradict the Christians' lay and expert testimony, and the records, merely substantiate issues of fact making summary judgment improper. Therefore, the Christians request the court of appeals reverse the trial court and return this matter for trial on all issues.

RESPECTFULLY SUBMITTED this 14th day of May, 2015.

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CERTIFICATE OF SERVICE

I hereby certify that on the 14th day of May, 2015, I caused a true and correct copy of the foregoing to be served on the following in the manner indicated below:

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