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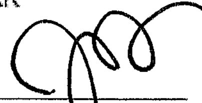

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SUPREME COURT NO. 928371

COURT OF APPEALS NO. III-325784

IN THE SUPREME COURT

OF

THE STATE OF WASHINGTON

DIANE AND CASEY CHRISTIAN, ***Plaintiffs/Petitioners,***

v.

ANTOINE TOHMEH, M.D., et al., ***Defendants/Respondents.***

PLAINTIFFS'/APPELLANTS' PETITION FOR REVIEW

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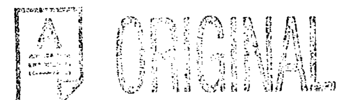


TABLE OF CONTENTS

I. IDENTITY OF PETITIONER.....1

II. COURT OF APPEALS DECISION.....1

III. ISSUES PRESENTED FOR REVIEW.....1

IV. STATEMENT OF THE CASE.....3

A. NATURE OF THE CASE.....3

B. SURGERY AND POST OPERATIVE HOSPITALIZATION.....3

V. ARGUMENT.....19

A. REVIEW.....19

B. THE FACTS BEFORE THE COURT SUPPORT THE TORT OF OUTRAGE.....20

C. THE STANDARD OF REVIEW OF RECONSIDERATION OF SUMMARY JUDGMENT IS DE NOVO WHEN ADDITIONAL EVIDENCE IS CONSIDERED.....23

D. THE TRIAL COURT CONSIDERED THE NEW AND SUPPLEMENTAL EVIDENCE ON RECONSIDERATION AS SHOULD THE COURTS ON APPEAL.....25

VI. CONCLUSION.....27

TABLE OF AUTHORITIES

Cases

Davies v. Holy Family Hosp., 144 Wn. App. 483, 497
183 P.3d 283 (2008), ...14.

Folsom v. Burger King, 135 Wn.2d 658, 663, 958 P.2d 301 (1998).......24

Keck v. Collins, 184 Wn.2d 358, 370, 357 P.3d 1080 (2015)...............25

Keck v. Collins, 181 Wn. App. 67, 78, 325 P.3d 306 (2014)...............25

Rivers v. Wash. State Conf. of Mason Contrs., 145 Wn.2d
674, 41 P.3d 1175 (Waqsh. 2002)....................................25

Robel v. Roundup Corp., 148 Wn.2d 35, 51,
59 P.3d 611 (2002)...20, 21, 22, 23

Regulations

CR 59...13

RAP 10.3(a)(6)..27

RAP 13.4(b)(1)..19

I. IDENTITY OF PETITIONER

Michael J. Riccelli and Bruce E. Cox, attorneys for Diane Christian and Casey Christian, plaintiffs and appellants herein, ask this Court to accept review of the court of appeal's decisions designated in Part "II" of this petition.

II. COURT OF APPEALS DECISION

A copy of the Division III Court of Appeals Published Opinion filed December 15, 2015, is attached in the Appendix as pages A-1. A copy of Division III Court of Appeals Order filed February 4, 2016, is attached in the Appendix at pages A-2. The court of appeals considered the trial court's action dismissing petitioners' loss of chance medical malpractice and tort of intentional infliction of emotional distress outrage claims. The appellate court reversed the trial court's dismissal of the medical malpractice claim, and confirmed dismissal of the outrage claim. *Christian v. Tohmeh*, 191 Wn. App. 709, (Wash. Ct. App. 2015) (reconsideration denied).

III. ISSUES PRESENTED FOR REVIEW

1. When considering the evidence that, in an apparent effort to avoid a claim of professional medical malpractice, a physician:

   a. deceives his patient about the nature and extent of her injuries and implies that they are psychosomatic and otherwise due to her lethargy and obesity;

   b. intentionally fails to provide the appropriate medical diagnosis and

treatment;

c. intentionally attempts to persuade another physician to change her diagnosis (and therefore treatment) of the same patient's medical condition; and

d. causes the patient severe mental and emotional distress and harm,

is this evidence sufficient to create issues of fact as to a claim of outrage.

2. Where a trial court reconsiders a summary judgment motion and considers new and/or supplemental evidence, and the appellant assigns error as to the sufficiency of evidence on summary judgment and reconsideration, should the appellate court apply a de novo standard of review, or one based upon abuse of discretion.

3. Where: (a) an appellant appeals from an adverse trial court ruling on a motion for summary judgment, and a subsequent denial on reconsideration; (b) the trial court considered additional evidence on reconsideration; and (c) is the appellant's general arguments on sufficiency of the evidence, which includes the evidence reviewed upon reconsideration, sufficient argument to address the motion for reconsideration on appeal.

4. Where a trial court states in an order that it reviewed various enumerated documents submitted by the moving and opposing parties, should an appellate court conclude that use of the term 'reviewed' by the trial court does not clearly establish whether the trial court considered or contemplated these

documents when rendering its opinion on the motion.

5. Whether the court erred in making inference on the evidence favorable to the prior moving party.

IV. STATEMENT OF THE CASE

A. Nature of the Case

This matter arises from and relates to claims of injury and damage due to the alleged post-surgical negligence of respondent Dr. Tohmeh. Appellant Diane Christian suffered permanent physical injury and neurological deficits, which became symptomatic shortly after low back spinal surgery by Dr. Tohmeh. Diane's husband, Casey Christian, is claiming loss of consortium. (CP 7). In addition, the Christians claim the tort of outrage (the intentional infliction of emotional distress) caused by Dr. Tohmeh. (CP 6-7). Specifically, the Christians claim Dr. Tohmeh's post-surgical care and conduct: (1) breached the applicable standard of care; (2) constituted intentional and outrageous conduct which caused Diane severe and lasting emotional distress. (CP 6-7).

B. Surgery and Post Operative Hospitalization

As claimed in a preoperative assessment, Diane, then age 49 at surgery, had a history of bilateral leg pain and numbness (right more than left), 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, 103). During the surgery, the spinal cord dura (enclosure) was punctured,

which Dr. Tohmeh repaired by stitching. (CP 184). Pertinent hospital nursing and physical therapy notes indicate the following:

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 394).

12/6/05. **New symptom**: "Slight tingling in toes, bilaterally. " (CP 395-96).

12/7/05. **New symptom**: "Strong tingling to feet bilaterally… " (CP 396-97). **New symptom**: Additional ***complaints of severe pain in thighs and buttocks bilaterally (rated at "7" while medicated for pain)*** due to muscle spasms. Administered a laxative due to lack of bowel movement for three days. *(Id)*. **New symptom**: Cool sensation bilaterally to the thighs, and down the anterior portion of legs. Dr. Tohmeh was there and was aware of patient's complaints. *(Id.)* Physical therapy note – "complaint of tingling, numb feet." (CP 397-98). Physical therapy note: tingling, numbness. *(Id.)*. 15 mg morphine administered. *(Id.)*

12/8/05. Bowel tones noted. Patient complained of bilateral toe numbness. "Doctor aware of complaints." *(Id.)* Patient wants urinary catheter to remain (catheter apparently removed). *(Id.)* Physical therapy note – "Feet are still tingling." (CP 397-98). **New symptom**: Vaginal and perineal (saddle area) numbness, unable to void, at this time. *(Id.)* **New symptom**: Physical therapy

note – Loss of sensation in perineum, and unable to urinate. *(Id.)* Patient unsuccessful at attempts at voiding bladder and bowel movement. Patient complains of numbness to perineal area. *(Id.)* 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.)* Patient voids 260 ml. Nurses continue to observe bladder function. *(Id.)*

12/9/05. Continued complaints of numbness to vaginal area, tingling to ankles and feet, bilaterally. (CP 398-99). Continued complaints of numbness to both feet and vaginal area. *(Id.)* Dr. Tohmeh visits and advises patient that in-home nursing will be necessary to monitor urinary output and writes prescription for same. *(Id.)* Physical therapy note – numb feet. *(Id.)*. Patient voids approximately 100 ml from bladder, retaining approximately 400 ml. (CP 109). Dr. Tohmeh authorizes patient release to home with orders for a Foley catheter and home nursing. (CP 109-10*)*. Catheter reinserted, and approximately additional 500 ml voided. *(Id.)* 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 other new neurogenic symptoms. (Note: surgery was 12/5/05, but summary not dictated until 1/5/06, and digitally authenticated by Dr. Tohmeh 2/2/06.)*** (CP 41-42).

OUTRAGEOUS CONDUCT

On concerns raised by Diane, and on referral from Dr. Tohmeh, Diane's bladder symptoms were 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 Diane's bladder retention issues. (CP 195-97). ***Dr. Olefin also found decreased sensation in the left labia and left portion of the vagina, also in the medial portion of Diane's thighs, extending down her leg***. (CP 196).

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

> "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."**
>
> 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

Dr. Tohmeh also referred Diane to physiatrist Larry K. Lamb, M.D. to perform an EMG (an electrodiagnostic nerve conduction study) on Diane's left leg. (CP 121, 126). Dr. Lamb provided results on testing lumbar nerves and sacral nerves S1 and S2, but not S3 through S5. (CP 126). The test was inconclusive. (CP 126). During this time, Diane did not improve and continued to raise concerns with Dr. Tohmeh. (CP 117-20).

On March 2, 2006, Dr. Tohmeh wrote a letter to Diane addressing the fact that Diane had discussed several concerns with Dr. Tohmeh's assistant. (CP 116). As is thoroughly discussed in Diane's return letter to Dr. Tohmeh dated March 16, 2006, Diane had been doing internet research and found that her symptoms coincided with a constellation of neurological deficits known in the medical community as cauda equina syndrome ("CES"). (CP 117-120). Diane's internet search is 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

As a result of the surgery: Diane suffered from bowel, bladder, and sexual dysfunction; had mobility issues necessitating the use of a cane; gained weight; suffered physical pain requiring pain control medication; suffered from fatigue; and had significant depression. (CP 154, 157, 194, 121-24). 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*** which Dr. Tohmeh states rules out any issues with S3 through S5. (CP 116). Clearly, then, Dr. Tohmeh knew S3 through S5 were at issue, and misrepresented Dr. Olefin's

findings. Further, according to Dr. Wang, Dr. Tohmeh's expert surgical witness, any physician, out of general anatomy knowledge, should know that nerve roots below S2 (S3, S4 and S5) affect bladder and saddle area muscles and nerves. Again, Dr. Olefin diagnosed a neurogenic bladder and found decreased left labial, vaginal, and medial thigh sensation, none of which is addressed by Dr. Tohmeh. (CP 116; CP 196-97) Dr. Tohmeh's letter clearly and intentionally deceives Diane when addressing Dr. Lamb's L5, S1 and S2 EMG test results, when knowing the S3, S4 and S5 nerve roots should be tested. Diane wrote a letter to Dr. Tohmeh on March 16, 2006, in which she expresses her frustration, anguish, anger, and pain over her condition and her post surgical treatment by Dr. Tohmeh:

> "... 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 117-20).

Diane's letter (an excerpt of which is provided above) clearly establishes her emotional distress caused by Dr. Tohmeh's lack of addressing her physical symptoms, and his inference of psychosomatic causation. (CP 117-20)

Diane also testified in her deposition that Dr. Tohmeh, in his office, became angry and yelled at her and her husband, and his presumption that there is nothing neurologically wrong with her, leaving the converse (psychosomatic) as the inference of choice. (CP 182-87). This testimony underwrites the nature and tenor of Diane's March 16, 2006 letter (CP 177-20).

Diane 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 CES.*** (CP 121-24). The diagnosis was based upon objective and subjective symptoms, clinical observations, and testing. (CP 122-26) ***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*** as did Dr. Olefin's diagnoses of neurogenic bladder and left labial, vaginal, and saddle area sensory deficits. (*Id.*, CP 197). Further, in her summary, provided Diane's primary care

physician, Dr. Moise noted the following, which confirmed Dr. Tohmeh's role in causing Diane emotional distress and depression.

> "Physical Examination:
>
> This is a patient with depressed affect who was tearful during much of this visit (she had no problem with depression before her surgery but has been **very depressed by the symptoms listed above, for which no one has seemed to have acknowledged a cause or even the fact that these are valid and true symptoms related to a true problem).** Blood pressure is 100/82, heart rate 88, and respirator rate 16. This patient gives a very accurate and reliable history, and I did not see any sign of psychologic overlay, amplification or malingering."

Dr. Moise testified in her discovery deposition, recalling her interaction with Dr. Tohmeh after she diagnosed Diane with CES, 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 Diane, 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 Diane 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 cauda equina-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 129-30)

TRIAL AND APPELLATE PROCEDURE

The trial court granted the defendants' motion for summary judgment on May 6, 2014 (CP 218-220) and denied the Christians' motion for reconsideration on June 3, 2014 (CP 323-324). The Christians briefed the trial court on its discretion to consider new and supplemental evidence on reconsideration. (CP 325-34. The court required (and considered) new and additional evidence in the

form of the Christians' medical expert's declaration, and medical ethics experts declaration and Dr. Tohmeh's medical expert's depositions: Dr. Bigos (CP 235-47), Dr. Pearlman (CP 243-49), and Dr. Wang (CP 261-69). The Christians timely appealed both the trial court's granting of defendants' motion for summary judgment and its denial of their motion for reconsideration.

In a published opinion dated December 15, 2015, the court of appeals reversed the trial court's entry of summary judgment with respect to the Christians' medical malpractice loss of chance of a better outcome claim. However, the court of appeals affirmed the trial court's dismissal of their intentional infliction of emotional distress (outrage) claim and declined to address the Bigos and Pearlman declarations and Wang's testimony, from the motion for reconsideration, apparently for lack of assignment of specific error under CR 59, and/or lack of briefing and argument on an abused discretion standard of review. The court of appeals stated:

> ***A thorough analysis and citation to authority is particularly needed for us to consider Diane Christian's claimed error in the trial court's denial of her motion for reconsideration.*** CR 59(a) lists nine grounds on which a trial court may reconsider a decision. Diane Christian sought reconsideration on four grounds. Those grounds, with their language from CR 59(a), are
>
> (4) Newly discovered evidence, material for the party making the application, which the party could not with reasonable diligence have discovered and produced at the trial;
>
> . . .
>
> (7) That there is no evidence or reasonable inference from the evidence to

justify the verdict or the decision, or that it is contrary to law;

(8) Error in law occurring at the trial and objected to at the time by the party making the application; or

(9) That substantial justice has not been done.

This court reviews a trial court's decision to grant or deny a motion for reconsideration for abuse of discretion. *Davies v. Holy Family Hosp.*, 144 Wn. App. 483, 497, 183 P.3d 283 (2008).

On appeal, Diane Christian does not identify upon which of the four reconsideration grounds she relies, nor does she provide any analysis to assist us in declaring one of the grounds germane. ***In her briefs, Christian cites to the subsequent declaration of Dr. Stanley Bigos and the deposition testimony of Dr. Jeffrey Wang, and she assumes we will consider the testimony. Nevertheless, Christian does not address whether the evidence was newly discovered and whether the evidence could not have reasonably been supplied to the trial court before entry of the summary judgment order.***

Christian, supra at 191 Wn. App. 709, 728-729.

Both parties timely moved the court of appeals for reconsideration which the Division III court denied on February 2, 2016.

In rendering its opinion on the Christians' outrage claim, the court of appeals made certain factual assumptions or inferences that are: inconsistent with; not supported by; are not contained in the record; and are not favorable to the non-moving party, the Christians. Rather, it is apparent that the appellate court resolved most factual evidence and reasonable inferences therefrom to the benefit of the moving part, Dr. Tohmeh. Correction of these assumptions may assist this court in considering the Christians' Petition for Review. On page two of the

opinion, the court wrote:

> "According to Christian, Dr. Tohmeh must have caused damage to her cauda equina, a bundle of nerves in the low back, during the surgery".

There is no evidence the Christians contend Dr. Tohmeh caused injury to Diane's cauda equina. There is medical evidence that injury to Diane's cauda equina was a result of or related to the surgery. (CP 144, 158). Further, according to Dr. Tohmeh's own medical expert, Dr. Wang, had Diane reported new neurological symptoms and severe back pain, Dr. Tohmeh should have ordered low back radiology performed and performed exploratory surgery. Most often the cause of CES, post-surgically, is a hematoma (CP 263-64). Depending on delay and severity, patient improvement varies between no improvement to full recovery. (CP 264). Post surgery, Diane had severe buttock and thigh pain, and new neurological symptoms. (CP 111).

On pages two and three of the opinion, the court of appeals wrote that the stated purpose of a second surgery by Dr. Tohmeh would be to determine whether Diane's cauda equina had suffered damage, and if so, that the second surgery might have allowed Dr. Tohmeh to repair damage to the cauda equina. There is no testimony to support either of those statements. There is testimony to support the fact that a common suspected cause of this type of injury after lower back surgery is bleeding that results in a hematoma (blood clot), the pressure of which may compress and injure nerve roots, that a second surgery would be exploratory

in nature, and if a hematoma is found, the surgery would decompress the pressure of the hematoma. (CP 145; 240, 264). According to Dr. Bigos, the Christians' medical surgical expert:

> "9. The predictability of individual outcomes relate to objective clinical conditions prior to taking action upon neurological symptoms that are consistent with Cauda Equina Syndrome (CES), or any other similar neurological deficit. These factors include, but are not limited to, the degree, nature, and extent of new neurological symptoms; time from onset at which a proper evaluation occurs; when deemed appropriate, subsequent surgical intervention occurs, with respect to onset of symptoms; and, the nature and extent of original surgical intervention. This could be a laminectomy (decompression) or discectomy (removal of offending hematoma intervertebral disc or other material).
>
> 10. The literature and animal studies suggest that the sooner the decompression the better without a cutoff within the timeline of recorded alerting complaints and findings. This, even though, as an example, medical action within the first or second day and/or with varying symptoms, might be considered as within the standard of care, and thereafter, not. Certainly, the progressive (rather than sudden) onset of symptoms, coupled with early medical intervention, suggest Ms Christian's potential for recovery would have been incrementally better than had the opposite been true."

In such an instance, such recovery would be consistent with Dr. Bigos' testimony regarding a 40 percent loss of chance. (CP 145). In no instance is there any testimony that any direct action by Dr. Tohmeh or any other physician would serve to directly repair damage to cauda equina.

On page five of the opinion, the court noted the Christians do not contend the puncture to the dura surrounding the spinal cord caused CES. However, since Dr. Tohmeh did not do any imaging or perform subsequent exploratory surgery to

assess whether a hematoma was present post-surgery, it is unclear what actually caused Diane's neurological injuries diagnosed as CES. (CP 143-148). Regardless, ***it is clear that her neurological injuries resulted from the surgery***, according to: Diane's expert medical witnesses Dr. Bigos (CP 143-148, 237-238) and Dr. Seroussi (CP 158); and Diane's treating physician Dr. Moise (CP 121-124, 136, 137). Further, that Diane's condition is fully consistent with a post-surgical hematoma causing the nerve damage. (CP 121-24). Even Dr. Tohmeh's expert medical witness Dr. Wang admits Diane had some nerve damage (CP 268).

On page 37 of the opinion, the court of appeals wrote:

> "Diane Christian claims that Dr. Antoine Tohmeh outrageously attempted to avoid liability by denying she experienced cauda equina syndrome. Nevertheless, Dr. Tohmeh referred Christian to a gynecologist, neurologist, bowel specialist, and urologist. Referring a patient to a number of specialists is not the conduct of a physician seeking to avoid liability. Christian emphasizes that the neurologist did not study her nerve conduction in the critical area of her spine, and she suggests Tohmeh is to blame for an incomplete nerve study. Nevertheless, no evidence suggests that Tohmeh and the neurologist conspired to hide information from Christian. The neurologist was free to perform the conduction study at levels of the spine deemed appropriate."

This is the most troublesome set of assumptions made by the court. Diane did not see a gynecologist at the behest of Dr. Tohmeh. Diane telephone Dr. Tohmeh's office on March 2, 2006, wherein Diane complaint about Dr. Tohmeh's lack of addressing her severe and apparent permanent neurological deficits. (CP 177-20). In response, Dr. Tohmeh wrote a letter of that date. (CP 116). In that letter, he says he awaits the report of Dr. McNevin and says he

is scheduling her to be seen by a gynecologist. (CP 116). The referral was never accomplished, as Diane left the services of Dr. Tohmeh, in favor of Dr. Moise (CP 121-24). Further, the evidence is clear that Diane pleaded with Dr. Tohmeh to be referred to a neurologist, but that no such referral was made. (CP 116-20). Again, Dr. Lamb, a physiatrist, not a neurologist, performed a limited EMG test, not a global neurological assessment. (CP 121, 116). Factually, Dr. Tohmeh tried to convince Diane her problems were gynecological and colorectal in nature, but not neurological, which Diane thought otherwise. (CP 117-20). When the court wrote "referring a patient a number of specialists is not the conduct of a physician seeking to avoid liability," it must have presumed Dr. Tohmeh referred Diane to various specialists with orders to diagnose, or rule out, or rule in, nerve damage or CES arising from or relating to Diane's surgery. There is no evidence to support this. Further, there is no evidence or allegation to support the court's reference to a conspiracy between Dr. Tohmeh and Dr. Lamb, the doctor who performed the EMG nerve conduction study. Contrary, to anyone who has been referred from one physician to another, it is apparent, if not common knowledge, that the referring physician provide written orders or requests as to specific treatment or diagnosis sought. Further, that the referred physician reports back to the referring physician, not the patient. This is what occurred here when Dr. Tohmeh carefully filtered Dr. Olefin's report of a neurogenic bladder and sensory deficits when communicated with Diane. (CP 116). Further, Dr. Tohmeh used the inconclusive

S1-S2 EMG report by Dr. Lamb to further attempt to reinforce his "psychosomatic" façade with Diane, failing to reveal that testing for CES should include S3 through S5.

We already know, factually, that Dr. Tohmeh misrepresented the findings of the urologist, and that any physician should know that levels below S2 need to be tested for the symptoms Diane had. (CP 267-68; 121). Further, there is no evidence the physician who performed the nerve conduction study was a neurologist. In fact, Dr. Lamb, at the time of the study, was a physiatrist and in practice with Dr. Moise. (CP 121)

V. ARGUMENT

A. Review

The Washington Supreme Court may accept a Petition for Review of a decision by the Court of Appeals:

> "(1) If the decision of the Court of Appeals is in conflict with a decision of the Supreme Court; or ...
>
> (4) If the Petition involves an issue of substantial public interest that should be determined by the Supreme Court."

RAP 13.4(b)(1)(4).

The Court should accept review of this matter because: (1) the underlying Court of Appeals decision is in conflict with prominent decisions of the Washington Supreme Court regarding the standard of review and sufficiency of evidence; and (2) this petition presents an issue of substantial public interest

which should be determined by the Supreme Court. This is, generally, under what factual circumstances a physician may breach his fiduciary and ethical responsibilities and duties to a patient without exposing him to a claim of outrage.

B. The Facts Before the Court Support the Tort of Outrage.

A physician's intentional acts, such as Dr. Tohmeh's, in putting his interests before his patient's to the extent the patient is: (a) misdiagnosed by him; (b) deceived by him; and (c) he interferes with her care, among other things, must be seen as outrageous conduct by any court and by any member of the public. This is patent, even without reference to Dr. Wang's deposition testimony, Dr. Bigos' medical testimony, and Dr. Pearlman's medical ethics testimony.

> "To prevail on a claim for outrage, a plaintiff must prove three elements: (1) extreme and outrageous conduct; (2) intentional or reckless infliction of emotional distress; and (3) severe emotional distress on the part of the plaintiff."
>
> *Robel v. Roundup Corp.*, 148 Wn.2d 35, 51, 59 P.3d 611 (2002).

The first element requires proof that the conduct was so outrageous in character and so extreme in degree as to go beyond all possible bounds of decency, and to be regarded as atrocious and utterly intolerable in a civilized community. Although the three elements are fact questions for the jury, this first element of the test goes to the jury only after the court determines if "reasonable minds could differ on whether the conduct was sufficiently extreme to result in liability." *Id.* If not universal in condemnation of Dr. Tohmeh's acts and

omissions, reasonable minds could, at minimum, differ as to the nature of his conduct. The fiduciary and ethical obligation of a physician to their patient, just as an attorney to their client, should remain inviolate, and require the highest of adherence by the physician. Here, the violations are extreme and outrageous in nature and character. In this matter, the nature and frequency of various and extreme breaches of Dr. Tohmeh's professional ethical obligations patently supports an actionable claim of outrage.

In *Robel*, the plaintiff was employed at the service deli of the Francis Avenue Fred Meyer store in Spokane. She sustained a work place injury and filed a worker's compensation claim. She was given a light duty assignment where she stood at a display table outside the deli area offering samples of food items to customers. Over the course of approximately two months in August and September of 1996, various deli workers laughed and acted out a slip and fall as one of them yelled "Oh, I hurt my back, L&I, L&I!" They audibly called her a "bitch" and "cunt." They "told customers she had lied about her back and was being punished by Fred Meyer …." The Assistant Deli Manager and others made fun of her, laughed, pointed, and gave her "dirty looks." The Assistant Deli Manager and other workers would stare at her, whisper out loud, laugh and pretend to hurt their backs. Various deli workers laughed and audibly admonished each other not to harass Robel. They talked about her and laughed at her, called her names, and pretended to hurt their backs yelling "L&I." One day before

Robel left the deli she overheard the Assistant Deli Manager say to other employees, "Can you believe it, Linda's going to sit on her big ass and get paid." *Id.* at p. 40-41.

Robel later filed suit against Fred Meyer for numerous claims including intentional infliction of emotional distress. *Id.* at p. 41. The case went to a non-jury trial in which the court found for the plaintiff on all of her causes of action awarding special and general damages, attorney fees and costs. *Id.* at p. 42. Fred Meyer appealed and the court of appeals reversed on all claims. *Id.* The Supreme Court reversed the court of appeals.

With respect to the intentional infliction of emotional distress claim brought by *Robel*, the Supreme Court wrote:

> "While the standard for an outrage claim is admittedly very high (by which we mean that the conduct supporting the claim must be appallingly low), we disagree with the court of appeals on the threshold legal question and conclude that reasonable persons could deem the employer's conduct, as set forth in the unchallenged findings, sufficiently outrageous to trigger liability ... we believe that reasonable minds (such as the one exercised by the trial judge) could conclude that, in light of the severity and context of the conduct, it was *beyond all possible bounds of decency ... atrocious, and utterly intolerable in a civilized community...* This court has recognized that in an outrage claim the relationship between the parties is a significant factor in determining whether liability should be imposed. ... added impetus is given to an outrage claim when one in a position of authority, actual or apparent, over another has allegedly made racial slurs and jokes and comments ..." (emphasis added)
>
> *Robel,* 148 Wn.2d at 51-52.

Based on this evidence, the Christians allege Dr. Tohmeh engaged in a

pattern of intentional behavior to obfuscate diagnosis of Diane's neurological deficits and, therefore, prevent a proper diagnosis and treatment in an attempt to avoid legal liability. Diane was emotionally harmed and affected, in addition to physical harm. To make matters worse, Dr. Tohmeh was in both: (a) a position of authority having unique professional medical knowledge not possessed by his patient; (b) charged with advocating for and promoting Diane's health and well being; and (c) in a professional, fiduciary relationship with Diane, requiring he resolve any issue or conflict to her health and well being in her favor, and, most importantly avoiding any act or omission that could cause her harm.

Surely, Dr. Tohmeh's actions have at least as much implication of concern to the public. What is also clear is that Dr. Tohmeh displayed more devious intent, then is found in the facts of *Robel*.

C. The Standard of Review of Reconsideration of Summary Judgment is De Novo When Additional Evidence is Considered.

The Division III Court's errors, are patent. In their Amended Appeal Brief, the Christians set forth three assignments of error. None specifically refer to the summary judgment motion or the motion for reconsideration, but substantively deal with: a) Sufficiency of evidence of loss of chance; b) Treatment of the outrage claim I this case as an ordinary tort; and sufficiency of evidence of the tort of outrage. ***Here, no assignment of error under CR59 is necessary, as: 1) the trial court accepted the new and supplemental evidence, and it is not an***

issue here, and 2) where factual issues are at issue in a motion for reconsideration of a summary judgment, the standard of review is de novo, not abuse of discretion, especially when new or additional facts are considered:

> An appellate court would not be properly accomplishing its charge if the appellate court did not examine all the evidence presented to the trial court, including evidence that had been redacted. ***The de novo standard of review is used by an appellate court when reviewing all trial court rulings made in conjunction with a summary judgment motion.*** This standard of review is consistent with the requirement that evidence and inferences are viewed in favor of the nonmoving party, Lamon, 91 Wn.2d at 349 (citing Morris, 83 Wn.2d at 494-95), and the standard of review is consistent with the requirement that the appellate court conduct the same inquiry as the trial court. Mountain Park Homeowners Ass'n, 125 Wn.2d at 341.
>
> *Folsom v. Burger King*, 135 Wn.2d 658, 663, 958 P.2d 301, 305 (Wash. 1998)(emphasis added)

This holding from *Folsom* was confirmed by *Keck v. Collins*, 184 Wn.2d 358, 357 P.3d 1080, (2015). There, the Supreme Court distinguished *Keck* from *Folsom*. It held that a motion to strike evidence, which was at issue on summary judgment, was subject to an abuse of discretion standard of review, as the procedural aspect, not consideration of the actual evidence, was it issue.

Here, on reconsideration of a motion for summary judgment, the trial court clearly entertained new and supplemental facts, and those facts should be part of a de novo review. There is no Washington Supreme Court authority to allow substantive, factual summary judgment motions for reconsideration to be held to an abuse of discretion standard of review. Appellate court cases to the direct

contrary are in conflict with Washington Supreme Court cases cited immediately above such as Division III's *Keck v. Collins*, 181 Wn. App. 67, 325 P.3d 306, 2014 Wash. App. 2014. Conversely, ***trial court motions for reconsideration on <u>procedural matters</u> are reviewed for abuse of discretion.*** *Rivers v. Wash. State Conf. of Mason Contrs.*, 145 Wn.2d 674, 41 P.3d 1175 (Wash. 2002). It would simply be incongruent to allow the de novo review of a judge's determination of the sufficient of evidence relating to an original judgment motion, and apply an abuse of discretion standard when a judge considers additional or new evidence on reconsideration. How could this incongruence be reconciled with the interests of justice. This, especially considering reconsideration of an order of summary judgment in a pre-trial motion results in no prejudiced as might a post trial motion for a new trial for newly discovered evidence.

D. <u>The Trial Court Considered the New and Supplemental Evidence on Reconsideration as Should the Courts on Appeal</u>.

The trial court considered the deposition testimony of Dr. Wang, the declaration of Dr. Pearlman, and the supplemental declaration of Dr. Bigos. (CP 323-4)

On page 19 of the underlying opinion, the court of appeals wrote:

> "The trial court denied Diane Christian's Motion for Reconsideration. The Order denying the motion mentions that the court *<u>read</u>* the supplemental pleadings filed by Diane Christian. The order, however, does not indicate whether the trial court *<u>considered</u>* the evidence in the pleadings ... when determining whether to grant the motion for reconsideration." (Emphasis added).

The court of appeals also wrote, at page 19:

> "The trial court denied the motion, but we do not know if the court excluded the additional testimony from *contemplation* when denying the motion." (Emphasis added).

The court of appeals is making a distinction without a difference. In its June 3, 2014 order denying the Christians' motion for reconsideration, the trial court wrote in relevant part:

> "This matter having come before the court on the motion of Plaintiffs ... Christian for reconsideration ... the Court having *reviewed* the files and records herein, mindful of its previous decision re: summary judgment, having *reviewed* Plaintiffs' Motion for Reconsideration, Memorandum in Support of Reconsideration, Declaration of Olive E. Easterwood in Support of Reconsideration, with attachments thereto, Declaration of Stanley J. Bigos, M.D., in support of reconsideration, Declaration of Robert A. Pearlman, M.D., M.P.H., in support of reconsideration, and the Declaration of Michael J. Riccelli in Support of Reconsideration, with attachments thereto, having *reviewed* defendant Antoine Tohmeh's Response to Plaintiffs' Motion for Reconsideration, and otherwise being fully advised, NOW ORDERS AS FOLLOWS:" Christians' Motion for Reconsideration is Denied. (Emphasis added).

In fact, the trial court's use of the term "review" is most appropriate here, more so than the term "contemplation." Consider the following from Black's law dictionary:

> "CONTEMPLATION. The act of the mind in considering with attention. Continued attention of the mind to a particular subject. Consideration of an act or series of acts with the intention of doing or adopting them. The consideration of an event or state of facts with the expectation that it will transpire.
>
> REVIEW. To re-examine judicially. A reconsideration; second view or examination; revision; consideration for purposes of correction. Used

especially of the examination of a cause by an appellate court; and of a second investigation of a proposed public road by a jury of viewers." (citations omitted)

Black's Law Dictionary, 4 ed.

The trial court's utilization of the word 'reviewed' demonstrates by definition it considered, and therefore 'contemplated' Dr. Wang's deposition testimony (CP 261-69), the Declaration of Dr. Pearlman (CP 243-48), and the Supplemental Declaration of Dr. Bigos (CP 236-242). The trial court wrote that it 'reviewed' these documents and was 'fully advised.' This evidence is undoubtedly part of the record and should have been considered by the court of appeals when rendering its opinion.

VII. CONCLUSION

The trial court 'reviewed' Dr. Wang's deposition transcript, Dr. Pearlman's declaration and Dr. Bigos' supplemental declaration. The court of appeals should have considered these prior to rendering its opinion. To the extent Christian violated RAP 10.3(a)(6), a minor technical violation of the rules should be overlooked and this case decided on its merits. This is particularly so because there is no evidence Dr. Tohmeh was prejudiced and the court of appeals did not write it was inconvenienced by the violation. Finally, the Christians have presented admissible evidence of Dr. Tohmeh's extreme and outrageous conduct. A jury is required to adjudicate whether Dr. Tohmeh intentionally inflicted emotional distress upon the plaintiffs. For these reasons, the court is requested to

grant the Christians' Petition for Review.

RESPECTFULLY SUBMITTED this 15 day of March, 2016.

MICHAEL J RICCELLI PS

By: [signature]
Michael J. Riccelli, WSBA #7492

DECLARATION OF SERVICE

I caused to be served a true and correct copy of the foregoing by the method indicated below, and addressed to the following:

Christopher J. Kerley,
Markus W. Louvier
James B. King
Evans, Craven & Lackie, P.S.
818 w. Riverside, Suite 250
Spokane, WA 99201

____ Overnight Mail
XX U.S. Mail
____ Hand-Delivered
____ E-Mail
____ Facsimile

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Dated this 15th day of March, 2016

[signature]

RECEIVED
SUPREME COURT
STATE OF WASHINGTON
Mar 15, 2016, 4:58 pm
BY RONALD R. CARPENTER
CLERK

APPENDIX

RECEIVED BY E-MAIL

Appendix Page Nos.	Date Filed	Pleading Title
A-1	12/15/15	Published Opinion
A-2	2/4/16	Order Denying Motions for Reconsideration

FILED
DECEMBER 15, 2015
In the Office of the Clerk of Court
WA State Court of Appeals, Division III

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION THREE

DIANE CHRISTIAN and CASEY CHRISTIAN, wife and husband, Appellants, v. ANTOINE TOHMEH, M.D., and "JANE DOE" TOHMEH, husband and wife, and the marital community composed thereof; PROVIDENCE HEALTH CARE, a Washington business entity and health care provider; HOLY FAMILY HOSPITAL, a Washington business entity and health care provider; ORTHOPAEDIC SPECIALTY CLINIC OF SPOKANE, PLLC, a Washington business entity and health care provider; and DOES 1-5, Respondents.	)	No. 32578-4-III PUBLISHED OPINION

FEARING, J. — We face again the question of whether a patient presented essential expert testimony to defeat her physician's summary judgment motion in a case in which the patient claims a lost chance of a better outcome because of an alleged breach in the standard of care by the physician. The patient in our appeal also pleads the tort of

outrage, a cause of action unusual in the patient-physician setting. The trial court granted the physician summary judgment and dismissed both causes of action. The major question on appeal is whether the patient, in response to a summary judgment motion, must provide expert testimony particularizing or describing the nature of the better outcome in addition to offering a percentage for the chance of the improved outcome. We answer the question negatively. Thus, we reverse the judgment in favor of the physician on the medical malpractice claim. We affirm the judgment dismissing the claim of intentional infliction of emotional distress.

FACTS

Plaintiffs are Diane and Casey Christian, wife and husband. For ease in reading, we refer to the plaintiffs only as Diane Christian, the patient of defendants Dr. Antoine Tohmeh and Orthopaedic Specialty Clinic of Spokane, PLLC (Clinic). Tohmeh was a physician employed by the Clinic. We refer to the defendants collectively as Dr. Tohmeh.

Dr. Antoine Tohmeh performed laminectomies on Diane Christian's lower back on December 5, 2005. According to Christian, Dr. Tohmeh must have caused damage to her cauda equina, a bundle of nerves in the low back, during the surgery. She does not argue that Tohmeh breached the standard of care when initiating damage to the cauda equina. She instead contends that her postoperative symptoms should have alerted Tohmeh to the possibility of damage and led Tohmeh to perform another surgery to

explore if the cauda equina suffered damage. In turn, Christian maintains that postoperative surgery would have increased her chances for a healthier recovery by forty percent. Although neither party discusses the nature or ramifications of postoperative surgery, presumably the surgery might have allowed Dr. Tohmeh to discover and repair any damage to the cauda equina. Diane Christian sues for a loss of a better chance of recovery from surgery.

The principal question on appeal is whether Diane Christian presented expert testimony sufficient to overcome Dr. Antoine Tohmeh's summary judgment motion. Although we present the facts and the testimony that picture Christian's case in the best light, we also detail some of the opinion testimony favorable to Dr. Tohmeh.

Plaintiff Diane Christian experienced chronic low back pain and weakness in her legs. On April 14, 2005, defendant Dr. Antoine Tohmeh evaluated Christian to address her continuing symptoms. Christian's general physician, Dr. Richard Parker, requested the evaluation.

During the April 14 appointment, Diane Christian complained about pain in both legs, with the pain focused in the front thighs. The thighs also suffered numbness. Christian could not walk two blocks without assistance. Christian then encountered no bowel or bladder disturbance. We mention the lack of bowel and bladder problems because Christian underlines her suffering from bowel and bladder difficulties, after the surgery performed by Dr. Antoine Tohmeh, as evidence of cauda equina that should have

led to a second surgery to repair damage to the cauda equina.

After he reviewed Diane Christian's MRI (magnetic resonance imaging) and an X ray of her lower back, Dr. Antoine Tohmeh diagnosed Christian with two bulging discs and severe and abnormal narrowing of the spinal canal at multiple levels in the thoracic and lumbar regions of the spine. Medicine labels abnormal narrowing of the spinal canal as stenosis. On April 14, Tohmeh spoke at length with Christian and her husband about her options for achieving pain relief. Christian understandably wished minimally invasive surgery. Dr. Tohmeh explained, however, that given the abnormalities at multiple levels of her spine, an open, invasive surgery would be more expedient and efficient. At the conclusion of the April 14 consultation, the physician and patient decided to forgo immediate surgery and instead pursue a course of epidural spinal injections and physical therapy.

Between April and October 2005, Diane Christian underwent three epidural injections, which provided excellent, but temporary, pain relief. On October 18, 2005, Dr. Antoine Tohmeh evaluated Christian again. Christian reported continuing pain in both legs from the anterior thigh down to her knees, but not in her abdomen or groin. She recounted three recent falls. Christian did not report any bowel or bladder trouble. Christian, her husband, and Tohmeh again discussed her options. Dr. Tohmeh again recommended invasive surgery to resolve the symptoms at many levels of the spine. Christian consented to laminectomies.

On December 5, 2005, Dr. Anotine Tohmeh performed on Diane Christian partial L-2, complete L-3, complete L-4, and complete L-5 laminectomies. "L" stands for the lumbar spine, and the number attached to the "L" refers to the level of the lumbar spine with the lower number corresponding to a higher level. A laminectomy removes or trims the lamina of the vertebra to widen the spinal canal and create more space for the spinal nerves. Tohmeh also performed bilateral partial facetectomies and foraminotomies of the L-2, L-3, and L-4 nerve roots. The latter two procedures release pressure on the spinal nerves. During the surgery, Dr. Tohmeh accidentally punctured Christian's dura, a thick membrane surrounding the spinal cord. The puncture resulted in leaking of spinal fluid. Tohmeh sutured the needle-sized puncture wound completely to render the area "watertight." Clerk's Papers (CP) at 471. Christian does not contend that the puncture caused cauda equina syndrome. Christian tolerated the surgery well.

While recovering from surgery, Diane Christian experienced symptoms from which she did not earlier suffer. Christian reported tingling and numbness in her feet, pain in her buttocks, an inability to urinate and defecate, and a loss of sensation in her vagina and perineum. She rated the pain in her buttocks as a seven out of a possible ten. Christian also reported muscle spasms that impeded her ability to perform physical therapy. Hospital staff placed a Foley catheter into Christian's bladder to monitor urinary function.

On December 8, 2005, hospital staff removed the Foley catheter. Diane Christian then attempted to void her bladder on her own, but could not do so completely. Bladder scans revealed that Christian retained between 400 and 500 ml of urine and could only void between 100-200 ml at a time. On December 9, hospital staff reinserted a catheter in Christian, and the tube finally enabled her to completely void her bladder. Dr. Antoine Tohmeh discharged Christian, with the catheter inserted, the same day. Tohmeh then instructed Christian to return to the hospital for removal of the catheter once she could void normally at home. Tohmeh prescribed in-home nursing care to monitor Christian's urinary output.

On December 13, 2005, Dr. Antoine Tohmeh referred Diane Christian to Dr. Michael G. Oefelein, an urologist in Spokane. Dr. Oefelein diagnosed Christian with urinary retention, constipation, and grade I cystocele. A cystocele is the weakening of the supportive tissues between the bladder and vagina. Dr. Oefelein recommended Christian take Flomax and conduct a voiding trial. On December 14, Oefelein saw Christian again and performed an ultrasound. The ultrasound revealed that Christian retained 220 cc of urine in her bladder after attempting to void. Oefelein instructed Christian to continue taking Flomax and to return to him in four weeks, or sooner if she was unable to void.

On January 3, 2006, Diane Christian underwent a postoperative examination by Dr. Antoine Tohmeh. By January 3, the December 5 surgery had rid Christian of thigh

weakness and pain. Christian, nonetheless, suffered from a multitude of other symptoms, such as constipation, inability to fully void her bladder, and numbness in her left buttock, rectum, vagina, left leg, and right foot. Christian told Tohmeh that she stopped taking the Flomax prescribed by Dr. Oefelein, after which she encountered increased difficulty voiding her bladder. Dr. Tohmeh noted on his January 3 chart notes:

> Diane is recovering from her lumbar laminectomy. She has a multitude of symptoms. This could be related to chronic deconditioning and previous lack of activity as she was limited by her thigh pain and weakness and therefore would not walk enough to have foot symptoms. She recently went to Costco and walked around for about 20 minutes; she had to sit down because of foot pain. Prior to surgery she would use a shopping cart and lean over it when at the store. Overall, she has made some progress but needs water therapy for reconditioning. I also gave her a prescription for Cymbalta to hopefully improve her dysesthetic symptoms in the left buttock and left leg.

CP at 522. As a result of the January 3 symptoms, Tohmeh referred Christian again to urologist Michael Oefelein and to a colorectal specialist.

On January 4, 2006, Dr. Michael Oefelein evaluated Diane Christian again. Dr. Oefelein conducted a pelvic examination and found Christian still experienced perineal numbness. Christian reported frequent urination, including voiding throughout the night. Oefelein described Christian's condition as "neurogenic bladder with urinary retention status post multilevel lumbar laminectomy." CP at 197. An ultrasound of Christian's bladder after urination showed she only retained 36 cc of urine. Thus, Oefelein concluded that Christian's urinary retention had resolved. He instructed Christian to

decrease her fluid consumption to reduce frequent urination and to return in three to six months if she experienced bladder difficulties again.

On February 7, 2006, Diane Christian returned to Dr. Antoine Tohmeh. Christian complained of continuing numbness of the left buttock, rectum, and vagina. She described a sensation like a tourniquet around the left foot and complained of numbness in the foot.

During the February 7 examination, Dr. Antoine Tohmeh observed resolution of Diane Christian's presurgery back symptoms. Tohmeh reviewed a note prepared by Dr. Michael Oefelein on January 4 that stated Christian's urinary retention was resolved. Christian told Tohmeh that her bladder symptoms are tolerable and need not be addressed. Christian complained instead of vaginal numbness, and she told Tohmeh that she could not feel an inserted tampon. Christian reported severe constipation for which her primary physician prescribed Miralax. Tohmeh told Christian that her symptoms could relate to inactivity, pain medications, and anesthesia. Dr. Tohmeh referred Christian to Dr. Shane McNevin for a bowel workup and Dr. Larry Lamb for a nerve conduction study on her left leg.

On February 27, 2006, Dr. Larry Lamb conducted a nerve study on Diane Christian. The study detected no abnormality that would cause either incontinence or pain in the buttocks, perineum, and thighs. Nevertheless, the study did not monitor nerves at the S3-S5 level of Christian's spine, the area of the cauda equina.

On March 2, 2006, Dr. Antoine Tohmeh sent a letter to Diane Christian regarding concerns she expressed in the meantime to Tohmeh's assistant. Tohmeh explained to Christian that both the nerve study and an urologist report established that the nerves that might cause her symptoms functioned normally. Dr. Tohmeh concluded his letter by noting that none of the testing presented objective reasons for Christian's pain and discomfort. Tohmeh, however, referred Christian to a gynecologist for another evaluation and reminded her that Dr. McNevin had yet to perform the bowel evaluation.

On March 9, 2006, Dr. Shane McNevin conducted a segmental colonic transit time study. The study measures flow in the colon and can detect constipation. Dr. McNevin concluded that Diane Christian had a global abnormal delay in colon transit. McNevin recommended physical therapy for pelvic floor rehabilitation.

On March 16, 2006, Diane Christian and her husband returned to Dr. Antoine Tohmeh. Christian expressed disappointment with Tohmeh. Christian stated she wished she had not undergone the laminectomies since her postoperative symptoms exceeded her preoperation pain.

During the March 16 conference, Diane Christian declared her belief that she developed cauda equina syndrome. The cauda equina, Latin for "horse's tail," is a bundle of spinal nerves and nerve roots in the lower back. The nerves innervate the pelvic organs, perineum, bladder, sphincter muscles, hips, and legs. Cauda equina syndrome constitutes a serious neurologic condition in which damage to the cauda equina

causes loss of function of nerve roots in the lower spinal canal. Cauda equina syndrome results in severe back pain, numbness in the perineum, vagina, and anus, bladder and bowel dysfunction, sexual dysfunction, pain radiating into the legs, and gait disturbance.

During the March 16 meeting between patient and physician, Dr. Antoine Tohmeh disagreed with Diane Christian's self-diagnosis because her leg pain and weakness subsided significantly after the surgery and Christian never suffered from "overflowing" bowel or bladder incontinence. Tohmeh urged Christian to visit his recommended gynecologist and undergo the physical therapy prescribed by Dr. Shane McNevin. Christian declined Tohmeh's referral to a gynecologist. She handed Tohmeh a letter memorializing her grievances and concerns about her health. Tohmeh recommended that Christian see another physician for a second opinion and ordered an MRI to provide the second doctor with a complete evaluation.

During the March 16 conference, Dr. Antoine Tohmeh raised his voice defensively and interrupted Diane Christian and her husband when they questioned Tohmeh's conclusion that Christian lacked any neurological symptoms. In her deposition, Christian averred that Dr. Tohmeh yelled words to the effect of "[T]here['s] nothing wrong with you!" CP at 187. Casey Christian testified during his deposition that Dr. Tohmeh raised his voice when Diane challenged Tohmeh and insisted that she developed cauda equina syndrome. Tohmeh corrected himself and apologized for raising his voice. Diane Christian attested that neither she nor her husband grew angry during

the appointment with Tohmeh.

By the end of the March 16 meeting, Diane Christian concluded that her patient relationship with Dr. Tohmeh had ended since he insisted she had no injury. Dr. Tohmeh, however, never declared the doctor-patient relationship terminated.

On April 1, 2006, Diane Christian underwent an MRI of her lumbosacral spine. The images showed no abnormalities that would explain Christian's persistent symptoms.

In April 2006, Richard Parker, Diane Christian's primary care physician, referred her to physiatrist Vivian Moise. Dr. Moise found Christian's symptoms to be "highly consistent with a diagnosis of cauda equina injury." CP at 123. Moise opined that the results of the nerve conduction study did not preclude a finding of cauda equina syndrome because Christian's cauda equina symptoms lie in the S3, S4, and S5 dermatome and myotome muscles and the conduction study did not address those muscles. Moise believed Christian experienced neurologic impairment.

As a result of the April 2006 examination of Diane Christian, Dr. Vivian Moise ordered urodynamic testing and performed a rectal examination. According to Moise, the May 1 test and examination confirmed that Christian had cauda equina syndrome. Dr. Moise spoke with Dr. Tohmeh and shared her diagnosis with him. Tohmeh replied that Christian experienced significant emotional or psychologic issues that called into question her complaints. During her deposition, Moise declared that Tohmeh objected angrily and strongly to her diagnosis of cauda equine syndrome.

PROCEDURE

Diane Christian filed suit against Antoine Tohmeh. Christian alleged that Dr. Tohmeh violated the applicable standard of care by failing to provide "immediate and emergency medical intervention" to address Diane's postsurgical symptoms. CP at 6. Christian also alleged that Dr. Tohmeh "negligently or intentionally failed to order 'medical testing' of [Ms. Christian] that would [have] more definitively diagnose[d] or rule[d] out cauda equina syndrome." CP at 15. Christian further alleged that Tohmeh sought to obfuscate her symptoms in order to avoid legal liability, which conduct constituted outrageous and extreme conduct. In essence, Christian pled medical malpractice resulting in a lost chance of a better outcome and the tort of outrage.

This case in part entails a battle of medical experts. Diane Christian retained Dr. Stanley Bigos, an orthopedic surgeon, as an expert witness. Dr. Bigos opined that Diane Christian suffered from cauda equina syndrome, although he did not know what caused the syndrome. He testified that based on his education, training, background, experience, and his review of Christian's file, Dr. Tohmeh breached the applicable standard of care in his postoperative treatment of Christian. He testified that Christian's postoperative symptoms should have aroused suspicion in Dr. Tohmeh as to lead him to review and monitor her full neurologic picture.

In a critical passage in his deposition, Dr. Stanley Bigos testified:

> Q Regardless of whatever an MRI might have shown back at that time, was Dr. Tohmeh obligated to go ahead and operate on a patient like this based on her postoperative complaints in December of '05?
>
> A Her postoperative complaints, yes.
>
> Q So even if he had a clean MRI he still had to take her to surgery?
>
> A I think that's the prudent thing to do.
>
> Q And he would tell her beforehand that she needs to be explored and has a 40 percent chance of achieving some improvement in her condition for reasons that we don't understand?
>
> A Yeah. That's right.

CP at 694.

Dr. Bigos explained further:

> A . . . If we have somebody with findings, we get an MRI. The MRI doesn't show anything obvious, we will still decompress it or go back in to make sure that the imaging didn't miss something, period.
>
> And, like I said, a fair enough of times you'll go in and you really don't see anything. You say, well, it might be this or it might be that. You close it back up. And you still get the improvement on some number of patients.
>
> Q What percentage of your patients had some kind of neurological symptom like toe tingling or something postoperatively?
>
> A Between 25 and 50 percent, I would suppose.
>
> Q And what percentage of those patients did you take back to surgery because they had that symptom?
>
> A Hardly any. That's not—there's a ratcheting up, like DEFCON 1, 2, 3, 4 and 5. Changes in neurologic exam, like tingling in the toes, would only be DEFCON 1. It's really ratcheting up your index of suspicion saying I'll do more on the physical examination and figure out what's going on the best I can.
>
> Once you start getting into saddle symptoms, bladder and bowel symptoms, then you're there. The onus is really on you to say this is outside the paradigm of postoperative care. This is in the paradigm of something potentially serious with the patient.
>
> . . . .
>
> 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 [Defense counsel]: Objection. Lacks foundation.
>
> BY MR. RICCELLI [plaintiff's counsel]:
>
> Q Do you believe there was a breach of standard of by care [sic] 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.
>
> . . . 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.

CP at 696-97.

Dr. Bigos then testified that, if Dr. Antoine Tohmeh immediately returned Diane Christian to surgery, Christian had a forty percent chance of decreased symptoms. Bigos, based on medical literature, could not better Christian's forty percent chance of improvement due to the infrequency of the variety of complications experienced by

Christian.

> Q So if Dr. Tohmeh complied with the standard of care and took the patient to surgery after an MRI which didn't show anything, more likely than not there would have been no change in her neurologic status, because 60 percent of the time the surgery doesn't do any good?
>
> A You could state it that way, but the bottom line is when we're—if you're driving along the road and there's a curve and there's a 500-foot drop, you drive a little slower around that curve.
>
> Q But the data tells us—
>
> A The data is totally incomplete to tell us what those percentages are. When we're talking about three out of five people, the P value goes out the window as far as being able to say anything statistically.
>
> Q But you're using the same data for 40 percent that I'm using for 60 percent, right?
>
> A The 60/40 is there. But the 60/40 could not be confirmed with the information that we had.
>
> Q So all we're left to do is speculate then? Is that what you're saying?
>
> A That's right.
>
> Q Okay.
>
> A We'll put our hands in our pockets and wear suspenders and a belt.
>
> Q The current data, even though it's speculative, says more often than not surgery will not do any good?
>
> A Well, there isn't current data. There's smatterings of different things. Nobody has put it together and looked at the quality of different things. I use 40 percent because that's the best I can derive from the literature with specks of everybody's inexperience with four of them per career. I can't do 60/40 because I had only four.

CP at 147-48. Dr. Bigos also testified that it was not possible for him to determine with certainty if Diane Christian would have fallen into the forty percent of patients that experience improvement after a second corrective surgery.

Diane Christian also retained Dr. Richard E. Seroussi of Seattle Spine & Sports

Medicine to examine her for litigation purposes. Dr. Seroussi diagnosed Christian with cauda equina syndrome, multilevel bilateral lumbar radiculopathy, neurogenic bladder dysfunction, neurogenic bowel dysfunction, impaired balance, impaired daily activities, dysphoria, decreased vocational potential, and a preexisting history of obesity, significantly worsened by complications from the laminectomies. Seroussi determined that Christian had a poor prognosis of her body returning to normal function and, while the symptoms might lessen over time, her injuries were chronic. Christian maintains that Seroussi testified that Dr. Antoine Tohmeh breached the standard of care in his postsurgical treatment of her. A deposition excerpt established that he intended to testify to the standard of care, but the record lacks such testimony. Dr. Seroussi declared that Christian exhibited new neurologic deficits after surgery. Seroussi also remarked that lack of intensive pain and an absence of incontinence, factors that Tohmeh used to rule out cauda equina syndrome, would not have surfaced after the surgery due to Christian's heavy ingestion of pain medication and extended use of a Foley catheter.

Dr. Antoine Tohmeh moved for partial summary judgment. In support of his motion, Tohmeh offered deposition testimony from his expert, Dr. Jeffrey Larson, a neurosurgeon. Dr. Larson testified that Diane Christian's immediate postoperative symptoms could have also been the result of irritated nerve roots caused by an increased blood flow to the cauda equina. He also testified, contrary to the opinions of Dr. Moise, Dr. Bigos, and Dr. Seroussi, that Christian never developed cauda equina syndrome. Dr.

Larson supported Dr. Tohmeh's conclusion that a lack of weakness in Christian's legs strongly indicated that she did not suffer from the syndrome.

The trial court granted Dr. Tohmeh's motion for summary judgment "in total" and dismissed all claims with prejudice. CP at 220. In a written ruling, the trial court concluded that Diane Christian failed to satisfy her burden of proof on summary judgment as to the standard of care or proximate cause. The written ruling made no comment on the deficiencies of Christian's claim for intentional infliction of emotional distress.

Diane Christian moved for reconsideration. In the motion, Christian argued that the trial court committed legal error. Christian also asked the trial court to consider newly discovered evidence. The new evidence was a supplemental declaration from Dr. Stanley Bigos, a declaration of Dr. Robert Pearlman, and the deposition of defense expert witness, Dr. Jeffrey Wang. Christian could not depose Dr. Wang until after the summary judgment motion hearing.

In his deposition, Dr. Jeffrey Wang testified to the standard of care to which a back surgeon should be held when a patient encounters the postoperative symptoms experienced by Diane Christian. Dr. Wang testified that he reviewed Christian's hospital charts and concluded Dr. Tohmeh had no reason to order an imaging study before he discharged Diane Christian on December 9, 2005. Wang, however, testified that the standard of care required Tohmeh to order and review postoperative X rays of the patient

after laminectomies. Dr. Wang also averred that he would perform postoperative exploratory surgery with patients who exhibited pain disproportionate to the initial procedure.

Dr. Stanley Bigos' declaration reiterated that Diane Christian would have had a forty percent chance of diminished symptoms if Dr. Antoine Tohmeh performed immediate postoperative exploratory surgery. Bigos averred:

> 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.

CP at 238.

Dr. Robert Pearlman is a professor of medicine at the University of Washington and the Chief of Ethics Evaluation at the National Center for Ethics in Healthcare. In his declaration, Pearlman faulted Dr. Antoine Tohmeh for deficiency in medical charting. Pearlman stated that Dr. Tohmeh may have violated ethical standards by failing to

provide Diane Christian of information that she suffered from cauda equina syndrome, dissuading her from believing she suffered from the syndrome, and discouraging her from seeing another physician.

The trial court denied Diane Christian's motion for reconsideration. The order denying the motion mentions that the court read the supplemental pleadings filed by Diane Christian. The order, however, does not indicate whether the trial court considered the evidence in the pleadings as newly discovered evidence and evidence to consider when determining whether to grant the motion for reconsideration.

LAW AND ANALYSIS

Motion for Reconsideration and Evidence on Appeal

Before addressing the merits of Diane Christian's appeal, we must determine what evidence to consider when deciding whether the evidence defeats Dr. Antoine Tohmeh's summary judgment motion. As part of a motion for reconsideration, Christian asked the trial court to consider the deposition of Jeffrey Wang, the declaration of Robert Pearlman, and a supplemental declaration of Stanley Bigos. The trial court denied the motion, but we do not know if the court excluded the additional testimony from contemplation when denying the motion.

On appeal, Diane Christian assigns error to the denial of the motion for reconsideration and thus asks this court to include the Jeffrey Wang, the Robert Pearlman, and the additional Stanley Bigos testimony in our calculation of whether the

summary judgment order should be affirmed. We decline to address this assignment of error because Christian did not adequately brief the law attendant to the assignment. Thus, we refuse to consider the late filed testimony.

Diane Christian restricts her argument on appeal. Although she assigns error to the order denying the motion for reconsideration, the content of the argument comprises one statement articulating the standard of review and a general statement that all arguments against the grant of summary judgment should encompass the argument against denial of the motion for reconsideration.

Diane Christian did not follow RAP 10.3. RAP 10.3(a)(6) directs that an appeal brief include:

> The argument in support of the issues presented for review, together with citations to legal authority and references to relevant parts of the record.

To enforce the rule, this court does not review issues not argued, briefed, or supported with citation to authority. *Valente v. Bailey*, 74 Wn.2d 857, 858, 447 P.2d 589 (1968); *Avellaneda v. State*, 167 Wn. App. 474, 485 n.5, 273 P.3d 477 (2012). We do not consider conclusory arguments. *Joy v. Dep't of Labor & Indus.*, 170 Wn. App. 614, 629, 285 P.3d 187 (2012), *review denied*, 176 Wn.2d 1021, 297 P.3d 708 (2013). Passing treatment of an issue or lack of reasoned argument is insufficient to merit appellate review. *West v. Thurston County*, 168 Wn. App. 162, 187, 275 P.3d 1200 (2012); *Holland v. City of Tacoma*, 90 Wn. App. 533, 538, 954 P.2d 290 (1998).

A thorough analysis and citation to authority is particularly needed for us to consider Diane Christian's claimed error in the trial court's denial of her motion for reconsideration. CR 59(a) lists nine grounds on which a trial court may reconsider a decision. Diane Christian sought reconsideration on four grounds. Those grounds, with their language from CR 59(a), are:

> (4) Newly discovered evidence, material for the party making the application, which the party could not with reasonable diligence have discovered and produced at the trial;
>
> ....
>
> (7) That there is no evidence or reasonable inference from the evidence to justify the verdict or the decision, or that it is contrary to law;
>
> (8) Error in law occurring at the trial and objected to at the time by the party making the application; or
>
> (9) That substantial justice has not been done.

This court reviews a trial court's decision to grant or deny a motion for reconsideration for abuse of discretion. *Davies v. Holy Family Hosp.*, 144 Wn. App. 483, 497, 183 P.3d 283 (2008).

On appeal, Diane Christian does not identify upon which of the four reconsideration grounds she relies, nor does she provide any analysis to assist us in declaring one of the grounds germane. In her briefs, Christian cites to the subsequent declaration of Dr. Stanley Bigos and the deposition testimony of Dr. Jeffrey Wang, and she assumes we will consider the testimony. Nevertheless, Christian does not address whether the evidence was newly discovered and whether the evidence could not have reasonably been supplied to the trial court before entry of the summary judgment order.

Lost Chance of Better Outcome

Diane Christian argues that the trial court erred in dismissing her claim for lost chance of a better outcome. Dr. Antoine Tohmeh contends that the trial court correctly granted summary judgment because no reasonable juror could conclude that Christian developed cauda equina syndrome or that Tohmeh violated the standard of care by not diagnosing or treating the condition. Dr. Tohmeh further argues that Christian failed to provide expert testimony as to the nature of the better outcome alleged, and Tohmeh contends that such proof is essential to defeat a summary judgment motion. We side with Diane Christian. The supplemental testimony filed by Christian in support of a motion for reconsideration was not necessary to defeat a summary judgment motion. The deposition testimony of Dr. Stanley Bigos filed to initially oppose the motion suffices. Testimony of Drs. Richard Seroussi and Vivian Moise bolsters proof of some of the elements of Christian's claim.

Washington, in line with other jurisdictions, recognizes a lost chance claim, a tweaked version of a medical malpractice cause of action. A lost chance claim is not a distinct cause of action but an analysis within, a theory contained by, or a form of a medical malpractice cause of action. *Rash v. Providence Health & Servs.*, 183 Wn. App. 612, 630, 334 P.3d 1154 (2014), *review denied*, 182 Wn.2d 1028, 347 P.3d 459 (2015).

Lost chance claims can be divided into two categories: lost chance of survival and lost chance of a better outcome. *Herskovits v. Grp. Health Coop. of Puget Sound*, 99

Wn.2d 609, 624, 664 P.2d 474 (1983); *Mohr v. Grantham*, 172 Wn.2d 844, 857, 262 P.3d 490 (2011); *Rash v. Providence Health & Servs.*, 183 Wn. App. at 630. Diane Christian complains that Antoine Tohmeh decreased her chances of a better outcome. In a lost chance of a better outcome claim, the chance of a better outcome or recovery was reduced by professional negligence. *Mohr v. Grantham*, 172 Wn.2d at 857 (2011); *Rash*, 183 Wn. App. at 631. In a traditional medical malpractice case, a professional's negligence likely led to a worse than expected outcome. *Rash*, 183 Wn. App. at 631. Under a lost chance of a better outcome theory, the bad result was likely even without the health care provider's negligence, but the malpractice reduced the chances of an improved result by a percentage of fifty percent or below. *Rash*, 183 Wn. App. at 631.

Washington lost chance decisions were decided with the backdrop of Washington's 1976 health care act that covers actions for injuries resulting from health care. Ch. 7.70 RCW. Under RCW 7.70.030: "Unless otherwise provided in this chapter, the plaintiff shall have the burden of proving *each fact essential* to an award by a *preponderance of the evidence*." (Emphasis added.) One essential element is that the health care provider's "failure was a *proximate cause of the injury complained of*." RCW 7.70.040(2) (emphasis added). Based on *Herskovits v. Group Health* and *Mohr v. Grantham*, a plaintiff need not forward medical testimony that negligence of the health care provider was the likely cause of injury. *Rash*, 183 Wn. App. at 636. But, the

plaintiff must provide a physician's opinion that the health care provider "likely" caused a lost chance of a better outcome. *Rash*, 183 Wn. App. at 631.

A review of familiar summary judgment principles is as important to this appeal as a discussion of the substantive law of a lost chance of a better outcome. Appellate courts review a trial court's order granting summary judgment de novo. *Briggs v. Nova Servs.*, 166 Wn.2d 794, 801, 213 P.3d 910 (2009). Summary judgment is appropriate if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law. CR 56(c); *Hartley v. State*, 103 Wn.2d 768, 774, 698 P.2d 77 (1985). We construe all facts and reasonable inferences in the light most favorable to the nonmoving party. *Lybbert v. Grant County*, 141 Wn.2d 29, 34, 1 P.3d 1124 (2000).

Expert testimony is required to establish the standard of care and most aspects of causation in a medical negligence action. *Seybold v. Neu*, 105 Wn. App. 666, 676, 19 P.3d 1068 (2001). In a lost chance suit, a plaintiff carries the burden of producing expert testimony that includes an opinion as to the percentage or range of percentage reduction of the better outcome. *Herskovits v. Grp. Health Coop. of Puget Sound*, 99 Wn.2d at 611 (1983); *Mohr v. Grantham*, 172 Wn.2d at 849 (2011); *Rash v. Providence Health & Servs.*, 183 Wn. App. at 636 (2014).

Dr. Antoine Tohmeh first argues that Diane Christian failed to present evidence that she suffered from cauda equina syndrome. Tohmeh notes that no expert witness testified on behalf of Christian that a postoperative hematoma, a dural graft, or any conduct by Dr. Tohmeh during the surgery led to the syndrome. Tohmeh suggests that Christian did not exhibit any of the cardinal signs or symptoms of cauda equina syndrome while recovering in the hospital. He emphasizes testimony that an imaging study six months after the surgery showed no bleeding, hematoma, or arachnoiditis and that this negative imaging ruled out cauda equina syndrome. Tohmeh contends that none of the specialists to whom he referred Christian diagnosed cauda equina syndrome. He then maintains, based on the testimony of his own expert witness, Dr. Jeffrey Larson, that no reasonable person could conclude that Christian developed cauda equina syndrome.

Antoine Tohmeh looks into a large crowd and see only his friends. For purposes of summary judgment, he may not limit the record to the opinions of his expert or specialists to whom he referred Diane Christian. We may not weigh which physician's or physicians' testimony is more credible. Drs. Stanley Bigos, Richard Seroussi, and Vivian Moise testified that Christian developed cauda equina syndrome.

We do not find any passage in which one of Diane Christian's experts directly declared that the lower back surgery caused the syndrome. Dr. Stanley Bigos testified that he did not know what caused the cauda equina syndrome, but one should not conclude that he ruled out the syndrome developing during the laminectomies. A

reasonable inference from his testimony is that Bigos did not know what conduct during the surgery caused the syndrome, despite the syndrome developing during the surgery. Drs. Bigos, Seroussi, and Moise commented that Christian suffered from postoperative symptoms. The term "postoperative" infers that symptoms occurred during the operation. The inferences from all three physicians' testimony inescapably lead to a conclusion that the cauda equina syndrome resulted from the low back surgery. Under summary judgment principles, this court construes all facts and reasonable inferences in the light most favorable to the nonmoving party. *Wilson v. Steinbach*, 98 Wn.2d 434, 437, 656 P.2d 1030 (1982); *Barber v. Bankers Life & Cas. Co.*, 81 Wn.2d 140, 142, 500 P.2d 88 (1972).

Although testimony supports that the cauda equina syndrome occurred as a result of the December 5, 2005, surgery, such testimony is not indispensable. Diane Christian and her experts criticize Dr. Tohmeh for failing to attend to Christian's symptoms that appeared after the surgery. The reasonable inference may be drawn that the experts would opine that Tohmeh failed to properly care for Christian after the surgery regardless of whether the symptoms were causally related to the surgery. Christian exhibited cauda equina syndrome symptoms that demanded immediate exploration.

Dr. Antoine Tohmeh next argues that Diane Christian presented no testimony to establish that he violated the standard of care. In so arguing, Tohmeh underscores that no physician testified that he violated the standard of care during the surgery and that no

physician identified what action caused the cauda equina syndrome during the surgery. We agree, but Tohmeh's emphasis ignores the focus of Diane Christian's allegation and her expert's testimony. Christian contends Dr. Tohmeh violated the standard of care when rendering postoperative care, not in performing the surgery. Dr. Stanley Bigos testified to the applicable standard of care and that Tohmeh's postsurgical care of Christian fell below that standard. According to Bigos, Christian's symptoms should have led Dr. Tohmeh to perform a second exploratory surgery. Bigos further testified that Tohmeh's failure to order additional imaging of Christian's lower back and to conduct exploratory surgery deprived Christian of a forty percent chance of decreased symptoms.

Finally, Antoine Tohmeh astutely contends that Diane Christian fails to defeat the summary judgment motion because her expert, Dr. Stanley Bigos, did not specify what the better outcome would have been if Tohmeh conformed to the standard of care and performed an exploratory operation. We agree that Bigos did not identify those symptoms of cauda equina syndrome that had a forty percent chance of alleviation. He was never asked his opinion on this question in his deposition. Dr. Tohmeh further contends that Dr. Bigos testified that it would be pure speculation to say what the "better outcome" might have been. We disagree. Bigos' reference to speculation came in response to a different question in his deposition based on insufficient records of Christian's care.

Based on an absence of testimony as to the nature of the possible better outcome, Antoine Tohmeh contends that a jury could not apply the loss of chance formula to her damages. According to Dr. Tohmeh, the jury could not determine those symptoms that may have been reduced with the postoperative surgery. We recognize that a jury may wish to hear additional testimony from Dr. Stanley Bigos or another physician as to what symptoms of cauda equina syndrome might have been erased or reduced if Tohmeh complied with the standard of care. Nevertheless, Tohmeh advances no case and we find no case that demands a patient, in response to a summary judgment motion, qualify or quantify the extent or nature of damages incurred. For instance, in a traditional medical malpractice suit, the patient needs expert testimony that shows the breach of the standard of care caused some damage or injury, but the law does not require that the expert detail the precise pain and suffering caused by the defendant doctor's negligence. Absent such case law, we hold that a plaintiff need only provide testimony from a qualified expert that the violation of the standard of care caused some injury or reduced the chance of a better outcome by a stated percentage to survive a summary judgment motion. A physician need not particularize those symptoms that would have decreased.

Dr. Antoine Tohmeh's argument fails to recognize that Dr. Stanley Bigos could not definitively testify to the nature and extent of a better outcome, because the outcome depended on how quickly Tohmeh returned Diane Christian to surgery. The quicker the return, the better the outcome, such that the forty percent chance of a better outcome

could have entailed a complete recovery if Tohmeh returned Christian to surgery the following day.

Our holding conforms to general principles emanating from the law of damages in tort and other legal actions. The doctrine respecting the matter of certainty, properly applied, is concerned more with the fact of damage than with the extent or amount of damage. *Gaasland Co. v. Hyak Lumber & Millwork, Inc.*, 42 Wn.2d 705, 712-13, 257 P.2d 784 (1953); *Alpine Indus., Inc. v. Gohl*, 30 Wn. App. 750, 754, 637 P.2d 998, 645 P.2d 737 (1981). Damages are not precluded simply because they fail to fit some precise formula for measuring them. *Pugel v. Monheimer*, 83 Wn. App. 688, 692, 922 P.2d 1377 (1996). We are reluctant to immunize a defendant once damage has been shown merely because the extent or amount thereof cannot be ascertained with mathematical precision, provided the evidence is sufficient to afford a reasonable basis for estimating loss. *Jacqueline's Wash., Inc. v. Mercantile Stores Co.*, 80 Wn.2d 784, 786, 498 P.2d 870 (1972); *Lewis River Golf, Inc. v. O.M. Scott & Sons*, 120 Wn.2d 712, 717, 845 P.2d 987 (1993);*Dep't of Fisheries v. Gillette*, 27 Wn. App. 815, 824, 621 P.2d 764 (1980).

Intentional Infliction of Emotional Distress

Diane Christian next contends that the trial court erred in dismissing her claim for intentional infliction of emotional distress or outrage. The tort of outrage is synonymous with a cause of action for intentional infliction of emotional distress. *Kloepfel v. Bokor*,

149 Wn.2d 192, 194, 66 P.3d 630 (2003); *Snyder v. Med. Serv. Corp. of E. Wash.*, 145 Wn.2d 233, 250, 35 P.3d 1158 (2001).

In order to make a prima facie case of intentional infliction of emotional distress, a plaintiff seeking to survive summary judgment must produce evidence showing three elements: (1) extreme and outrageous conduct, (2) intentional or reckless infliction of emotional distress, and (3) actual result to the plaintiff of severe emotional distress. *Kloepfel v. Bokor*, 149 Wn.2d at 195 (2003); *Grimsby v. Samson*, 85 Wn.2d 52, 59, 530 P.2d 291 (1975). This appeal focuses on element one of the tort. Extreme and outrageous conduct must be conduct that the recitation of the facts to an average member of the community would arouse his resentment against the actor and lead him to exclaim "'Outrageous!'" *Kloepfel*, 149 Wn.2d at 196 (internal quotation marks omitted) (quoting *Reid v. Pierce County*, 136 Wn.2d 195, 201-02, 961 P.2d 333 (1998)). Liability exists only when the conduct has been so outrageous in character and extreme in degree as to go beyond all possible bounds of decency and to be regarded as atrocious and utterly intolerable in a civilized community. *Grimsby*, 85 Wn.2d at 59 (quoting RESTATEMENT (SECOND) OF TORTS § 46 cmt. d (1965)).

Generally, the elements of a claim for intentional infliction of emotional distress are questions of fact. *Strong v. Terrell*, 147 Wn. App. 376, 385, 195 P.3d 977 (2008). On summary judgment, however, a trial court must make an initial determination as to whether the conduct may reasonably be regarded as so extreme and outrageous as to

warrant a factual determination by the jury. *Sutton v. Tacoma Sch. Dist. No. 10*, 180 Wn. App. 859, 869, 324 P.3d 763 (2014); *Strong v. Terrell*, 147 Wn. App. at 385. No case suggests that the standard to defeat a summary judgment motion is harsher for plaintiffs asserting outrage claims than plaintiffs in other tort suits. Nevertheless, Washington courts, like other courts, have considered themselves gatekeepers for purposes of allowing a jury to decide claims of intentional infliction of emotional distress. The trial court and, in turn, the appeals court, renders an initial screening to determine whether the defendant's conduct and mental state, together with the plaintiff's mental distress, rise to the level necessary to make out a prima facie case. *Benoy v. Simons*, 66 Wn. App. 56, 63, 831 P.2d 167 (1992); *Orwick v. Fox*, 65 Wn. App. 71, 87-88, 828 P.2d 12 (1992). The requirement of outrageousness is not an easy one to meet. *Ortberg v. Goldman Sachs Grp.*, 64 A.3d 158, 163 (D.C. 2013). The level of outrageousness required is extremely high. *Reigel v. SavaSeniorCare LLC*, 292 P.3d 977, 990 (Colo. Ct. App. 2011).

In response to Diane Christian's intentional infliction of emotional distress claim, Dr. Antoine Tohmeh contends that his conduct was well within the standard of care and that no witness testified that his conduct met the high threshold for liability for intentional infliction of emotional distress. We disagree with the relevance of these twin arguments. Conforming to a physician's standard of care may be a factor to consider in an outrage suit against a doctor, but this factor does not control the outcome. Anyway, physicians testified that Dr. Tohmeh violated the standard of care. No case supports a rule that an

expert witness, or any witness, must characterize the defendant's conduct as outrageous in order to sustain a claim of intentional infliction of emotional distress.

We list the conduct of Dr. Antoine Tohmeh that Diane Christian contends was extreme and outrageous:

1. Engaging in a pattern of intentional behavior to obfuscate a true diagnosis of Christian's neurological deficits in an attempt to avoid legal liability;

2. Referring Christian to neurologist Dr. Larry Lamb but not ordering nerve conductions studies at the S3-S5 level, the nerves associated with cauda equina syndrome;

3. Yelling and shouting at Christian;

4. Telling Christian that she had no neurological deficits, her problems were all in her head, and whatever was wrong would have happened anyway;

5. Implying to Christian that she was lazy and obese;

6. Speaking angrily to Dr. Vivian Moise and attempting to influence her diagnosis of cauda equina syndrome;

7. Telling Dr. Moise that Christian suffered from significant emotional or psychological issues that rendered Christian's history less valid; and

8. Referring Christian to urologist Dr. Michael Oefelein, who found a neurogenic bladder, yet telling Christian that Oefelein's findings were normal.

Diane Christian likens the conduct of Dr. Antoine Tohmeh to physicians in *Doe v. Finch*, 133 Wn.2d 96, 942 P.2d 359 (1997) and *Grimsby v. Samson*, 85 Wn.2d 52 (1975). In *Finch*, Dr. Finch engaged in a sexual relationship with John Doe's wife, while Finch provided marital counseling for Doe and his wife. Our Supreme Court addressed whether the statute of limitations barred Doe's suit. The court did not analyze the merits of the claim for intentional infliction of emotional distress.

In *Grimsby*, Arne Grimsby allegedly watched his wife die in agonizing pain, while Dr. Werner Samson abandoned her care. On appeal, the Evergreen State Supreme Court recognized for the first time the tort of outrage or intentional infliction of emotional distress. The trial court dismissed the suit on a motion to dismiss pursuant to CR 12(b)(6) rather than a summary judgment motion. The court focused on whether Washington would recognize the tort. The Supreme Court reversed the dismissal, while recognizing that it needed to read Grimsby's complaint liberally.

We evaluate Diane Christian's claim of outrage by reviewing and comparing reported decisions primarily from other jurisdictions. In these cases, health care professionals behaved in ways similar to conduct about which Diane Christian complains. In all of the decisions, the appellate courts ruled that the plaintiff failed to show facts sufficient to sustain a cause of action because the health care professional's conduct was not outrageous. A review of the cases might lead one to ask if the conduct of a health care provider might ever be considered outrageous. Although the cases involve only one

or two of those behaviors attributed to Antoine Tohmeh rather than the full extent of the alleged extreme behavior, we conclude that aggregating the behavior in this context adds nothing to the analysis of whether Dr. Tohmeh's conduct was outrageous. Many of the decisions involve more disgraceful cumulative behavior. Therefore, we affirm the trial court's summary judgment dismissal of Diane Christian's intentional infliction of emotional distress action.

One Washington decision addresses whether conduct of a physician sustains a claim for intentional infliction of emotional distress. In *Benoy v. Simon*, 66 Wn. App. 56, 831 P.2d 167 (1992), Saundra Benoy sued neonatologist Robert Simon for intentional infliction of emotional distress. Benoy gave birth to a severely disabled premature child at Kadlec Medical Center in Richland, where Dr. Simon provided care. When the infant's condition deteriorated, Dr. Simon transferred him to Children's Orthopedic Hospital in Seattle, where the boy later died. Benoy contended that Simon needlessly pressured her family to create a guardianship, maintained the infant needlessly on life support, led her to believe her son's condition improved when it deteriorated, told her to bring her son's body home on a bus, and billed her for needless care. This court affirmed summary judgment in favor of Dr. Simon. Even assuming the events occurred as described by Benoy, the physician's conduct did not fall within the perimeters of outrageous conduct.

Courts in other jurisdictions have also reviewed suits for outrageous conduct against health care providers. In *Reigel v. SavaSeniorCare LLC*, 292 P.3d 977 (Colo. Ct. App. 2011), the plaintiff's husband died from a heart attack. The wife visited the husband in the nursing home, during which visit the husband exhibited signs of an attack. According to the wife, nursing home staff refused her requests for assistance, told her in a caustic voice that there was no emergency, implied that she overreacted and was crazy, and falsified chart records. The Court of Appeals affirmed dismissal of the claim for outrage.

In *Cangemi v. Advocate South Suburban Hospital*, 364 Ill. App. 3d 446, 845 N.E.2d 792, 300 Ill. Dec. 903 (2006), a mother sued her obstetrician for damages suffered by her son during birth. The mother alleged that the physician attempted to conceal the injuries sustained by the boy by fraudulently telling her that the size of the baby's head necessitated a caesarean section. The court summarily dismissed a claim for intentional infliction of emotional distress.

In *Harris v. Kreutzer*, 271 Va. 188, 624 S.E.2d 24 (2006), Dr. Jeffrey Kreutzer performed an independent medical examination on Nancy Harris, who claimed a brain injury as a result of an automobile accident. Harris claimed that Dr. Kreutzer verbally abused her, raised his voice at her, caused her to cry, and accused her of being a faker and malingerer. The Virginia Supreme Court affirmed dismissal of the claim of outrage. The

court characterized the physician's conduct as insensitive and demeaning, but not outrageous under caselaw.

In *Hart v. Child's Nursing Home Co.*, 298 A.D.2d 721, 749 N.Y.S.2d 297 (2002), the plaintiffs complained about the care of their mother in a nursing home. The plaintiffs alleged that nursing staff threatened them with physical violence, otherwise harassed them, interfered in their visits with their mother, and provided them inaccurate information regarding their mother's health and death. The reviewing court affirmed the trial court's dismissal of the action for outrage. The conduct of the nursing staff did not transcend the bounds of human decency.

In *Albert v. Solimon*, 252 A.D.2d 139, 684 N.Y.S.2d 375 (1998), Crystal Albert sued her physician, Ezzat Solimon. The doctor's nurse showed Albert and her service dog to an examination room. When Dr. Solimon entered the room, the dog's head and mouth lay on the examination table. The physician screamed: what is the dog doing here? An upset Albert rushed out of the room with her dog. The reviewing court affirmed dismissal of the cause of action for intentional infliction of emotional distress because the conduct, viewed in the light most favorable to Albert, was not sufficiently outrageous in character and extreme in degree as to exceed all bounds of decency.

Finally, in *C.M. v. Tomball Regional Hospital*, 961 S.W.2d 236 (Tex. App. 1997), plaintiff sought treatment at the hospital after being raped. She testified that hospital staff treated her "like dirt," told her that the hospital does not treat rape victims, suggested that

she lost her virginity by riding a bike or horse, and interviewed her in a rude and insensitive manner in a public waiting room. The Court of Appeals affirmed summary dismissal of a claim for intentional infliction of emotional distress.

A plaintiff's evidence of the defendant's behavior should not be viewed in isolation, but considered in the context of the undisputed facts concerning the entire relationship between the parties. *Ortberg v. Goldman Sachs Grp.*, 64 A.3d at 163 (D.C. 2013); *Richard Rosen, Inc. v. Mendivil*, 225 S.W.3d 181, 192 (Tex. Ct. App. 2005). The court should consider the totality of the evidence pertaining to the defendant's conduct. *Reigel v. SavaSeniorCare LLC*, 292 P.3d at 991 (Colo. Ct. App. 2011).

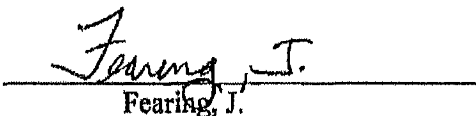
Diane Christian claims that Dr. Antoine Tohmeh outrageously attempted to avoid liability by denying she experienced cauda equina syndrome. Nevertheless, Dr. Tohmeh referred Christian to a gynecologist, neurologist, bowel specialist, and urologist. Referring a patient to a number of specialists is not the conduct of a physician seeking to avoid liability. Christian emphasizes that the neurologist did not study her nerve conduction in the critical area of her spine, and she suggests Tohmeh is to blame for an incomplete nerve study. Nevertheless, no evidence suggests that Tohmeh and the neurologist conspired to hide information from Christian. The neurologist was free to perform the conduction study at levels of the spine deemed appropriate.

Diane Christian underscores Dr. Antoine Tohmeh's yelling at her in his office. Casey Christian testified that, although Dr. Tohmeh raised his voice, Tohmeh corrected

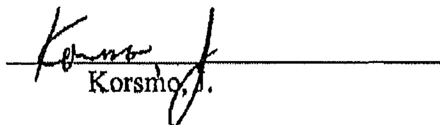
himself and apologized. Neither Diane nor Casey Christian were angry or upset when they left the appointment.

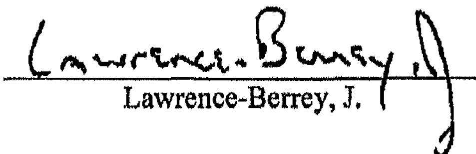
CONCLUSION

We affirm in part and reverse in part the trial court's dismissal of plaintiffs Christians' claim. We affirm the summary judgment dismissal of the Christians' cause of action for intentional infliction of emotional distress. We reverse the summary judgment dismissal of the Christians' cause of action for medical malpractice.


Fearing, J.

WE CONCUR:


Korsmo, J.


Lawrence-Berrey, J.

FILED
FEBRUARY 4, 2016
In the Office of the Clerk of Court
WA State Court of Appeals, Division III

COURT OF APPEALS, DIVISION III, STATE OF WASHINGTON

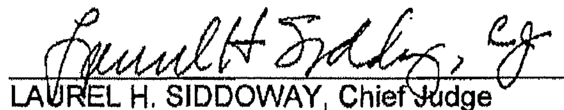
DIANE CHRISTIAN and CASEY CHRISTIAN, wife and husband, Appellants, v. ANTOINE TOHMEH, M.D., and "JANE DOE" TOHMEH, husband and wife, and the marital community composed thereof; PROVIDENCE HEALTH CARE, a Washington business entity and health care provider; HOLY FAMILY HOSPITAL, a Washington business entity and health care provider; ORTHOPAEDIC SPECIALTY CLINIC OF SPOKANE, PLLC, a Washington business entity and health care provider; and DOES 1-5, Respondents.	)	No. 32578-4-III ORDER DENYING MOTIONS FOR RECONSIDERATION

THE COURT has considered the appellants' and respondents' motions for reconsideration and is of the opinion the motions should be denied. Therefore,

IT IS ORDERED, the motions for reconsideration of this court's decision of December 15, 2015 are hereby denied.

PANEL: Judges Fearing, Korsmo, Lawrence-Berrey

FOR THE COURT:



LAUREL H. SIDDOWAY, Chief Judge

EXHIBIT A-2

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Please see appellants brief for filing in above-referenced matter. (brief)

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(appendix)

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