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SUPREME COURT OF
THE STATE OF
WASHINGTON

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Washington State Supreme Court

BEVERLY VOLK, et al.,

Appellants,

v.

JAMES B. DEMEERLEER, et al.,

Respondents.

OCT 13 2015
Ronald R. Carpenter
Clerk *bjh*

BRIEF OF AMICUS CURIAE
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I. IDENTITY & INTEREST OF *AMICUS CURIAE*

The Washington Defense Trial Lawyers ("WDTL") is a nonprofit organization of attorneys who devote a substantial portion of their practice to representing individuals, companies, or entities in defense of civil litigation. WDTL appears in this and other courts as *amicus curiae* to pursue its mission of fostering justice balance in the civil courts. As *amicus curiae* in this case, WDTL will assist the Court by critically analyzing the competing policy interests at issue. WDTL will also provide information regarding the real world implications of the rules that the Plaintiffs advocate.

II. SUMMARY OF ARGUMENT

The WDTL is interested in two separate issues in this case. The first issue relates to the generalized warning duty that the Court of Appeals' decision imposes on Washington's physicians. The second issue relates to Washington's law regarding loss of a chance. The Court of Appeals' decision imposes too broad a duty to warn on Washington's physicians. The Court of Appeals, however, correctly held that the evidence presented did not support a claim for loss of a chance. The WDTL, therefore, respectfully urges the Court to:

- hold that a physician's duty to warn others of a patient's potential for violence arises only in situations involving a threat directed towards a readily identifiable person;

- hold that RCW 71.05.120's immunity is not limited to formal civil commitment hearings but, instead, applies in all physician decisions regarding whether to pursue mental health commitment;
- hold that "but for" is the standard for causation in loss of chance cases; and
- hold that loss of a chance can only be submitted to the jury where the plaintiff has presented sufficient evidence to permit the jury to numerically quantify the lost chance, without resorting to speculation.

III. STATEMENT OF THE CASE

The WDTL relies upon the facts set forth by the briefing submitted by Dr. Howard Ashby.

IV. ARGUMENT

A. A PHYSICIAN'S DUTY TO WARN CAN ONLY ARISE WHERE THERE IS SOMEONE TO WARN.

Mr. DeMeerleer killed Ms. Schiering. There is no evidence that Mr. DeMeerleer ever told Dr. Ashby that he intended to – or even considered to – do so. There is no evidence that Mr. DeMeerleer ever expressed to Dr. Ashby, or anybody else, an angry or aggressive sentiment towards Ms. Schiering. And the last documented angry or aggressive sentiment expressed by Mr. DeMeerleer toward anyone was literally years prior to his attack on Ms. Schiering.

The scope of the duty that Ms. Schiering's family (hereinafter "the Schierings") are advocating is truly extraordinary. Though the Schierings argue that this case is about a duty owed to Ms. Schiering, the duty that is being proposed is far broader. The same analysis and the same purported duty apply to everyone in Mr. DeMeerleer's life. The Schierings are advocating that every physician carry an indelible duty to warn whenever a patient has – at any point during treatment – expressed any violent, angry or antisocial thought. And in order to faithfully discharge that duty, the physician would have to consistently monitor the social circle for each of his/her patients, and each time a new relationship was formed (coworker, neighbor, intimate), the provider would be obliged to issue a new warning.¹

Recall that the last report of angry or aggressive feelings by Mr. DeMeerleer to Dr. Ashby was approximately four years prior to Mr. DeMeerleer's attack on Ms. Schiering. The Schierings' proposed duty is, therefore, truly indelible, as any angry comment, no matter how remote, would trigger an ongoing duty to warn. If adopted, that duty would be all but impossible to discharge; it would ensnare even the most wary of physicians. In the absence of a specific

¹ Dr. Ashby's briefing ably demonstrates that the Plaintiffs' proposed rule would improperly violate patient privacy rights. The WDTL is in full agreement with Dr. Ashby and in the interest of brevity will not repeat those arguments.

threat to a readily identifiable victim, the physician is left to wonder how far the duty to warn extends. Contemplating the logistics of actually discharging the duty that the Court of Appeals imposed quickly illustrates the rule's impossibility.

Washington's existing medical notification systems illustrate the impropriety of the Court of Appeals' decision. Health care providers have a duty to participate in the Washington Department of Health Sexually Transmitted Disease Services Section. *See* RCW Ch. 70.24. Under that Section, a provider cannot inform his/her patient's entire social circle that the patient suffers from a communicable ailment. *See id.* Nor do we require Washington citizens to notify their physician regarding romantic prospects so that the physician can send a notice to those prospects. *See id.* Instead, Washington only permits notification to persons who face an identifiable risk of contracting a communicable illness. *See id.* There is no reason to treat mental health conditions any differently. If a readily identifiable person is the subject of a specific and articulated threat, there should be notice. However, a generalized notice that a person carries the potential for violence is no less repugnant than a generalized notice that a person carries a communicable disease.

There is a cruel assumption behind the Court of Appeals' rule. The rule relies on the assumption that we cannot heal.² Imposing a duty to warn the people in a patient's life, based upon a four year-old statement, tells the mental health community that the State does not believe that progress was made in the patient's condition – even if the provider believes that profound progress was made.

The impact that this rule would have on health care in Washington State is impossible to overstate. It is undisputable that the Court of Appeals' decision would serve as a disincentive to people getting the mental health treatment that they need. Patients will be reluctant (or even outright unwilling) to candidly describe their mental health symptoms if they know that reporting any angry or aggressive thought could result in their physician warning everyone in the patient's social circle that the patient is potentially violent.

The societal consequences of disincentivizing mental health treatment are apparent. One NGO reports that violent episodes by individuals with untreated mental health issues account for at least 5% of murders committed in the United

² This prejudice is manifest when comparison is made to sexually transmitted disease reporting. *See* RCW 70.24. Even though we know some sexually transmitted diseases are incurable, we do not impose the type of ongoing monitoring and reporting that the Plaintiffs are advocating for mental health conditions.

States and that severe and persistent mental illness is a factor in 9% to 15% of violent acts.³

There is also an irony to the duty imposed by the Court of Appeals. Every day the State of Washington releases persons from corrective custody. Many of those people have made angry or aggressive comments and some have committed angry or aggressive acts. However, the State does not warn all the people in those ex-convicts' lives that there is a potential for violence.⁴

The rule advocated by Dr. Ashby strikes the appropriate balance among protecting third persons from harm, protecting patient rights, and imposing a duty that physicians can actually perform. A physician's duty to warn others of his/her patient's potential for violence only arises where there is a threat made towards a readily identifiable person or persons. Absent some reason to believe that a specific person or discrete group of persons is in danger, the duty would be ineffectual,⁵ unreasonably violative of patient rights, and impossible to discharge. The WDTL respectfully asks the Court to limit a physician's duty to warn others

³ Mental Illness Policy Org., "Homelessness, Incarceration, Episodes of Violence: Way of Life for Almost Half of Americans with Untreated Severe Mental Illness," <http://mentalillnesspolicy.org/consequences/consequences.html>.

⁴ The Court of Appeals' decision impliedly imposes the same duty on the State – at least insofar as any of those ex-convicts received health care while in the State's custody and made any angry or aggressive comment to (or in the presence of) a health care provider.

⁵ A vague warning regarding a potential for violence is far less likely to be successful than a specific warning regarding a targeted threat.

of a patient's potential for violence to those situations involving a patient's threat directed toward an identifiable person or a discrete group of persons.

B. RCW 71.05.120'S IMMUNITY IS BASED UPON THE NATURE OF THE PHYSICIAN'S DECISION – NOT UPON THE FORUM IN WHICH THE DECISION IS MADE.

The Schierings' claim is more about involuntary commitment than it is about a duty to warn third persons. The Schierings advocate for a generalized duty to warn. However, they cannot genuinely expect physicians to warn every person within every patient's social circle that the patient has a potential to be violent. The Schierings must concede that such warnings would be logistically impossible to provide. As such, if physicians are to have a duty to protect third parties – absent a threat towards a readily identifiable person or group – the only feasible method to accomplish that protection is to restrain the patient. And the only way to do that is via involuntary mental commitment. Thus, the Schierings' real criticism of Dr. Ashby is that he did not seek to detain Mr. DeMeerleer for mental health evaluation or treatment.

In that manner, RCW 71.05.120's immunity is directly implicated.⁶ The statute provides immunity to a physician "with regard to the decision of whether"

⁶ Again, Dr. Ashby's briefing ably argues that RCW 71.05.120's statutory immunity applies outside of the civil commitment context. The WDTL offers this briefing to supplement, rather than to supplant, Dr. Ashby's arguments.

to undertake a number of mental health interventions with a patient, including whether to detain the patient for evaluation and treatment. RCW 71.05.120. That immunity applies to Dr. Ashby in his treatment of Mr. DeMeerleer.

It is the nature of the decision regarding whether to pursue a patient's commitment that justifies the immunity – not the forum in which the decision is made. By attempting to limit the immunity to formal civil commitment actions, the Court of Appeals wrote a limitation into the statute where none exists. Specifically, the Court of Appeals limited the statute such that physicians are only immune from claims by patients. If the immunity is only applicable in a formal civil commitment proceeding, then the immunity only applies once the decision to pursue commitment has already been made, and the only potential claimant (against the physician) would be the patient himself. That, however, is not what the statute says. Instead, the statute applies "with regard to the decision of whether to admit . . . or detain" a patient. RCW 71.05.120. If the Legislature intended the immunity to be as limited as the Plaintiffs contend, the language would read: "with regard to the decision to admit . . . or detain." By including the word "whether" the Legislature expressed a clear intent to **cover both decisions to admit and the decision not to admit**. *See id.* Thus, the immunity arises from the nature of the decision whether to admit, not from the decision to admit, or the forum in which the decision is made.

The Court should, therefore, hold that RCW 71.05.120's immunity is not limited to decisions made within a formal civil commitment hearing. Instead, the Court should hold that a physician is immune from liability when deciding whether to pursue an involuntary mental health commitment – regardless of whether the physician decides to pursue or not to pursue.

C. **"BUT FOR" REMAINS THE APPROPRIATE STANDARD FOR CAUSATION IN ALL MEDICAL NEGLIGENCE CASES – INCLUDING LOSS OF A CHANCE CASES.**

Loss of a chance was developed, as a theory of liability, to respond to perceived inequities arising in cases involving plaintiffs who, prior to the conduct at issue in the case, had a less than even chance of survival/a better outcome. In those cases, the less than even chance usually owed itself to underlying/preexisting health conditions. It was perceived that requiring the plaintiff to demonstrate that it was the defendant's conduct – rather than the underlying/preexisting condition – that caused injury or death, was too great an evidentiary burden.

Washington's appellate courts have considered whether "but for" or "a substantial factor" should be the standard for causation in loss of a chance cases multiple times. And each time, the courts have concluded that "but for" is the appropriate standard.

1. In 1983, Washington's State Supreme Court First Recognized Loss of a Chance, and in So Doing Preserved the Traditional "But For" Test.

Washington's State Supreme Court first recognized a cause of action for loss of a chance in *Herskovits v. Group Health Cooperative of Puget Sound*, 99 Wn.2d 609 (1983). While the Court was in agreement that a cause of action should exist, there was division regarding how to do so.

Justice Dore penned the lead opinion, which applied a lesser causation standard than the traditional "but for" test. *Id.* at 610-19. That opinion was joined by only one Justice. *Id.* at 619.

Justice Pearson wrote a concurring opinion that was joined by three Justices, and, therefore, became the plurality opinion. *Id.* at 636. Rather than address the issue through causation, the plurality redefined the injury, or the compensable interest, at issue. *Id.* at 623-24. Instead of focusing on whether the defendant's conduct caused the plaintiff's death, the plurality focused on whether the defendant's conduct caused a "substantial reduction in [the plaintiff's] chance of survival." *Id.* at 634. Under the plurality's approach, the plaintiff still must demonstrate causation by the traditional "but for" standard, but the harm that must be caused by the defendant's conduct is not death itself, but a reduction in the plaintiff's chance of beating death. *Id.* at 623-24.

2. In 1990, the Court of Appeals Confirmed That Loss of a Chance Cases Require a Showing of "But For" Causation, and in 2011, the State Supreme Court Confirmed it Again .

In the years following *Herskovits*, there was some uncertainty regarding whether Justice Dore's lead opinion or Justice Pearson's plurality opinion represented Washington State law regarding loss of a chance. See *Zueger v. Public Hosp. Dist. No. 2 of Snohomish County*, 57 Wn. App. 584, 589-91 (1990). However, in 1990, the Court of Appeals held that Justice Pearson's plurality opinion represented the law on loss of a chance. *Id.* at 591. And in *Mohr v. Grantham*, 172 Wn.2d 844 (2011), the State Supreme Court formally adopted Justice Pearson's plurality opinion. *Mohr*, 172 Wn.2d at 857.

In addition to confirming that Justice Pearson's opinion in *Herskovits* represented Washington's law on loss of a chance, the *Mohr* Court extended the loss of chance analysis to "claims where the ultimate harm is something short of death." 172 Wn.2d at 855. Thus, after *Mohr*, a claim for loss of a chance could be maintained where: (i) the defendant was negligent; and (ii) "but for" such negligence the plaintiff would have enjoyed a substantially greater chance of survival/a better outcome.

3. In 2013, the Court of Appeals, Yet Again, Confirmed That Loss of a Chance Cases Are Governed by the "But For" Standard for Causation.

In 2013, the question of whether "but for" should remain the standard for causation in loss of a chance cases came before the Court of Appeals once more. *Estate of Dormaier v. Columbia Basin Anesthesia, PLLC*, 177 Wn. App. 828 (2013). In *Estate of Dormaier v. Columbia Basin Anesthesia, PLLC*, the Court of Appeals considered Washington's prior loss of chance cases, and observed that:

Herskovits [v. Group Health Cooperative of Puget Sound] and Mohr [v. Grantham] established a medical patient's lost chance of survival or a better outcome as an injury distinct from death or disability but nonetheless actionable under the wrongful death and medical malpractice statutes.

Id. at 845. The Court of Appeals went on to confirm that, even in loss of a chance cases, "traditional tort principles . . . require[] the plaintiff to prove the defendant breached a duty owed to the patient and, thereby, proximately caused the patient to lose a chance . . ." *Id.* The *Dormaier* Court then held that:

. . . a plaintiff must prove proximate cause by a " 'probably' or 'more likely than not' " standard, traditional tort principles would require the plaintiff to prove loss of a chance greater than 50 percent.

Id. at 846. The Court also explained that proximate cause principles require a plaintiff to prove that the defendant's conduct was both a "cause in fact of the injury" and that "as a matter of law liability should attach." *Id.* at 862 (citations and quotations omitted).

Lest there was any doubt regarding what is required to demonstrate that a defendant's conduct is a "cause in fact" of a plaintiff's injury, the *Dormaier* Court held:

Cause in fact refers to the "but for" consequences of an act – the physical connection between an act and an injury. Thus, the plaintiff may prove factual cause by showing but for the defendant's breach of duty, the injury would not have occurred.

Id. at 862-63 (citations and quotations omitted). Finally, the *Dormaier* Court cautioned plaintiffs that "expert testimony is deemed based on speculation and conjecture if it does not go beyond . . . 'might have' or 'possibly did' . . ." *Id.* at 863 (citations and quotations omitted).

Washington's appellate courts have consistently held that "but for" is the appropriate standard for causation in loss of a chance cases. The Plaintiffs, nonetheless, continue to raise the issue. The Court should take this opportunity to confirm and clarify that "but for" is the standard of causation that governs medical negligence cases in the State of Washington – regardless of whether they are pled under traditional principles or under loss of a chance.

D. THIS CASE IS NOT APPROPRIATELY CAST AS A LOSS OF A CHANCE CASE.

The Plaintiffs' allegations are fundamentally incompatible with a loss of chance claim. Ms. Schiering did not suffer from any pre-existing condition that caused her to have a less than 50% chance of survival or a better outcome. Ms.

Schiering did not lose a chance of survival. Ms. Schiering did not lose a chance for a better outcome. Ms. Schiering was the victim of homicide. A loss of chance claim is simply impossible on these facts.

Loss of a chance does not apply to "all or nothing" cases, like this one. Loss of a chance only applies when the plaintiff recognizes his/her own inability to prove causation in a traditional claim. In this case, the Plaintiffs are improperly attempting to use loss of a chance as the moral equivalent of a "lesser included offense" in the criminal context – that is, to reduce the Plaintiffs' burden of proof. However, none of the Washington cases on loss of a chance allow the doctrine to be used to hedge a plaintiff's bet.

The *Herskovits* plurality recognized that "existing principles" of tort law fully address cases in which the plaintiff's pre-negligence chance of survival was better than even (*viz.*, more than 50%):

[C]ases where the chance of survival was greater than 50 percent . . . are unexceptional in that they focus on the death of the decedent as the injury, and they require proximate cause to be shown beyond the balance of probabilities. Such a result is consistent with existing principles in this state. . . .

99 Wn.2d at 631. When the plaintiff's chance of survival is better than even, the claim is an "unexceptional" wrongful death action, in which the plaintiff must prove that but for the defendant's conduct, the plaintiff would still be alive.

The cause of action that the *Herskovits* plurality recognized was characterized by "the loss of a less than even chance [being] an actionable injury." *Id.* at 634 (emphasis added). Stated differently, *Herskovits* recognized a new cause of action for situations where, independent of any alleged negligence, the plaintiff had a less than even chance of avoiding whatever damage, loss or injury is being sought.

Herskovits and *Mohr* do not allow a wrongful death plaintiff to pursue a fallback "loss of chance" claim (predicated on a chance of survival that exceeded 50%). As the court held in *Haney v. Barringer*, 2007 WL 4696827 (Ohio Ct. App. Dec. 27, 2007)⁷, "the loss-of-chance doctrine is not simply a fallback position when a plaintiff cannot establish proximate cause . . .," and loss of chance does not apply "in a case where the injured patient had a greater-than-even chance of recovery at the time of the alleged medical negligence." *Id.* at *3.

This case is a stark illustration of how far from its intended scope loss of chance has strayed. The Plaintiffs are contending that Dr. Ashby's failure to warn Ms. Schiering that Mr. DeMeerleer was potentially violent caused her to lose a chance of avoiding Mr. DeMeerleer's homicidal assault. Worse than that, to make

⁷ See Appendix A; see also Ohio Supreme Court Rules for the Reporting of Opinions 3.4 ("All opinions of the courts of appeals issued after May 1, 2002 may be cited as legal authority and weighted as deemed appropriate by the courts without regard to whether the opinion was published or in what form it was published.").

the claim fit within established loss of a chance principles, the Plaintiffs would have to acknowledge that even with "adequate" warnings, Ms. Schiering would have enjoyed a less than 50% chance of evading Mr. DeMeerleer's attack.

The complete misfit between this case and loss of a chance principles makes this case an ideal opportunity for the Court to bring the doctrine back into reason. The Court should confirm what *Herskovits* established – that a loss of a chance claim can only be asserted where there is affirmative evidence that some pre-existing condition caused the plaintiff to have a less than 50% chance of survival or the desired outcome **before** the events giving rise to the suit.

E. LOSS OF A CHANCE CAN ONLY GO TO THE JURY WHERE THE PLAINTIFF HAS OFFERED PROOF OF A NUMERICALLY QUANTIFIABLE LOSS OF A CHANCE.

Crucial to the *Herskovits* plurality opinion was stipulated medical evidence regarding the decedent's statistical chance of survival, both with and without the defendant's negligence. 172 Wn.2d at 858. As the *Mohr* Court explained:

The lost opportunity [for which a plaintiff can recover damages] may be thought of as the adverse outcome discounted by the difference between the ex ante probability of the outcome in light of the defendant's negligence and the probability of the outcome absent the defendant's negligence.

Id. (citations omitted). Moreover, calculation of a lost chance must be

based on expert testimony, which in turn is based on significant practical experience and on data obtained and analyzed scientifically as part of the repertoire of diagnosis and treatment, as applied to the specific facts of the plaintiff's case.

Id. at 857-58 (citations, internal quotations, and ellipses omitted). Thus, both *Herkovits* and *Mohr* emphasize and rely upon the plaintiff's ability to present medical expert testimony stating, **in percentage terms**, what chance had been lost. *Id.* at 849, 859-60.

Without scientific evidence, which is capable of identifying the percentage lost chance, no claim for loss of a chance can survive even the most summary scrutiny. Without such evidence, the jury would be left to speculation and conjecture regarding the nature and extent of damages. *Sposari v. Matt Malaspina & Co.*, 63 Wn.2d 679, 688 (1964) ("testimony establishing the [plaintiff's] loss must be free of speculation and conjecture.").

The *Dormaier* Court also analyzed whether Mrs. Dormaier had offered sufficient evidence to support her proffered loss of a chance instruction. *Id.* at 851-53. The *Dormaier* Court observed that the calculation of a lost chance must be "based on expert testimony." *Id.* at 852 (citations and quotations omitted). The Court also reaffirmed *Mohr v. Grantham's* holding, requiring that expert testimony be "based on significant practical experience and on data obtained and analyzed scientifically." *Id.* (quoting *Mohr*, 172 Wn.2d at 857-58).

V. CONCLUSION

The WDTL respectfully asks the Court to consider this brief in rendering judgment in this matter. The Court's decision with respect to a physician's duty to warn could have significant impacts on the medical community. And the Court's decision with respect to loss of a chance will guide civil practice in our Courts. The WDTL is grateful for the opportunity to assist the Court with respect to these important issues.

RESPECTFULLY SUBMITTED, this 2 day of October, 2015.

WITHERSPOON· KELLEY, P.S.

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CERTIFICATE OF SERVICE

I, Stewart A. Estes, hereby certify under the laws of the State of Washington that on the 2d day of October 2015, I electronically filed a true and accurate copy of the *Brief of Amicus Curiae WDTL* with the Washington Supreme Court via email to this address: Supreme@courts.wa.gov. I further certify under the laws of the State of Washington that I caused true and accurate copies of the same document to be served on all parties of record by the method indicated below:

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Done this 2 day of October 2015

Stewart A. Estes

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Dear Mr. Carpenter:

Pursuant to our pending application, please find attached WDTL's *Amicus Curiae Brief* in the above matter.

I am contemporaneously serving this brief electronically, by copy of this message, on counsel for the parties, and the Washington State Association for Justice Foundation, who by agreement have accepted this method of service.

Thank you,

Stew
Chair, WDTL Amicus Committee

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Firm Website

Personal Bio

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