No. 898655-5

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

DORENDER GRAY AND TEMI OGUNLEYE, AS INDIVIDUALS AND ON BEHALF OF OTHERS SIMILARLY SITUATED,

Plaintiffs-Appellants,

v.

WASHINGTON PHYSICIANS HEALTH PROGRAM,

Defendant-Appellee.

PLAINTIFFS-APPELLANTS' OPENING BRIEF

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I. INTRODUCTION

Defendant-Appellee Washington Physicians Health Program holds itself out as a place that helps doctors who are impaired by substance abuse and mental health issues get back to safely practicing medicine. The Program promises doctors that if they enter the Program and follow its directives, it will clear them to return to the practice of medicine, before they face suspensions or discipline from their schools, residency programs, employers, or licensing entities. This deal sounds appealing, but it gives the Program extraordinary power over the lives of those who enter its system.

What the Program claims is a "voluntary" process is the opposite in practice: if a doctor refuses to participate, questions the Program's demands, or disobeys a directive, the Program threatens to report the doctor as unfit to practice medicine. The Program uses its power to silence critics and take advantage of doctors, residents, and medical students to enrich its "preferred provider" treatment centers, testing labs, and itself. The Program

can act with such impunity because, it believes, it *is* immune. The Program claims complete civil immunity for all of its acts under a provision in the Uniform Disciplinary Act for the regulation of health professions, RCW 18.130. The relevant provision provides that "an impaired practitioner program approved by a disciplining authority . . . [is] immune from suit in a civil action based on any disciplinary proceedings or other official acts performed in the course of their duties." RCW 18.130.300(2).

But the Program and its conduct do not qualify for immunity under that provision. First, the Program is not "an impaired practitioner program approved by a disciplining authority." There is no evidence that it is approved by a disciplining authority; at best, the Program is a "physician health program," as described in other provisions. *See, e.g.*, RCW 18.130.175. Second, this civil action is not "based on any disciplinary proceedings" or "other official acts" of the Program. The allegations do not arise from any disciplinary proceedings, nor do they involve any activities connected to Washington's

official licensing authorities. Thus, the Program cannot be immune from this suit. Indeed, if the Program were immune from this civil suit under RCW 18.130.300, then the statute would violate constitutional due process rights.

Plaintiffs-Appellants Dr. Temi Ogunleye and Dr. Dorender Gray are just two of many doctors who have been ensnared by the Program. Dr. Gray and Dr. Ogunleye were well on their way to becoming fully fledged doctors in the community when the Program derailed their careers, forced them to sign unfair contracts and made them see unqualified out-of-state doctors, and held their careers hostage. The doctors bring this case to protect themselves, their community, and the medical profession from the predatory and unchecked power of the Program. Although the Program has operated with apparent impunity, it is not immune from judicial oversight. This Court should reverse the order below and allow the case to proceed.

II. ASSIGNMENTS OF ERROR

1. The trial court erred in extending RCW 18.130.300

immunity to Program conduct that did not constitute an "official act" qualified for immunity under the statute.

2. The trial court erred in extending RCW 18.130.300 immunity to the Program without establishing that the Program qualifies as an "impaired practitioner program" under the statute.

3. The trial court erred in extending RCW 18.130.300 immunity to the Program without establishing that the Program was "approved by a disciplining authority" as the statute requires.

4. The trial court erred in applying RCW 18.130.300 to bar the doctors' claims because, as applied, the statute deprived them of their due process rights in pursuing their chosen professions, in violation of the Washington State Constitution.

III. STATEMENT OF THE CASE

Plaintiffs-Appellants Dr. Gray and Dr. Ogunleye excelled at their respective medical schools and were thriving in their first years of residency at the University of Washington: Dr. Gray, in the OB/GYN program, and Dr. Ogunleye, in orthopedic surgery.

Clerk's Papers ("CP") 10, 12. Then the all-too-common stresses of medical residency caught up with them: Dr. Gray was tired and had a disagreement with an attending doctor, and Dr. Ogunleye overslept and was late to rounds. In response, their supervisors referred them to the Washington Physicians Health Program. CP 10, 12–13.

The Washington Physicians Health Program began as a peer-to-peer organization founded by doctors to help their colleagues experiencing drug or alcohol addiction. CP 6–7. The founders hoped that impaired colleagues could seek treatment and rehabilitation, rather than stigma and discipline, when their addiction threatened the safe practice of medicine. *Id.* Through the Program, doctors could find suitable treatment, and, once treatment was complete, they could be certified to safely return to the practice of medicine. *Id.*

Now, the Washington Physicians Health Program has expanded far beyond this focused service to addicted doctors, claiming that it can help medical professionals experiencing "any

health condition." CP 9. The nonprofit accepts referrals from licensing authorities, residency programs, and medical schools associated with Doctors of Allopathic Medicine (MDs), Doctors of Osteopathic Medicine (DOs), dentists, podiatrists, veterinarians, and physician assistants, plus medical students and residents of the associated professions. CP 7. Referrals can be made by employers, programs, supervisors, peers, members of the public, and by the participants themselves. *Id.* In all cases, the Program purports to provide a "safe, confidential, therapeutic opportunity for healing." CP 8–9.

Dr. Gray's and Dr. Ogunleye's experiences were anything but therapeutic. Once referred for help with the challenges they experienced in residency, the Program forced them to sign agreements that committed them to do whatever the Program said. CP 4. If they refused, the Program could report them to the University of Washington residency program for noncompliance and as unfit to practice medicine; the only way back to residency, and their chosen careers, was through the Program. CP 9.

Unsurprisingly, given the stakes, both complied. As part of their initial evaluations, the Program forced them to take drug and alcohol tests, even though no one had suggested that either doctor had a substance-abuse problem. CP 11, 13. Dr. Gray tested positive for amphetamines, which was no surprise given she was taking her regularly prescribed ADHD medication. CP 13. (A UW physician had previously diagnosed Dr. Gray with ADHD, and she had worked with her doctors to find the right combination of medications and other treatment to manage her diagnosis. *Id.*) But the Program questioned Dr. Gray's diagnosis and her need for the medication. *Id.* As a result, Dr. Gray stopped using her medication, worried that the Program would use it against her in her quest to return to her residency program. *Id.*

After their initial intake, both Dr. Gray and Dr. Ogunleye were made to undergo psychological testing at one of the Program's "preferred providers." CP 5, 11, 13. Dr. Ogunleye was evaluated by a preferred provider in Washington, and Dr. Gray, by a preferred facility in Colorado (notably, the "preferred

providers" who performed Dr. Gray's evaluation virtually were not licensed to practice in Washington). CP 11, 13. At this stage, their experiences took a turn.

Dr. Ogunleye was diagnosed with a major neurocognitive disorder and early onset dementia. CP 11. These diagnoses seemed unlikely; Dr. Ogunleye had completed his Doctor of Osteopathic Medicine degree and was well on his way through his UW residency in orthopedic surgery. He felt the report was about someone else, and it probably was: in addition to the unlikely diagnoses, it listed the wrong date of birth, wrong age, and wrong hand dominance. *Id.* It mentioned nothing about his existing ADHD diagnosis. *Id.*

Dr. Gray, meanwhile, was initially "deemed safe to practice medicine with reasonable skill and safety." CP 13–14. She returned to her residency program, where she received excellent reviews from patients. *Id.* Her supervisors raised no academic concerns. *Id.* She was back on track. *Id.* But the Program would not release her. Instead, it required her to

undergo additional neuropsychological testing, by another preferred provider. This time, the evaluation was to determine if she really had ADHD. CP 14.

The Program's preferred provider had little experience with neuropsychological assessments. *Id.* But Dr. Gray duly sat for the eight-hour evaluation, then waited for the results. CP 14. On a Zoom call with Program representatives, this provider informed Dr. Gray that she was acutely impaired, with serious visual and auditory impairments, and suffered from extremely low memory and recall functions. *Id.* Without providing a written report or results from her testing, the provider diagnosed Dr. Gray with an "unspecified neurocognitive disorder." *Id.* As a result, the Program ordered her immediate removal from clinical duties. *Id.*

As with Dr. Ogunleye's diagnoses, Dr. Gray's results seemed unlikely. Dr. Gray's long-time physicians had never suggested similar concerns, and Dr. Gray had performed at a high level her entire academic career at the University of

Washington and the UW School of Medicine. CP 14. Three weeks after her meeting with WPHP, Dr. Gray was finally given access to the written report, and like Dr. Ogunleye, felt that it was about someone else. CP 14–15. Again, it likely was: the report attributed Dr. Gray's work stress to her brother's suicide attempt and other childhood trauma. *Id.* But Dr. Gray's brother never attempted suicide, and she did not recognize the "childhood trauma" that the report referred to. *Id.*

Dr. Ogunleye and Dr. Gray each alerted the Program to the obvious flaws in the tests and reports. CP 11, 14–5. But the Program would not agree to clear them to return to their residency programs. CP 11–12, 15. The Program insisted that Dr. Ogunleye's results were correct and ordered him to undergo an MRI of his brain. CP 11. His insurance, through Kaiser, concluded that the MRI was not warranted, and refused to cover the cost. *Id.* But the Program insisted; it told Dr. Ogunleye to undergo the MRI at its preferred provider, or else, it threatened, it would tell his residency program that he was not cooperating

and unfit to return to work. *Id.* (Dr. Ogunleye complied; the MRI he paid for showed no abnormality. CP 11.) Similarly, the Program insisted that Dr. Gray's diagnoses were correct and insisted on its required treatment before she could return to practice. CP 15.

While they watched from the sidelines as their classmates continued their residencies, Dr. Ogunleye and Dr. Gray sought alternatives to the unwarranted treatment programs that the Program was requiring. Eventually, both doctors were able to receive second opinions. CP 11–12, 15. The doctor who performed both Dr. Ogunleye and Dr. Gray's second evaluations, Dr. Sanchez (a Washington-licensed doctor with years of experience performing and evaluating neurocognitive function tests) concluded that the Program's "preferred providers" were unqualified to perform or interpret the tests they did and had reached entirely incorrect diagnoses. *Id.* Dr. Sanchez provided her conclusions to the Program and firmly recommended that both doctors be allowed to return to work. *Id.*

Even then, the Program dragged its feet, coming up with bogus non-medical reasons to wait to clear Dr. Gray and Dr. Ogunleye. CP 11–12, 15–16.

Today, neither Dr. Gray nor Dr. Ogunleye is practicing medicine in Washington. Troubled by the stigma from his year-long referral to the Program, Dr. Ogunleye wanted a fresh start out of state, so he decided to move to California and complete his residency there. *See* CP 12. Dr. Gray has remained in Washington near family but has not yet been able to resume her residency training. *See* CP 16.

This state of affairs is bad not just for these two doctors, but also for Washington, which has now lost the services of two promising and driven doctors. As they learned that they were not alone in their experiences—that the Program engages in a pattern and practice of unfair and deceptive acts—the doctors brought this action on behalf of themselves and scores of other doctors, residents, and medical students who suffered at the hands of the Program. CP 5. Dr. Gray and Dr. Ogunleye brought two causes

of action on behalf of the class and one on their own behalf based on the Program's misrepresentation of its scope, transparency, and voluntary nature.

The Program moved to dismiss; the doctors opposed. CP 25–38, 109–35. Both parties requested oral argument. In a two-page order, the court dismissed the case with prejudice, without oral argument, on grounds that "Defendant Washington Physicians Health Program is entitled to absolute immunity from all claims asserted pursuant to RCW 18.130.300." CP 181. This appeal followed.

IV. ARGUMENT

A. Legal standard

1. Appellate review

This Court reviews the trial court's ruling on a motion to dismiss de novo. *Becker v. Cmty. Health Sys., Inc.*, 184 Wn.2d 252, 257–58 (2015). "Factual allegations are accepted as true, and unless it appears beyond doubt that the plaintiff can prove no

set of facts consistent with the complaint that would entitle him or her to relief, the motion to dismiss must be denied." *Id.*

2. Motion to dismiss

"Under CR 12(b)(6) a plaintiff states a claim upon which relief can be granted if it is *possible* that facts could be established to support the allegations in the complaint." *McCurry v. Chevy Chase Bank, FSB*, 169 Wn.2d 96, 101 (2010).

In deciding a motion to dismiss, "[a]ll facts alleged in the plaintiff's complaint are presumed true." *Jackson v. Quality Loan Serv. Corp.*, 186 Wn. App. 838, 843–44 (2015). "Generally, in ruling on a CR 12(b)(6) motion to dismiss, the trial court may only consider the allegations contained in the complaint and may not go beyond the face of the pleadings." *Rodriguez v. Loudeye Corp.*, 144 Wn. App. 709, 725 (2008).

3. Presumption against immunity

The Program claims, and the lower court granted, "absolute immunity" from the asserted claims. CP 181. From the outset, the Court should presume that this immunity does not

apply. The Washington Supreme Court has stressed that absolute immunity "runs contrary to the most fundamental precepts of our legal system" because it "necessarily leaves wronged claimants without a remedy." *Lutheran Day Care v. Snohomish County*, 119 Wn.2d 91, 105 (1992) (citing *Butz v. Economou*, 438 U.S. 478, 506 (1978) ("No man in this country is so high that he is above the law. No officer of the law may set that law at defiance with impunity.")).

For this reason, Washington courts extend absolute immunity in very limited situations:

> Absolute privilege is usually confined to cases in which the public service and administration of justice require complete immunity. Legislatures in debate, judges and attorneys in preparation or trial of cases, statements of witnesses or parties in judicial proceedings, and statements of executive or military personnel acting within the duties of their offices are frequently cited examples. . . . Generally, some compelling public policy justification must be demonstrated to justify the extraordinary breadth of an absolute privilege.

Bender v. City of Seattle, 99 Wn.2d 582, 600 (1983). Only those functions which are subjected to the "crucible of the judicial

process" have sufficient checks against misconduct to warrant absolute immunity. *Gilliam v. Dep't of Soc. & Health Servs., Child Protective Servs.*, 89 Wn. App. 569, 583–84 (1998); *see also Lallas v. Skagit County*, 144 Wn. App. 114, 117 (2008), *aff'd*, 167 Wn.2d 861 (2009) ("Absolute immunity is strong medicine that is justified only when the danger of officials being deflected from effective performance of their duties is very great."). In the context of common-law immunity, when a court determines "whether a particular act entitles the actor to absolute immunity," the Washington Supreme Court has instructed that courts "must start from the proposition that there is no such immunity." *Lutheran Day Care*, 119 Wn.2d at 105.

The same presumption should apply here. After all, courts recognize that same principles that govern common-law immunity also apply to evaluation of statutory immunity. As a court analyzing the same statutory immunity at issue here observed, the "same policy considerations that control the extension of absolute immunity to governmental entities for the

official acts of their prosecutors and judges are present in this case." *Janaszak v. State*, 173 Wn. App. 703, 718 (2013) (holding that cases "addressing the extension of prosecutorial and judicial immunity provide guidance" to the interpretation of RCW 18.130.300). Although the Program claims only civil immunity, that claim would still have the "extraordinary breadth" of absolute immunity, given criminal law's legal and practical limitations. Accordingly, this Court should start with the presumption that there is no such immunity.

B. Washington law sets forth specific requirements for physician health programs and impaired practitioner programs.

Determining the scope of the Program's immunity requires an understanding of the statutory schemes that govern doctors and their licensing and regulatory boards and agencies, and a careful reading of the statutory text at issue here. Because the immunity the Program claims here is an extraordinary power, the Court should be certain that the Legislature intended to immunize the Program.

1. Profession-specific statutes contemplate physician health programs.

Washington law regulates medical professionals through several licensing statutes. Some are profession-specific. Chapter 18.71, for example, regulates physicians with Doctor of Medicine degrees such as Dr. Gray. *See* RCW 18.71.010. It establishes the Washington Medical Commission as their licensing and regulatory authority, defines the scope of medical practice, and sets forth licensing requirements. RCW 18.71.002, -.015, -.011, and -.021. Similarly, Chapter 18.57 regulates physicians such as Dr. Ogunleye with Doctor of Osteopathic Medicine degrees. *See* RCW 18.57.001. It establishes the Washington State Board of Osteopathic Medicine and Surgery and defines the scope and requirements of those licenses. RCW 18.57.003.

These profession-specific statutes also contemplate physician health programs. *See* RCW 18.71.300; *see also* RCW 18.57.015 (DOs); RCW 18.22.250 (podiatrists); RCW 18.32.534

(dentists); RCW 18.71A.020 (physician assistants); RCW 18.92.047 (veterinarians). Chapter 18.71 is illustrative. A "Physician health program" as defined under the Chapter "means the program for the prevention, detection, intervention, referral for evaluation and treatment, and monitoring of impaired or potentially impaired physicians established by the commission pursuant to RCW 18.71.310(1)." RCW 18.71.300(3). "Entity" means "a nonprofit corporation formed by physicians who have expertise in substance use disorders, mental illness, and other potentially impairing health conditions and who broadly represent the physicians of the state and that has been designated to perform any or all of the activities set forth in RCW 18.71.310(1) by the commission." RCW 18.71.300(1).

RCW 18.71.310 sets out the relationship between the Commission, the "entity," and the "physician health program." RCW 18.71.310(1). It provides that "[t]he commission shall enter into a contract with the entity to implement a physician health program." *Id.* It also lists the activities of the program,

which "may include" such things as monitoring of program participants and providing education services. RCW 18.71.310(1)(a)–(h). The entity's work under its contract with the Commission is to be funded by surcharges "collected by the department of health." RCW 18.71.310(2).

2. The Uniform Disciplinary Act further delineates physician health programs.

A single chapter regulates discipline across these professions. The intent of Chapter 18.130, the Uniform Disciplinary Act, is to "strengthen and consolidate disciplinary and licensure procedures for the licensed health and health-related professions and businesses." RCW 18.130.010. As relevant here, the Chapter defines "Department" to mean "the department of health." RCW 18.130.010(5). In accordance with the profession-specific statutes, it defines "Disciplining authority," to mean "the agency, board, or commission having the authority to take disciplinary action" against licensees. RCW 18.130.020(7). For MDs, for example, such authority is vested in

the Washington Medical Commission; for DOs, the Washington State Board of Osteopathic Medicine and Surgery. *See* RCW 18.130.040(2)(b)(vii), (ix). RCW 18.130.050 sets out the authority of the disciplining authorities, which includes responsibilities like investigating complaints, holding hearings, issuing subpoenas, taking depositions, compelling attendance, issuing citations and assessing fines, suspending licenses, imposing sanctions, and granting or denying license applications.

RCW 18.130.175 addresses physician health programs. It provides that under certain circumstances, the disciplining authority may refer a license holder "to a physician health program . . . approved by the disciplining authority." RCW 18.130.175(1). It also addresses immunity for the program: RCW 18.130.175 states that "[a] person who, in good faith, reports information or takes action in connection with this section is immune from civil liability for reporting information or taking the action." RCW 18.130.175(6). (Because it includes a "good faith" requirement, this immunity is a qualified immunity.) That

provision specifies that "[t]he persons entitled to immunity shall include . . . An approved physician health program." RCW 18.130.175(6)(a)(1).

3. A separate statutory provision governs immunity for certain acts of "impaired practitioner programs."

Although RCW 18.130.175 expressly addresses the qualified immunity provided for actions taken by an approved physician health program, the Program contends that in fact another provision, RCW 18.130.300, governs its immunity in this case. CP 32–35. That section has two provisions. The first provides that "[t]he secretary, members of the boards or commissions, or individuals acting on their behalf are immune from suit in any action, civil or criminal, based on any disciplinary proceedings or other official acts performed in the course of their duties." RCW 18.130.300(1).

In 1998, the Legislature extended RCW 18.130.300's immunity. The second provision now provides that "[a] voluntary substance abuse monitoring program or an impaired

practitioner program approved by a disciplining authority, or individuals acting on their behalf, are immune from suit in a civil action based on any disciplinary proceedings or other official acts performed in the course of their duties." RCW 18.130.300(2).

C. RCW 18.130.300 does not apply to the Program or the acts at issue in this case.

The Program's assertion of immunity under RCW 18.130.300(2) depends on (1) whether the Program's actions at issue in this case constitute "other official acts"; (2) whether the Program qualifies as an "impaired practitioner program"; and (3) whether it is "approved by a disciplining authority." These questions are informed by the profession-specific statutes and the Uniform Disciplinary Act itself. In the end, a close examination of the Program and the statutory scheme reveals that the Program and the conduct challenged here meet none of these requirements.

1. RCW 18.130.300 does not apply because this suit is not "based on" any "official" acts.

RCW 18.130.300 immunizes an impaired practitioner program from suit "based on any disciplinary proceedings or other official acts performed in the course of their duties." This immunity does not apply here because this lawsuit is not "based on any disciplinary proceedings" or any "other official acts."

The Program appears to acknowledge that this action is not "based on any disciplinary proceedings" themselves. This lawsuit challenges the Program's misrepresentations about the scope, transparency, and voluntary nature of the Program, along with its improper testing, evaluation, and treatment requirements. CP 16–18. Indeed, Dr. Gray's and Dr. Ogunleye's experiences had nothing to do with the disciplinary authorities governing their licenses; they were referred to the Program by their residency programs and never interacted with the Washington Medical Commission or Washington State Board of Osteopathic Medicine and Surgery. *See* CP 10–16.

Instead, the Program contends that it is immune from suit because the actions complained of are "other official acts." *See* CP 34–35, 138. But it appears that the Program assumes that all of its acts must be "official" simply because it is, as it argues, an entity contemplated by a statute. *Id.* That cannot be true. "Official" must be assigned some meaning. *See Smith v. Greene*, 86 Wn.2d 363, 371 (1976) ("Whenever possible, a statute should be construed so that no portion of it is superfluous or insignificant."). The language of the provision itself demonstrates that not all of the Program's acts are "official": it only covers "*official* acts performed in the course of their duties," meaning that some of the Program's acts, even those performed in the course of their duties, are not "official." And if all of the Program's acts were official, the provision would simply extend it complete civil immunity—it would not limit its immunity to lawsuits "based on any disciplinary proceedings or other official acts."

Indeed, the Legislature knew how to refer to all acts: in contrast to the "official acts" terminology in RCW 18.130.300, RCW 18.130.175 grants immunity to entities that, "in good faith, . . . take[] action," and later refers again to "taking the action." RCW 18.130.175(6). A valid interpretation of these sections must assign meaning to the use of "official" in -.300, and its omission in -.175. Indeed, the Program's interpretation would make RCW 18.130.175 entirely superfluous: a program would not need any qualified immunity under -.175 if it had full immunity under -.300.[1] *See State v. Costich*, 152 Wn.2d 463, 470 (2004) ("Recalling our primary goal is to give effect to the legislature's intent, we derive such intent by construing the language as a whole, giving effect to every provision.").

Thus, not all of the Program's acts can be "official" and immunized by -.300. So, what acts are encompassed in "other

[1] The 1998 revisions that added the second provision to RCW 18.130.300 also revised RCW 18.130.175, so the Legislature was aware of RCW 18.130.175 when it added limited immunity under RCW 18.130.300(2).

official acts performed in the course of [the Program's] duties"? Washington courts interpreting RCW 18.130 have held that an act is "official" if it derives from the responsibilities of the disciplinary authorities.

In *Janaszak*, a dentist alleged misconduct relating to the investigation and restriction of his dental license. 173 Wn. App. at 709. He sued, among others, the Washington Dental Quality Assurance Commission and the investigator who performed its authorized investigation. *Id.* at 709–10. Among other issues, this Court analyzed whether the investigator's sua sponte expansion of the investigation into a related complaint fell within the scope of her investigatory duties; if it did, she would be immune under RCW 18.130.300(1). This Court held that the expansion did fall within the investigator's duties: the investigator had "received the Commission's authorization to investigate," and her decision to expand the scope of the investigation fell within that authorization. *Id.* at 714–15. Similarly, in *Hiesterman v. Department of Health*, the court held that RCW 18.130.300(1)

immunity applied because the acts at issue fell within the Board of Osteopathic Medicine and Surgery's official reporting function, which was statutorily mandated under RCW 18.130.110(2)(c). 24 Wn. App. 2d 907, 919 (2022). Although the act of reporting was not strictly quasi-prosecutorial, it was unquestionably official. Likewise, in *Clark v. Washington State Department of Health*, the court determined that the consideration of an EMT license fell within the bounds of "official acts." 735 F. Supp. 3d 1334, 1344 (W.D. Wash. 2024).

These decisions all require some connection between the responsibilities of the disciplinary authorities and the challenged conduct. That requirement comports with the foundation and purpose of the immunity provided in RCW 18.130.300. "Historically, an absolute privilege has been extended to three general areas: (1) judicial proceedings, (2) legislative proceedings, and (3) acts of state by important government officials." *Davidson v. Glenny*, 14 Wn. App. 2d 370, 379 (2020). The authority granted under RCW 18.130.300 derives from these

judicial and prosecutorial immunities. Interpreting RCW 18.130.300's immunity for the licensing authorities, this Court has recognized that in their performance of their disciplinary duties, "the immunized individuals perform duties analogous to those of prosecutors and judicial officers." *Janaszak*, 173 Wn. App. at 718. This Court explained that, "[a]nalogous to the immunity afforded prosecutors and judges, the immunity afforded by RCW 18.130.300 exists not to protect individuals but to protect the integrity of a uniform disciplinary process for health care professionals." *Id.* at 719.

Here, the Program's conduct at issue lacks any analogous connection to any official disciplining authority's prosecutorial or judicial function. Instead, Dr. Gray and Dr. Ogunleye claim that the Program has misrepresented what the Program does, the skill it has, and the care it takes with participant doctors. When the Program advertises that it makes decisions based on sound medical science, but requires participants to undergo testing that is not warranted, and is performed by practitioners who lack the

expertise to perform the tests, the Program acts entirely independent of any official authority.

The challenged actions here are not the sort of quasi-judicial or quasi-prosecutorial that might warrant immunity. The allegations do not touch the investigation or revocation of licenses. The Program's conduct here lacks any connection to the disciplinary authorities' responsibilities as set forth in the profession-specific statutes or the Uniform Disciplinary Act. The Program might play a role in those functions in its reporting to licensing entities, but it was not doing so when it harmed Dr. Gray and Dr. Ogunleye. Indeed, the authorities that would govern Dr. Gray and Dr. Ogunleye's licenses were not involved whatsoever in their alleged experiences. Instead, the challenged conduct—the misrepresentations and unfair practices—all occurred "in house" at the Program.

To be sure, the Program's actions here have "some" connection with the official disciplining authorities, in that the Program could have (improperly) reported the doctors to

disciplining authorities governing their licenses. *See* RCW 18.71.320(4). But as this Court has held, some "degree of association with [a] judicial phase" is not sufficient to warrant immunity when the work in question is "more peripheral than the core functions of judging, advocating, prosecuting, fact-finding, and testifying." *Gilliam*, 89 Wn. App. at 583–84. In *Gilliam*, this Court held that caseworkers investigating allegations of child abuse did not have absolute immunity. *Id.* at 584. It explained that the mechanisms of the adversarial process do not directly promote proper investigative practices, nor do they supply sufficient assurance that carelessness or deliberate misconduct will come to light before irreparable harm occurs." *Id.* The same can be said of the acts alleged here: the Program's acts are so outside the official disciplinary process that none of that system's mechanisms sufficiently promote proper practices within the Program, nor do they provide sufficient assurance that carelessness or deliberate misconduct by the Program will come to light before irreparable harm occurs. Therefore, the actions

about which the doctors complain are not "official acts" and cannot be immune from suit.

2. RCW 18.130.300 does not apply because the Program is not "an impaired practitioner program."

Setting aside whether its acts are official, the Program is not even the sort of program the statute immunizes. Although the Program might be a sort of "physician health program," as contemplated by RCW 18.130.175, it is not an "impaired practitioner program," which is the term that RCW 18.130.300(2) uses. Thus, the Program is not entitled to any immunities established there.

The Washington Physicians Health Program is not an "impaired practitioner program." Before 2022, the MD-specific Chapter, RCW 18.71, defined and described an "Impaired physician program."[2] *See* CP 79 (reflecting the 2022 revisions to

[2] The statute expressly defined "Physician" and "practitioner" interchangeably. *See* CP 79 (reflecting revisions to 18.71.300(4)).

RCW 18.71.300(3)). An impaired physician program meant a "program for the prevention, detection, intervention, monitoring, and treatment of impaired physicians established by the commission." *Id.* The law required that the "commission shall enter into a contract with [an] entity to implement an impaired physician program." CP 79 (reflecting revisions to RCW 18.71.310(1)). The law defined "Entity" as "a nonprofit corporation formed by physicians who have expertise in the areas of alcohol abuse, drug abuse, alcoholism, other drug addictions, and mental illness." CP 78–79 (reflecting revisions to RCW 18.71.300(1)).

In sum, an impaired physician program would have a contract with the Washington Medical Commission to treat and otherwise attend to practitioners who are impaired. The Program is a different beast entirely. First, the Program does not and did not have a contract with Washington Medical Commission to implement an impaired physician program. Second, the Program accepts referrals of any practitioner, without any required

threshold finding of impairment. CP 8–9. And third, the Program accepts referrals not just for substance abuse and mental illness, but instead for "any health condition," workplace or behavioral concern, or, in Dr. Ogunleye's case, tardiness. CP 8–9, 17. Finally, the Program itself does not provide "treatment" at all, instead referring its "participants" to preferred providers. CP 5, 9. Thus, it is not an impaired practitioner program that benefits from -.300 immunity.

The Program responds that it is a physician heath program[3] and that the difference between an impaired practitioner program and a physician health program is merely semantic. It points to the 2022 revisions to Chapters 18.71 and 18.130 that removed some references to impaired practitioner programs and replaced them with physician health programs. Although the Legislature did not change the language of 18.130.300(2), which continues to use the term "impaired practitioner program," the Program

[3] As discussed in the section below, the Program is also not a physician health program contemplated by these provisions.

argues that impaired practitioner programs and physician health programs should be considered equivalent, and that they should therefore benefit from the equivalent immunity.

The first problem with the Program's argument is that it asks the Court to ignore the actual language of RCW 18.130.300, and to simply assume that when the Legislature left the term "impaired practitioner program" there, it made a mistake. *See* CP 33. But courts "presume the legislature says what it means and means what it says." *Costich*, 152 Wn.2d at 470. This interpretive principle is particularly important here, where the Program seeks absolute immunity from suit; close enough is not good enough. And it cannot be that the Legislature simply forgot about Chapter 18.130: the 2022 revisions *did* update the language in RCW 18.130.175, which now grants *qualified* immunity to a "physician health program." *See* CP 87 (amending RCW 18.130.175(6)(a)(i)).

The second problem with the Program's argument is that it rests on an incorrect premise: that the Legislature "simply

changed the terminology in 2022" from impaired physicians to physician health programs (and, presumably, just forgot about RCW 18.130.300). CP 136. In fact, when the Legislature amended Chapters 18.71 and 18.130 to update the language, it did not merely "remove outdated and stigmatizing language from certain terms." CP 33. Although the Program contends that the "terminology changes [did] not modify the substance of the provision," *id.*, that is not true: the 2022 revisions went well beyond terminology changes: they changed the reach and role of physician health programs under the law.

As noted above, under the old statute, an "impaired physician program" was one for the "prevention, detection, intervention, monitoring, and treatment of impaired physicians." CP 79. The revised physician health programs' roles are designed to serve impaired "or potentially impaired" physicians. *Id.* And physician health programs reach not just substance use disorders and mental illness, but also "other potentially impairing health conditions." CP 78–79 (revising RCW 18.71.300(1)). And

"treatment" was removed from the scope of the new physician health programs; all provisions referring to treatment by the program were struck, further distancing such new programs from the peer-to-peer medical care once at the heart of impaired physician programs. *See, e.g.*, CP 79 (striking "treatment" in subsection (3)); CP 80 (striking "treatment" at subsection (f)); CP 83 (striking references to "treatment" in subsection (d)(ii)); CP 85 (striking subsection (4)). In short, in 2022, the Legislature created a new type of entity, the "physician health program," that differs in important ways from the existing "impaired practitioner program."

Thus, the changes are not merely semantic. Instead, they provide reason to believe that the Legislature did not make a mistake when it denied the new programs -.300's broad immunity; it makes good sense not to extend RCW 18.130.300's immunity to reach these new, expanded programs.

The Program may indeed enjoy the qualified immunity of RCW 18.130.175 for certain of its acts (an issue it did not brief).

But because it is not an impaired practitioner program, it does not enjoy the absolute immunity that RCW 18.130.300 extends to such entities.

3. RCW 18.130.300 does not apply because the Program is not "approved by a disciplining authority."

Whether or not the Program is an impaired practitioner program, the Program is not subject to RCW 18.130.300's immunity because it is not "approved by a disciplining authority," as the section also requires. RCW 18.130.300(2).[4] Indeed, the Program points to no allegation or evidence that it is such an approved entity.

At most, the Program highlights its contract with the Department of Health, which is not before this Court.[5] But even

[4] The full provision reads: "A voluntary substance abuse monitoring program or an impaired practitioner program approved by a disciplining authority, or individuals acting on their behalf, are immune from suit in a civil action based on any disciplinary proceedings or other official acts performed in the course of their duties." RCW 18.130.300(2).

[5] The lower court's decision did not take judicial notice of anything or make any findings or fact. CP 181–84.

if it were, that contract would not suffice to make the Program "approved by a disciplining authority." First, a contract with the Department of Health does not signify "approval," and second, the Department of Health is not a disciplining authority.

Afterall, RCW Chapter 18.130 defines "[d]isciplining authority" to refer to licensing authorities such as the Washington Medical Commission, not the Department of Health. RCW 18.130.020(7) ("'Disciplining authority' means the *agency, board, or commission having the authority to take disciplinary action* against a holder of, or applicant for, a professional or business license . . . ." (emphasis added)); *see also* RCW 18.130.040(2)(b) (defining the authority of the listed boards and commissions). "Department," referring to the Department of Health, is defined separately. *See* RCW 18.130.040(2)(a) (defining the authority of the secretary of the Department of Health in the delineated professions). There is no indication that the Program even has a contract with the

Washington Medical Commission or any other disciplinary authority, much less the approval of a disciplinary authority.

Because it is not "approved by a disciplining authority," the Program cannot avail itself of the immunity provided to programs that are.

4. Other statutory provisions do not make the Program "approved" or its acts "official."

The Program argued in the lower court that it is an approved program, and that all of its conduct is "official," because it is a physician health program contemplated by the profession-specific statute that applies to MD-holders, Chapter 18.71. *See* CP 34–35 (citing RCW 18.71.310(1)(a)–(h)). The problem is that the Program does not meet the definitions of a physician health program under that Chapter.

First, Chapter 18.71 defines a "Physician health program" to be a program "established by the commission." RCW 18.71.300(3). There is no indication that the Program is or ever was established by the Washington Medical Commission. The

Program emphasized in the lower court that it has been "recognize[d]" by the Washington Medical Commission, CP 33, but "recognized by" is not the same as "established by."

Second, that Chapter defines a physician health program as an entity "designated" by the Washington Medical Commission "to perform" certain listed activities. RCW 18.71.300(1). Here, there is no evidence that the Commission has designated the Program to perform any activities. Third, the Chapter contemplates that the "*commission* shall enter into a contract with the entity to implement a physician health program." RCW 18.71.310(1) (emphasis added). Here, there is no evidence that the Washington Medical Commission has entered into any contract with the Program.

Furthermore, there is no indication that the list of activities in RCW 18.71.310(1) that a program "may" undertake is a list of activities that are "official" for the purposes of RCW 18.130.300's immunity. RCW 18.71.310 does not use the term "official"; instead, it lists "any or all" of the activities that a

physician health program "may include." RCW 18.71.310(1). Listing the potential activities of a nonprofit entity in a statute does not make the entity's activities "official," much less immune. Thus, the Program cannot lean on Chapter 18.71 to transform it (or its acts) into the program (or the conduct) immunized in Chapter 18.130.

5. For any of these independent reasons, the Court should conclude that RCW 18.130.300 does not apply here.

Immunity is an extraordinary departure from the ordinary rule of legal accountability, and it should extend no further than the Legislature clearly provided. Here, the Legislature set certain basic requirements for immunity, and the Program does not meet them. The challenged practices are not "official acts," the Program is not an "impaired practitioner program," and it is not "approved by" a licensing authority. As a result, the Program cannot have immunity from the claims in this case.

To be sure, the Program may believe that it satisfies these conditions. It may look a lot like a program contemplated by

Chapters 18.71 or 18.130. And it may act as if it has immunity. But it does not. A court can find that an entity has immunity only when there is no question that our Legislature intended to grant such extraordinary power, and this Court should look closely at the statutory structure before finding immunity. To the extent it is a close question, the extreme consequences of civil immunity counsel against expanding RCW 18.130.300 to an entity that it does not, by its terms, reach. This Court should not be the first[6]

[6] Plaintiffs located only one unpublished decision that involves the question of whether RCW 18.130.300 applies to the Program. In *Farzad v. State of Washington Department of Health-Medical Quality Assurance Commission*, the pro se plaintiff sued the Program and several other entities and associated individuals. No. 51340-4-II, 2019 WL 4667963, at *2 (Wash. Ct. App. Sep. 24, 2019). The complaint "related to [the Commission's] decision to suspend the [plaintiff's] medical license." *Id.* Defendants, including the Program, asserted immunity under RCW 18.130.300. *Id.* The trial court granted immunity, and the plaintiff appealed. *Id.* at *3. The plaintiff, however, "provide[d] no argument or authority" on the issue of immunity, so the court "decline[d] to consider his assignment of error relating to immunity." *Id.* Thus, it appears that no appellate decision has addressed, much less analyzed, whether RCW 18.130.300 applies to the Program. In any event, *Farzad* is distinguishable: unlike here, the acts at issue

to extend an extraordinarily broad immunity to a nonprofit corporation for acts entirely disconnected from any governmental body or activity. For all these reasons, the Court should conclude that the Program is not immune from this suit.

D. If RCW 18.130.300 grants immunity to the Program, then it is unconstitutional as applied.

1. Any immunity enjoyed by the Program must be construed narrowly to avoid constitutional questions.

The conclusion that RCW 18.130.300 does not apply to this lawsuit is bolstered by the fact that such application would raise serious constitutional questions. As discussed further below, the Program's interpretation of RCW 18.130.300, as applied to the doctors' claims, implicates at least the Fourteenth Amendment of the U.S. Constitution and Article I, Section 8 of the Washington State Constitution. As the Washington Supreme Court has explained, in such contexts "[w]e construe statutes to avoid constitutional doubt." *State v. Blake*, 197 Wn.2d 170, 188–

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there "related to" the "decision to suspend [the plaintiff's] medical license," which would necessarily be "official" acts.

89 (2021) (quoting *Utter ex rel. State v. Bldg. Indus. Ass'n of Wash.*, 182 Wn.2d 398, 434 (2015)). Here, the Court should narrowly construe the statute to avoid constitutional questions.

The due process clause of the Fourteenth Amendment of the U.S. Constitution ensures that the State cannot "deprive any person of life, liberty, or property, without due process of law." U.S. Const. amend. XIV, § 1. The "right to pursue the lawful career of [their] choice without arbitrary interference by the State is a well-established 'liberty interest protected by the due process clause.'" *Fields v. State of Wash. Dep't of Early Learning*, 193 Wn.2d 36, 43–44 (2019) (quoting *Amunrud v. Bd. of Appeals*, 158 Wn.2d 208, 219 (2006)). Procedural due process ensures that anyone deprived of their right to pursue a career have "an opportunity to be heard to guard against erroneous deprivation" of that protected interest. *Id*. (quoting *Amunrud*, 158 Wn.2d at 216). If the Program is correct, then RCW 18.130.300 would deprive Dr. Gray, Dr. Ogunleye, and the putative class of their due process rights to pursue their chosen careers, which they

have spent decades training for, without any review process at all—RCW 18.130.300 would thus be unconstitutional.

Our State's Constitution also provides that "[n]o law granting irrevocably any privilege, franchise or immunity, shall be passed by the legislature." Const. art. I, § 8. According to the Program's interpretation of RCW 18.130.300, the Legislature has granted it "absolute civil immunity to be applied to these programs and associated individuals." CP 29. If that is right, then the Legislature has granted a corporation immunity in direct conflict with the Washington State Constitution. The constitutional questions that application of RCW 18.130.300 creates can be avoided if the statute is interpreted as the doctors' contend.

If the Program is correct that RCW 18.130.300 grants immunity from this suit, then the statute is unconstitutional as applied here.

2. Applying the immunity statute here violates State and Federal Due Process.

If applied to bar their claims, RCW 18.130.300 would deprive Dr. Gray and Dr. Ogunleye of their constitutional right to pursue their chosen professions.

The due process clause of the Fourteenth Amendment provides that no state may "deprive any person of life, liberty, or property, without due process of law." U.S. Const. amend. XIV, § 1. The right to pursue a lawful career of one's choice without arbitrary interference by the State is a well-established "liberty interest protected by the due process clause." *Fields*, 193 Wn.2d at 43–44. And as the Washington Supreme Court has explained, "[p]rocedural due process requires that an individual receive . . . [the] opportunity to be heard to guard against erroneous deprivation of a protected interest." *Id.* at 44.

Accordingly, the Constitution requires the State to provide sufficient process before Dr. Gray and Dr. Ogunleye can be deprived of their careers in medicine. Washington courts apply a

three-part test to determine whether a given process is sufficient. In *Fields*, for example, a state regulation prohibited a licensing agency from conducting a case-by-case determination on whether a convicted felon could work in a daycare facility; instead, the law imposed a flat ban on allowing felons in daycares. *Id*. at 44–45. The plaintiff argued that her single conviction for purse snatching should not automatically disqualify her from her chosen career as a daycare provider. *Id.* No one has an inviolable right to work as a daycare provider, but the plaintiff argued that she at least should be allowed to present her facts to the state agency for an individual determination. *Id.* The court agreed. *Id.*

In reaching its conclusion, the Washington Supreme Court applied the three-part *Mathews* test from the U.S. Supreme Court. It considers three factors:

> First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the

> Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.

Id. at 45–46 (quoting *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976)).

Analyzing the first and the third factors, the court accepted that the plaintiff had a "strong interest in pursuing her chosen profession without arbitrary interference by the State" and that the agency had a strong interest in protecting children. *Id.* at 46. The court was left to determine if the procedures afforded the plaintiff would prevent the erroneous deprivation of the plaintiff's rights. *Id*. Although the plaintiff could file a case under the state's administrative procedure act, which would also give her the right to review in a state court, the court explained that "[t]he added time and expense involved in the judicial review process, in addition to the difficulty in obtaining relief, raises significant concerns about [the procedural] adequacy in light of the high risk of erroneous deprivation presented here." *Id*. at 50.

A simple fix would change that: "an individualized determination would drastically reduce the risk of erroneous deprivation in [the plaintiff's] case." *Id.* As a result, the court concluded that because the "regulations prevent [the plaintiff] from pursuing her chosen occupation without a rational basis for doing so, she has been erroneously deprived of a protected interest." *Id.* at 46.

The violation of Dr. Gray's and Dr. Ogunleye's due process rights in this case is even more stark. As in *Fields*, the doctors have strong interests in pursuing their chosen professions, and the State has a strong interest in protecting patients. So, the Court must assess "the risk of an erroneous deprivation of [Plaintiffs'] interest through the procedures used." *Mathews*, 424 U.S. at 334–35. Under the Program's reading of RCW 18.130.300, Dr. Gray and Dr. Ogunleye have no procedures at all to challenge the Program's decisions—the very decisions that de facto prevented them from practicing medicine or returning to their residency programs. The Program's

evaluations of doctors carry significant weight with the licensing authorities, residency programs, and medical schools. *See* CP 8. Participants face no real choice but to comply with its requirements. CP 8, 16–17. And the Program's threats are coupled with an extreme lack of transparency. *See* CP 18. At most, whether Program participants have real alternatives to preserve their medical training or careers is a question of fact that cannot be resolved at this stage.

As alleged, the Program's combined influence and lack of transparency leave doctors without the ability to challenge the Program's conclusions about their diagnoses, appropriate treatment, and ability to practice medicine. The doctors and other Program participants in Washington have no chance at all to "guard against erroneous deprivation" of their right to practice their chosen careers. In *Fields*, it was enough to establish a due process violation simply where the plaintiff's path to challenge an agency action was long and expensive. 193 Wn.2d at 50. Here,

according to the Program, the doctors have no path to review at all.

The risk that the Program erroneously deprives them of a right to pursue their careers is not hypothetical. For both Dr. Gray and Dr. Ogunleye, the Program made and ignored dramatic errors in assessing them and their abilities to practice medicine. The Program repeatedly dismissed their concerns and erroneously and unfairly refused to approve them to return to their residency programs. Without judicial review, the doctors and others like them in the putative class have no way to prevent the Program from continuing to arbitrarily and unfairly deprive them of their rights.

That there may be other entities that the doctors could sue is irrelevant. CP 29 (suggesting parties could challenge "their disciplining authority" or "their employer under the protections provided by their union contract or employment agreement"). The Program directly controls the fate of doctors, residents, and students who are referred to it; its recommendations are trusted

by the licensing authorities and residency programs. CP 2. If it can do whatever it chooses without the threat of judicial oversight, then availability of procedures within, or appeal to, some other entity is of little use to Dr. Gray, Dr. Ogunleye, and other participants stuck in the Program. When doctors complain about their mistreatment at the Program, the Program can always brand them as liars and addicts whose stories are untrustworthy. *See, e.g.*, CP 131.

Finally, there is no compelling reason for the Legislature to grant the Program, a nongovernmental entity, blanket immunity from civil suit. The Program suggests that the purpose of the immunity is to further the purpose of encouraging the participation in" the Program. CP 26. But this makes no sense at all. Doctors who might participate in the Program would likely be *disincentivized* from participating if they understood they had no legal recourse against the Program. And although the State might have a compelling reason to encourage doctors to participate in programs like the Washington Physicians Health

Program, there is no need for it to insulate the Program from liability to do so.

Here, allowing doctors to bring suits against the Program "would drastically reduce the risk of erroneous deprivation" of doctors' rights. *Fields*, 193 Wn.2d at 50. Allowing for judicial review does nothing to prevent the State from protecting the health and safety of patients. The Program, the Washington Medical Commission, residency programs, medical schools, and other licensing and disciplining entities in the medical system could still review and assess the fitness of doctors, even if affected doctors could challenge the actions of the Program in court, at least as far as those actions were separate from the Program's function in the disciplinary process itself. In short, there is no rational basis for giving the Program blanket immunity from civil suit; and indeed, such a grant of immunity would violate the due process clause of the Fourteenth Amendment of the U.S. Constitution and Article I, Section 3 of the Washington State Constitution.

3. The immunity statute violates Article I, Section 8 of the Washington State Constitution.

As interpreted by the Program and if applied here, RCW 18.130.300 would also run afoul of Article I, Section 8 of the Washington State Constitution. That section prevents the Legislature from passing a "law granting irrevocably any privilege, franchise or immunity."[7] Const. art. I, § 8. Washington State's Constitution was "[p]assed during a period of distrust toward laws that served special interests" and works to "prevent favoritism and special treatment for a few, to the disadvantage of others." *Ockletree v. Franciscan Health Sys.*, 179 Wn.2d 769, 775–76 (2014). Our Constitution ensures that the Legislature cannot vest anyone, including nonprofit corporations, with the authority to take advantage of Washingtonians without recourse.

[7] This is not the first time a plaintiff has argued that RCW 18.130.300 violates Article I, Section 8. *See Hiesterman*, 24 Wn. App. 2d at 910. The court declined to reach the Constitutional issue because the plaintiff "failed to preserve this argument for appeal." *Id*.

The Program argues that RCW 18.130.300 gives it immunity from liability for "[e]ach and every action taken by WPHP as alleged in the Complaint," CP 35, including knowingly subjecting doctors to drug and mental tests without sound medical bases, sending doctors to providers who lack proper qualifications and skill, purposefully withholding clearance to return to work based on factors unrelated to a doctor's ability to safely practice medicine, and falsely claiming the Program is voluntary and transparent, *see* CP 17–18. If the Program is right that the law allows it to take these actions without consequence, then the statute violates Article I, Section 8 of the Washington State Constitution, because it acts to give the Program an irrevocable immunity to this case.

The immunity the Program claims is irrevocable, and thus unconstitutional, because the immunity has no time limits and, under the Program's interpretation, purports to grant the Program immunity from *all* acts it and its employees have taken, with no opportunity for judicial oversight. In other words, the law would

shield the Program forever from being held accountable for harms it inflicted on Dr. Gray, Dr. Ogunleye, and the putative class. This is unconstitutional.

True, the Legislature could "revoke" RCW 18.130.300. But that is true of any law, and does not mean that RCW 18.130.300 is not an irrevocable immunity within the meaning of section 8. The question, instead, should be whether the grant of immunity is irrevocable as to the plaintiffs in a particular case. Here, if the statute applies to bar the doctors' claims, then the statute is "irrevocable" as to the doctors and others similarly situated—no one, and no further process, will give them the opportunity to protect their rights to work; the Program's immunity will have been irrevocable to them.

The immunity is also "irrevocable," because, according to the Program, it is absolute. Under the Program's view, it can never be held to account in civil court. Without limitations on time or scope of immunity, the grant of immunity would be irrevocable and unconstitutional.

Our Constitution does not allow such unchecked power in the hands of unaccountable private institutions. If the Program's interpretation is correct, the statute is unconstitutional.

V. CONCLUSION

The Program is not an "impaired practitioner program," it is not "approved by a disciplining authority," and the misconduct alleged here—sham evaluations, coerced testing, and false promises of a voluntary process—are not "official acts" with any connection to the official licensing authorities.

Dr. Gray and Dr. Ogunleye do not challenge the existence of a program to help impaired doctors and protect their patients, but it should not share an immunity normally reserved for judicial figures. The State has provided disciplining authorities immunity because we trust that the mechanisms of the adversarial process provide sufficient alternative protection. No such guardrails constrain the Program.

As alleged in the Complaint, the Program currently operates as an unaccountable organization free to impose

whatever requirements it wishes, double down on its mistakes, and derail careers, all without the threat of oversight or consequence. If the decision below stands, its misconduct will only continue. This Court should reverse and allow the case to proceed.

This document contains 9,164 words, excluding the parts of the document exempted from the word count by RAP 18.17.

RESPECTFULLY SUBMITTED this 3rd day of September, 2026.

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CERTIFICATE OF SERVICE

I certify that on September 3, 2026, I caused a true and correct copy of the foregoing document to be served on the parties listed below, as follows:

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