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COMPLAINT -1 of 202

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4 ATTORNEYS FOR PLAINTIFFS

5 IN THE UNITED STATES DISTRICT COURT
6 EASTERN DISTRICT OF WASHINGTON

7 MERLE JANES, MD, a physician)
8 licensed by the State of Washington;) No.
9 JOHN DOE, JANE DOES A and B, and)
10 DOES C, D, E, F, G, H, I, J, K, L, M, N,) COMPLAINT FOR DECLARATORY
11 O, P, Q, R, S, T, U, V, W, X, Y, and Z,) AND INJUNCTIVE RELIEF AND
12 as individuals and as Class) DAMAGES
13 Representatives under F.R.C.P. 23,)
14) DEMAND FOR JURY TRIAL

13 Plaintiffs,)

14 vs.)
15)

16 PETER J. HARRIS, Individually, and as)
17 agent for the WASHINGTON)
18 DEPARTMENT OF HEALTH;)
19 GEORGE HEYE, MD, Individually,)
20 and as agent of the WASHINGTON)
21 DEPARTMENT OF HEALTH; ERIN)
22 OBENLAND, Individually, and as agent)
23 for the WASHINGTON)
24 DEPARTMENT OF HEALTH;)
25 FREDERICK H. DORE, JR., MD,)
26 Individually, and as agent for the)
27 WASHINGTON DEPARTMENT OF)
28 HEALTH; THE STATE OF)
WASHINGTON, THE WASHINGTON)

COMPLAINT -2 of 202

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1 MEDICAL QUALITY ASSURANCE)
2 COMMISSION, THE WASHINGTON)
3 DEPARTMENT OF HEALTH, and)
4 THE WASHINGTON AGENCY)
5 MEDICAL DIRECTORS GROUP,)
6 consisting of GARY M. FRANKLIN,)
7 MD, Individually, and as Director of the)
8 Washington Department of Labor and)
9 Industries, and as Chairman of The)
10 Washington Agency Medical Directors)
11 Group; CRAIG McLAUGHLIN,)
12 Individually, and as Director of the)
13 Washington State Board of Health, and)
14 as a member of the Washington Agency)
15 Medical Directors Group; MARC)
16 STERN, Individually, and as Director of)
17 the Washington State Department of)
18 Corrections, and as a member of the)
19 Washington Agency Medical Directors)
20 Group; MICHAEL ARNIS,)
21 Individually, and as Director of the)
22 Washington State Office of the)
23 Insurance Commissioner, and as a)
24 member of the Washington Agency)
25 Medical Directors Group; MAXINE)
26 HAYES, MD, Individually, and as)
27 Director of the Washington State)
28 Department of Health, and as a member)
of the Washington Agency Medical)
Directors Group; NANCY FISHER,)
MD, Individually, and as Director of the)
Washington State Health Care)
Authority, and as a member of the)
Washington Agency Medical Directors)
Group; ALFIE ALVAREDO-RAMOS,)

1 Individually, and as Director of the)
2 Washington State Department of)
3 Veteran Affairs, and as a member of the)
4 Washington Agency Medical Directors)
5 Group; THE WASHINGTON)
6 AGENCY MEDICAL DIRECTORS)
7 GROUP, as an instrumentality of the)
8 State of Washington, and CHRISTINE)
9 GREGOIRE, as Governor of the State of)
10 Washington, and TWO OR MORE)
11 UNNAMED AGENTS OF THE)
12 WASHINGTON MEDICAL QUALITY)
13 ASSURANCE COMMISSION OR)
14 WASHINGTON DEPARTMENT OF)
15 HEALTH, designated herein as DOE)
16 OFFICIALS 1 and 2, Individually, and)
17 as Officials of the Washington Medical)
18 Quality Assurance Commission or)
19 Washington Department of Health,

20 Defendants.

21 INTRODUCTION

- 22 1. This action seeks injunctive and declaratory relief pursuant to the
23 federal Declaratory Judgments Act, 28 U.S.C. §§ 2201-2202, under
24 the Civil Rights Act of 1861, 1866, and 1871, 42 U.S.C. §§ 1983,
25 1985 & 1986 (hereinafter the “Civil Rights Acts”), under the
26 Americans With Disabilities Act of 1990, 42 U.S.C. § 12101 *et seq.*

1 (hereinafter the "ADA"), and directly under the Constitution of the
2 United States and under the laws of the State of Washington ("state
3 law"), for, *inter alia*, declaratory, temporary, preliminary, and
4 permanent injunctive relief, damages, and such other and further relief
5 as may be just and proper in accordance with law and equity, from
6 past, current, and threatened deprivations of Plaintiffs' rights under
7 the Constitution and laws of the United States and the State of
8 Washington, by the Defendants, acting individually and in concert.

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11
12 2. Merle Janes, MD [hereinafter "Dr. Janes"] and the Plaintiffs John Doe
13 and Jane Does A and B, as well as Does C-Z [hereinafter "Pain
14 Patients"] facially challenge the Interagency Guidelines on Opioid¹
15 Dosing for non-Cancer Pain [hereinafter "Dosing Guidelines"]
16 [attached hereto as Exhibit A] promulgated by the Washington
17 Agency Medical Directors' Group [hereinafter "Group"], and
18 published on the internet at
19
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21
22 <http://www.agencymeddirectors.wa.gov/Files/OpioidGdline.pdf>.

23
24 ¹ "Opioid" is used herein consistently with Washington health regulation WAC
25 246-919-800(3) to mean "any natural or synthetic medication that has morphine
26 like activity."

- 1 a. Such Dosing Guidelines are *ultra vires*, and do not constitute any
2 form of valid law or enforceable policy;
3
4 b. in the alternative, the Dosing Guidelines represent additions to an
5 FDA-Approved drug labeling regime, and are pre-empted under
6 federal law;
7
8 c. In the alternative, the Dosing Guidelines are arbitrary, vague,
9 overbroad, and carried out in derogation of specific statutory
10 policy and direction.
11
12 d. As a consequence, the Dosing Guidelines must be declared void
13 for any lawful purpose.
14

15 3. Dr. Janes and the Pain Patients also challenge the Washington
16 Medical Quality Assurance Commission’s licensure enforcement
17 regime, as applied,² and exemplified by recent licensure enforcement
18
19

20 ² All references to physicians herein is intended to include allopathic, medicine,
21 emergency medicine, podiatric, naturopathic, and osteopathic physicians, and the
22 term “medical” or “medicine” is used inclusively to subsume all of these
23 professionals as they are regulated through the uniform disciplinary act. All
24 references to the Medical Quality Assurance Commission or MQAC are intended
25 to include the additional regulatory and licensing boards for other physicians
26 included herein to the extent that such regulatory bodies exercise jurisdiction over
27 physicians who treat chronic nonmalignant pain.
28

1 proceedings based on an irrational discriminatory animus known in
2 the medical literature as “Opiophobia”³ -- including, as examples,
3 those undertaken against Dr. Merle Janes and Dr. Alan Hunt, on the
4 grounds that such regime violates fundamental federal rights and
5 antidiscrimination laws with respect to the *patients* at the center of the
6 inquiry.⁴
7
8
9

10
11 ³ “Opiophobia” is an irrational discriminatory phenomenon that has long been
12 recognized as an impediment to effective pain treatment. It is described in the
13 excerpt below, taken from a textbook of pain medicine issued from the University
14 of Wisconsin, the site of the first pain treatment program in the United States.

15 Opiophobia is the syndrome of failure to administer adequate opioid
16 analgesics because of the fear of producing addiction or toxicity. The
17 etiology of opiophobia is multifactorial: Peer pressure (provider and patient),
18 regulatory agency pressure (real or perceived), and lack of education on
19 opioids and the fundamentals of pain management all contribute to its
20 persistence. Lower socioeconomic groups, younger patients, and other
21 minority populations are particularly likely to be its targets; these patients
22 frequently receive lower doses of opioids but higher levels of scrutiny. All of
23 these factors contribute to the underuse of these relatively simple and very
24 effective medications, due to no fault of the patients.

25 Loeser: BONICA'S MANAGEMENT OF PAIN, 3RD ED., Copyright © 2001 Lippincott
26 Williams & Wilkins.

27 ⁴ Dr. Alan Hunt is not a party to this action, and Dr. Merle Janes’ property interest
28 in his medical license is not the legal interest for which protection is being sought
in this proceeding. To clarify, Dr. Janes only appears herein as a representative of
patients’ interests under the standing doctrine of *jus tertii*. The pendency of either

1 JURISDICTION AND VENUE

2
3 4. As hereinafter more fully appears, this action arises under the
4 Constitution and laws of the United States, specifically: under the
5 Constitution of the United States [the Supremacy Clause, the
6 Commerce Clause (art. I §8, cl.[3]), and the Due Process and Equal
7 Protection Clauses of the Fourteenth Amendment]; and the Americans
8 with Disabilities Act and the Civil Rights Act. Accordingly, this
9 Court has jurisdiction of the subject matter of this action under 28
10 U.S.C. §§ 1331 and the doctrine of supplemental jurisdiction codified
11 at 28 U.S.C. § 1367(a).
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15

16 proceeding is no bar here because the plaintiff patients could not intervene therein
17 even if they were so inclined. The Plaintiff Pain Patients in this case are instead
18 asserting completely separate federal rights of their own, including, *inter alia*,
19 violation of antidiscrimination rights under the Americans With Disabilities Act, as
20 well as their own fundamental equal protection and due process liberty interests in
21 seeking necessary medical care for intolerable pain for which no adequate
22 alternative exists. Quite simply, these claims are not subject to abstention
23 principles because patient interests are absent from those state proceedings -- even
24 though as a matter of public policy patient welfare *should be* the *central* issue in
25 medical licensure matters. What is asserted here are the rights of *Pain Patients* to
26 challenge the state authority that has systematically abandoned, shunned, and
27 stigmatized them, and which has arbitrarily denied or limited their potentially life-
28 saving and certainly necessary medical care to the point that the state is now
inflicting “torture or a lingering death.”

1 5. In addition, as hereinafter more fully appears, this Court has
2 jurisdiction of the subject matter of this action: under 28 U.S.C. §
3 1343(a)(3), for relief against violations of the Civil Rights Act; and 42
4 U.S.C. § 2000d *et seq.*, for relief against violations of the ADA Titles
5 II and III. Venue is properly laid in the Eastern District of
6 Washington pursuant to 28 U.S.C. § 1391(b)(2) in that this is the
7 District in which the critical events and omissions giving rise to the
8 claims herein arose; venue is also appropriate under the specific
9 provisions of 42 U.S.C. § 2000e-5(f)(3).
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14 **PARTIES**

15 6. Jane Doe A is a mentally competent adult residing in the State of
16 Washington in the Spokane area. Jane Doe A is a patient of Dr. Merle
17 Janes. Jane Doe A has well-diagnosed and documented physical or
18 mental impairments that substantially limit one or more major life
19 activities; these physical or mental impairments arise from serious
20 medical conditions, which conditions also cause severe, chronic pain,
21 the mitigation of which requires treatment with opioid medications in
22 excess of 120 milliequivalents [hereinafter “MEQs”] per day.
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1 7. Jane Doe B is a mentally competent adult residing in the State of
2 Washington in the Spokane area. Jane Doe B is a former patient of
3 Dr. Merle Janes. Jane Doe B has well-diagnosed and documented
4 physical or mental impairments that substantially limit one or more
5 major life activities; these physical or mental impairments arise from
6 serious medical conditions, which conditions also cause severe,
7 chronic pain, the mitigation of which requires treatment with opioid
8 medications in excess of 120 MEQs per day. Because of the financial
9 toll her disability has taken on her, Jane Doe B now subsists on public
10 assistance. She now receives her medical care from another
11 Washington physician licensee who accepts reimbursement through
12 the Washington Medicaid program, which is associated with the
13 Washington State public assistance program.

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20 8. John Doe is a mentally competent adult residing in the State of
21 Washington in the Spokane area. John Doe is not a patient of Dr.
22 Merle Janes. John Doe has well-diagnosed and documented physical
23 or mental impairments that substantially limit one or more major life
24 activities; these physical or mental impairments arise from serious
25
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1 medical conditions, which conditions also cause severe, chronic pain,
2 the mitigation of which requires treatment with opioid medications in
3 excess of 120 MEQs per day.
4

5 a. John Doe has been unable to secure care from a physician within
6 the State of Washington despite substantial efforts to do so, and
7 believes that any further efforts to find a local physician willing to
8 treat his pain within the prevailing Washington State Department
9 of Health opioid-prescribing regulatory environment, as described
10 below, would be futile based on his past efforts. John Doe is
11 therefore currently obtaining treatment from a physician licensed
12 in Oregon specifically because he is unable to secure necessary
13 medical treatment from any physician licensee within the State of
14 Washington.
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20 b. Although John Doe now receives care from a physician in Oregon,
21 he would prefer to obtain care from a local physician because the
22 out-of-state arrangement complicates his care and his life in a not-
23 insignificant way. John Doe is worried that his current care
24 arrangements will be undermined upon disclosure to government
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1 officials of his identity or the fact that he crosses state lines to
2 receive it.
3

4 9. Does C-Z are all mentally competent adults residing in the State of
5 Washington in the Spokane area. They are all patients of Dr. Merle
6 Janes. Each one has one or more well-diagnosed and documented
7 physical or mental impairments that substantially limit one or more
8 major life activities; these physical or mental impairments arise from
9 serious medical conditions, which conditions also cause severe,
10 chronic pain, the mitigation of which requires treatment with opioid
11 medications. Does C-Z were receiving opioid medication
12 prescriptions from Dr. Merle Janes for the treatment of their chronic
13 pain conditions until April 30, 2008.
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17

18 10. As a direct result of threats to his medical license received by Dr.
19 Janes from agents of MQAC which undermined the opioid treatments
20 treatments provided to Does A-Z as a matter of law as described
21 below, Dr. Merle Janes notified Does A-Z by letter that he would
22 discontinue their opioid pain prescriptions after April 30, 2008.
23
24

25 [Letter attached hereto as Exhibit D.]
26
27
28

1 11.Does A-Z are all patients who were under the care of Dr. Merle Janes,
2 and whose necessary medical treatment has been disrupted as a direct
3 result of actions taken by agents of the MQAC. Upon information
4 and belief, no alternative services have been offered Does A-Z by
5 MQAC or its agents.
6

7
8 12.Upon information and belief, the medical care for Does A-Z have
9 been specifically stigmatized by agents of the MQAC, based on the
10 conduct of those agents described below. For that reason, and in order
11 to preserve their medical privacy, Does A-Z and John Doe are here
12 identified anonymously; their actual identity is contained in a
13 “substitution key” for which a qualified protective order is being
14 sought in order to preserve their rights of privacy.⁵
15
16

17
18 13.Plaintiff Merle Janes, MD, [hereinafter “Dr. Janes”] is a physician
19 licensed by the State of Washington to practice medicine.
20

21
22 ⁵ For purposes of all public filings, these plaintiffs will be referred to by their
23 anonymous designators as listed herein. A qualified protective order to protect the
24 privacy of the actual personal and medical details supporting the claims of Does A-
25 Z and John Doe is being sought from the Court herein, and the identity of Does A-
26 Z and John Doe as well as those supporting details will be subject to this Court’s
27 ruling on the requested protective order.
28

- 1 a. He is a Board-certified pain specialist, and the current treating
2 physician for the Plaintiff Pain Patients here enumerated
3 anonymously as Does A-Z, except that he is the former treating
4 physician for Jane Doe B.
5
6
7 b. He is not the treating physician for the Plaintiff Pain Patient here
8 enumerated anonymously as John Doe.
9
10 c. Dr. Janes only appears here as a representative of patient interests
11 under the standing doctrine of *jus tertii*. As such, he sues as a
12 representative of pain patients. He also sues as a representative of
13 patients who are residents of the State of Washington but who –
14 due to state impediments to treatment of chronic pain with opioid
15 medication -- must seek care outside the State of Washington
16 (including John Doe).
17
18
19 d. Dr. Janes also serves as a Class Representative for each Class of
20 Patients specified below based on the doctrine of *jus tertii*, in that
21 he is suffering a sufficiently direct threat of personal detriment as
22 to constitute a justiciable controversy, the physician and the patient
23 have a relationship in which the patient’s ability to safely and
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1 legally secure opioid pain medication cannot occur without the
2
3 assistance of a physician who is willing to provide such
4
5 medication, such that the physician’s professional judgment and
6
7 the patient’s well-being are inextricably intertwined, and the
8
9 patients are legally unable to assert their own rights in these cases
10
11 without sacrificing their privacy and personal reputations or
12
13 fearing government backlash or rebuke.

14. The WASHINGTON DEPARTMENT OF HEALTH [hereinafter
15
16 “Department”] is an instrumentality of the State of Washington
17
18 responsible for licensing and regulating the practice of medicine
19
20 within the State.

21. The WASHINGTON MEDICAL QUALITY ASSURANCE
22
23 COMMISSION [hereinafter “MQAC”] is an instrumentality of the
24
25 State of Washington, and functions as the investigative arm of the
26
27 Washington Department of Health; specifically, the MQAC is
28 responsible for defining and taking licensure actions based on
 “unprofessional conduct” within the meaning of the Uniform
 Disciplinary Act as applied to physician licensees under RCW

1 18.130.180 (hereinafter “UDA”).

2
3 a. As used herein and described in footnote 2, MQAC also embraces
4 any Washington health disciplinary authority for physicians who
5 treat chronic, nonmalignant pain, including (when applicable)
6 allopathic, medicine, emergency medicine, podiatric, naturopathic,
7 and osteopathic physicians.
8

9
10 16. Upon information and belief, the WASHINGTON AGENCY
11 MEDICAL DIRECTORS GROUP [hereinafter “Group”] is a non-
12 statutory group self-described on its website as consisting of the
13 Directors of the Washington Department of Labor and Industries, the
14 Washington State Board of Health, the Washington State Department
15 of Corrections, the Washington State Office of the Insurance
16 Commissioner, the Washington State Department of Health, the
17 Washington State Health Care Authority, and the Washington State
18 Department of Veteran Affairs.
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21
22 a. The Group has no apparent specific statutory authority⁶ of its own;
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24
25 ⁶ Although this specific Group was not formed by legislative direction, a smaller
26 interagency group was legislatively created in RCW 43.70.068: “The department
27

1 instead, it is a cooperative effort voluntarily initiated by the heads
2 of the various Washington health authorities to coordinate their
3 various activities.
4

5 b. By its nature, it is an instrumentality of the State of Washington;
6 however, it lacks statutory authority as an independent entity to
7 engage in any substantive regulatory activity.
8

9
10 17. Upon information and belief, defendant GARY M. FRANKLIN, MD
11 (“Dr. Franklin”) was the Director of the Washington Department of
12 Labor and Industries at the time of promulgation of the Dosage
13 Guidelines, and served as Chairman of the Washington Agency
14 Medical Directors Group, which is the state instrumentality that
15 developed the Dosing Guidelines. He is sued in both his official and
16 individual capacities.
17
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19 18. Upon information and belief, defendant CRAIG McLAUGHLIN
20 (“McLaughlin”) was the Director of the Washington State Board of
21

22 of health, the health care authority, the department of social and health services,
23 the office of the insurance commissioner, and the department of labor and
24 industries shall form an interagency group for coordination and consultation on
25 quality assurance activities and collaboration on final recommendations for the
26 study required under RCW 43.70.066.”
27

1 Health at the time of promulgation of the Dosage Guidelines, and
2 served as a member of the Washington Agency Medical Directors
3 Group. He is sued in both his official and individual capacities.
4

5 19. Upon information and belief, defendant MARC STERN (“Stern”) was
6 the Director of the Washington State Department of Corrections at the
7 time of promulgation of the Dosage Guidelines, and served as a
8 member of the Washington Agency Medical Directors Group. He is
9 sued in both his official and individual capacities.
10

11 20. Upon information and belief, defendant MICHAEL ARNIS (“Arnis”)
12 was the Director of the Washington State Office of the Insurance
13 Commissioner at the time of promulgation of the Dosage Guidelines,
14 and served as a member of the Washington Agency Medical Directors
15 Group. He is sued in both his official and individual capacities.
16

17 21. Upon information and belief, defendant MAXINE HAYES, MD (“Dr.
18 Hayes”) was the Director of the Washington State Department of
19 Health at the time of promulgation of the Dosage Guidelines, and
20 served as a member of the Washington Agency Medical Directors
21 Group. She is sued in both her official and individual capacities.
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1 22. Upon information and belief, defendant NANCY FISHER, MD (“Dr.
2 Fisher”) was the Director of the Washington State Health Care
3 Authority at the time of promulgation of the Dosage Guidelines, and
4 served as a member of the Washington Agency Medical Directors
5 Group. She is sued in both her official and individual capacities.
6
7

8 23. Upon information and belief, defendant LOURDES E. ALVARADO-
9 RAMOS (“Alvarado-Ramos”) was the Director of the Washington
10 State Department of Veteran Affairs, and serve at the time of
11 promulgation of the Dosage Guidelines as a member of the
12 Washington Agency Medical Directors Group. She is sued in both
13 her official and individual capacities.
14
15

16 24. The Department, the Group, Dr. Franklin, McLaughlin, Stern, Arnis,
17 Dr. Hayes, Dr. Fisher, and Alvarado- Ramos are hereinafter
18 collectively referred to as the “State Defendants.”
19
20

21 25. Defendant CHRISTINE GREGOIRE is the Governor of the State of
22 Washington (“Governor”) and is sued in her official capacity for
23 actions taken under color of state law. Defendant Governor is the
24 chief law enforcement officer of the State of Washington, and is
25
26
27

1 therefore responsible for seeing that the laws of the State of
2 Washington are followed and enforced.
3

4 26. Upon information and belief, defendant PETER J. HARRIS
5 ["Harris"], is an agent for the Washington Department of Health, and
6 was part of the licensure enforcement team that issued an unlawful
7 threat of emergency licensure suspension to Dr. Merle Janes on
8 February 19, 2008. He is sued in both his official and individual
9 capacities.
10

11
12 27. Upon information and belief, defendant GEORGE HEYE, MD ["Dr.
13 Heye"], is an agent for the Washington Department of Health, and
14 was part of the licensure enforcement team that issued an unlawful
15 threat of emergency licensure suspension to Dr. Merle Janes on
16 February 19, 2008. He is sued in both his official and individual
17 capacities.
18

19
20 28. Upon information and belief, defendant FREDERICK H. DORE, JR.,
21 MD ["Dr. Dore"], is an agent for the Washington Department of
22 Health, and was part of the licensure enforcement team that issued an
23 unlawful threat of emergency licensure suspension to Dr. Merle Janes
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1 on February 19, 2008. He is sued in both his official and individual
2 capacities.
3

4 29. Upon information and belief, defendant ERIN OBENLAND
5 ["Obenland"] is an agent for the Washington Department of Health
6 who initiated the licensure enforcement action against Dr. Merle Janes
7 for which an unlawful threat of emergency licensure suspension was
8 made on February 19, 2008. Upon information and belief, defendant
9 Erin Obenland lacked any lawful good faith basis for initiating that
10 proceeding. She is sued in both her official and individual capacities.
11
12

13 30. The MQAC, Harris, Dr. Heye, Dr. Dore, and Obenland are hereinafter
14 collectively referred to as the "MQAC Defendants" or the "MQAC
15 Agents."
16
17

18 31. Doe Officials 1 and 2 are named anonymously because Plaintiffs
19 currently lack sufficient information to identify the true names of said
20 Defendants. Upon information and belief, Plaintiffs believe that said
21 state officials exist and are all agents or officials of the Washington
22 Medical Quality Assurance Commission or the Washington
23 Department of Health, or both, and that the said state officials have
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1 acted under color of state authority, to deprive Plaintiffs and similarly
2 situated individuals of their federal and state constitutional and
3 statutory rights. As information is revealed through discovery in this
4 action, Plaintiffs will seek leave to amend this complaint to include
5 the true identities of the said state officials and to include such
6 officials as named defendants and to list relevant facts involving such
7 officials, and to list such officials in the style of this action. Those
8 Officials may include one or more of the State Defendants listed
9 herein. Official Defendants 1 and 2 are hereinafter collectively
10 referred to as “Health Department Officials” or “Health Official
11 Defendants.”
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17 **CLASS ACTION ALLEGATIONS**

18 32. Dr. Janes, under the doctrine of *jus tertii*, and Plaintiffs Jane Does A
19 and B and John Doe bring this action as representatives of PAIN
20 PATIENT CLASSES A and B, described below, on behalf of all other
21 persons similarly situated, pursuant to Rules 23(a) and 23(b)(2) of the
22 Federal Rules of Civil Procedure.
23
24

25 a. CLASS A consists of all persons who reside in Washington State
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27

1 who have substantial impairments of major life activities (who are
2 considered persons with disabilities within the meaning of the
3 Americans With Disabilities Act [hereinafter “ADA”] which
4 disabilities have resulted in severe, chronic, nonmalignant
5 intractable pain syndromes, and who on or after March 1, 2007,
6 required opioid pain relieving agents in excess of 120 MEQ per
7 day for effective mitigation of pain to be prescribed by a
8 Washington-licensed physician.

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- 12 a. Membership in this class includes, *inter alia*, John Doe and
13 Does A-Z; Does A and B and Dr. Janes are designated as its
14 representatives.
15
- 16
- 17 b. CLASS B consists of all persons who will in the future reside in
18 Washington state and who will have substantial impairments of
19 major life activities (and who will therefore be considered persons
20 with disabilities within the meaning of the ADA), which
21 disabilities will result in severe, chronic, nonmalignant intractable
22 pain syndromes, and who will in the future require pain relieving
23 agents in excess of 120 MEQ per day for effective mitigation of
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1 pain to be prescribed by a Washington-licensed physician.

- 2
3 a. Membership in this class *currently* includes, *inter alia*, John
4 Doe, and John Doe and Dr. Janes are designated as its
5 representative.
6

7 33. The exact size of the Pain Patient Classes are unknown to the
8 Plaintiffs but Plaintiff Jane Does A and B and John Doe and Dr. Janes
9 believe the size of the Classes are so numerous that joinder of all
10 members is impracticable; joinder is also impracticable because, due
11 to the stigmatizing nature of the necessary medications, Class A and B
12 members are not likely to be willing to broadcast to the world that
13 they require the use of pain relieving agents to treat a chronic,
14 nonmalignant intractable pain syndrome, especially if the amount of
15 that medication required for treatment exceeds arbitrary state
16 descriptions of “high” dosages such as those established in the Dosage
17 Guidelines and targeted for physician deterrence by State Defendants.
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21 34. There are questions of law or fact common to both Pain Patient
22 Classes; to wit, whether the regulatory scheme imposed by the MQAC
23 Agents and Health Department Officials with respect to the licensure
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1 regime or the State Defendants with respect to the Dosage Guidelines
2 violates the Pain Patients' and Classes' rights under the ADA, federal
3 Civil Rights statutes, and the United States Constitution; common
4 issues exist regarding treatment of persons with disabilities who have
5 chronic, nonmalignant intractable pain conditions and who require
6 treatment with opioid medications in excess of Dosage Guidelines,
7 and whether the state action here is pre-empted, deprives the Pain
8 Patients and Classes of fundamental liberty interests, due process, or
9 equal protection of the law, results in arbitrary treatment, or
10 unlawfully discriminates against Pain Patients and their represented
11 Classes.
12

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17 35. The claims of the named Pain Patient Plaintiff Class Representatives
18 are typical of the claims of the Patient Plaintiff Classes; to wit, the
19 Defendants have abridged named and Class A and B members' rights
20 under the United States Constitution, the ADA, and federal Civil
21 Rights statutes.
22

23
24 36. With respect to the Class claims, the Defendants have acted or refused
25 to act on grounds generally applicable to the Pain Patient Classes, and
26
27

1 the statutory and regulatory schemes at issue herein operate equally to
2 all members of the Pain Patient Classes, thereby making appropriate
3 final injunctive and corresponding declaratory relief with respect to
4 the Pain Patient Classes as wholes.
5

6
7 37. The named Pain Patient Plaintiffs and Dr. Janes will fairly and
8 adequately protect the interests of all members of Classes A and B,
9 thereby making appropriate final injunctive relief and corresponding
10 declaratory relief with respect to the Classes as a whole.
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1 **NATURE OF THE ACTION**

2 38. This action arises from official actions on the part of the senior-most
3 Washington State Health Officials that has gravely harmed countless
4 numbers of Washington state citizens. Those officials engaged in
5 overreaching when, while acting under color of their authority as
6 state officials, they knowingly crafted *ultra vires* public health policy,
7 which they also knowingly passed off as a form of “apparent” law
8 entitled “Interagency Guidelines on Opioid Dosing for non-Cancer
9 Pain” [hereinafter “ Dosing Guidelines”]. These Dosing Guidelines
10 are based on an opiophobic discriminatory animus and are
11 irreconcilable with the statutory mandate for physicians to provide
12 effective treatment for chronic, nonmalignant pain. In crafting and
13 publishing the Dosing Guidelines in contravention of existing law,
14 those senior-most state health officials completely ignored the limits
15 of their own statutory authority as well as their fundamental statutory
16 mission to safeguard the public health. Instead, these officials used
17 their authority as senior state public health officials to create an
18 “appearance of authority” that would effectively overrule current
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1 explicit statutory and administrative law with which they disagreed.

2
3 a. The Dosing Guidelines are irreconcilable with the statutory
4 mandate of ensuring availability of effective pain relief –
5 regardless of dosage – and are further irreconcilable with standard
6 science-based medical protocols for the treatment of chronic pain
7 based on titration to analgesic effect; promotion of the Dosing
8 Guidelines for any purpose impedes delivery of quality health
9 services to the public and is *ultra vires*.

10
11
12 b. The actions of the senior-most Washington health officials as
13 members of the Group typifies the systemic and shocking failure of
14 Washington State Health Officials to recognize the humanity and
15 citizenship of the Class Pain Patients, and is illustrative of an
16 extreme anti-opioid discriminatory animus or zealotry known as
17 Opiophobia that informs, permeates, and perniciously corrupts the
18 development and management of public health policy throughout
19 the current Washington State Public Health culture.
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24
25 39. The Health Official Defendants at all times pertinent hereto have been
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27

1 statutorily and administratively responsible for regulating the practice
2
3 of medicine in the State of Washington through the instrumentalities
4 of the MQAC and the Department of Health.

5 40. Upon information and belief, in contravention of existing science and
6
7 law, the State Defendants have directed Health Official Defendants to
8 develop companion public policies that apply the same Opiophobic
9 animus that motivated creation of the Dosage Guidelines to other
10 aspects of Washington public health policy within the purview of the
11 State Defendants, thus creating *de facto* public health policy based on
12 a similar opiophobic animus.
13

14
15 41. The Dosing Guidelines are evidence of the Opiophobic animus that
16 has been implemented as policy in subordinate public health
17 functions,⁷ including specifically the physician licensing apparatus of
18
19
20

21 ⁷Another critical public health function that has been affected by the opiophobic
22 animus is the administrative regime governing workers compensation at the
23 Department of Labor and Industries. However, as a matter of law, medical
24 practice standards adopted by that Department are not allowed materially to
25 deviate from those adopted by MQAC in its licensing enforcement. Consequently,
26 bringing MQAC medical practice standards in line with statutory and
27 constitutional requirements should also effect a similar, simultaneous change at the

1 the State Department of Health within the MQAC.

2
3 a. Such companion public policies have been adopted by the Health
4 Department's licensure enforcement authority within the MQAC,
5 such that the Department of Health now enforces Opiophobic
6 medical practice standards in their regime which the State
7 Defendants (and certainly the Director of the Department of
8 Health) knew or reasonably should have known will cause
9 physician licensees to deprive Class Pain Patients of potentially
10 life-saving and certainly necessary medical care for treatment of
11 legitimate, serious, and potentially fatal chronic, nonmalignant
12 pain conditions for which no meaningful or effective alternative is
13 available other than the deterred opioid pain treatment.
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18 b. Examples of the application of nonstatutory opiophobic medical
19 practice standards exists in the MQAC Decision rendered on the
20 license of Dr. Alan Hunt, issued on May 22, 2008, as well as in the
21 recent MQAC proceeding involving Dr. Merle Janes.
22
23

24
25 Department of Labor & Industries as a matter of law. As a consequence, those
26 policies need not be separately challenged here.

1 42. The Opiophobic animus of senior public health officials has created
2 an overall opiophobic state health regulatory culture that has created a
3 public health crisis for non-cancer patients seeking chronic pain care
4 who require opioid medication to carve out a decent quality of life;
5
6 a. Many such patients need the opioid medication simply to survive
7 what would otherwise be intolerable pain, and a plethora of
8 opiophobic regulatory barriers create impediments to such
9 patients' very survival.
10
11 b. In creating deliberate barriers to effective pain care within the State
12 of Washington, the State Defendants, the Health Department
13 Officials, and MQAC Agents have cruelly impaired Pain Patients
14 and Members of Classes A and B [hereinafter "Class Pain
15 Patients"] from receiving necessary medical care for which no
16 meaningful or effective medical alternative is available, and
17 without which Class Pain Patients already have and will continue
18 to face a hastened death, permanent neurological injury, serious
19 disability and relentless pain.
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1 43. This cruelty results directly from a regulatory regime that knowingly
2 unreasonably impairs the physician-patient relationship;
3

4 a. Specifically, herein the State of Washington deters physicians from
5 exercising their best professional and scientific judgment in
6 prescribing opioid drugs for their patients in two⁸ specific,
7 identifiable ways: through publication and “implementation” of the
8 Dosing Guidelines, and through MQAC’s investigation of
9 physicians who have treated chronic, nonmalignant pain patients
10 with opioid pain medications by applying medical practice
11 standards grounded in opiophobic bias – i.e., nonstatutory
12 standards based neither on science nor the medical ethic of
13 treatment, but rather on unproven fear about the medications being
14 prescribed, while similarly *failing* to enforce health department
15 pain regulations requiring treatment with opioids when necessary
16 or providing appropriate referral to a physician who will do so.
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22 44. The Health Official Defendants use the MQAC to deter physicians
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25 ⁸ See also footnote 7, *supra*, regarding the administrative regime at the Department
26 of Labor & Industries.

1 from undertaking effective pain treatment with opioids through
2 arbitrary investigations and punishments of physicians who do so, and
3 by taking no action against physicians who violate the clear regulatory
4 mandate to provide such treatment or refer.
5

6
7 a. Such threat of investigation creates barriers for physicians who
8 would exercise their best professional and scientific judgment in
9 choosing to prescribe opioid drugs for their patients, and such
10 barriers are imposed even when such prescriptions are medically
11 necessary with no adequate medical alternative, and such barriers
12 are imposed even though such specific medical use is authorized
13 by Washington state law and has already been determined to be
14 safe and effective by the Federal Food and Drug Administration.
15
16
17

18 45. Through those impairments of opioid pain treatment, the Health
19 Department Officials disregard their own law; such officials also
20 require their own licensees to deprive Class Pain Patients of their
21 fundamental liberty interest in choosing to use pain relieving agents
22 that have been approved by the FDA within an existing drug labeling
23 regime, when medically necessary and in consultation with a licensed
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1 physician, to mitigate intractable pain which – if left untreated –
2 would otherwise make life intolerable.
3

4 46. As an alternative, through those impairments of opioid pain treatment,
5 the Health Official Defendants unduly burden the physician-patient
6 relationship, and thereby deprive Class Pain Patients of their
7 fundamental due process liberty interest in receiving potentially life-
8 saving and certainly necessary medical care consisting of treatment of
9 intolerable pain with opioid medications, based on a physician’s best
10 undeterred medical judgment.
11
12

13
14 47. Through impairments of medically-necessary opioid pain treatment
15 for patients with chronic, nonmalignant pain, the Health Official
16 Defendants also require their own licensees to implement – as a
17 condition of their licenses, and upon threat of loss or impairment
18 thereof -- unlawful discrimination against those Class Pain Patients
19 within the meaning of the ADA.
20
21

22 48. Upon information and belief, State of Washington health authorities
23 do not enforce their own regulations which require physicians to
24 provide effective pain treatment to chronic pain patients with opioid
25
26
27

1 medications when necessary – i.e., to titrate to analgesic effect -- or
2 provide appropriate referral.
3

4 49. Upon information and belief, many physicians openly enforce “no
5 opioid” policies, which policies are imposed regardless of medical
6 need and without the concomitant assurance of referral to a physician
7 who will prescribe opioid medications. Such brazen nonstatutory
8 physician licensee behavior is neither investigated nor in any tangible
9 way penalized by Washington State health authorities.
10

11
12 50. However, despite statutory directives to the contrary, Washington
13 State health authorities target for official action those physician
14 licensees who do prescribe opioids for chronic nonmalignant pain.
15

16
17 51. Washington State health authorities impose upon physicians who
18 prescribe opioids for chronic nonmalignant pain burdensome
19 administrative standards that are fluid, vague and not well-defined,
20 and such burdensome administrative standards are not similarly
21 imposed on any other treatment modality.
22

23
24 52. The combined regulatory effect of the opiophobic policies listed
25 above has been to actively discourage physicians from undertaking
26

1 treatment of chronic nonmalignant pain with opioid medications, and
2 such discouragement has been so effective that many patients with
3 chronic pain within the State of Washington who require opioids for
4 mitigation of that pain cannot find a single physician willing to
5 provide it.
6

7
8 53. Class Pain Patients have physical impairments that substantially limit
9 their ability to perform one or more major life activities. Class Pain
10 Patients must rely on pain relieving agents for treatment and
11 mitigation of intractable pain associated with their physical
12 impairments and resulting disabilities, and Class Pain Patients must
13 rely on opioid pain medications for that treatment because there is no
14 effective medical alternative.
15
16

17
18 54. Chronic pain patients who are denied opioid pain medications in
19 dosages required for effective treatment have potentially *preventable*
20 *terminal illnesses* because of the documented increased risk of suicide
21 among those patients.
22

23
24 a. When a State knowingly imposes barriers to treatment for what
25 would otherwise be a preventable terminal illness, and a patient
26

1 thereafter dies as a direct or proximate result of undertreatment of
2 pain, the State is chargeable for that death.
3

4 55. Chronic pain patients who are denied opioid pain medications in
5 dosages required for effective treatment are subjected to a *malignancy*
6 in the sense that when left untreated, such pain is demonstrated in
7 medical references to increase in intensity and to spread to areas of the
8 body that were not previously affected, resulting in progressive
9 neurological damage through the physiological processes known as
10 central sensitization and neuroplasticity.
11

12
13 a. Untreated chronic pain therefore results in irreversible, tangible
14 organic injury beyond psychological suffering, and consequently
15 has an irremediable deleterious impact upon a pain patient's
16 overall health and quality of life, as well as potentially making life
17 itself intolerable.
18
19
20

21 56. Chronic pain patients who are denied opioid pain medications in
22 dosages required for effective treatment face *preventable irreparable*
23 *injury* because of the process of central sensitization and
24 neuroplasticity.
25
26
27

1 a. When a State knowingly imposes barriers to treatment for what
2 would otherwise be a preventable irreparable injury, and a patient
3 thereafter suffers irreparable injury as a direct or proximate result
4 of undertreatment, the State is chargeable for that injury.
5

6
7 57. From a medical standpoint, for both physiological and psychological
8 reasons, and because an individual's *very life* may be at stake,
9 treatment of pain is a scientific and medical *imperative*.
10

11 a. For that reason, pain is regarded as "the fifth vital sign" in
12 widespread medical references.
13

14 58. This imperative is also recognized by the Joint Commission on
15 Accreditation of Healthcare Organizations ["JCAHO"], which has set
16 standards for pain management which U.S. hospitals and nursing
17 homes must meet in order to continue to receive their JCAHO
18 accreditation, the abrogation of which would subject such hospitals
19 and nursing homes to loss of accreditation.
20

21
22 59. JCAHO pain management standards are irreconcilable with the
23 Dosage Guidelines and their Opiophobic fundamentals, thus creating
24 a Hobson's choice for Washington physician licensees who practice
25
26
27

1 within accredited facilities.

2
3 a. Such physicians are required to disregard JCAHO standards and
4 endanger accreditation for the facilities in which they practice
5 medicine, or, alternatively, disregard the Dosage Guidelines and
6 companion *de facto* public-policies based on the same Opiophobia,
7 as implemented by senior-most Washington public health officials
8 and their subordinate followers, and risk licensure investigations,
9 threats, and other unspecified disadvantages or punishments from
10 state health officials and their subordinates which flow from
11 implementation of Opiophobia as official Washington State public
12 health policy.
13
14
15
16

17 60. Continuity of medical care is essential to the life, health, and well-
18 being of Class Pain Patients.

19 61. Class Pain Patients must seek out physicians who are willing to
20 prescribe necessary pain relieving agents for their legitimate medical
21 needs.
22

23 62. Law-abiding Class Pain Patients who must rely on opioid pain
24 medications for their treatment because there is no effective medical
25
26

1 alternative must obtain such medications from physicians who have
2 valid medical licenses and federal DEA prescribing privileges.
3

4 a. The State of Washington thus interposes itself between a patient
5 and his potential life-saving medical care.
6

7 63. When a state interposes itself between a patient and his potential life-
8 saving medical care such that the state's authority constitutes "control
9 or dominion" over that care, then even if the patient is not
10 incarcerated the State through its officials is nevertheless obligated
11 under the Eighth Amendment to the United States Constitution to
12 prevent infliction of "torture or a lingering death."
13

14 a. Infliction of "torture or a lingering death" within the meaning of
15 the Eighth Amendment occurs when state officials demonstrate
16 "deliberate indifference to serious medical needs" for individuals
17 over whose care they have exercised "control or dominion."
18
19
20

21 64. When by operation of law Washington public health authorities deter
22 physicians from prescribing potential life-saving and certainly
23 necessary opioid pain relieving agents, such deterrence disrupts the
24 continuity of medical care essential to the life, health, and well-being
25
26
27

1 of those Class Pain Patients, and constitutes “control or dominion”
2 over that modality of necessary medical treatment.
3

4 a. When public health officials exercise “control or dominion” over
5 the very availability of opioid pain treatment as has occurred in the
6 Dosage Guidelines, and then limit the potentially life-saving,
7 medically-necessary complex care of over half a million people to
8 a potential specialty field consisting of only a dozen names, such
9 limitation demonstrates “deliberate indifference to serious medical
10 needs” as a matter of law, in violation of the Eighth Amendment to
11 the United States Constitution, as incorporated into the Fourteenth
12 Amendment.
13

14 b. It is not the lawful public health policy of the State of Washington
15 for public health officials to provide inmates in state prisons a legal
16 right to obtain necessary medical treatment for chronic pain with
17 opioid medication as required under the Eighth & Fourteenth
18 Amendments, but simultaneously to eliminate all reasonably
19 lawful means of obtaining such treatment by law-abiding citizens.
20

21 c. It is not the lawful public policy of the State of Washington to
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23
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1 criminalize the condition of chronic, nonmalignant pain, nor to
2 criminalize any medically necessary treatment thereto – e.g.,
3
4 opioid medications.

5 i. As a corollary, it is not the lawful public policy of the State
6
7 of Washington to criminalize any reasonable efforts an
8
9 individual would undertake to seek treatment.

10 ii. It is not the lawful public policy of the State of Washington
11
12 to require, as a condition precedent to obtaining necessary
13
14 medical treatment, that any citizen be required to forfeit
15
16 important constitutional or other rights.

17 iii. As a corollary, it is not the lawful public policy of the State
18
19 of Washington for physician licensees to require, as a
20
21 condition precedent to providing necessary medical
22
23 treatment, that any citizen be required to forfeit important
24
25 constitutional or other rights.

26 1. It is the lawful public policy of the State of
27
28 Washington to prohibit physician licensees from
requiring, as a condition precedent to obtaining

1 necessary medical treatment, that any citizen be
2 required to forfeit important constitutional or other
3 rights.
4

5 65. While all chronic, nonmalignant pain patients who rely on opioid
6 medications for effective treatment are harmed by state deterrence of
7 treatment, Class Pain Patients included herein require pain relieving
8 agents in dosages that exceed 120 MEQs per day for adequate
9 mitigation of pain because those are the specific individuals facially
10 targeted for treatment deterrence by the Dosing Guidelines, which has
11 set an arbitrary “ceiling threshold dosage” of 120 MEQs per day.
12

13
14
15 66. Actions taken by the State Defendants, as well as the Health Official
16 Defendants and the MQAC Agent Defendants that deter physicians
17 from prescribing necessary opioid pain relieving agents in excess of
18 120 MEQs per day have a known, foreseeable and disproportional
19 impact on Class Pain Patients herein.
20
21

22 23 **BACKGROUND – DOSING GUIDELINES**

24
25 67. Washington’s State Constitution provides in Article XX, Section 2,
26
27

1 that “[t]he legislature shall enact laws to regulate the practice of
2 medicine and surgery, and the sale of drugs and medicines.”
3

4 68.The legislature specifically delegated the authority to develop medical
5 practice standards to the Washington Medical Quality Assurance
6 Commission [hereinafter “MQAC”]. RCW 18.71.002 states that “[i]t
7 is the purpose of the medical quality assurance commission to regulate
8 the competency and quality of professional health care providers
9 under its jurisdiction by establishing, monitoring, and enforcing
10 qualifications for licensing, consistent standards of practice,
11 continuing competency mechanisms, and discipline. Rules, policies,
12 and procedures developed by the commission must promote the
13 delivery of quality health care to the residents of the state of
14 Washington.”
15
16
17
18

19 69.Under the statutory mandate, the MQAC is prohibited from applying
20 medical practice standards that will impede delivery of quality health
21 care to the residents of the state of Washington.
22
23

24 70.The legislature also provided specific direction to the Secretary of the
25 Department of Health – which Department contains the MQAC -- to
26
27

1 implement guidelines relating to opioid therapy for *effective pain*
2 *treatment* in RCW 18.130.340: “The secretary of health shall
3
4 coordinate and assist the regulatory boards and commissions of the
5 health professions with prescriptive authority in the development of
6 uniform guidelines for addressing opiate therapy for acute pain, and
7 chronic pain associated with cancer and other terminal diseases, or
8 other chronic or intractable pain conditions. The purpose of the
9 guidelines is to assure the provision of effective medical treatment in
10 accordance with recognized national standards and consistent with
11 requirements of the public health and safety.”
12
13
14

15
16 a. In fulfillment of that legislative direction, the Washington Medical
17 Quality Assurance Commission, which had been statutorily
18 empowered to develop medical practice standards, approved on 18
19 April 1996 its “Guidelines for Management of Pain” [hereinafter
20 “1996 Guidelines”]. Those Guidelines are still valid regulatory
21 authority. See Exhibit C attached hereto.
22
23

24
25 i. Osteopathic physicians are regulated by their own licensing
26
27

1 board, as well as disciplinary authority within the MQAC;
2 such physicians are provided regulatory guidance for
3 chronic pain treatment with opioids through Guidelines
4 issued in 2002 by the Department of Health which are not
5 materially different from the 1996 Guidelines cited above.
6 Thus, references herein to the 1996 Guidelines for allopathis
7 physicians should be interpreted to refer to the osteopathic
8 Guidelines when appropriate.
9
10
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15 71. Washington legislatively-directed policy regarding pain treatment
16 with opioid medications is further codified in the Washington
17 Uniform Controlled Substances Act, RCW 69.50.308(g) which
18 provides a statutory immunity for physicians treating intractable pain
19 who “dispense or deliver a controlled substance to or for an individual
20 . . . for medical treatment . . . in the ordinary course of that
21 practitioner's profession.”
22
23

24
25 a. The 1996 Guidelines also recognize the importance of allowing
26
27

1 physicians discretion to treat chronic pain with opioid medications,
2 and provide in the introductory “Policy Statement” that “[i]t is the
3 position of the Department of Health that opioids may be
4 prescribed, dispensed, or administered when there is an indicated
5 medical need without fear of injudicious discipline.” See Exhibit
6 C attached hereto.
7
8

9
10 b. Department of Health MQAC Pain Management Regulations,
11 found at WAC §§ 246-919-800-830 also specifically affirm this
12 approach.
13

14
15 i. Practitioners “need not fear disciplinary action from the
16 commission for prescribing, dispensing, or administering
17 opioids when treating pain so long as the care provided is
18 consistent with currently acceptable medical practices. This
19 includes acute, chronic and intractable pain (RCW
20 69.50.308(g)).”
21
22

23
24 ii. “No disciplinary action will be taken against a practitioner
25 based solely on the quantity and/or frequency of opioids
26
27

1 prescribed.”

2
3 iii. These guidelines also set forth the duty to treat or refer.

4 “Practitioners who cannot or choose not to treat patients who
5 have complex or chronic pain conditions should offer
6 appropriate referrals for those patients.”
7

8
9 72. These articles of positive law within the State of Washington

10 demonstrate that the legislatively-directed primary goal of public
11 health policy with respect to pain is the provision of *effective*
12 *treatment* within the sound discretion of the treating physician, that no
13 physician should ever simply deny treatment without appropriate
14 referrals, and that a dearth of physicians to whom to refer such
15 patients should serve as primary evidence that the needs of public
16 health are not being met within the State of Washington.
17

18
19
20 73. To the extent that public health officials take affirmative steps that

21 cause any physicians actively to discourage, shun, abandon, cease,
22 arbitrarily limit, or otherwise fail to provide effective pain
23 management with opioid medications, those public health officials are
24
25
26
27

1 impeding delivery of necessary health services within the State of
2 Washington, and such conduct is contrary to statutory mandate.

3
4 a. Physicians have a duty to treat or refer patients; public health
5 officials should never take affirmative steps that would cause a
6 physician simply to abandon, shun, or arbitrarily limit care to any
7 patient.
8

9
10 74. Before public health officials take any affirmative steps to cause any
11 physician licensee to actively decline to provide effective pain
12 management with opioid medications, such officials must first
13 determine that patients who rely on such necessary medical treatment
14 have sufficient referral resources to other physicians who would
15 provide such effective treatment with opioid medications, and failure
16 to do so impedes delivery of necessary health services within the State
17 of Washington, contrary to statutory mandate.
18

19
20
21 a. Regulatory burdens placed specifically and exclusively upon that
22 treatment modality increases the “control and dominion” exercised
23 by the state.
24

25 b. The regulatory environment imposed specifically and exclusively
26

1 upon that treatment modality has caused physicians to refuse to
2 provide it, resulting in a dearth of treating physicians within the
3 State and a severe crisis of physician availability for patients who
4 need effective opioid treatment for their chronic pain within
5 Washington State.
6
7

8 75. “Effective” chronic pain treatment in the context of opioid therapy is
9 well-understood by pain physicians and is defined to mean “titration
10 to analgesic effect”⁹ which requires increasing dosage until adequate
11 analgesia occurs or intolerable or unmanageable side effects
12 supervene.
13
14

15 76. It is not the lawful statutorily-mandated public health policy of the
16 State of Washington for public health officials to require physicians to
17 disregard the science of pain treatment in devising effective
18 treatments for their chronic pain patients who require opioid
19 medications to treat their pain.
20
21

22 a. It is not the lawful statutorily-mandated public health policy of the
23

24 ⁹ Fine PG, Portenoy, RK. A Clinical Guide To Opioid Analgesia. The McGraw-
25 Hill Companies. Healthcare Information Programs, revised 2004 (Available: [Pain
26 and Chemical Dependency: For Professionals](#))
27

1 State of Washington for public health officials to require
2 physicians to deny or disregard the principle of titration of opioid
3 medication to analgesic effect.
4

5 77. It is the lawful statutorily-mandated public health policy of the State
6 of Washington for public health officials to require physicians to
7 follow the science of pain treatment in devising effective treatments
8 for their chronic pain patients who require opioid medications to treat
9 their pain.
10
11

12 a. It is the lawful statutorily-mandated public health policy of the
13 State of Washington for public health officials to require
14 physicians to follow the principle of titration of opioid medication
15 to analgesic effect.
16
17

18 78. It is not the lawful statutorily-mandated public health policy of the
19 State of Washington for public health officials to require physicians to
20 deny necessary or effective medical treatment for their chronic pain
21 patients who require opioid medications to treat their pain.
22
23

24 a. It is not the lawful statutorily-mandated public health policy of
25 the State of Washington for public health officials to require
26
27

1 physicians to avoid treating patients who may require titration of
2 opioid medication to analgesic effect.
3

4 79. It is the lawful statutorily-mandated public health policy of the State
5 of Washington for public health officials to require physicians to
6 provide necessary or effective medical treatment for their chronic pain
7 patients who require opioid medications to treat their pain, or to refer
8 such patients to other physicians who will provide such treatment.
9

10
11 a. When physician licensees in the State of Washington implement
12 “no opioid” policies, regardless of medical need, and without the
13 additional assurance that a patient would in fact receive a referral
14 to a physician who would do so, the MQAC has a duty to
15 investigate and sanction such physicians.
16
17

18 i. To date, upon information and belief, the MQAC has failed
19 to do so at all.
20

21 b. It is the lawful statutorily-mandated public health policy of the
22 State of Washington for public health officials to require
23 physicians to undertake treating patients who may require titration
24 of opioid medication to analgesic effect or refer such patients to
25
26
27

1 physicians who will provide such treatment.

- 2
- 3 i. However, in contravention of this mandate, the MQAC
- 4 targets physicians who provide chronic pain patients with
- 5 opioid medications, and *regularly* investigates and sanctions
- 6 physicians for doing so.
- 7

8 80. It is not the lawful statutorily-mandated public health policy of the

9 State of Washington for public health officials to require or encourage

10 physicians to shun or turn away chronic pain patients just because

11 they may require opioid medications to treat their pain.

12

- 13
- 14 a. It is not the lawful statutorily-mandated public health policy of the
- 15 State of Washington for public health officials to require or
- 16 encourage physicians to shun or turn away patients who may
- 17 require titration of opioid medication to analgesic effect, in order
- 18 to avoid having to prescribe opioid medications.
- 19

20

21 81. It is the lawful statutorily-mandated public health policy of the State

22 of Washington for public health officials to prevent and discourage

23 physicians from shunning or turning away chronic pain patients who

24 require opioid medications to treat their pain.

25

1 a. It is the lawful statutorily-mandated public health policy of the
2 State of Washington for public health officials to prevent or
3 discourage physicians from shunning or turning away patients who
4 may require titration of opioid medication to analgesic effect in
5 order to avoid having to prescribe opioid medications.
6
7

8 82. It is not the lawful statutorily-mandated public health policy of the
9 State of Washington for public health officials in any way to direct or
10 to require physicians, whether formally or informally, whether by
11 regulation or by Guideline, whether by threat of sanction or by any
12 other form of official pressure or intimidation, whether by express
13 authority or application of the appearance of lawful authority, to
14 arbitrarily limit by dosage , length of time, or in any other manner the
15 provision of effective chronic pain treatment with opioid medications
16 within the sound discretion of the treating physician.
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21 a. It is not the lawful statutorily-mandated public health policy of the
22 State of Washington for public health officials in any way to direct
23 or to require physicians, whether formally or informally, whether
24 by regulation or by Guideline, whether by threat of sanction or by
25
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27

1 any other form of official pressure or intimidation, whether by
2 express authority or application of the appearance of lawful
3 authority, to arbitrarily limit by dosage , length of time, or in any
4 other manner the process of titration to analgesic effect within the
5 sound discretion of the treating physician.
6
7

8 i. This is in recognition of the fact that there is no generally
9 applicable upper limit to the dosage level of opioid drugs
10 that may be safely administered without toxicity or life-
11 threatening effects.
12

13
14 ii. This is also in recognition of the fact that the process of
15 titration to analgesic effect may require wide individual
16 variation among patients in the dosage levels required to
17 achieve and maintain effective pain relief, due in large part
18 to wide individual variation among patients in the dosage
19 levels at which patients may experience adverse effects, and
20 the effect of “tolerance” that may require increasing dosage
21 levels to maintain pain relief.
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25 83. It is not the lawful statutorily-mandated public health policy of the
26

1 State of Washington for public health officials to require or encourage
2 physicians to stigmatize necessary and effective medical pain
3 treatment, even when such treatment requires the prescription of
4 opioid medications and the process of titration to analgesic effect.
5

6
7 84.It is the lawful statutorily-mandated public health policy of the State
8 of Washington for public health officials to actively destigmatize
9 necessary and effective medical pain treatment when such treatment
10 requires the prescription of opioid medications and the process of
11 titration to analgesic effect.
12

13
14 85.It is not the lawful statutorily-mandated public health policy of the
15 State of Washington for public health authorities to substitute,
16 displace, or otherwise compromise the lawful primary legislative
17 objective of providing effective medical pain treatment (e.g., titration
18 to analgesic effect) with other objectives, including law enforcement
19 or drug prohibition objectives.
20

21
22 86.It is the lawful statutorily-mandated public health policy of the State
23 of Washington for public health authorities to resist compromise of
24 the lawful primary legislative objective of providing effective medical
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26

1 pain treatment (e.g., titration to analgesic effect) with other objectives,
2 including law enforcement or drug prohibition objectives.
3

4 87.It is not the lawful statutorily-mandated public health policy of the
5 State of Washington for public health authorities to create medical
6 practice standards or duties that deny or disregard widely-accepted
7 principles of medical science.
8

9
10 88.It is the lawful statutorily-mandated public health policy of the State
11 of Washington for public health authorities to create medical practice
12 standards or duties that comport with widely-accepted principles of
13 medical science.
14

15 89. It is not the lawful statutorily-mandated public health policy of the
16 State of Washington for public health authorities to create medical
17 practice standards or duties that deny or disregard the basic medical
18 ethic of providing treatment to patients who need medical assistance.
19

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21 90.It is the lawful statutorily-mandated public health policy of the State
22 of Washington for public health authorities to create medical practice
23 standards or duties that comport with the basic medical ethic of
24 providing treatment to patients who need medical assistance.
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1 91.It is not the lawful statutorily-mandated public health policy of the
2 State of Washington for public health authorities to create medical
3 practice standards or duties that require physicians to deny potentially
4 life-saving medical treatment to patients in need; such policy would
5 constitute a medical duty to abandon, and if the patient’s condition
6 resulted in death and were preventable, such policy would constitute a
7 form of state-inflicted “torture or a lingering death.”
8
9
10

11 92.It is the lawful statutorily-mandated public health policy of the State
12 of Washington for public health authorities to create medical practice
13 standards or duties that require physicians to provide potentially life-
14 saving medical treatment to patients in need, particularly when
15 treatment cannot be obtained without the assistance of a physician.
16
17

18 93.It is not the lawful statutorily-mandated public health policy of the
19 State of Washington for public health authorities to create medical
20 practice standards or duties that require physicians to deny necessary
21 medical treatment to patients in need, especially when treatment
22 cannot be obtained without the assistance of a physician; such policy
23 would constitute a medical duty to abandon.
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1 94.It is the lawful statutorily-mandated public health policy of the State
2 of Washington for public health authorities to create medical practice
3 standards or duties that require physicians to provide necessary
4 medical treatment to patients in need, especially when treatment
5 cannot be obtained without the assistance of a physician; such policy
6 would constitute a medical duty to treat or refer.
7
8

9
10 95.It is not the lawful statutorily-mandated public health policy of the
11 State of Washington for public health officials to create medical
12 practice standards or duties that require physicians to arbitrarily limit
13 by dosage or length of time the process of titration to analgesic effect.
14

15 96.It is not the lawful statutorily-mandated public health policy of the
16 State of Washington for public health authorities to create medical
17 practice standards or duties that actively discourage physicians from
18 providing necessary medical treatment to patients in need.
19
20

21 97.It is not the lawful statutorily-mandated public health policy of the
22 State of Washington for public health authorities to create medical
23 practice standards or duties that require physicians to withhold
24 necessary medical treatment from patients in need.
25
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1 98. The Group as an instrumentality has no statutory authority
2 independent of the authority existing within the individual State
3 Health instrumentalities headed up by the agency directors who are
4 among its members.
5

6
7 99. The Group as an instrumentality also has no statutory authority to
8 regulate physicians or in any manner define “unprofessional conduct”
9 as that term applies to physician licensees within the State of
10 Washington.
11

12 100. Members of the Group in their official capacities have no
13 statutory authority to regulate physicians in any manner inconsistent
14 with the medical practice standards determined and applied by
15

16 101. The Group as an instrumentality does not have budgetary
17 authority independent of the authority existing within the individual
18 State Health instrumentalities represented by members of the Group.
19

20
21 102. Nevertheless, despite the absence of statutory authority or valid
22 statutory delegation, in derogation of the requirements of basic
23 Washington administrative law and procedures, and despite pre-
24 existing regulatory authority and guidance established by the MQAC
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1 within the 1996 Guidelines, the Group purported to set specific
2 Dosing Guidelines for treatment of chronic, nonmalignant pain by
3 primary care physicians with the express goal of limiting prescribing
4 of opioid medications for patients in chronic pain when in March
5 2007 it published the Dosing Guidelines.
6
7

8 103. The Dosing Guidelines attempt to regulate physician
9 prescribing behavior based on drug safety and effectiveness concerns
10 with respect to FDA pharmaceuticals that are covered within a pre-
11 existing drug label regime;
12

13 a. The Dosing Guidelines are therefore pre-empted under federal
14 FDA law as an impermissible intrusion in a reserved federal
15 subject, to-wit, pharmaceutical drug labeling based on safety and
16 effectiveness concerns;
17
18

19 b. As such, the Guidelines do not constitute valid and enforceable
20 law.
21

22 104. In the alternative, the Dosing Guidelines were promulgated and
23 published without any specific statutory delegation of authority to the
24 Group and are *ultra vires*; as such, the Guidelines do not constitute
25
26
27

1 valid and enforceable law.

2
3 105. In the alternative, the Dosing Guidelines conflict with the 1996
4 Guidelines which were based on a specific grant of statutory
5 authority; and also with overall legislative policy encouraging the
6 provision of effective pain treatment with opioid medications, which
7 requires titration to analgesic effect without regard to specific dosage
8 ceilings or targets, and as such they are *ultra vires* and do not
9 constitute valid and enforceable law.
10

11
12 106. Despite their lack of legal authority, the State Defendants have
13 imbued the Dosing Guidelines with the “appearance of authority” by
14 publishing them on an official state website and taking other action
15 that creates an intended false indicia of authority, including, *inter alia*,
16 by repeatedly referring to them as “Guidelines” in public, and by
17 repeatedly citing them in public as a source of official authority in the
18 State of Washington.
19

20
21 107. Despite their lack of legal authority, the State Defendants have
22 also knowingly imbued the Dosing Guidelines with the “appearance
23 of authority” by using them as a basis for conducting specific
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1 programs within their auspices. Any action taken by agents of the
2 State of Washington based on the Dosing Guidelines is without
3 authority and is therefore arbitrary and violates due process.
4

5 a. Specifically, the Dosing Guidelines are incorporated by reference
6 in written report demands to treating physicians issued by the
7 Department of Labor and Industries when worker claims are
8 submitted for payment for opioid prescriptions. Such demands are
9 *ultra vires* and constitute evidence of the abuse of authority by the
10 member of the InterAgency Group who implements them (in this
11 case, Dr. Gary Franklin).
12
13
14

15 108. The existence of the Dosing Guidelines on a state-sponsored
16 website in which they are clearly labeled “Guidelines” also creates an
17 impermissible “appearance of authority”, which violates due process.
18 Further, any citation to or distribution of the Dosing Guidelines for
19 any purpose is without authority and is therefore arbitrary and violates
20 due process.
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24 109. Actions taken by medical licensees within the State of
25 Washington based on a reasonable perception of the appearance of
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1 authority surrounding the Guidelines were reasonably foreseeable, and
2 harm accruing from such actions is proximately connected to the
3 publication of the Guidelines and chargeable to members of the
4 Group.
5

6
7 110. The Dosage Guidelines are themselves primary evidence that
8 members of the Group who promulgated them are impeding delivery
9 of quality health care to the public of the State of Washington, based
10 on the discriminatory, unscientific and extreme animus demonstrated
11 in those Guidelines against treatment of chronic pain patients with
12 opioid medications.
13

14
15 111. Public health policies flowing from the same discriminatory,
16 extreme and unscientific animus that caused members of the Group to
17 produce the Dosage Guidelines are also demonstrable in the medical
18 licensing regime operated by subordinates of a Group member.
19

20
21 **BACKGROUND – LICENSURE**
22

23 112. Upon information and belief, MQAC Defendants have
24 implemented a licensure enforcement Regime based on the same
25

1 discriminatory animus which formed the development of the Dosage
2 Guidelines; which Regime now targets physicians who prescribe
3 opioid medications for nonmalignant chronic pain patients for
4 discipline in violation of regulatory provisions to the contrary; such
5 MQAC Defendants employ that unlawful and discriminatory standard
6 in their evaluation of the professional conduct of those physician
7 licensees, with the express goal of extracting disciplinary stipulations
8 limiting the prescribing of opioid medications by such licensees, thus
9 limiting treatment for chronic pain patients with opioid medications,
10 which limitations they would not otherwise lawfully be allowed to
11 impose.
12

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17 113. This Regime has a specific, foreseeable effect on the targeted
18 Class Pain Patients in that those patients are thereby deprived of
19 medically-necessary treatment, while being provided no meaningful
20 or effective alternatives.
21

22 114. An additional deleterious effect on Class Pain Patients from this
23 Regime is increased undertreatment of pain resulting from entrenched
24 physician unwillingness to prescribe opioid medications due
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1 specifically to physician fear of coming within the investigative
2 purview of state authorities, or of being subjected to onerous
3 documentation and other practice requirements specifically and
4 exclusively imposed upon the chronic pain opioid medication
5 treatment modality.
6
7

8 115. Medical practice standards imposed on physician licensees that
9 are designed to deter medically-necessary treatment will impede
10 delivery of quality health care to the residents of the State of
11 Washington and are non-statutory and arbitrary as a matter of law, and
12 imposition of such standards by the State or one of its
13 instrumentalities constitutes a violation of due process within the
14 meaning of the Fourteenth Amendment to the United States
15 Constitution.
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19 116. Evidence of application by the State Department of Health of
20 non-statutory medical practice standards designed to deter medically-
21 necessary treatment for chronic, nonmalignant pain is demonstrated in
22 the recent Findings of Fact and Conclusions of Law involving Dr.
23 Alan Hunt, and issued May 22, 2008 [see Exhibit E, attached hereto].
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1 117. Evidence of application by the State Department of Health of
2 non-statutory medical practice standards designed to deter medically-
3 necessary treatment for chronic, nonmalignant pain is also
4 demonstrated in the recent MQAC investigation of Dr. Merle Janes.
5

6
7 118. Dr. Janes, as a patient representative, and the Class Pain
8 Patients specifically challenge actions taken by MQAC Agent
9 Defendants and Health Official Defendants and their Group member
10 Supervisor that have the effect of requiring any professional licensee
11 in the State of Washington to deny Class Pain Patients and other
12 similarly situated individuals of the full and equal access to and
13 enjoyment of necessary medical services provided by state regulated
14 medical licensees within their best professional and scientific
15 judgment; as a corollary, Dr. Janes, as a patient representative, and the
16 Class Pain Patients and other similarly situated individuals challenge
17 regulatory actions taken against medical licensees as a result of their
18 treatment of patients with opioid medications to the extent that those
19 medical licensees' treatments were consistent with the dictates of the
20 science of pain, Department of Health regulations, and the 1996
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1 Guidelines but were nevertheless subjected to licensure proceedings
2 based on other unscientific, unethical, or otherwise arbitrary or
3 unlawful standards of practice [hereinafter the “Scheme”].
4

5 119. The Scheme as implemented requires all Washington licensees
6 who are regulated under it to subject Class Pain Patients, solely by
7 reason of their requirement for opioid pain relieving agents to mitigate
8 the effects of chronic nonmalignant pain resulting from their
9 underlying disabilities, to arbitrary treatment and unlawful
10 discrimination, in violation of the ADA. That Scheme also unlawfully
11 deprives such licensees and the Class Pain Patients they treat and all
12 similarly situated individuals of equal protection of the law as
13 guaranteed by the Fourteenth Amendment to the United States
14 Constitution.
15

16 120. That Scheme also unduly burdens the Class Pain Patients’ and
17 all similarly situated individuals’ fundamental substantive due process
18 liberty interest in choosing to use FDA-approved pain relieving
19 agents, when medically necessary and in consultation with a licensed
20 physician, where there are no adequate alternatives, to mitigate
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1 nonmalignant intractable pain which – if left untreated – would make
2 life intolerable.

3
4 121. In the alternative, that Scheme also unduly burdens the Class
5 Pain Patients’ and all similarly situated individuals’ fundamental
6 substantive due process liberty interest in engaging in an unburdened
7 physician-patient relationship in which a physician is allowed to use
8 his best professional and scientific judgment on behalf of his patients.
9
10 The State of Washington unduly burdens the physician-patient
11 relationship by enforcing a licensure Scheme designed to deter
12 physicians from exercising their best professional and scientific
13 judgment in medically-appropriate prescribing opioid drugs for their
14 patients; in the alternative, the State of Washington unduly burdens
15 the physician-patient relationship by enforcing a licensure Scheme in
16 which medical practice standards are imposed without regard to the
17 pertinent science and the ethic of treatment. Such Scheme creates
18 barriers for physicians who would, but for the Scheme, exercise their
19 best professional and scientific judgment in choosing to prescribe
20 medically-appropriate opioid drugs for their patients, and as a result
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1 such Scheme deters physicians from freely exercising their best
2 professional and scientific judgments on behalf of such patients; as a
3 direct consequence, physician licensees *refuse to undertake that care*
4 *at all or only upon express condition of waiving any demand by the*
5 *patient for present or future prescribing of opioid medications,*
6 *regardless of medical need.* Such additional burdens are imposed
7 even when opioid prescriptions are medically necessary with no
8 adequate medical alternatives, and even though this medical use of
9 opioids has already been determined to be safe and effective by the
10 federal Food and Drug Administration, and are imposed in derogation
11 of the well-established medical and legal imperatives to treat pain.
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17 122. Upon information and belief, as a direct result of Defendants'
18 arbitrary and unjustifiably discriminatory acts and deprivations in the
19 Scheme not taken in good faith, Class Pain Patients have been
20 severely harmed and disadvantaged. The Class Pain Patients and
21 other similarly situated individuals have been and will continue to be
22 denied reasonable access to necessary medical services by Dr. Janes
23 and similar medical licensees, as well as all other physicians licensed
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1 or regulated by the Health Official Defendants under the Scheme, and
2 have been and will continue to be forced to suffer unnecessary
3 extreme pain, unnecessary substantial impairments of major life
4 activities, as well as potential permanent neurologic injury, hastened
5 death, and certain degradation, humiliation, unnecessary personal
6 expense and effort, and grave emotional distress by reason of Health
7 Official Defendants, MQAC Agents', and their Group Supervisor's
8 Scheme imposed specifically and exclusively upon medical treatment
9 and services that are necessary to mitigate the chronic, nonmalignant
10 pain resulting from the disabilities of Class Pain Patients' and other
11 similarly situated individuals, for which no adequate medical
12 alternative is available, which has already specifically been
13 determined to be safe and effective by the Federal Food and Drug
14 Administration, and in derogation of the well-established medical and
15 legal imperatives to treat pain.
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23 **THE MEDICAL TREATMENT OF CHRONIC NONMALIGNANT**
24 **PAIN**

25 123. Based on the published scientific evidence and consensus of the
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1 leading academics in the field, the following are governing
2 cornerstone principles of medical pain management, the denial or
3 abrogation of which principles should disqualify as an expert in the
4 field any individual who espouses such denial or abrogation:
5

- 6 a. Treatment of pain is a medical imperative.
- 7
- 8 b. Chronic nonmalignant pain is itself a recognized clinical
9 syndrome.
- 10
- 11 c. The treatment of chronic nonmalignant pain through the use of
12 opioid drugs is a recognized and accepted method of treatment in
13 the medical profession, and is a recognized and accepted method
14 of treatment under the law of the State of Washington.
- 15
- 16 d. There is no generally applicable upper limit to the dosage level of
17 opioid drugs that may be safely administered to chronic pain
18 patients; even at high dosages, when chronically administered,
19 such medications have not been demonstrated to have toxicity or
20 life-threatening effects.
- 21
- 22 e. Many patients experience a “tolerance” effect that requires
23 increasing dosage levels to maintain pain relief over time.
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- 1 f. There is wide individual variation among patients in the dosage
2 levels required to achieve and maintain effective pain relief and the
3 dosage levels at which patients may experience adverse effects.
4
5 g. The dosage levels required to treat chronic nonmalignant pain may
6 result in the prescription of large numbers of dosage units when
7 opioid drugs are administered orally.
8
9 h. The absolute dosage or the number of dosage units prescribed to a
10 given patient or the period of time over which they are
11 administered is not reflective of the medical propriety of the
12 treatment; any standard of practice imposed on physicians based
13 on “morphine equivalents” or other dosage measurements, either
14 as an absolute or over a specific period of time is purely arbitrary
15 from a medical standpoint.
16
17 i. There is no medical or scientific basis for distinguishing between
18 or among chronic nonmalignant pain opioid dosages above or
19 below 120 MEQ per day; such dosage limit is purely arbitrary
20 from a medical and scientific standpoint, and was in fact a political
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1 decision introduced by the Group to the Dosage Guidelines for
2 political reasons.
3

4 124. The foregoing is recognized in the laws of several states,
5 including the Revised Code of Washington, which includes statutes
6 expressly authorizing physicians to prescribe *effective* dosages –
7 whatever they may be -- to patients suffering from intractable pain.
8 RCW 69.50.308(g) provides that “[a] practitioner may dispense or
9 deliver a controlled substance to or for an individual . . . for medical
10 treatment . . . in the ordinary course of that practitioner's profession.
11 Medical treatment includes dispensing or administering a narcotic
12 drug for pain, including intractable pain.”]
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17 **REGULATORY ACTION DIRECTED AT MEDICAL CARE OF PAIN**
18 **PATIENTS**

19 125. Upon information and belief, Dr. Merle Janes is a physician
20 who is licensed by the State of Washington who has upheld his ethical
21 and statutory duty to treat his patients even when those patients have
22 had chronic nonmalignant pain required treatment with opioid pain-
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1 relieving medications. Dr. Janes' primary focus in his practice is on
2 the provision of prolotherapy.¹⁰
3

4 126. Upon information and belief, Dr. Janes has endured repeated
5 investigated by the MQAC, specifically based upon his treatment of
6 patients who have required treatment with opioid pain-relieving
7 medication for chronic, nonmalignant pain. In 1998, and at great
8
9

10 ¹⁰ "Prolotherapy" - Prolotherapy is a treatment using a proliferant solution that is
11 droplet-injected into the ligament or tendon where it attaches to the bone. "*Prolo*"
12 is short for *proliferation*, because the treatment causes the proliferation (growth,
13 formation) of new connective tissue in an area where it has become weak. The
14 principle is to encourage the body to repair itself using an innate ability that the
15 body has. Prolotherapy accomplishes this because the solution causes the release
16 of "growth factors" which in turn result in the attraction of specific repair cells to
17 create specific tissue structures. For example, vascular endothelial growth factor
18 [VEGF] promotes the creation of new blood vessels, which -- like building new
19 railroads into the wilderness -- will allow the body to bring in other supplies and
20 cells to further the repair work, including, *inter alia*, nerve growth factor [NGF],
21 and epidermal cell growth factor [ECF]. Prolotherapy is a medical treatment
22 intended to gently nudge the body's self-repair mechanisms into healing a damaged
23 area that the body "forgot" to heal completely when the original injury occurred.
24 Prolotherapy is direct, simple, and safe, and is considered an effective treatment for
25 the underlying cause of pain arising from localized damage to the skeletal muscles,
26 ligaments, and tendons, which constitutes a very common cause of chronic pain.
27 Dr. Janes uses prolotherapy in cases where it has a strong chance of correcting the
28 underlying cause of pain by improving or restoring original tissue strength in the
damaged area without surgery. The goal of prolotherapy is to relieve pain and
reduce or eliminate the need for pain medication, if possible. Prolotherapy was
invented by an orthopedic surgeon in Ohio in the 1930's and, like Jazz, is a truly
American invention.

1 expense of time and resources to Dr. Janes, one such investigation
2 was taken as far as a full Commission hearing. Nonetheless, Dr. Janes
3 was fully exonerated during that hearing.
4

5 127. Upon information and belief, Dr. Janes now finds himself under
6 the microscopic eye of the MQAC again *specifically for his treatment*
7 *of patients who have chronic, nonmalignant pain and who require*
8 *continuous treatment with opioid pain-relieving medication, including*
9 *Jane Does A and B.*
10

11
12 128. As part of that MQAC proceeding, Dr. Janes and his attorney
13 attended a conference on February 19, 2008. Upon information and
14 belief, during the Feb. 19 conference, all of the MQAC agents in
15 attendance admitted their complete ignorance about prolotherapy –
16 which forms the basis for Dr. Janes’ treatment of his patients. By
17 their own admission, MQAC agents sent to evaluate the professional
18 practice of this licensee were thus not even *aware of the nature of the*
19 *professional care he provided.* By its own admission, the reviewing
20 panel was therefore not professionally competent to review the
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1 practice of Dr. Janes, and any conclusions this panel drew about that
2 practice were arbitrary as a matter of law.
3

4 a. This admission as a matter of law undermines any good faith basis
5 the MQAC agents had for investigating the prolotherapy *ab initio*,
6 and vitiates any deference the panel may otherwise have expected
7 as experts in the field or as agents of the State operating in good
8 faith in fulfillment of a statutory mission. Because the MQAC did
9 not see fit to send experts that had even the slightest notion of what
10 the physician licensee was doing on a professional basis, it could
11 not as a matter of law have been operating as an expert *medical*
12 regulator, nor as a fair evaluator of the professional conduct of its
13 own licensee.
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18 129. The charges which the MQAC agents were investigating on
19 February 19 required MQAC agents to be familiar with the standard
20 of care required of physician licensees in the state of Washington for
21 treatment of chronic nonmalignant pain with opioid medications.
22
23

24 130. Based on the medical practice standards articulated in the Order
25 attached hereto as Exhibit E, the State of Washington Department of
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1 Health now applies in its physician licensure proceedings medical
2 practice standards for the treatment of chronic, nonmalignant pain
3 with opioid medications that abrogate the science of pain and the
4 medical ethic of treatment, and has instead created a non-statutory
5 medical duty to abandon, shun or arbitrarily limit pain treatment for
6 patients who require opioid medications for treatment of chronic non-
7 malignant pain, and enforces those duties to abandon, shun or
8 arbitrarily limit treatment through application of its MQAC licensure
9 regime.
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14 131. Based on the statements made by MQAC Agents at the
15 conference with Dr. Janes on February 19, 2008, the medical practice
16 standards employed in the Order attached hereto as Exhibit E are the
17 medical practice standards applied generally by direction of Health
18 Official Defendants and their Group Supervisor in that those MQAC
19 agents' own statements were in conformity therewith, and evince an
20 expectation of the physician to abrogate the science of pain and the
21 ethic of treatment, in favor of the standard applied in Order Exhibit E,
22 which imposes a non-statutory medical duty to abandon, shun or
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1 arbitrarily limit pain treatment for patients who require opioid
2 medications for treatment of chronic non-malignant pain; further,
3 those MQAC agents specifically articulated an intent to enforce that
4 duty to abandon, shun or arbitrarily limit treatment through the
5 MQAC licensure regime, as demonstrated by the statements and
6 threats they made to Dr. Janes at that conference.
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8

9
10 132. Upon information and belief, the intent of the State Defendants,
11 the Health Official Defendants, and their agents is to overreach the
12 proper boundaries of their lawful authority by the use of the
13 appearance of authority, licensure threats, and other unlawful
14 intimidations against physicians outside their statutory mandate to
15 deprive Class Pain Patients and similarly situated individuals of
16 legitimate, necessary and lawful medical care, without which such
17 Class Pain Patients are likely to suffer irreversible neurological injury
18 and significant impairment of their quality of life, as well as
19 intolerable pain and potential, preventable loss of life.
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24 133. The State Defendants and the Health Official Defendants and
25 their agents' efforts will in fact have the foreseeable effect of
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1 increasing the mortality of and significantly decreasing the quality of
2 life of patients in pain as well as their families, and thereby
3 undermining their own express statutory mission to improve the
4 public health, as well as violating their statutory duty not to impede
5 delivery of quality health services.
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8 134. These actions have been taken with callous disregard for the
9 pain, suffering, and *lives* of Class Pain Patients, and out of an
10 irrational, unscientific, and disproven fear of the legitimate medical
11 use of pain relieving opioid drugs, which was also clearly
12 demonstrated in the Dosage Guidelines.
13
14

15 135. These actions are not the lawful policy of the State of
16 Washington, are in derogation of the science of pain, the ethic of
17 medical treatment, and the requirement to titrate to analgesic effect as
18 required by state statutes, and is therefore being carried out by State
19 Defendants, the Health Official Defendants and their subordinate
20 MQAC Agents outside the scope of their permissible authority, and in
21 derogation of positive law to the contrary.
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1 136. To the extent that the Health Official Defendants and their
2 MQAC Agent subordinates apply through licensure enforcement a
3 standard of medical pain care that is not science-based and requires
4 the abandonment, non-treatment or undertreatment of chronic
5 nonmalignant pain by physicians who come within the purview of
6 such investigations or who fear becoming the target of future
7 investigations, Class Pain Patients in the State of Washington for
8 whom there is no meaningful or effective medical alternatives are
9 denied potentially life-saving, and certainly necessary medical
10 treatment through the application of Washington State law.

- 11 a. Class Pain Patients cannot lawfully obtain treatment without the
12 assistance of a licensed physician.
- 13 b. When operation of law prevents Class Pain Patients from obtaining
14 treatment required to prevent their suffering or their deaths, that
15 operation of law becomes a cause of their suffering or their deaths.
- 16 c. When such Class Pain Patients have preventable death or suffering
17 that is attributable to undertreated pain by operation of law, those
18 Class Pain Patients will have state-ordained suffering not unlike a
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1 form of torture, and death not unlike a form of capital punishment,
2 both of which in the absence of a conviction of crime are expressly
3 forbidden by the Eighth Amendment to the United States
4 Constitution, as incorporated into the Fourteenth Amendment.
5

6
7 d. It is not the lawful public health policy of the State of Washington
8 for public health authorities, through operation of law, to cause the
9 death or unnecessary suffering of its citizens.
10

11 137. Upon information and belief, an example of the arbitrary nature
12 of the proceedings undertaken against physicians who treat chronic,
13 nonmalignant pain with opioid medications is demonstrable in the
14 proceeding undertaken against Dr. Janes, wherein statements made by
15 the MQAC agents on February 19, 2008, disclosed that the nature of
16 the proceeding was contrived to extract a stipulation that those MQAC
17 agents would not otherwise lawfully be able to demand, and was only
18 sought because Dr. Janes was known to have provided opioid pain
19 medications to specific patients to treat their chronic, nonmalignant
20 pain in accord with the relevant science and ethic of treatment.
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1 a. The stipulation was offered as a form of settlement, along with a
2 \$1,000.00 fine, and agreement to attend a 2-week long school; or
3 as an alternative Dr. Janes would face formal charges, including an
4 immediate license suspension for five years as a “clear and present
5 danger to the public.”
6
7

8 138. Based on the conduct of the MQAC agents as well as their
9 enforcement of discriminatory practice standards and rejection of the
10 basic science and ethic of medical treatment, Dr. Janes has reasonably
11 concluded that MQAC Agents or the Health Official Defendants who
12 direct them are enforcing a duty to abandon, shun, or arbitrarily limit
13 necessary medical treatment for specific chronic pain patients, and
14 that in any event no reasonably reliable science-based ethical standard
15 of care currently applies to the prescribing of opioid medications for
16 chronic non-malignant pain patients within the State of Washington,
17 such that continued treatment offered to Class Pain Patients subjects
18 medical licensees – including himself -- to unreasonable risk of threats
19 to the medical license when such treatment is offered. As a
20 consequence, Dr. Janes has been forced against his better ethical and
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1 scientific judgment to inform Does A-Z by letter that he will no longer
2 prescribe opioid medications for them after April 30, 2008. See Copy
3 of Letter from Dr. Janes, attached as Exhibit D.
4

5 139. For the same reason, no other physician has been identified in
6 the entire State of Washington east of the Cascade Mountains who is
7 currently willing to take referrals of chronic pain patients who require
8 treatment with opioid medications.
9
10

11 140. Chronic pain patients in the State of Washington are currently
12 experiencing a “crisis of treatment” in that no physician is willing to
13 undertaken their care, as defined by titration to analgesic effect, and
14 the State Defendants are actively discouraging such treatment from all
15 physicians within their purview, as evidenced by the Dosage
16 Guidelines.
17
18

19 141. As a direct result of the actions taken by the State Defendants,
20 the Health Official Defendants and their subordinate MQAC Agent
21 defendants against Dr. Janes and other similarly situated Washington
22 medical licensees, as well as the promulgation of the Dosage
23 Guidelines, Pain Patients Does A-Z and Class Pain Patients and all
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1 similarly situated Pain Patients within the State of Washington, who
2 require opioid medications to treat their chronic, nonmalignant pain, --
3 and especially those who require in excess of 120 MEQs per day --
4 have had their necessary medical treatment stigmatized, abandoned,
5 shunned, arbitrarily limited, or denied altogether, and neither MQAC,
6 the Department of Health, nor any of its officials or agents have
7 offered any meaningful or effective alternatives to any of them.
8
9
10

11 142. Treatment of chronic nonmalignant pain with opioid
12 medications through standard titration to analgesic effect, even when
13 medically necessary with no meaningful or effective alternatives, is
14 now so exceedingly difficult to obtain from Washington medical
15 licensees that it is effectively impossible to obtain anywhere within
16 the Washington state medical community, so much so that some Pain
17 Patient Class members, including specifically John Doe, have had to
18 cross state lines to obtain it, and the patients Does A-Z who have had
19 to locate alternative sources of care have been unable to find it
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24 *anywhere else within Washington State.*
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1 143. Upon information and belief, by thus threatening Dr. Janes, and
2 by applying the medical practice standards articulated in Order
3 Exhibit E, the targeted Pain Patients Jane Does A and B, as well as
4 other affected Pain Patients Does C-Z, along with Class Pain Patients
5 are left with grave uncertainty as to their ability to receive potentially
6 life-saving and certainly necessary health care from any Washington
7 physician licensee now or in the future.
8
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10

11 144. Vanishingly few physicians are willing to treat chronic pain
12 patients with opioid medications by titrating to analgesic effect within
13 the State of Washington. The few who remain are threatened by the
14 non-statutory Regime in place at MQAC.
15
16

17 145. The actions taken against Dr. Janes and other physician
18 licensees based on the medical practice standards articulated in Order
19 Exhibit E are specifically designed by the State of Washington Health
20 Officials to reduce or eliminate the prescribing of therapeutic dosages
21 of opioid pain medications to these Class Pain Patients, which are
22 protected mitigation measures for the patients who need them within
23 the meaning of federal antidiscrimination law, and despite the fact that
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1 many such patients are people with disabilities within the meaning of
2 federal antidiscrimination law.
3

4 146. These medical practice standards have been imposed by
5 Washington State Health Officials without regard to the legitimate
6 serious medical needs that those Class Pain Patients have for the
7 medications they receive, and no meaningful alternatives have been
8 provided to those Class Pain Patients by MQAC or any related agent
9 or official.
10
11

12 147. In essence, State Health Officials are “serving” this segment of
13 the public *by denying them necessary health services, and*
14 *undermining the care they already receive, and seem oblivious to the*
15 *role they play as state officials in the active infliction of “torture or a*
16 *lingering death” upon these people.*
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5 **CLAIMS**

6 ***COUNT 1 – CONSTITUTIONAL SECTION 1983 CLAIMS- GUIDELINES***
7

8 148. Plaintiffs reallege and reincorporate herein by reference each
9 and every allegation contained in ¶¶ 1 through 147 above as though
10 fully set forth herein.
11

12 149. This Count is stated by all Plaintiffs against all State
13 Defendants jointly and severally, in both their official and individual
14 capacities, and arises under the Civil Rights Act, 42 U.S.C. § 1983,
15 which provides a federal civil remedy, for damages or injunctive or
16 other relief, for the deprivation, under color of state law, custom, or
17 usage, of any rights, privileges or immunities secured by the
18 Constitution or laws of the United States, against any person causing
19 such deprivation.
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1 150. The State Defendants are “persons” for purposes of 42 U.S.C.
2 1983, and are sued in both their individual and official capacities,
3 jointly and severally.
4

5 151. The State Defendants have taken their actions challenged herein
6 as Agents of the Departments of which they are heads, and as such
7 these Agents have acted “under color of state law” for purposes of 42
8 U.S.C. 1983.
9
10

11 152. By reason of the State Defendants’ creation and publication of
12 the Dosage Guidelines, which are constitutional violations as set forth
13 below, and which were wholly taken under color of authority of the
14 State of Washington, and by reason of the lack of any good faith or
15 reasonable belief by State Defendants in the legality of their actions,
16 each Plaintiff is entitled to declaratory, injunctive relief, and damages
17 and other relief against each State Defendant herein.
18
19
20

21 153. This Count arises directly under the Constitution of the United
22 States, specifically the Fourteenth Amendment Due Process Clause,
23 or, in the alternative, the Supremacy Clause.
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1 154. The Dosing Guidelines are *ultra vires* within the meaning of
2 Washington administrative law, and are therefore arbitrary and
3 capricious as a matter of law, any enforcement of which would
4 constitute a violation of the Due Process Clause of the Fourteenth
5 Amendment.
6

7
8 a. Article XX of the Washington State Constitution provides that
9 “[t]he legislature shall enact laws to regulate the practice of
10 medicine and surgery, and the sale of drugs and medicines.” In the
11 State of Washington, only legislative authority may be used to
12 regulate the practice of medicine.
13

14
15 b. The legislature delegated the authority to develop medical practice
16 standards to the Washington MQAC. RCW 18.71.002 provides
17 that “[i]t is the purpose of the medical quality assurance
18 commission to regulate the competency and quality of professional
19 health care providers under its jurisdiction by establishing,
20 monitoring, and enforcing qualifications for licensing, consistent
21 standards of practice, continuing competency mechanisms, and
22 discipline. Rules, policies, and procedures developed by the
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1 commission must promote the delivery of quality health care to the
2 residents of the state of Washington.“
3

4 c. No statutory delegation exists that empowers the Group *as a*
5 *Group*. These State Defendants can neither “invent” nor “enlarge”
6 their designated statutory authority as heads of their various
7 agencies; nor does their “combination” have that effect.
8

9
10 d. Nevertheless, despite the absence of any specific statutory
11 delegation to the Group to establish medical practice standards, the
12 Group purported to set *dosing standards* for medical pain practice,
13 but completely unrelated to and in repudiation of the statutory goal
14 of titration to analgesic effect, when in March 2007 it published
15 what the Group itself entitled “Interagency Guidelines on Opioid
16 Dosing for Chronic Non-Cancer Pain” [hereinafter “Dosing
17 Guidelines”].
18
19
20

21 e. The absence of a specific grant of authority to the Group to
22 establish medical practice standards, coupled with an explicit grant
23 of such authority to the MQAC to do so renders any medical
24 practice standards purportedly established by the Group *ultra vires*
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1 within the meaning of Washington law. As such, the Dosing
2 Guidelines are *ultra vires* within the meaning of the law of the
3 State of Washington, and publication of the Dosing Guidelines
4 violates the due process clause of the Fourteenth Amendment to
5 the United States Constitution, as they were developed and
6 published wholly without authority and are therefore invalid; the
7 Guidelines should be enjoined *in toto* by this Court and declared
8 invalid for any lawful purpose.
9
10
11

12 155. In the alternative, the Dosing Guidelines are *ultra vires* within
13 the meaning of Washington medical practice law, and are therefore
14 arbitrary and capricious as a matter of law, any enforcement of which
15 would constitute a violation of the Due Process Clause of the
16 Fourteenth Amendment.
17
18

19 a. The Secretary of Health was delegated authority to develop an
20 overall approach to *effective pain treatment* including opioid
21 therapy within RCW 18.130.340. The requirements of RCW
22 148.130.340 were fulfilled with the approval by the Washington
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1 MQAC] of its 1996 Guidelines, see Exhibit C, attached hereto, and
2 have never been repealed.
3

4 b. Even if State Defendants had colorable authority to establish
5 medical practice standards to be used under programs operated by
6 State Defendants' Departments, such authority does not permit
7 State Defendants to establish standards that are contrary to existing
8 specific lawful standards of medical practice developed by MQAC.
9 The Dosing Guidelines specifically conflict with the 1996
10 Guidelines for Treatment of Pain, approved by the Washington
11 Medical Quality Assurance Commission. As such, the Dosing
12 Guidelines are *ultra vires* within the meaning of the law of the
13 State of Washington, and publication of the Dosing Guidelines
14 violates the due process clause of the Fourteenth Amendment to
15 the United States Constitution and should be enjoined *in toto* by
16 this Court and declared invalid for any lawful purpose.
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22 156. In the alternative, the Dosing Guidelines are pre-empted under
23 federal law as additions to an FDA-approved drug label regime, and
24 publication of the Dosing Guidelines violates the Supremacy Clause
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1 of the United States Constitution, and are therefore invalid; the
2 Guidelines should be enjoined *in toto* by this Court and declared
3 invalid for any lawful purpose.
4

5 157. In the alternative, the Dosing Guidelines unduly burden a
6 mentally-competent adult's fundamental liberty interest in seeking
7 necessary medical care that will allow him to avoid intolerable pain
8 and suffering, including choosing medically-necessary, suitable
9 physician-prescribed FDA-approved opioid drugs to mitigate chronic
10 nonmalignant intractable pain, when no effective alternatives are
11 available.
12

13 a. The right to make this choice is a fundamental right under the due
14 process clause, and is entitled to the strongest degree of
15 constitutional protection.
16

17 b. The Dosing Guidelines do not further a compelling state interest
18 and are not narrowly drawn to express only the legitimate state
19 interests at stake; those Dosing Guidelines therefore cannot survive
20 strict scrutiny.
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1 c. Publication of the Dosing Guidelines therefore violates the due
2 process clause of the Fourteenth Amendment to the United States
3 Constitution, and should be enjoined *in toto* by this Court.
4

5 158. In the alternative, the Dosing Guidelines unduly burden a
6 mentally competent adult's fundamental liberty interest in avoiding
7 intolerable pain and suffering by seeking a physician-patient
8 relationship wherein a physician is allowed to exercise his best
9 professional and scientific judgment, even when such judgment is that
10 pain treatment with opioid medications in excess of 120 MEQ per day
11 is medically necessary and no adequate alternative exists.
12

13 a. The Fourteenth Amendment guarantees the liberty of physicians to
14 practice medicine consistent with their best professional judgment,
15 including using their skills and powers to facilitate the exercise of
16 the decision of competent adults to choose, if necessary to mitigate
17 chronic nonmalignant intractable pain, the use of suitable
18 physician-prescribed FDA-approved opioid drugs, and thereby
19 avoid intolerable pain and suffering.
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1 b. The right to make this choice is a fundamental right under the due
2 process clause, and is entitled to the strongest degree of
3 constitutional protection.
4

5 c. The Dosing Guidelines do not further a compelling state interest
6 and are not narrowly drawn to express only the legitimate state
7 interests at stake; those Dosing Guidelines therefore cannot survive
8 strict scrutiny.
9

10 d. Publication of the Dosing Guidelines therefore violates the due
11 process clause of the Fourteenth Amendment to the United States
12 Constitution, and should be enjoined *in toto* by this Court.
13

14
15 159. In the alternative, the Dosing Guidelines unduly burden a
16 mentally competent adult's fundamental liberty interest in not being
17 subjected to cruel and unusual punishment under circumstances
18 wherein conduct committed under color of State authority constitutes
19 dominion or control over the ability of a person or class of persons to
20 obtain medical care, and such State authority demonstrate deliberate
21 indifference to the serious medical needs of that person or class of
22 persons.
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- 1 a. When the state exercises sufficient “control and dominion” over
2 the life circumstances of an individual so that it becomes
3 impossible for the individual to obtain necessary support , such as
4 medical care, then by virtue of state “control and dominion” over
5 those life circumstances, the state undertakes the obligation to
6 make that support available to the extent that absence of such
7 support would result in “torture or a lingering death.”
8
9
10
11 b. The State’s overall and unduly restrictive regulatory impairment of
12 the only legal mechanisms whereby individuals *could* obtain
13 necessary medical care with FDA-approved pharmaceuticals –
14 here, lawful treatment of severe chronic pain with opioid
15 medications as restricted through the Dosage Guidelines combined
16 with the licensure Regime as described above -- results in “control
17 and dominion” over the medical circumstances of persons who,
18 without such treatment, would have to live in intolerable
19 conditions. When a State, such as here, chooses to exercise
20 *complete* “control and dominion,” then by virtue of the state
21 regulatory environment impairing the availability of necessary
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1 medical care, citizens on the street have less “freedom” to obtain
2 that care than incarcerated prisoners who have a legal entitlement
3 thereto under the Eighth Amendment.
4

5 c. When the State chooses to exercise such complete “control and
6 dominion” that it effectively proscribes or stigmatizes all
7 reasonable lawful avenues for receiving necessary medical care,
8 then the State has a concomitant obligation to ensure that adequate
9 resources are available for treatment of those medically necessary
10 needs which, absent interference by the state, would not otherwise
11 produce physical “torture or a lingering death.” By virtue of state
12 “control and dominion” it is the state impairment that is
13 responsible for the physical “torture or a lingering death.”
14
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18 d. When the State exercises such complete “control or dominion”,
19 then the State itself should make available directly to patients
20 medical services whereby their chronic pain will be titrated with
21 opioids to analgesic effect, or, in the alternative, the State should
22 be required to ascertain that sufficient referral sources exist within
23 the State where patients with chronic pain will be assured to have
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1 their pain titrated to analgesic effect, and to provide such referrals
2 upon request for patient needs.
3

4 i. In the absence of either form of resource, the State should
5 not exercise such “control or dominion” over the necessary
6 medical treatment.
7

8 ii. If insufficient referral sources for such treatment exist within
9 the State, then public health officials who exacerbate the
10 already insufficient academy of professionals by
11 implementing onerous Dosage Guidelines that further limit
12 the willingness of physicians to provide such care are
13 actively impeding delivery of quality care to state residents.
14

15 e. The Dosage Guidelines as published are reasonably perceived by
16 physicians and patients as exercising “dominion and control” over
17 the ability of patients to obtain from Washington medical licensees
18 medically-necessary opioid medication to treat chronic,
19 nonmalignant pain, regardless of medical need, and have resulted
20 in complete “control and dominion” by the state over the
21 availability of such treatment. Implementation of these Dosage
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1 Guidelines as they are perceived by physicians and the public will
2 result in physical “torture or a lingering death” unless the state
3 undertakes an affirmative corresponding duty to ensure that
4 adequate medical resources are available for necessary medical
5 treatment that is no longer available in the private medical
6 marketplace due to the state’s own impairment of that marketplace.
7

8
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10 f. In the alternative, the combined effect of the licensure Regime as
11 described below, along with the Dosage Guidelines as published
12 are reasonably perceived by physicians and patients as exercising
13 “dominion and control” over the ability of patients to obtain from
14 Washington medical licensees medically-necessary opioid
15 medication to treat chronic, nonmalignant pain, regardless of
16 medical need, and have resulted in complete “control and
17 dominion” by the state over the availability of such treatment.
18 Implementation of these Dosage Guidelines and the Licensure
19 Regime as they are perceived by physicians and the public will
20 result in physical “torture or a lingering death” unless the state
21 undertakes an affirmative corresponding duty to ensure that
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1 adequate medical resources are available for necessary medical
2 treatment that is no longer available in the private medical
3 marketplace due to the state's own impairment of that marketplace.
4

5 i. The dosage ceiling of 120 MEQ per day contained in the
6 Dosing Guidelines is based on neither science nor medical
7 evidence, and as a matter of law demonstrates by the
8 officials who implemented it deliberate indifference to the
9 serious medical need of individuals who have a medical
10 need for such medication to treat intolerable pain, and for
11 which there is no effective alternative.
12

13 ii. Readily available chronic pain prevalence data when
14 coupled with state population estimates conservatively
15 suggest that more than half a million chronic pain patients
16 exist within Washington State.
17

18 1. No official could reasonably believe that interposing a
19 referral requirement for half a million potential
20 patients with a list of only twelve referring physicians
21 would result in reasonable care.
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1 2. Interposition of this blanket referral requirement, as a
2 matter of law, demonstrates deliberate indifference to
3 serious medical need for these patients.
4

5 iii. Even for patients who obtain a referral, no physician is
6 identified in many areas of the state, including Spokane, and
7 interposition of a blanket referral requirement with no local
8 resources *for a patient in untreated pain* demonstrates
9 deliberate indifference to serious medical need.
10

11 g. The Dosing Guidelines do not further a compelling state interest
12 and are not narrowly drawn to express only the legitimate state
13 interests at stake; those Dosing Guidelines therefore cannot survive
14 strict scrutiny.
15

16 h. Publication of the Dosing Guidelines therefore violates the due
17 process clause of the Fourteenth Amendment to the United States
18 Constitution, and should be enjoined *in toto* by this Court.
19

20 160. As the result of Publication of the Dosing Guidelines, Plaintiff
21 Patients John Doe and Class Pain Patients have sustained injury. Such
22 injuries have been and will continue to be present, to not be fully
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1 reparable by retrospective monetary damages, and are likely to
2 continue unless Defendants' continuing violations are also restrained
3 and enjoined by this Court.
4

5 161. State Defendants' actions were undertaken without a good faith
6 or reasonable belief in the constitutionality or legality of said actions,
7 and therefore are not immune or privileged from liability for personal
8 damages.
9

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11 162. Regardless of the good faith or reasonableness of the State
12 Defendants' actions, no State Defendant is immune or privileged from
13 Declaratory and Injunctive Relief as ordered by this Court to redress
14 State Defendants' constitutional violations.
15
16

17 ***COUNT 2 -- STATUTORY 1983 CLAIMS AGAINST STATE DEFENDANTS***
18 ***FOR VIOLATIONS OF ADA – Dosage Guidelines***

19 163. Plaintiffs reallege and incorporate herein by reference each and
20 every allegation contained in ¶¶1 through 147 above as though fully
21 set forth herein.
22

23 164. This Count is stated by John Doe and all members of Classes A
24 & B against all State Defendants who are members of the Group,
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1 jointly and severally, in both their official and individual capacities,
2 and arises under the Civil Rights Act, 42 U.S.C. § 1983, which
3 provides a federal civil remedy, for damages or injunctive or other
4 relief, for the deprivation, under color of state law, custom, or usage,
5 of any rights, privileges or immunities secured by the Constitution or
6 laws of the United States, against any person causing such
7 deprivation.
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11 165. The State Defendants are “persons” for purposes of 42 U.S.C.
12 1983, and are sued in both their individual and official capacities,
13 jointly and severally.
14

15 166. Through the combination that calls itself the “Interagency
16 Medical Directors Group” the State Defendants hold themselves out
17 as an authorized instrumentality of the State of Washington; as such
18 the Group has acted “under color of state law” for purposes of 42
19 U.S.C. 1983. As officials, the Defendants are heads of State
20 Departments, which are public entities. The State Defendants have
21 taken their actions challenged herein as Agents of the Departments of
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1 which they are heads, and as such these Agents have acted “under
2 color of state law” for purposes of 42 U.S.C. 1983.
3

4 167. The Defendants’ statutory violations are set forth below in
5 Count 3, all of which were wholly based upon actions taken under
6 color of authority purportedly granted by the laws of the State of
7 Washington, or in aid and assistance of others purportedly so acting.
8

9
10 168. The disparate treatment of John Doe and members of Classes A
11 and B was specifically contemplated by the Dosing Guidelines, and
12 was therefore caused by State Defendants who are members of the
13 Group. The State Defendants could not reasonably have believed that
14 their actions were consistent with the ADA, or been unaware that John
15 Doe and members of Classes A & B were intended beneficiaries of
16 the ADA. Moreover, the State Defendants could not reasonably have
17 believed that their actions were consistent with existing law, and their
18 own actions demonstrate awareness that their conduct lacked actual
19 authority. Their attempts to project the appearance of authority were
20 also intentional, and no qualified immunity or privilege from liability
21 for personal damages applies.
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1 169. As the result of Publication of the Dosing Guidelines, Plaintiff
2 Patients John Doe and members of Classes A and B have sustained
3 injury. Such injuries have been and will continue to be present, to not
4 be fully reparable by retrospective monetary damages, and are likely
5 to continue unless Defendants’ continuing violations are also
6 restrained and enjoined by this Court. Regardless of the good faith or
7 reasonableness of the Defendants’ actions, no Defendant is immune or
8 privileged from Declaratory and Injunctive Relief as ordered by this
9 Court to redress Defendants’ constitutional violations.
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13
14 170. John Doe and members of Classes A & B should be
15 compensated for the harm they have suffered as a direct result of the
16 actions of State Defendants that created an appearance of authority to
17 physicians within the State of Washington purporting to establish
18 specific dosage limitations for the treatment of chronic pain with
19 opioid medications in contravention of existing law.
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23 ***COUNT 3 -- VIOLATION OF ADA TITLE II – John Doe & CLASSES A & B—***
24 ***GUIDELINES – DIFFERENT SERVICE***

1 171. Plaintiffs reallege and incorporate herein by reference each and
2 every allegation contained in ¶¶1 through 147 above as though fully
3 set forth herein.
4

5 172. This Count is stated by John Doe and all members of Classes A
6 & B against the State Defendants, who are members of the Group, and
7 Health Defendant Officials, jointly and severally, in both their
8 individual and official capacities.
9
10

11 173. In the ADA, Congress defined "public entity" to mean "any
12 State or local government" or "any department, agency. . .of a State. .
13 .or local government." 42 U.S.C. § 12131(1)(A) and (B) [ADA §
14 201(1)(A) and (B)].
15
16

17 174. Through the combination that calls itself the "Interagency
18 Medical Directors Group" the State Defendants hold themselves out
19 as an authorized instrumentality of the State of Washington; as such
20 the Group is a public entity within the meaning of the ADA. As
21 individuals and officials, the Defendants are heads of State
22 Departments, which are public entities within the meaning of the
23 ADA.
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1 175. John Doe and members of Plaintiff Classes A and B are persons
2 with physical conditions resulting in substantial impairments of one or
3 more major life activities, and qualify as an individual and classes of
4 persons with disabilities, respectively, under 42 U.S.C. § 12102(2)
5 [ADA § 3(2)].
6

7
8 176. Under the ADA, unlawful discrimination occurs when a person
9 with a disability is "excluded from participation in or [is] denied the
10 benefits of the services, programs, or activities of a public entity. . ."
11 42 U.S.C. § 12132 [ADA § 202]. Through this provision, Congress
12 intended in the ADA to prohibit forms of discrimination which deny
13 disabled persons public services disproportionately due to their
14 disability.
15

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17
18 177. A public entity may provide different or separate benefits under
19 Title II if such action is necessary to provide qualified individuals
20 with disabilities with aids, benefits, or services that are equally as
21 effective as those provided to others. 28 C.F.R. § 35.130(b)(1)(iv); 28
22 C.F.R. § 41.51(b)(1)(iv).
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1 178. John Doe and members of Classes A and B require opioid
2 medications to mitigate the effects of chronic, nonmalignant pain
3 resulting from their disabilities in dosages exceeding 120 MEQ per
4 day, which dosages exceed the threshold dosages set forth in the
5 Dosing Guidelines that trigger differential treatment.
6
7

8 179. The pain medication required by John Doe and members of
9 Plaintiff Classes A and B is necessary to mitigate the effects of
10 chronic pain which results from their disability, and is considered a
11 mitigation measure within the meaning of the ADA. For John Doe
12 and members of Plaintiff Classes A and B, there is no alternative
13 treatment that is equally as effective as their opioid pain medication.
14
15

16 180. Under the law of the Ninth Circuit, when a public entity's
17 policies, practices, or procedures have a disproportionate impact on
18 the availability of a measure necessary to mitigate the effects of a
19 disability of a qualified person with a disability within the meaning of
20 the ADA, such disproportionate impact on the mitigation measure
21 constitutes discrimination based on the underlying disability within
22 the meaning of the ADA.
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1 181. A public entity must not differentially impact a physician's
2 prescribing of medically necessary opioid medication to mitigate the
3 effects of chronic, nonmalignant pain unless that public entity also
4 requires provision of alternative services equally as effective. Under
5 Ninth Circuit law, if there is no equally effective alternative available
6 within the regulatory scheme proposed, the public entity's differential
7 impact constitutes a complete denial of service to people with
8 disabilities.
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13 **Count 3A**

14 182. The Dosage Guidelines set a "ceiling threshold dose" that
15 triggers differential treatment. John Doe and members of the Pain
16 Patient Classes are persons with disabilities who rely on opioid
17 medication to mitigate the pain effects of their disability, and such
18 differential impact with no available effective alternative constitutes
19 facial discrimination and is impermissible within the meaning of the
20 ADA.
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1 **Count 3B**

2 183. The opiophobic animus of senior Washington state health
3 officials as demonstrated in the Dosing Guidelines has caused Health
4 Official Defendants to implement policies within the State
5 Department of Health that includes the MQAC, which policies
6 differentially impact patients who require opioid medications to
7 mitigate their chronic, nonmalignant pain, and particularly those who
8 require dosages in excess of 120 MEQs per day; such animus-driven
9 policies actively discourages physician licensees from providing
10 opioid medication to such patients, even when medically necessary.

11
12
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14
15 a. Complete physician abrogation of the duty to treat or refer for
16 chronic pain patients who require effective treatment with opioid
17 medications – i.e., titration to analgesic effect -- is left
18 unsanctioned by state authorities, and complete denial of such
19 treatment modality without referral happens with alarming
20 regularity within the Washington medical licensee community.

21
22
23 i. Upon information and belief, many such licensees have an
24 official *policy* of “no opioids” – *regardless of medical need*
25
26

- 1 i. Such failure to sanction by state officials undermines the
2 state's own regulation requiring treatment or referral, thus
3 vitiating any effective legal duty for such physicians to
4 provide alternative services equally as effective;
5
6 ii. Physician licensees feel no compulsion against denying
7 opioid treatment services at all, in violation of specific
8 health regulations to the contrary, and such abrogation of
9 effective legal duty is chargeable to the state due to no
10 enforcement of the pertinent regulation.
11

12
13
14 b. No enforcement of a regulation has the predictable effect of
15 denying the class of individuals protected by such regulation with
16 the benefit of enforcement such that physicians do not consider the
17 regulation controlling of their behavior as licensees.
18

19 c. Such differential treatment by Health Official Defendants charged
20 with enforcement of the MQAC of the class of persons intended to
21 be protected by the regulation constitutes a separate service within
22 the meaning of the ADA and is impermissible.
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1 **Count 3D**

2 185. The opiophobic animus instituted as official policy in the
3 Dosage Guidelines contain no requirement that physicians titrate
4 opioid medications for patients with chronic nonmalignant pain to
5 analgesic effect, and instead discourage physicians from prescribing
6 opioids *ab initio*.
7

8
9 a. The opiophobic animus instituted as official policy in the Dosage
10 Guidelines require no alternative treatments equally as effective as
11 titration to analgesic effect, and contain no exceptions for
12 situations when no alternative treatments *are* equally as effective
13 as titration to analgesic effect; in essence, such animus-driven
14 official policy does not require effective *pain treatment*, only
15 *dosage limitations*.
16
17
18

19 b. Such animus-driven official policy unduly stigmatizes what
20 Washington State statutory law clearly recognizes as a necessary
21 medical treatment.
22

23 i. The State Defendants created a false perception of authority
24 in publishing the Dosage Guidelines.
25
26
27

- 1 ii. The State Defendants include the senior-most health
2 officials in the State of Washington, including officials who
3 head up the State Department of Health, which includes the
4 MQAC.
5
6
7 iii. The “policies” based on the opiophobic animus were
8 developed and disseminated by public health officials who
9 include the head of the medical licensing disciplinary
10 authority and every other Washington state health authority,
11 and are now pervasive within Washington state health
12 culture.
13
14 iv. The “policies” based on the opiophobic animus are
15 reasonably perceived by physicians to represent governing
16 legal standards, the violation of which would subject such
17 physicians to official sanction.
18
19 v. The Opiophobic animus, as evidenced in the Dosage
20 Guidelines, as a matter of law, represent *de facto medical*
21 *practice standards, as evidenced in the recent MQAC Order*
22
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1 *involving Dr. Alan Hunt, and the recent MQAC*
2
3 *investigation of Dr. Merle Janes.*

4 vi. Under direction of that opiophobic animus as official policy
5 physicians choose not to prescribe opioid medications to
6 patients with disabilities who need them to mitigate the
7 effects of chronic, nonmalignant pain, and further provide
8 no alternative service equally as effective – including no
9 referral to a physician who will titrate the pain to analgesic
10 effect.
11

12
13
14 vii. Under direction of the State Defendants and the Health
15 Official Defendants such physician licensees offer a
16 “different or separate” service which is no service at all, and
17 such differential treatment can be attributable to the
18 opiophobic animus as official policy;
19

20
21 viii. Opiophobic animus as official policy results in differential
22 treatment of people with disabilities, and is a “different or
23 separate” service which is no service at all and constitutes
24 unlawful discrimination within the meaning of ADA § 202.
25
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27

1 **Count 3E**

2 186. As a matter of law, the Dosing Guidelines deny Pain Patients
3 with disabilities who rely on opioid medication to mitigate the effects
4 of their chronic, nonmalignant pain of the services of physicians who
5 reasonably believe they are subject to them as a source of official
6 authority, including services provided by physicians within the state
7 health agencies who participate in the Group.
8

9
10 a. When under direction of the Dosage Guidelines physicians choose
11 not to prescribe opioid medications to patients with disabilities
12 who need them to mitigate the effects of chronic, nonmalignant
13 pain, and no alternative service *can be* equally as effective, as a
14 matter of law this “different or separate” service is no service at all
15 and constitutes unlawful facial discrimination within the meaning
16 of ADA § 202.
17
18

19
20 b. As a matter of law, differential services provided under a
21 physician’s reasonable perception of the command of the Dosing
22 Guidelines are attributable directly to those Guidelines. The
23 Dosing Guidelines deny Class Pain Patients with disabilities that
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1 rely on opioid medication to mitigate the effects of their disabilities
2 of the benefit of the services of physicians who reasonably believe
3 they are subject to them, including services provided by physicians
4 within the state health agencies who participate in the Group.
5

- 6
7 c. The Dosing Guidelines require a “different or separate” service
8 which is no service at all to Class members and constitutes
9 unlawful discrimination within the meaning of ADA § 202.
10

11
12 **Count 3F**

13 187. The Dosing Guidelines create a regulatory barrier for
14 physicians who would prescribe medically-necessary opioid
15 medications for patients who require dosages exceeding 120 MEQ per
16 day, but do not do so because of Guideline instructions to refer such
17 patients to one of only 12 “pain specialists” statewide.
18

- 19 a. The referral requirement operates as a form of centralized
20 “disclosure” requirement whereby the patient referral would form
21 notice to official sources that a physician has been prescribing
22 opioids.
23
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28

1 b. The draconian regulatory medical practice standards imposed on
2 physicians who prescribe opioid medications creates a licensure
3 regime in which physicians actively avoid coming within its
4 purview.
5

6
7 i. Some physicians avoid prescribing above the threshold –
8 regardless of medical need – in order to avoid the referral
9 requirement and the subsequent disclosure.
10

11 ii. Other physicians avoid prescribing at all in order to avoid
12 the possibility of having to prescribe above the threshold.
13

14 iii. Such differential treatment constitutes a separate service
15 within the meaning of the ADA;
16

17 1. The Dosing Guidelines contain no requirement that
18 physicians who choose not to prescribe those
19 medications provide alternative services equally as
20 effective as treatment with opioid dosages that exceed
21 120 MEQ per day, nor do they contain an exception
22 for situations when no alternative treatments *are*
23 equally as effective.
24
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- 1 c. An interposed referral requirement as a legal *condition* of
2 treatment, coupled with a referral list of only 12 “pain specialists”
3 statewide for a population of patients that is conservatively
4 estimated to exceed half a million citizens is unequal as a matter of
5 law.
6
7
8 d. The Dosing Guidelines create a “different or separate” service
9 which is no service at all to Class members and constitutes
10 unlawful discrimination within the meaning of ADA § 202.
11
12

13 **Count 3G**

14 188. Based on the animus perpetrated by the Dosage Guidelines,
15 physicians are encouraged to avoid prescribing opioids *at all* –
16 regardless of medical need – and thereby avoid knowing whether
17 opioids would provide a form of effective pain treatment;
18

19 a. such physicians also thereby avoid the specific burdensome
20 requirements imposed on the opioid treatment modality by
21 licensing officials;
22

23
24 b. such physicians abrogate – without any form of official sanction –
25 their duty to prescribe or refer; by thus denying *ab initio* this form
26

1 of treatment to patients *as a condition of treatment*, physicians
2 avoid coming within the purview of state officials for such
3 prescriptions, and the state has taken no licensure actions against
4 its own medical licensees on that basis.

5
6
7 c. When under direction of the Dosage Guidelines or its directing
8 animus, physicians choose not to prescribe opioid medications *at*
9 *all*; or not in excess of 120 MEQ per day to patients with
10 disabilities who would otherwise need them to mitigate the effects
11 of chronic, nonmalignant pain, and such patients are provided no
12 alternative service equally as effective, or no alternative service
13 can be equally as effective, such differential can be directly
14 attributable to the Dosing Guidelines or its directing animus, which
15 create a “different or separate” service which is no service at all,
16 and such differential constitutes unlawful facial discrimination
17 within the meaning of ADA § 202.

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21
22 d. Additionally, when under direction of the Dosage Guidelines or its
23 directing animus, physicians choose not to prescribe opioid
24 medications *at all* to patients with disabilities who would
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1 otherwise need opioid medications in excess of 120 MEQ per day
2 to mitigate the effects of chronic, nonmalignant pain, and no
3 alternative service *can be* equally as effective, as a matter of law
4 the Dosing Guidelines or its directing animus are responsible for
5 having created a “different or separate” service which is no service
6 at all, and such differential treatment constitutes unlawful facial
7 discrimination within the meaning of ADA § 202.
8
9
10

11 **Count 3 Continued**

12 189. The conduct of the State Defendants in promulgating and
13 publishing official policy based on their opiophobic animus, including
14 the Dosage Guidelines, has proximately resulted in harm to John Doe
15 members of Class A, and will likely proximately result in harm to
16 John Doe and members of Class B in the future.
17

18 190. The conduct of State Defendants in developing and publishing
19 the Dosing Guidelines demonstrates deliberate indifference to the
20 serious medical needs of John Doe and members of Classes A & B.
21

22 191. The conduct of Health Official Defendants in failing to enforce
23 explicit state pain regulations through the MQAC licensure authority
24
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1 demonstrates deliberate indifference to the serious medical needs of
2 John Doe and members of Classes A & B.
3

4 192. The State Defendants and the Health Official Defendants
5 should be ordered to take all steps necessary to ensure the full
6 enjoyment of all rights guaranteed by the ADA to John Doe and the
7 Plaintiff Class Pain Patients. John Doe and the Plaintiff Classes A &
8 B are entitled to such injunctive relief under the ADA.
9
10

11 193. John Doe and members of Classes A & B should also be
12 compensated for the harm they have suffered as a proximate result of
13 the deliberate indifference of State Defendants to their serious medical
14 needs, and they are entitled to such damages under the ADA.
15
16

17 ***COUNT 4 – SECTION 1985 CLAIMS –GUIDELINES - Conspiracy***

18 194. Plaintiffs reallege and incorporate herein by reference each and
19 every allegation contained in ¶¶1 through 147 above as though fully
20 set forth herein.
21

22 195. This Count is stated by John Doe and all members of Classes A
23 & B against all State Defendants who are members of the Group,
24 jointly and severally, in both their official and individual capacities,
25
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1 and arises under the Civil Rights Act, 42 U.S.C. § 1985(3), which
2 provides a federal civil remedy, for damages or injunctive or other
3 relief, for harm resulting from a conspiracy to deprive a suspect class
4 of legal rights.
5

6
7 196. The Dosage Guidelines are contrary to the 1996 Guidelines,
8 which commit treatment of chronic, nonmalignant pain with opioids
9 to the sound discretion of the treating physician; the 1996 Guidelines
10 require physicians to use whatever dosage is effective, without regard
11 to unscientific dosage limits or other arbitrary discouragements.
12

13
14 197. The State Defendants had an agreement to deprive members of
15 a suspect class of an important legal right.

16
17 a. The State Defendants established a policy – the Dosing Guidelines
18 – which was motivated by an invidiously discriminatory class-
19 based opiophobic animus.
20

21
22 b. John Doe and the Members of Classes A and B are people with
23 disabilities who require opioid medication in excess of 120 MEQs
24 per day to mitigate the pain effects of their disabilities, for which
25 there is no effective medical alternative;
26

- 1 c. The State Defendants’ Dosing Guidelines knowingly deprives this
2 class of people with disabilities of the equal protection of the law.
3
4 d. State Defendants abused their power and positions as senior state
5 public health officials by taking specific actions to undermine
6 existing lawful *Guidelines* with which they disagreed -- the 1996
7 *Guidelines* – and replacing them with their own self-described
8 *Guidelines* – the invidiously discriminatory policy known as the
9 Dosage Guidelines.
10
11 e. The actions taken by the State Defendants were specifically
12 designed to create an “appearance of authority” for the Dosage
13 Guidelines so that physicians would regard them as imbued with
14 the mantel of state authority and take actions on that basis;
15
16 f. The Dosage Guidelines were specifically calculated to discourage
17 physicians from prescribing opioids to their patients with chronic
18 nonmalignant pain, and especially not in excess of a ceiling
19 threshold dosage of 120 MEQs per day.
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24 198. In furtherance of that agreement, the State Defendants, *inter*
25 *alia*, helped organize and/or participated in sessions designed to create
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27

1 the appearance of official approval of their policy by certain favored
2 physicians.
3

4 a. State Defendants knew that such physicians had no authority to
5 create official policy in that manner, and simply used the physician
6 sessions to enhance the *appearance* of authority for the Dosage
7 Guidelines among physicians.
8

9 i. The sessions were designed to include physicians who might
10 object to the lawfulness of a policy created in their absence,
11 but who State Defendants believed could be disquieted and
12 co-opted by including them in this manner.
13

14 ii. To achieve physician participation and compliance in the
15 effort to create a false appearance of authority, the favored
16 physicians were very well-paid for their participation.
17

18 1. Given that the Interagency Group had no statutory or
19 budgetary authority of its own, if payments to these
20 physicians were drawn on state accounts, such
21 payments must have been diverted from other, lawful
22 state agency programs.
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1 2. If such diversion of funds occurred at the direction of
2
3 State Defendants to support their *ultra vires* conduct,
4 these physician payments may represent primary
5 evidence of official corruption by State Defendants.
6

7 iii. Upon information and belief, among the favored physicians
8 who participated in co-opting sessions was Dr. David
9 Tauben of Seattle.
10

11 b. The “favored” physicians included were limited to physicians
12 whose licenses were within the jurisdiction of the State
13 Defendants’ control; the physician sessions specifically did not
14 include widely-recognized national medical pain management
15 physicians or expert groups, because such physicians or experts
16 could not be “purchased” or “intimidated” by Washington state
17 health authorities.
18
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21 199. In furtherance of that agreement, the State Defendants each also
22 applied their official authority to the Dosing Guidelines as policy, and
23 authorized the publication of those Dosing Guidelines on the internet
24 with their appearance of approval as senior state health officials.
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- 1 a. At least one or more of the State Defendants authorized the
2 specific content and appearance of the Dosing Guidelines as they
3 appear on the website.
4
- 5 b. At least one or more of the State Defendants authorized the
6 creation of a specific “list” of purported “recognized pain
7 specialists” that contained only 12 names, and none from the entire
8 Spokane area, to be attached to those Dosing Guidelines and
9 incorporated by reference therein as an exclusive referral source
10 list for statewide pain specialist physicians for all members of the
11 Pain Patient Classes, along with at least a half a million other
12 souls.
13
- 14 c. The State Defendants repeatedly refer to those Dosage Guidelines
15 as “*Guidelines*” in public, and repeatedly cite them in public as a
16 source of official authority in the State of Washington.
17
- 18 d. The Department of Labor and Industries incorporates the Dosage
19 Guidelines by reference as an apparent source of authority in its
20 written demands for reports from treating physicians whenever
21 claims are submitted for payment for opioid prescriptions for
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1 injured workers.

2
3 i. The requirements of those written reports (and, by
4 implication, the treatment standards used by the Department
5 of Labor and Industries in its administrative functions) are
6 also representative of subsidiary opiophobic animus now
7 pervading Washington public health culture; the
8 requirements are irreconcilable with the science of pain as
9 well as the Health Department chronic pain treatment
10 statutory mandate and implementing regulations.

11
12 e. The State Defendants have remained silent in the face of false
13 assertions of the authority of the Dosage Guidelines in press
14 accounts.

15
16 f. The State Defendants have remained silent in the face of citation of
17 the Dosage Guidelines as a source of authority by public health
18 officials and other health-care decision-makers within and without
19 the State of Washington.

20
21 200. The harm resulting from this agreement is interference with the
22 fundamental basis of a physician-patient relationship, including the
23

1 legal right of contract for necessary medical care in accordance with
2 lawful medical practice standards with private physicians, or,
3 alternatively, undue burden of the fundamental liberty interest
4 described below, in that private physicians who reasonably perceive
5 the Dosing Guidelines as controlling authority must, as a matter of
6 logic, be required to assume that they displace the 1996 Guidelines;
7 the Dosage Guidelines also create the appearance of authority of
8 official power, such that physicians now reasonably believe the
9 Dosage Guidelines represent a form of controlling official state public
10 health policy respecting opioid medications, with the result that such
11 physicians now view themselves as legally *unable* without the threat
12 of government sanction from any or all of the agencies whose
13 directors are State Defendants to prescribe medically-necessary opioid
14 medication for their patients with disabilities, even when such
15 prescriptions are medically necessary to mitigate intolerable chronic,
16 nonmalignant pain arising out of such disabilities, and even when
17 there are no effective medical alternatives; whereas other persons are
18 freely able to obtain necessary medical care from those same private
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1 physicians within the relevant standards of care without regard to any
2 such arbitrary limits or appearance of official prohibition by the state.

3
4 a. Despite the existence of *law*, the sole *enforcers* of state public
5 health law have made their intentions clear, and those intentions
6 are to use official sanction to discourage the prescribing of opioid
7 medications to patients with chronic, nonmalignant pain despite
8 contrary law.
9

10
11 b. The Fourteenth Amendment guarantees the liberty of physicians to
12 practice medicine consistent with their best professional judgment,
13 including using their skills and powers to facilitate the exercise of
14 the decision of competent adults who choose to mitigate chronic
15 nonmalignant intractable pain through the use of suitable
16 physician-prescribed opioid drugs; this liberty interest extends to
17 patients and their physicians who, in their best professional
18 judgment, would prescribe medically necessary FDA-approved
19 opioid pain relieving agents, for which there is no effective
20 medical alternative.
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1 c. In the alternative, the relationship between a physician and a
2 patient is a legal personal services contract. Under the law of the
3 State of Washington, actions that are deliberately calculated to
4 disrupt that relationship, and to induce the physician to breach or
5 otherwise fail to perform that contract in a lawful manner
6 constitutes tortious interference with a contractual relationship.
7

8
9
10 201. The conduct of State Defendants has denied Pain Patients with
11 disabilities who rely on opioid medication to mitigate the effects of
12 their chronic, nonmalignant pain of the benefit of effective pain
13 management in dosages exceeding of 120 MEQs per day from all
14 physicians who reasonably believe they are subject to the authority of
15 State Defendants, including all services provided by physicians within
16 the auspices of the state health agencies whose directors participate in
17 the Group;
18
19

20
21 a. this denial of the benefits of state programs to members of the Pain
22 Patient Classes, which constitute suspect classes within the
23 meaning of 42 U.S.C. §1985(3), occurs as a result of the agreement
24 of State Defendants to interfere with private contracts between
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1 physicians and their patients in a manner that constitutes a
2 violation of law as described in the preceding paragraph.
3

4 202. The conduct of the State Defendants has proximately resulted in
5 harm to John Doe members of Class A, and will likely proximately
6 result in harm to John Doe and members of Class B in the future.
7

8 203. The State Defendants should be ordered to take all steps
9 necessary to ensure the full enjoyment of all rights guaranteed to John
10 Doe and the Plaintiff Classes. John Doe and the Plaintiff Classes A &
11 B are entitled to such injunctive relief.
12

13 204. All State Defendants' actions were undertaken without a good
14 faith or reasonable belief in the constitutionality or legality of said
15 actions, and therefore are not immune or privileged from liability for
16 personal damages under the Constitution or laws of the United States.
17

18 205. Regardless of the good faith or reasonableness of the State
19 Defendants' actions, no State Defendant is immune or privileged from
20 Declaratory and Injunctive Relief as ordered by this Court to redress
21 State Defendants' constitutional violations.
22
23
24

1 206. John Doe and members of Classes A & B should also be
2 compensated for the harm they have suffered as a result of this
3 unlawful agreement, and they are entitled to such damages under
4 federal law.
5
6
7

8 ***COUNT 5A – SECTION 1986 CLAIMS –GUIDELINES – Failure to Prevent***
9 ***Harm***

10 207. Plaintiffs reallege and incorporate herein by reference each and
11 every allegation contained in ¶¶1 through 147 above as though fully
12 set forth herein.
13

14 208. This Count is stated by John Doe and all members of Classes A
15 & B against Dr. Gary Franklin, who is a member of the Group, in both
16 his official and individual capacities, and arises under the Civil Rights
17 Act, 42 U.S.C. § 1986, which provides a federal civil remedy, for
18 damages or injunctive or other relief, for harm resulting from the
19 failure of participants or observers of the agreement described above
20 in Count 4 to prevent harm.
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1 209. Upon information and belief, as Chairman of the Group, Dr.
2
3 Gary Franklin had actual knowledge of the agreement described in
4 Count 4 above, and appears to have been the official who provided
5 authorization for publication of the website; if so, he had the power to
6 prevent or aid in preventing the harm described in Count 4, and
7 neglected or refused to do so.
8

9
10 a. As a result, a wrongful act was committed, e.g., publication of the
11 “appearance of authority” for the Dosage Guidelines on the
12 InterAgency website, and Dr. Franklin is thereby liable for all
13 damages that he could have prevented with reasonable diligence.
14

15 210. Upon information and belief, as Chairman of the Group, and as
16 Director of the Department of Labor and Industries, Dr. Gary Franklin
17 had actual knowledge of the agreement described in Count 4 above,
18 and appears to have been the official who directed the Department of
19 Labor & Industries to incorporate the Dosage Guidelines by reference
20 in written report demands issued to every treating physician following
21 submission of a worker’s compensation claim for payment for opioid
22 medication.
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- 1 a. Such demands are knowingly *ultra vires*, and through such
2 demands, the Department has produced a further statewide
3 “appearance of authority” for the Dosage Guidelines to every
4 physician who has received such demand.
5
6 b. Dr. Gary Franklin had the power to prevent or aid in preventing the
7 harm described in Count 4, which can now be traced to every
8 physician within the State of Washington who has received such a
9 demand from the Department of Labor & Industries, and Dr. Gary
10 Franklin has neglected or refused to do so.
11
12 c. As a result, a wrongful act was committed, e.g., promulgation of
13 the “appearance of authority” for the Dosage Guidelines in the
14 Department of Labor and Industries forms issued to treating
15 physicians, and Dr. Franklin is thereby liable for all damages that
16 he could have prevented with reasonable diligence.
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21 ***COUNT 5B – SECTION 1986 CLAIMS –GUIDELINES – Failure to Prevent***

22 211. Plaintiffs reallege and incorporate herein by reference each and
23 every allegation contained in ¶¶1 through 147 above as though fully
24 set forth herein.
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1 212. This Count is stated by John Doe and all members of Classes A
2 & B against Dr. Maxine Hayes, who is a members of the Group, in
3 both her official and individual capacities, and arises under the Civil
4 Rights Act, 42 U.S.C. § 1986, which provides a federal civil remedy,
5 for damages or injunctive or other relief, for harm resulting from the
6 failure of participants or observers of the agreement described above
7 in Count 4 to prevent harm.
8

9
10
11 213. Upon information and belief, as Secretary of Health, Dr.
12 Maxine Hayes was the official the most chargeable with knowledge
13 about administrative law requirements to replace the 1996 Guidelines,
14 and that the Dosing Guidelines were in derogation thereto, were *ultra*
15 *vires*, or were pre-empted under federal law.
16
17

18 214. Upon information and belief, Dr. Hayes had actual knowledge
19 of the agreement described in Count 4 above, and had the power as
20 the senior Washington Health Department official participating in
21 regulatory actions on this topic to prevent or aid in preventing the
22 harm described in Count 4 by informing members of the Group about:
23 the scientific and legal invalidity of their actions; chronic pain
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1 prevalence data; the questionable nature of an interposed referral
2 requirement in the face of such prevalence data; the relevant science
3 in contradiction to a dosage ceiling; the medical ethic of treatment in
4 contradiction to a dosage ceiling and the recent science demonstrating
5 the imperative to treat pain; the carving out of children, the elderly
6 and cancer patients from coverage by the Dosage Guidelines as
7 arbitrary; the inclusion of a threshold dosage ceiling as arbitrary and
8 in derogation of the current science; the failure to define terms and use
9 medical approaches in the protocols contained therein such as the
10 confusion between addiction and pseudoaddiction; the infringement
11 upon the jurisdiction of the FDA based on concerns about safety and
12 effectiveness in drug prescribing; the dearth of already-available
13 referral sources for specialty pain management with opioids; as well
14 as a host of other issues of which she should have been aware;

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21 a. As the senior most Washington Health Department official
22 participating in development and implementation of the Dosage
23 Guidelines, she had the power to prevent or aid in preventing the
24 harm described in Count 4, and neglected or refused to do so.
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1 b. As a result, a wrongful act was committed, e.g., publication of the
2 Dosage Guidelines with their current content on a state website as
3 authorized by her as Director of the Department of Health, giving
4 them the “appearance” of state health authority, and Dr. Hayes is
5 thereby liable for all damages that she could have prevented with
6 reasonable diligence.
7
8

9
10 ***COUNT 5C – SECTION 1986 CLAIMS –GUIDELINES – Failure to Prevent***

11 215. Plaintiffs reallege and incorporate herein by reference each and
12 every allegation contained in ¶¶1 through 147 above as though fully
13 set forth herein.
14

15 216. This Count is stated by John Doe and all members of Classes A
16 & B against the State Defendants, jointly and severally, who are
17 members of the Group, in both their official and individual capacities,
18 and arises under the Civil Rights Act, 42 U.S.C. § 1986, which
19 provides a federal civil remedy, for damages or injunctive or other
20 relief, for harm resulting from the failure of participants or observers
21 of the agreement described above in Count 4 to prevent harm.
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1 217. Upon information and belief, each State Defendant had actual
2 knowledge of the agreement described in Count 4 above, and had the
3 power to prevent or aid in preventing the harm described in Count 4
4 above, and neglected or refused to do so. As a result, one or more
5 wrongful acts were committed by each, including authorizing
6 publication of the Dosage Guidelines on a website with the
7 appearance of the authority of each official, and each State Defendant
8 is thereby liable for all damages that he or she could have prevented
9 with reasonable diligence.
10

11 218. Other similar liabilities for additional individuals may become
12 evident through discovery and will be asserted as revealed. For
13 example, as facts are adduced through discovery, some of the
14 physician consultants, including Dr. David Tauben, may have been in
15 a position to prevent or aid in preventing the Dosage Guidelines from
16 being authorized or published, and if such consultants negligently
17 refused to do so, such physician consultants could be held liable for
18 all damages that he or she could have prevented with reasonable
19 diligence.
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1 **COUNT 6 – CONSTITUTIONAL - SECTION 1983 CLAIMS- LICENSURE**

2
3 219. Plaintiffs reallege and reincorporate herein by reference each
4 and every allegation contained in ¶¶ 1 through 147 above as though
5 fully set forth herein.
6

7 220. This Count is stated by Does A-Z, as well as members of
8 Classes A and B and Dr. Janes as Class Representative against MQAC
9 Agents and Health Official Defendants, and arises under the Civil
10 Rights Act, 42 U.S.C. § 1983, which provides a federal civil remedy,
11 for damages or injunctive or other relief, for the deprivation, under
12 color of state law, custom, or usage, of any rights, privileges or
13 immunities secured by the Constitution or laws of the United States,
14 against any person causing such deprivation.
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18 221. The MQAC Agents and Health Official Defendants are
19 “persons” for purposes of 42 U.S.C. 1983; all are sued in both their
20 individual and official capacities; all are sued jointly and severally.
21

22 222. The MQAC Agents have taken their actions challenged herein
23 as Agents of the Department of Health, and as such these Agents have
24 acted “under color of state law” for purposes of 42 U.S.C. 1983.
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1 223. The Health Official Defendants have taken their actions
2 challenged herein as Agents of the Department of Health, and as such
3 these Agents have acted “under color of state law” for purposes of 42
4 U.S.C. 1983.
5

6
7 224. By reason of the MQAC Agents’ and Health Official
8 Defendants’ enforcement of an unlawful licensing Regime, which are
9 constitutional violations as set forth in paragraphs below, and which
10 were wholly taken under color of authority of the State of
11 Washington, and by reason of the lack of any good faith or reasonable
12 belief by MQAC Agents or Health Official Defendants in the legality
13 of their actions, each Plaintiff is entitled to declaratory, injunctive
14 relief, and damages and other relief against each MQAC Agent and
15 Health Official Defendant herein.
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18
19 225. This Count arises directly under the Constitution of the United
20 States, specifically the Fourteenth Amendment Due Process and
21 Equal Protection Clauses, as well as the Eighth Amendment as
22 incorporated into the Fourteenth Amendment.
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1 **Due Process**

2 a. The licensure Regime as currently applied by the Department of
3 Health MQAC, and as exemplified in Order Exhibit E, and as
4 further exemplified by proceeding on the license for Dr. Merle
5 Janes for which a conference was held on February 19, 2008,
6 unduly burdens a mentally-competent adult’s fundamental liberty
7 interest in seeking necessary medical care that will allow him to
8 avoid intolerable pain and suffering, including choosing medically-
9 necessary, suitable physician-prescribed FDA-approved opioid
10 drugs to mitigate chronic nonmalignant intractable pain, when no
11 effective alternatives are available.

12 i. The right to make this choice is a fundamental right under
13 the due process clause, and is entitled to the strongest degree
14 of constitutional protection.

15 ii. The licensure Regime as applied does not further a
16 compelling state interest and is not narrowly drawn to
17 express only the legitimate state interests at stake.

1 iii. The medical practice standards as applied require the
2 physician, as a condition of his medical license, to abandon,
3 shun or arbitrarily limit pain treatment for patients who
4 require opioid medications for treatment of chronic non-
5 malignant pain, and enforces that duty to abandon, shun or
6 limit treatment through its MQAC licensure Regime; that
7 licensure Regime therefore cannot survive strict scrutiny.
8

9 iv. In the alternative, the medical practice standards as applied
10 require the physician, as a condition of his medical license,
11 to disregard the science of pain and the medical ethic of
12 treatment; that licensure Regime therefore cannot survive
13 strict scrutiny.
14

15 b. In the alternative, the licensure Regime as applied unduly burdens
16 a mentally competent adult's fundamental liberty interest in
17 avoiding intolerable pain and suffering by seeking a physician-
18 patient relationship wherein a physician is allowed to exercise his
19 best professional and scientific judgment, even when such
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1 judgment is that pain treatment with opioid medications are
2 medically necessary and no adequate alternative exists.
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4 i. The Fourteenth Amendment guarantees the liberty of
5 physicians to practice medicine consistent with their best
6 professional judgment, including using their skills and
7 powers to facilitate the exercise of the decision of competent
8 adults to choose, if necessary to mitigate chronic
9 nonmalignant intractable pain, the use of suitable physician-
10 prescribed FDA-approved opioid drugs, and thereby avoid
11 intolerable pain and suffering.
12

13 ii. The right to make this choice is a fundamental right under
14 the due process clause, and is entitled to the strongest degree
15 of constitutional protection.
16

17 iii. The licensure Regime as applied does not further a
18 compelling state interest and is not narrowly drawn to
19 express only the legitimate state interests at stake.
20

21 iv. The medical practice standards applied require the
22 physician, as a condition of his medical license, to abandon,
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1 shun or arbitrarily limit pain treatment for patients who
2 require opioid medications for treatment of chronic non-
3 malignant pain, and enforces that duty to abandon, shun or
4 limit treatment through its MQAC licensure Regime; that
5 licensure Regime therefore cannot survive strict scrutiny.
6

7
8 v. In the alternative, the licensure Regime as applied does not
9 further a compelling state interest and is not narrowly drawn
10 to express only the legitimate state interests at stake in that
11 the medical practice standards as applied require the
12 physician, as a condition of his medical license, to disregard
13 the science of pain and the medical ethic of treatment; that
14 licensure regime therefore cannot survive strict scrutiny.
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18 vi. In the alternative, the licensure Regime as applied is not
19 narrowly drawn to express only the legitimate state interests
20 at stake in that the Department of Health made no
21 arrangements to provide continuity of care for the affected
22 patients before issuing the threat that undermined their care
23 from the challenged physician, and no effective replacement
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1 care is available within the local medical community; that
2 licensure Regime therefore cannot survive strict scrutiny.
3

4 c. In the alternative, the licensure Regime as applied unduly burdens
5 a mentally competent adult’s fundamental liberty interest in not
6 being subjected to “torture and a lingering death” as a result of
7 state dominion or control over the means of obtaining necessary
8 medical care; when a State exercises such dominion or control, and
9 also demonstrates deliberate indifference to the serious medical
10 needs of a person needing medical care, or has knowledge of a
11 substantial risk of serious harm to a person needing medical care,
12 the state is chargeable for that harm.
13

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16
17 i. A state exercises “control and dominion” over the life
18 circumstances of an individual by interposing itself between
19 necessary medical care and all lawful means of obtaining
20 such care.
21

22 ii. When state control over the means of obtaining necessary
23 medical care becomes so complete that necessary medical
24 care is no longer reasonably available then the state’s
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1 limitation or control of such care is constrained by the
2 principles of the Eighth Amendment as incorporated into the
3 Fourteenth Amendment.
4

5 iii. Under Eighth Amendment principles, a state must make
6 necessary medical support available to the extent that
7 absence of such support would result in state infliction of
8 “torture or a lingering death.”
9
10

11 iv. Washington State exercises control over the means of
12 obtaining necessary medical care through its MQAC
13 licensing regime for physicians, who are the only individuals
14 legally authorized to write prescriptions for treatment of
15 severe chronic pain with opioid medications; the exercise of
16 that authority has been so complete that chronic pain
17 treatment with opioids is no longer reasonably available
18 within the State.
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22 1. Such “control or dominion” certainly exists when by
23 virtue of the state regulatory environment impairing
24 the availability of necessary medical care, law-abiding
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1 citizens have less “freedom” or *ability* to obtain that
2 care than incarcerated prisoners who have a legal
3 entitlement thereto under the Eighth Amendment.
4

5 2. At this time, law-abiding citizens in Washington have
6 less ability to obtain effective chronic nonmalignant
7 pain care with opioid medications when medically
8 necessary than incarcerated prisoners who have a
9 legal entitlement thereto under the Eighth
10 Amendment.
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12

13
14 v. The medical practice standard applied to the treatment of
15 chronic, nonmalignant pain with opioid medications in the
16 licensure enforcement Regime as exemplified in the
17 proceeding against Dr. Janes and in the Order Exhibit E
18 specifically proscribes or stigmatizes the type of care
19 required by Plaintiff Does A-Z, and Class Pain Patients, and
20 has driven such care from the medical marketplace to such
21 an extent as to constitutes dominion or control, whereby
22 such Pain Patients have lost any reasonable ability to obtain
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1 meaningful, continuous, and effective necessary medical
2 care.

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4 1. The licensure regime as applied constitutes “dominion
5 and control” over the very ability of patients to obtain
6 from physicians medically-necessary opioid
7 medication to treat chronic, nonmalignant pain.
8

9
10 vi. When the State exercise such complete “control and
11 dominion” that it effectively proscribes or stigmatizes all
12 reasonable lawful avenues for receiving necessary medical
13 care, then the State has a concomitant obligation to ensure
14 that adequate resources remain for treatment of those
15 medically necessary needs which, absent interference by the
16 state, would otherwise have been available; failure to do so
17 would produce physical “torture or a lingering death.”
18
19

20
21 1. By virtue of state “control and dominion” it is the
22 state impairment that is responsible for the physical
23 “torture or a lingering death.”
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1 2. When available necessary medical care becomes
2 scarce or otherwise unavailable as a direct or
3 proximate result of state regulatory control, Eighth
4 Amendment principles require the state to consider, as
5 part of its regulatory control, the extent to which its
6 licensing action would impair available necessary
7 medical care in the local medical marketplace.
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11 3. The MQAC regulatory actions of the State of
12 Washington have made chronic nonmalignant pain
13 treatment with opioid medications so scarce that it is
14 virtually impossible to obtain and chronic pain
15 patients in Washington are now in a crisis of
16 undertreatment; many must seek care outside the
17 State, which violates a Guideline imposed by the
18 federal DEA; the threat of elimination or impairment
19 of each remaining individual medical provider as a
20 result of licensure action will only exacerbate the
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1 existing public health emergency within the chronic
2 pain community.

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4 4. Application of this licensure Regime has already
5 resulted and will continue to result in physical “torture
6 or a lingering death” for Does A-Z and members of
7 Classes A and B unless the state undertakes an
8 affirmative corresponding duty to ensure that
9 adequate and effective medical resources are available
10 for necessary medical treatment in the form of opioid
11 medications for chronic, nonmalignant pain in the
12 local medical marketplace;

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17 a. such “torture or a lingering death” is here
18 chargeable to the state’s own impairment of the
19 medical marketplace through its MQAC
20 licensing “dominion and control.”
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22

23 **Equal Protection**

24 d. The licensure Regime as applied denies equal protection of the law
25 to Class Pain Patients in that MQAC Agents and Health Official
26

1 Defendants neither investigate nor sanction physicians who
2 brazenly violate state health regulations by adopting “no opioids”
3 policies without assurance of appropriate referral to a physician
4 who will prescribe such medication when necessary, while
5 simultaneously such MQAC Agents and Health Official
6 Defendants routinely investigate physicians who do prescribe
7 opioid medications even when medically necessary, and when so
8 doing, apply medical practice standards that discourage physicians
9 from prescribing opioid medications, even when medically
10 necessary. *That Class Pain Patients are being denied equal*
11 *protection of the law by the State Department of Health medical*
12 *licensure armamenture could not be clearer; this is a classic case*
13 *of denial of equal protection.*

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20 i. The effect of the lack of equal protection is measurable:
21 despite state statutory treatment mandates, not a single
22 licensed physician can be found in the entire Spokane area
23 that is willing to undertake the care of a new patient who
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1 needs treatment for chronic, nonmalignant pain with
2 therapeutic dosages of opioid medications.
3

4 ii. While the law mandating effective chronic pain treatment
5 with opioids is clear, the *enforcers* of state public health law
6 have a different and opiophobic agenda, as exemplified by
7 the Dosage Guidelines, which are themselves evidence of
8 the discriminatory animus motivating the enforcement
9 policies of the Director of the Department of Health.
10

11
12 e. The medical practice standards imposed by MQAC upon licensees
13 who prescribe opioid medications are illusory in the sense that they
14 are not designed, in fact, to improve public health and are instead
15 designed to create vague, process-oriented complaints; these
16 complaints then form the basis for investigation without provable
17 (or disprovable) medical error in order to support contrived, pre-
18 determined outcomes designed to reduce Scheduled medications
19 prescribing authority by licensed physicians – which the State
20 would not lawfully be allowed to obtain without such threat;
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- 1 i. Such process-oriented standards are so fluid that licensing
2 authorities typically play “hide the ball” with medical
3 licensees in order to contrive allegations sufficient to
4 support agendized outcomes of reducing physician
5 prescribing authority.
6
7
8 ii. An example of this fluid process-oriented approach occurred
9 in the recent licensure investigation of Dr. Janes, in which
10 the original complaint was the lack of physical examinations
11 for patients treated with opioids; when the licensee pointed
12 out that extensive physicals had been performed and were
13 documented in the chart (but had been completely missed by
14 the investigator), the complaint suddenly became that the
15 physicals were “inadequate.” When the licensee pointed out
16 that his physical exams were so extensive that in one case it
17 took more than one entire visit and two days to perform, the
18 complaint morphed into lack of a “true” diagnosis. When
19 the licensee pointed out that each diagnosis had a valid ICD
20 code, the complaint morphed into problems with “the whole
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1 process” -- which is so fluid it is neither provable nor
2 disprovable. At that point, and after it was also revealed that
3 the investigating team had no knowledge about the very
4 basis of Dr. Janes’ medical practice (prolotherapy), the state
5 nevertheless persisted in threatening the licensee with
6 immediate license suspension if he did not agree to a
7 stipulated settlement which would prevent him from treating
8 chronic pain with opioid medications.
9
10
11

12 1. The agenda of the MQAC team was demonstrably not
13 to improve the care of the targeted patients -- who
14 would have been medically abandoned if Dr. Janes
15 had accepted the stipulated settlement, but rather to
16 impede prescribing of opioid pain medications to
17 chronic pain patients.
18
19
20

21 2. This agenda is consonant with the opiophobic animus
22 of senior Washington public health officials, as
23 demonstrated in the Dosage Guidelines, and was
24 directed by Health Official Defendants 1 and 2.
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1 3. Such agenda, however, is nonstatutory, *ultra vires*,
2 and violative of equal protection and both procedural
3 and substantive due process within the meaning of the
4 Fourteenth Amendment.
5

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7 f. Licensure enforcement actions involving physicians who prescribe
8 opioids for chronic pain patients are often undertaken despite the
9 lack of complaints by patients receiving treatment, and are often
10 conducted without regard to whether patients have been provided
11 effective pain care, while chronic pain patient complaints about
12 physicians who provide ineffective or inadequate pain treatment
13 remain uninvestigated and unsanctioned.
14

15
16 i. Physicians who inappropriately and reflexively label a
17 chronic pain patient an “addict” and impose an improper
18 addiction paradigm of treatment when presented with a
19 chronic pain patient who needs opioid medications are
20 neither investigated nor sanctioned; however, physicians
21 who appropriately treat chronic pain patients with opioid
22 medications are sanctioned for failing to adopt a
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1 nonstatutory addiction paradigm for their treatment. *See*
2 Order Exhibit E.
3

4 g. The real-world effects of a license investigation on a physician,
5 coupled with the high real-world statistical probability of license
6 investigations when opioids are prescribed, along with the real-
7 world statistical improbability of license investigations when
8 opioids are denied altogether despite rules to the contrary weighs
9 so heavily against physicians prescribing opioids for chronic
10 nonmalignant pain – despite the statutory mandate – that such care
11 is effectively unavailable.
12

13
14 i. Nor do physicians undertake the referral obligation because
15 there is simply *nobody to refer these patients to*.
16

17
18 h. Additional examples of denial of equal protection of the law
19 abound in licensure investigation cases involving physicians
20 accused of “improperly” prescribing opioid medications.
21

22 i. Order Exhibit E demonstrates that it is the policy of the State
23 of Washington MQAC to apply nonstatutory treatment goals
24 of *addiction* to chronic pain patients in place of the statutory
25
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1 mandate to provide effective pain treatment, which requires
2 titration to analgesic effect.
3

4 1. The treatment of chronic pain patients under the
5 rubric and paradigm of addiction as a matter of law
6 violates equal protection and due process.
7

8 ii. Order Exhibit E demonstrates that it is the policy of the State
9 of Washington MQAC, as applied, to require physicians to
10 abandon chronic pain patients who present co-morbid
11 conditions arbitrarily regarded as “contraindications” for
12 opioid pain treatment, in express abrogation of the science
13 of pain and the ethic of treatment, as well as the statutory
14 mandate to provide effective pain treatment.
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18 iii. For example, in the recent investigation involving Dr. Merle
19 Janes, the following has occurred:
20

21 1. Neither the MQAC Agents involved nor any
22 Department of Health official made any arrangements
23 for effective alternative care for the affected patients
24 before issuing a threat of license suspension to the
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1 physician that undermined their necessary medical
2 care, nor did any Department of Health official
3 determine whether effective alternative care for those
4 patients was available in the Spokane area *at all*.

5
6
7 2. While providing care to one of his chronic pain
8 patients (who happened to also be a registered nurse)
9 which included treatment with opioid medication, Dr.
10 Janes became aware that two other physicians to
11 whom he had never spoken who had been treating the
12 same patient had made derogatory comments to that
13 patient about the opioid pain medications she was
14 taking and “blaming” her other medical problems on
15 those medications (which disclosed uninformed
16 prejudicial Opiophobia on the part of the other
17 physicians, and which the patient knew to be
18 uninformed because the medical problems pre-dated
19 both her chronic pain and the opioid treatment
20 therefore), and which represented unprofessional
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1 conduct by those physicians in the extreme. In
2 response, Dr. Janes wrote letters to both physicians
3 memorializing the conversations he had had with his
4 patient, pointed out that the opinions expressed were
5 uninformed and not based on medical evidence, and
6 included his notes along with the letter. Neither
7 physician ever responded to Dr. Janes. However, in
8 its investigation of Dr. Janes, which included the same
9 patient, the MQAC used the letters Dr. Janes had
10 written to those two physicians as “evidence” *against*
11 Dr. Janes, while taking *no action* against the
12 uninformed opiophobic physicians to whom Dr. Janes
13 sent the letters.
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20 226. Enforcement of the licensure Regime as applied by the MQAC
21 Agents and Health Official Defendants who supervise them therefore
22 violates the Due Process and Equal Protection Clauses of the
23 Fourteenth Amendment to the United States Constitution, and should
24 be enjoined by this Court.
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1 227. MQAC Agents and Health Official Defendants, under color of
2 authority as agents of the State of Washington, declared that the
3 necessary medical care provided to Does A-Z, for which no adequate
4 alternative is available, was outside the standard of care, but without
5 providing a meaningful alternative for continuity of medical care for
6 such Pain Patients Does A-Z.

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8
9
10 a. MQAC Agents and Health Official Defendants did not make such
11 pronouncement in good faith or with a reasonable belief in the
12 constitutionality or legality of said actions, and therefore
13 Defendant MQAC Agents and Health Official Defendants are not
14 immune or privileged from liability for personal damages.

15
16
17 b. Defendants MQAC Agents knew or should have known that
18 emotional distress would likely result to Plaintiffs Does A-Z as a
19 direct or proximate result of their declaration that their necessary
20 medical care was outside the standard of care expected of
21 Washington physician licensees, in that no Washington physician
22 licensee would be willing to provide care under similar
23 pronouncement, and their necessary medical care would thereby
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1 become unavailable to Plaintiffs Does A-Z as a matter of law. The
2
3 conduct of Defendant MQAC Agents in declaring that the
4
5 necessary medical care for Plaintiff Does A-Z and similarly
6
7 situated patients was outside the standard of care expected of
8
9 Washington medical licensees as a matter of law was the
10
11 proximate cause of severe emotional distress to Plaintiff Does A-Z
12
13 and similarly situated patients.

14
15 i. The conduct of MQAC Agents in declaring that Does A-Z
16
17 and similarly situated patient's necessary medical care was
18
19 outside the standard of care for Washington physician
20
21 licensees, and thereby making such care unavailable to
22
23 Plaintiffs Does A-Z and similarly situated patients as a
24
25 matter of law, demonstrates deliberate indifference to the
26
27 serious medical needs of Does A-Z and similarly situated
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29 patients for the medication necessary to treat their
30
31 intolerable pain, for which there is no effective alternative.

32
33 The conduct of the MQAC Agents under color of their

1 authority has resulted in the unnecessary and wanton
2 infliction of pain to Plaintiffs Does A-Z.
3

4 ii. The licensure Regime as applied was not narrowly drawn to
5 express only the legitimate state interests at stake in that the
6 MQAC Agents made no arrangements for effective
7 alternative care for the affected patients before issuing the
8 threat that undermined their care; that licensure Regime
9 therefore cannot survive strict scrutiny.
10

11 iii. Enforcement of the licensure Regime as applied therefore
12 violates these *patients' rights* as a matter of law under the
13 due process clause of the Fourteenth Amendment to the
14 United States Constitution, and should be enjoined by this
15 Court *at this time*.
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18

19 228. As the result of enforcement of the licensure regime as applied
20 by MQAC Agent Defendants and Health Official Defendants against
21 all Washington medical licensees, Plaintiff Patients Does A-Z and
22 Class Pain Patients who are similarly situated patients have sustained
23 injury. Such injuries have been and will continue to be present, to not
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1 be fully reparable by retrospective monetary damages, and are likely
2 to continue unless Defendants' continuing violations are also
3 restrained and enjoined by this Court.
4

5 229. All MQAC Agent and Health Official Defendants' actions were
6 undertaken without a good faith or reasonable belief in the
7 constitutionality or legality of said actions, and therefore are not
8 immune or privileged from liability for personal damages.
9
10

11 230. Regardless of the good faith or reasonableness of the MQAC
12 Agent and Health Official Defendants' actions, no MQAC Agent or
13 Health Official Defendant is immune or privileged from Declaratory
14 and Injunctive Relief as ordered by this Court to redress Defendants'
15 constitutional violations.
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18 231. Plaintiff Does A-Z and Class Pain Patients should be
19 compensated for the harm they have suffered as a result of this
20 unlawful licensure enforcement Regime, and they are entitled to such
21 damages under federal law.
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1 **COUNT 7-- STATUTORY 1983 CLAIMS AGAINST MQAC AGENTS AND**
2 **SUPERIORS FOR VIOLATIONS OF ADA TITLE II - Individuals**

3 232. Plaintiffs reallege and incorporate herein by reference each and
4 every allegation contained in ¶¶1 through 147 above as though fully
5 set forth herein.
6

7
8 233. This Count is stated by Does A-Z, Dr. Janes, and all members
9 of Classes A & B against the MQAC Agents and Health Official
10 Defendants.
11

12 234. The MQAC Agents are “persons” for purposes of 42 U.S.C.
13 1983, and are sued in both their individual and official capacities,
14 jointly and severally. The Health Official Defendants are also agents
15 of the Washington Department of Health or the Washington Medical
16 Quality Assurance Commission, and as such are “persons” for
17 purposes of 42 U.S.C. 1983, and are sued in both their individual and
18 official capacities, jointly and severally.
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22 235. The MQAC Agents and the Health Official Defendants operate
23 on behalf of the Washington Medical Quality Assurance Commission,
24 which is the professional disciplinary arm of the Department of
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1 Health, or Directly for the Department of Health; as such these Agents
2 have acted “under color of state law” for purposes of 42 U.S.C. 1983.
3

4 236. The disparate treatment by licensed physicians in the State of
5 Washington of Does A-Z and members of Classes A and B described
6 below in Counts 8- 9 is caused by agents of the Department of Health,
7 including the MQAC Agents and Health Official Defendants.
8

9
10 237. Upon information and belief, the MQAC Agents were
11 implementing or executing a policy of their agency in establishing a
12 medical duty to abandon, shun, or arbitrarily limit opioid pain
13 treatment for patients with chronic nonmalignant pain, and the Health
14 Official Defendants were the “moving force” for that policy directing
15 the actions of those Department of Health agents, and are legally
16 answerable for the damages suffered by Does A-Z and members of
17 classes A and B.
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21 238. In the alternative, upon information and belief, the MQAC
22 Agents were implementing or executing a policy of Health Official
23 Defendants in establishing a medical duty to disregard the science and
24 the medical ethic of treatment for patients with chronic, nonmalignant
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1 pain and instead employing arbitrary non-medical considerations in
2 determining whether or in what amounts to provide treatment for
3 those patients; this policy would have a known differential impact on
4 the class of persons with disabilities who are patients with chronic,
5 nonmalignant pain who require opioid medications to mitigate their
6 pain; the Health Official Defendants who were the “moving force” for
7 that policy of disregarding the science and the ethic of treatment with
8 respect to the population of patients with disabilities who are patients
9 with chronic, nonmalignant pain in directing the actions of the
10 Department of Health MQAC agents in implementing such licensure
11 enforcement Regime, are legally answerable for the damages suffered
12 by Does A-Z and members of class A.
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18 239. In the alternative, upon information and belief, the MQAC
19 Agents were not trained about their nondiscrimination duties under
20 the ADA by Health Official Defendants despite a known historical
21 pattern by agents of MQAC in which similar discriminatory standards
22 have been applied, as demonstrated by the proceeding resulting in
23 Order Exhibit 5, and such failure to train amounts to deliberate
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1 indifference to an obvious need for such training by Health Official
2 Defendants.
3

4 240. In the alternative, the ADA is not new, and the social goal of
5 prevention of discrimination against people with disabilities is not
6 new or novel. A reasonable person should have known that persons
7 with disabilities are protected by the ADA and that classifications
8 which deny necessary medical care that differentially impact persons
9 with disabilities are suspect there under, and violate clearly
10 established statutory or constitutional rights of which a reasonable
11 person would have known, and therefore no qualified immunity
12 applies such that Does A-Z and members of Classes A should be
13 compensated for the harm they have suffered as a result of the actions
14 of the MQAC Agents as well as Health Official Defendants.
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19 241. In the alternative, upon information and belief, the MQAC
20 Agents were not trained about their nondiscrimination duties under
21 the ADA by Health Official Defendants despite a known historical
22 pattern by agents of MQAC of similar conduct, such as the proceeding
23 resulting in Order Exhibit 5, and such failure to train amounts to
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1 deliberate indifference to an obvious need for such training by Health
2 Official Defendants for which no qualified immunity applies, and
3 Does A-Z, and members of Class A should be compensated therefore.
4

5
6 **COUNT 8 -- VIOLATION OF ADA TITLE II -- CLASSES A & B—**
7 **LICENSURE -- DIFFERENTIAL BURDEN**

8 242. Plaintiff realleges and incorporates herein by reference each and
9 every allegation contained in ¶¶1 through 147 above as though fully
10 set forth herein.
11

12 243. This Count is stated by Dr. Janes and Does A-Z, along with all
13 members of Classes A & B against the MQAC Agents and the Health
14 Official Defendants jointly and severally.
15

16 244. In the ADA, Congress defined "public entity" to mean "any
17 State or local government" or "any department, agency. . .of a State. .
18 .or local government." 42 U.S.C. § 12131(1)(A) and (B) [ADA §
19 201(1)(A) and (B)].
20

21 245. The Medical Quality Assurance Commission is an
22 instrumentality of the State of Washington, and is a public entity
23 within the meaning of the ADA.
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1 246. The Department of Health is an instrumentality of the State of
2
3 Washington, and is a public entity within the meaning of the ADA.

4 247. Under the ADA, unlawful discrimination occurs when a person
5
6 with a disability is "excluded from participation in or denied the
7
8 benefits of the services, programs, or activities of a public entity. . ."
9
10 42 U.S.C. § 12132 [ADA § 202].

11 248. A public entity may provide different or separate benefits under
12
13 Title II if such action is necessary to provide qualified individuals
14
15 with disabilities with aids, benefits, or services that are equally as
16 effective as those provided to others. 28 C.F.R. § 35.130(b)(1)(iv); 28
17 C.F.R. § 41.51(b)(1)(iv).

18 249. Under the law of the Ninth Circuit, a public entity may not
19
20 provide different or separate benefits under Title II if the different or
21 separate benefit or service is not equally as effective as those provided
22 to others; nor may a public entity provide a different or separate
23 benefit under Title II which comprises no benefit or service at all.

24 250. Does A-Z and Plaintiff Classes A and B [together "Class Pain
25
26 Patients"] are composed of persons with physical or mental conditions

1 resulting in substantial impairments of one or more major life
2 activities, and qualify as persons with disabilities within the meaning
3 of 42 U.S.C. § 12102(2) [ADA § 3(2)].

4
5 251. MQAC Agents and Health Official Defendants through
6 licensure actions taken against physician licensees, including the
7 proceedings recently taken against Dr. Janes and Dr. Hunt as
8 exemplified in Order Exhibit E, have established a regulatory scheme
9 that unduly burdens Does A-Z as well as Plaintiff Classes A and B,
10 which are composed of persons with disabilities, which disabilities are
11 associated with chronic, nonmalignant intractable pain syndromes,
12 and for which pain syndromes treatment with opioid medication is
13 required to mitigate the painful effects of the underlying disability.
14 The burden placed on Does A-Z and Plaintiff Classes A & B in the
15 licensure enforcement Regime is different and greater than that
16 imposed on other members of the general public who obtain services
17 from physicians licensed by the State of Washington in that
18 physicians cannot avoid threats to their license by adhering to
19 scientific principles or reasonably articulated and lawful medical
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1 practice standards in the treatment of Does A-Z and members of
2 Classes A & B, and neither the MQAC Agents nor the Health Official
3 Defendants have proposed any alternative service equally as effective,
4 nor provided for alternative care arrangements for these patients to
5 take the place of the treatment they have condemned from the
6 challenged physicians, and have not demonstrated that such
7 alternative even exists.

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11 252. Enforcement of this licensure Regime as applied has resulted
12 and will reasonably foreseeably result in a separate service for Does A-
13 Z and members of Classes A and B, which consists of *no service* (e.g.,
14 *no meaningful effective medical treatment of their pain*) by physician
15 licensees within the State of Washington. Neither the MQAC Agents
16 nor the Health Official Defendants could reasonably have believed
17 that their actions in completely undermining medically-necessary
18 effective pain care to people with disabilities was consistent with the
19 ADA, or been unaware that Does A-Z and members of Classes A & B
20 were intended beneficiaries of the ADA.
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1 253. The MQAC Agents and Health Official Defendants should be
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3 ordered to take all steps necessary to ensure the full enjoyment of all
4 rights guaranteed by the ADA by Does A-Z and the Plaintiff Classes
5 A & B. Does A-Z and the Plaintiff Classes A & B are entitled to such
6 injunctive relief under the ADA, and such relief ripened under federal
7 civil rights laws when the violation occurred, e.g., when the licensure
8 threats were first issued based on the challenged pain treatment.
9

10
11 254. The conduct of MQAC Agents and Health Official Defendants
12 in undermining the medically-necessary pain treatment the Class Pain
13 Patients received, without providing an equally effective alternative
14 demonstrates deliberate indifference to the serious medical needs of
15 Does A-Z and members of Classes A & B.
16
17

18 255. Does A-Z and Members of Classes A & B should be
19 compensated for the harm they have suffered as a proximate result of
20 the deliberate indifference of MQAC Agents and the Health Official
21 Defendants to their serious medical needs, and they are entitled to
22 such damages under the ADA.
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1 **COUNT 9 -- ADA TITLE III - DR. JANES & CLASS PAIN PATIENTS --**
2 **SCREENING CRITERIA**

3 256. Plaintiffs reallege and incorporate herein by reference each and
4 every allegation contained in ¶¶1 through 147 above as though fully
5 set forth herein.
6

7 257. This Count is stated by John Doe, Does A-Z, Dr. Janes as Class
8 Representative, and members of Classes A and B against the MQAC
9 Agents and the Health Official Defendants jointly and severally, in
10 their individual and official capacities.
11

12 258. John Doe, Does A-Z and Members of Plaintiff Classes A & B
13 are persons with disabilities under 42 U.S.C. § 12102(2) [ADA §
14 3(2)].
15
16

17 259. Dr. Janes and other medical licensees are known to have a
18 relationship or association with Does A-Z, including Jane Doe A, who
19 is a member and representative of Class A; John Doe is a member and
20 representative of Class B, and Dr. Janes will have a relationship or
21 association with some members of Class B in the future, who will be
22 persons with disabilities within the meaning of the ADA, and as such
23 Dr. Janes and similarly situated physicians have an independent right
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1 of action based on that association within the coverage terms of the
2
3 ADA Title III, 28 C.F.R. § 35.130(g) Appx. A.

4 260. Under the principles of *jus tertii*, Dr. Janes has standing to
5 assert the interests of patients Does A-Z and members of Classes A
6 and B who have sought in the past or will seek in the future care from
7 him or other medical licensees within the State of Washington; as a
8 representative of patient Classes A & B, Dr. Janes has standing to
9 assert the interests of those Class Members who have sought in the
10 past or will seek in the future care from physician licensee who are
11 similarly situated.
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15 261. Similarly, under the reverse principles of *jus tertii*, John Doe,
16 Plaintiffs Does A-Z and members of Classes A and B have standing to
17 assert the interests of physician licensees from whom they have
18 sought or will seek care in the future in the State of Washington,
19 including Dr. Janes and similarly situated medical licensees.
20
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22 262. A professional office of a health care provider is covered as a
23 “service establishment” for purposes of the ADA. 42 U.S.C. §
24 12181(7)(F).
25
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1 263. The MQAC Agents and Health Official Defendants have
2
3 imposed licensing arrangements on physicians who operate places of
4 public accommodations, which physicians are subject to the ADA
5 anti-discrimination provisions of Title III. 42 U.S.C. § 12182(a)
6 [ADA § 302(a)].
7

8 a. 42 U.S.C. §12182(a) prohibits discrimination "on the basis of
9 disability in the full and equal enjoyment of the goods, services,
10 facilities, privileges, advantages, or accommodations of any place
11 of public accommodation by any person who owns, leases (or
12 leases to), or operates a place of public accommodation."
13
14

15 264. The MQAC Agents and Health Official Defendants will enforce
16 their regulatory scheme against physicians who operate places of
17 public accommodations under the ADA (42 U.S.C. § 12181(7)(L))
18 [ADA § 301(7)(L)].
19

20
21 a. Such public accommodations affect interstate commerce as they
22 sell services bundled with supplies which, upon information and
23 belief, have moved in interstate commerce.
24
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1 265. Public accommodations must not impose or apply eligibility
2 criteria that screen out or tend to screen out any class of individuals
3 with disabilities from fully and equally enjoying any goods, services,
4 facilities, privileges, advantages, or accommodations, unless the
5 criteria can be shown to be necessary for the provision of the goods,
6 services, facilities, privileges, advantages or accommodations being
7 offered. 42 U.S.C. § 12182(b)(2)(A)(I).
8
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11 266. The standards applied by MQAC Agents and Health Official
12 Defendants in the licensure proceeding against medical licensees, as
13 exemplified in the proceeding against Dr. Janes, and similarly applied
14 in Order Exhibit E, require such licensees to apply eligibility
15 requirements for treatment that have in fact already screened out Does
16 A-Z for otherwise lawful and necessary medical treatment, who are
17 persons with disabilities who have chronic, nonmalignant pain
18 syndromes that require mitigation with opioid medication for effective
19 pain mitigation, in violation of the ADA.
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24 267. The standards applied by MQAC Agents and Health Official
25 Defendants in licensure proceeding s will require such licensees,
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1 including Dr. Janes and any other physicians to whom those same
2 standards are applied, to impose eligibility requirements for treatment
3 that will tend to screen out members of Classes A and B, including
4 John Doe, who are persons with chronic, nonmalignant pain
5 syndromes that require mitigation with opioid medication from
6 eligibility for effective pain mitigation, in violation of the ADA.
7

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10 268. The MQAC Agents and the Health Official Defendants should
11 be ordered to take all steps necessary to ensure the full enjoyment of
12 all rights guaranteed by the ADA to people with disabilities and the
13 medical licensees who associate with them, including John Doe, Does
14 A-Z and Plaintiff Classes A and B. Medical licensees, including Dr.
15 Janes, and the people with disabilities whom they serve, including
16 John Doe, Does A-Z and Plaintiff Classes A and B are entitled to such
17 injunctive relief under the ADA. 42 U.S.C. § 2000a-3(a).
18
19

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21 269. As a proximate result of the discriminatory standards imposed
22 upon him and enforced against his patients by MQAC Agents and
23 Health Official Defendants, Dr. Janes, John Doe, members of Class A,
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1 and patients Does A-Z have suffered harm, which harm has resulted in
2 damage to Dr. Janes, John Doe, members of Class A, and Does A-Z.

3
4 270. The MQAC Agents and the Health Official Defendants could
5 not reasonably have believed that their actions were consistent with
6 the ADA, or been unaware that Dr. Janes and other medical licensees
7 who serve people with disabilities, including John Doe, Class A or B
8 members, or Does A-Z were intended beneficiaries of the ADA.
9
10

11 271. The conduct of MQAC Agents and the Health Official
12 Defendants demonstrates deliberate indifference to the legal
13 obligations of Dr. Janes and similarly situated medical licensees who
14 serve people with disabilities, and to the serious medical needs of
15 John Doe, Does A-Z, as well as members of Classes A and B, and
16 such Plaintiffs should be compensated therefore.
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20 ***COUNT 10 – SECTION 1985 CLAIMS –LICENSURE - Conspiracy***

21
22 272. Plaintiff realleges and incorporates herein by reference each and
23 every allegation contained in ¶¶1 through 147 above as though fully
24 set forth herein.
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1 273. This Count is stated by Jane Does A-Z and members of Classes
2 A & B against all MQAC Agent Defendants and Health Official
3 Defendants, jointly and severally, in both their official and individual
4 capacities, and arises under the Civil Rights Act, 42 U.S.C. § 1985(3),
5 which provides a federal civil remedy, for damages or injunctive or
6 other relief, for harm resulting from a conspiracy to deprive a suspect
7 class of legal rights.
8

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11 274. The Licensure Regime as applied by MQAC Agents and Health
12 Official Defendants is contrary to governing Washington law,
13 including the MQAC's own 1996 Guidelines, which commit
14 treatment of chronic, nonmalignant pain with opioids to the sound
15 discretion of the treating physician and assures against "injudicious"
16 licensure actions. But for the threats issued by the MQAC Agents and
17 Health Official Defendants implementing their unlawful standards,
18 Dr. Janes and other Washington medical licensees would otherwise be
19 free to treat patients Does A-Z with opioid medication whenever
20 medically necessary without fear of MQAC's licensure threats.
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1 275. Upon information and belief, the Health Official Defendants
2 and their MQAC Agents developed a license enforcement scheme that
3 was motivated by an invidiously discriminatory class-based animus in
4 which they would contrived charges against licensees who were found
5 to be issuing prescriptions for opioid medications to chronic pain
6 patients, such that an enforcement action could result in limitation of
7 licensee's prescribing authority.
8

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11 a. Upon information and belief, the invidiously discriminatory class-
12 based animus was directed at people with disabilities who require
13 opioid medication to mitigate the painful effects of their
14 disabilities, for which there is no effective medical alternative;
15

16
17 b. Upon information and belief, the licensure Regime knowingly
18 disproportionately deprived this group of people with disabilities
19 of the equal protection of the law by contriving charges and issuing
20 overreaching and unlawful threats against licensees who would
21 otherwise be free to treat them in accordance with governing law,
22 but who are within the Regime as applied prevented from
23 reasonably treating these patients
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1 i. Such licensee are instead held to a medical duty to abandon,
2 shun, or arbitrarily limit pain treatment offered – which
3 limits are so vague that many physicians have concluded
4 that the only reasonably cautious approach is to deny opioid
5 treatment for chronic nonmalignant pain altogether.
6
7

8 276. Upon information and belief, in furtherance of the agreement to
9 contrive charges in order to issue threats against the license to practice
10 medicine, as motivated by the invidiously discriminatory class-based
11 animus [which is hereinafter referred to as the “agreement”], in the
12 case of Dr. Janes, which harm was specifically visited upon Does A-
13 Z, the MQAC Agents attended a conference on February 19, 2008,
14 wherein that threat was specifically verbalized and each agent made
15 statements in support of that contrivance.
16
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19 277. The harm resulting from this agreement is interference with a
20 patient’s legal right of contract for necessary medical care with a
21 private physician, or, alternatively, undue burden of the patient’s
22 fundamental liberty interest described below, in that the private
23 physician who reasonable perceives the licensure Regime as applied
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1 controlling authority in place of the 1996 Guidelines also views
2 himself as legally *unable* without the threat of government sanction to
3 prescribe medically-necessary opioid medication for his patients with
4 disabilities, even when such prescriptions are medically necessary to
5 mitigate intolerable chronic, nonmalignant pain arising out of that
6 disability, and even when there are no effective medical alternatives;
7 whereas other persons are freely able to obtain necessary medical care
8 from the same private physician within the relevant science and
9 ethics-based standards of care pertaining to their conditions.
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14 a. The Fourteenth Amendment guarantees the liberty of physicians to
15 practice medicine consistent with their best professional judgment,
16 including using their skills and powers to facilitate the exercise of
17 the decision of competent adults who choose to mitigate chronic
18 nonmalignant intractable pain arising from a disability as
19 recognized in the ADA through the use of suitable physician-
20 prescribed opioid drugs; this liberty interest extends to patients and
21 their physicians who, in their best professional judgment, would
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1 prescribe medically necessary FDA-approved opioid pain relieving
2 agents, for which there is no effective medical alternative.
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4 b. In the alternative, the relationship between a physician and a
5 patient is a legal personal services contract. Under the law of the
6 State of Washington, actions that are deliberately calculated to
7 disrupt that relationship, and to induce the physician to breach or
8 otherwise fail to perform that contract in the manner required by
9 lawful medical practice standards constitutes tortious interference
10 with a contractual relationship.
11
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13
14 278. The conduct of the MQAC Agents has denied Does A-Z who
15 rely on opioid medication to mitigate the effects of their chronic,
16 nonmalignant pain resulting from their disabilities, of the benefit of
17 the services of Dr. Janes, who reasonably believes he is subject to that
18 licensure enforcement Regime as being enforced by MQAC Agents
19 and the Health Official Defendants. The conduct of the MQAC
20 Agents has proximately resulted in harm to that physician as well as
21 Does A-Z.
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1 a. As information is revealed through discovery identifying particular
2 state officials who participated in similar contrivances against
3 other physicians in which similar standards were applied, such
4 officials will be included herein by name in appropriate
5 amendments as granted through leave of this Court.
6
7

8 279. The MQAC Agents and the Health Official Defendants should
9 be ordered to take all steps necessary to ensure the full enjoyment of
10 all rights guaranteed to medical licensees and their Class Pain
11 Patients, including Dr. Janes and Does A-Z, and such licensees and
12 their patients including Dr. Janes and Does A-Z are entitled to such
13 injunctive relief.
14
15

16 280. All MQAC Agent and Health Official Defendants' actions
17 herein were undertaken without a good faith or reasonable belief in
18 the constitutionality or legality of said actions, and therefore are not
19 immune or privileged from liability for personal damages under the
20 Constitution or laws of the United States.
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1 281. Does A-Z should also be compensated for the harm they have
2 suffered as a result of this unlawful agreement, and they are entitled to
3 such damages under federal law.
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7 ***COUNT 11A – SECTION 1986 CLAIMS –LICENSURE – Failure to Prevent***

8 282. Plaintiffs reallege and incorporate herein by reference each and
9 every allegation contained in ¶¶1 through 147 above as though fully
10 set forth herein.
11

12 283. This Count is stated by Does A-Z against Peter J. Harris, in
13 both his official and individual capacities, and arises under the Civil
14 Rights Act, 42 U.S.C. § 1986, which provides a federal civil remedy,
15 for damages or injunctive or other relief, for harm resulting from the
16 failure of participants or observers of the agreement described above
17 in Count 10 to prevent harm.
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21 284. Upon information and belief, Peter J. Harris had actual
22 knowledge of the agreement described in Count 10 above, and was the
23 official who tendered the actual threat to Dr. Janes; as such, he had the
24 power to prevent or aid in preventing the harm described in Count 10,
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1 and neglected or refused to do so. As a result, a wrongful act was
2 committed, e.g., tendering of an unlawful threat resulting in
3 withdrawal of the care of patients Does A-Z, and Mr. Harris is thereby
4 liable for all damages that he could have prevented with reasonable
5 diligence.
6
7

8 ***COUNT 11B – SECTION 1986 CLAIMS –LICENSURE – Failure to Prevent***

9
10 285. Plaintiffs reallege and incorporate herein by reference each and
11 every allegation contained in ¶¶1 through 147 above as though fully
12 set forth herein.
13

14 286. This Count is stated by Does A-Z against George Heye, MD, in
15 both his official and individual capacities, and arises under the Civil
16 Rights Act, 42 U.S.C. § 1986, which provides a federal civil remedy,
17 for damages or injunctive or other relief, for harm resulting from the
18 failure of participants or observers of the agreement described above
19 in Count 10 to prevent harm.
20
21

22 287. Upon information and belief, as a licensed physician, and based
23 upon his own admission that he was unfamiliar with the nature of
24 prolotherapy – which formed the fundamental basis for Dr. Janes’
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1 practice -- George Heye, MD was well aware that the MQAC had not
2 sent a team capable of rendering an informed judgment about the
3 fundamental nature of the care provided by Dr. Janes, but nevertheless
4 persisted in pressing the charging claims including those challenging
5 the use of that therapy. Upon information and belief, as Dr. Heye had
6 actual knowledge of the agreement described in Count 10 above, and
7 had the power to prevent or aid in preventing the harm described in
8 Count 10 by informing members of the investigating team of the
9 insufficiency of their expertise and the overreaching nature of their
10 treats, but neglected or refused to do so, and as a result, a wrongful act
11 was committed, *i.e.*, tendering of an unlawful threat resulting in
12 withdrawal of the care of patients Does A-Z, and Dr. Heye is thereby
13 liable for all damages that he could have prevented with reasonable
14 diligence.
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21 ***COUNT 11C – SECTION 1986 CLAIMS –LICENSURE – Failure to Prevent***

22 288. Plaintiffs reallege and incorporate herein by reference each and
23 every allegation contained in ¶¶1 through 147 above as though fully
24 set forth herein.
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1 289. This Count is stated by Does A-Z against Frederick H. Dore,
2
3 Jr., MD, in both his official and individual capacities, and arises under
4 the Civil Rights Act, 42 U.S.C. § 1986, which provides a federal civil
5 remedy, for damages or injunctive or other relief, for harm resulting
6
7 from the failure of participants or observers of the agreement
8
9 described above in Count 10 to prevent harm.

10 290. Upon information and belief, as a licensed physician, and based
11 upon his own admission that he was unfamiliar with the nature of
12 prolotherapy – which formed the fundamental basis for Dr. Janes’
13 practice -- Frederick H. Dore, Jr., MD was well aware that the MQAC
14 had not sent a team capable of rendering an informed judgment about
15 the fundamental nature of the care provided by Dr. Janes, but
16
17 nevertheless persisted in pressing the charging claims including those
18 challenging the use of that therapy. Upon information and belief, as
19
20 Dr. Dore had actual knowledge of the agreement described in Count
21 10 above, and had the power to prevent or aid in preventing the harm
22 described in Count 10 by informing members of the investigating
23 team of the insufficiency of their expertise and the overreaching
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1 nature of their threats, but neglected or refused to do so, and as a
2 result, a wrongful act was committed, *i.e.*, tendering of an unlawful
3 threat resulting in withdrawal of the care of patients Does A-Z, and
4 Dr. Dore is thereby liable for all damages that he could have
5 prevented with reasonable diligence.
6
7

8 ***COUNT 11D – SECTION 1986 CLAIMS –LICENSURE – Failure to Prevent***
9

10 291. Plaintiffs reallege and incorporate herein by reference each and
11 every allegation contained in ¶¶1 through 147 above as though fully
12 set forth herein.
13

14 292. This Count is stated by Jane Does A-Z and all members of
15 Classes A & B against all MQAC Agent Defendants and the Health
16 Official Defendants, jointly and severally, in both their official and
17 individual capacities, and arises under the Civil Rights Act, 42 U.S.C.
18 § 1986, which provides a federal civil remedy, for damages or
19 injunctive or other relief, for harm resulting from the failure of
20 participants or observers of the agreement described above in Count
21 10 to prevent harm.
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1 293. Upon information and belief, each MQAC Agent and their
2 supervisor Health Official Defendants had actual knowledge of the
3 agreement described in Count 10 above, and had the power to prevent
4 or aid in preventing the harm described in Count 10, and neglected or
5 refused to do so. As a result, one or more wrongful acts were
6 committed by each, and each supervisory person for the MQAC
7 Agents, including possibly Health Official Defendants, is thereby
8 liable for all damages that he or she could have prevented with
9 reasonable diligence.
10

11 294. Other similar liabilities for additional individuals may become
12 evident through discovery and will be asserted as revealed. For
13 example, if more than one supervisor of the MQAC Agents was in a
14 position to prevent or aid in preventing the threat from being issued,
15 and if such additional supervisor negligently refused to do so, such
16 additional supervisor could be held liable for all damages that he or
17 she could have prevented with reasonable diligence. Other similar
18 liabilities for additional individuals may become evident through
19 discovery and will be asserted as revealed.
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1 **COUNT 12 - DECLARATORY RELIEF - GUIDELINES**

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3 295. Plaintiffs reallege and incorporate the allegations contained in
4 ¶¶1 through 147 as though fully set forth herein.

5
6 296. Despite the clear requirements of the ADA and the United
7 States Constitution, the State Defendants have promulgated the
8 Dosage Guidelines, and physicians who reasonably perceive
9 themselves subject thereto refrain from writing lawful prescriptions to
10 mitigate pain with opioid medications for members of Class A,
11 especially in dosages exceeding 120 MEQ per day, and will refrain
12 from writing lawful prescriptions to mitigate pain with opioid
13 medications for members of Class B, especially in dosages exceeding
14 120 MEQ per day.

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18 297. Through State Defendants' actions, an actual controversy exists
19 between Plaintiff and Plaintiff Classes and Defendants entitling
20 Plaintiffs to declaratory relief pursuant to 28 U.S.C. § 2201 as set
21 forth in the prayer hereof. Such relief will resolve the controversy
22 between Plaintiffs and Defendants.
23
24

1 to declaratory relief pursuant to 28 U.S.C. § 2201 as set forth in the
2 prayer hereof. Such relief will resolve the controversy between
3
4 Plaintiffs and Defendants.

5 302. Plaintiffs and Plaintiff Classes have no equally plain, speedy
6
7 and adequate remedy at law.

8 PRAYER FOR RELIEF

9 WHEREFORE, Plaintiffs respectfully pray:

- 10
- 11 1. That this Court assume jurisdiction;
 - 12 2. That this Court certify Plaintiffs' Classes A and B pursuant to Rules 23(a),
13 23(b)(1) and 23(b)(2) of the Federal Rules of Civil Procedure, as follows:
 - 14 ○ CLASS A consists of all persons who reside in Washington State who have
15 substantial impairments of major life activities (who are persons with
16 disabilities within the meaning of the ADA), which disabilities have resulted
17 in severe, chronic, nonmalignant intractable pain syndromes, and who on or
18 after March 1, 2007, required opioid pain relieving agents in excess of 120
19 MEQ per day for effective mitigation of pain to be prescribed by a
20 Washington-licensed physician.
 - 21 ○ CLASS B consist of all persons who will in the future reside in Washington
22 State and who will have substantial impairments of major life activities (who
23 are persons with disabilities within the meaning of the ADA), which
24 disabilities will have resulted in severe, chronic, nonmalignant intractable
25 pain syndromes, and who will at that time require pain relieving agents in
26 excess of 120 MEQ per day for effective mitigation of pain to be prescribed
27 by a Washington-licensed physician.

- 1 4. That this Court appoint Dr. Merle Janes and Jane Does A and B as
2 representatives of Class A. [Additional representative Plaintiffs may include
3 Does C-Z or John Doe].
- 4 5. That this Court appoint Dr. Janes and John Doe as representatives of Class B.
- 5 6. That this Court find that representation of Classes A and B is adequate.
- 6 7. That this Court issue a temporary and a permanent injunction enjoining State
7 Defendants, Health Official Defendants, their subordinates, and their officers,
8 successors, assigns and all persons in active concert or participation with them,
9 by:
 - 10 a. Declaring that the Interagency Guidelines on Opioid Dosing for Chronic
11 Non-Cancer Pain do not constitute enforceable law of any kind and
12 should be stricken and removed from all state publications of every
13 variety;
 - 14 b. Declaring that the Pain Patients Individuals and Classes are protected by
15 the ADA, that physician investigations based specifically upon treatment
16 of such Pain Patients are inherently suspect as discriminatory in nature
17 under the ADA; and that state action that specifically and unduly burdens
18 the treatment of severe pain of those classes with no meaningful
alternatives is unlawful;
 - 19 c. Prohibiting State Defendants from engaging in any practice or activity
20 which discriminates on the basis of disability within the meaning of the
Americans with Disability Act;
 - 21 d. Prohibiting State Defendants from imposing any regulatory scheme or
22 artifice that requires Washington licensees to commit unlawful
23 discrimination in any manner within the meaning of the Americans With
24 Disabilities Act;

- 1 e. Prohibiting State Defendants from defaming, or encouraging, aiding,
2 abetting, or in any way involving themselves in or contributing to any
3 conduct whatsoever that may have the current or future *effect* of
4 unlawfully depriving members of Classes A or B of access to necessary
5 medical care, specifically including, *inter alia*, applying standards of
6 practice not based on science, applying standards of practice based on
7 nonmedical concerns, failing to sanction medical licensees who currently
8 do so, unreasonably targeting for sanction medical licensees who provide
9 such care, applying special administrative requirements on such care, or
10 sanctioning any medical licensees when doing so would create an
11 unreasonable scarcity of such care in the local medical community;
- 12 f. Declaring that measures designed to treat the pain of Members of Class A
13 and B are protected as mitigation efforts by the ADA;
- 14 g. Declaring that physician investigations based specifically upon treatment
15 of such Class Members are inherently suspect as having differential
16 impact on mitigation measures for persons with disabilities under the
17 ADA;
- 18 h. Declaring that state action that unduly burdens the provision of
19 mitigation measures for members of Classes A and B is unlawful under
20 the ADA;
- 21 i. Declaring that State action that burdens the mitigation measures for
22 members of Classes A and B must be narrowly tailored and based upon
23 specific scientific evidence that establishes safety and effectiveness;
- 24 j. Finding as a matter of law that legally conclusive evidence of safety and
25 effectiveness is established when the FDA approves a drug label;
- 26 1. and further, that state law purporting to impose additional
27 conditions or limitations on treatment with any pre-existing FDA-
28 approved drug label is pre-empted as a matter of law;

1 2. or, alternatively, that state laws purporting to create additional
2 conditions or limitations for prescribing any pre-existing FDA-
3 approved drug relied on for mitigation by people with disabilities
4 creates a different and unequal health service within the meaning
5 of the ADA; and

6 k. Declaring that any additional conditions or limitations on the treatment of
7 pain with an FDA-approved drug that is imposed by a State in excess of
8 an existing drug label regime creates a different and unequal health
9 service within the meaning of the ADA;

10 l. Declaring medically-necessary pain care (in the form of FDA-approved
11 pharmaceuticals) when there is no effective alternative to be a
12 fundamental liberty interest of patients in severe pain;

13 m. Or alternatively, declaring existence of a fundamental liberty interest by
14 all patients in a physician-patient relationship wherein a physician is
15 allowed to exercise his best unburdened professional and scientific
16 judgment;

17 n. Ordering the Washington Department of Health, the Washington Medical
18 Quality Assurance Commission, and the Governor of the State of
19 Washington as its Chief law enforcement officer to take no action against
20 any other physician licensee in the State of Washington that would have
21 the effect of deterring such licensees from providing medically
22 appropriate treatment for patients in severe pain now or in the future, in
23 conformity with e., above; and

24 o. Ordering all State Defendants to take no other action that would have the
25 effect of deterring Washington medical licensees from providing
26 medically appropriate treatment for patients in severe pain now or in the
27 future, even when such treatment requires opioid medications, and
28 regardless of dosage or length of treatment, in conformity with e., above;
 and

- 1 p. Ordering that the Dosing Guidelines be de-published and replaced by a
2 specific notice to the public disseminated equally as widely as the
3 Guidelines were disseminated, of the withdrawal of the Dosing
4 Guidelines for any and all legal purposes;
- 5 q. Ordering the Governor as chief law enforcement officer, along with the
6 State Defendants, to undertake an effective campaign designed to educate
7 state health employees, medical and other health licensees, and the
8 general public about the medical imperative to treat pain, the nature of
9 Opiophobia, principles of science-based appropriate chronic pain
10 treatment with opioid medications , the difference between addiction and
11 dependence, and the great harm that results from applying addiction
12 paradigms and terminology to the treatment of chronic pain, with all
13 deliberate speed; and
- 14 r. Ordering all Defendants to pay all Plaintiffs the costs of this action and
15 attorney fees, in accordance with all applicable provisions of law,
16 including but not limited to the provisions of 42 U.S.C. § 12205 [ADA §
17 505] and 42 U.S.C. § 1988.; and
- 18 s. To award such other relief as the Court finds just and equitable.
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1 DATED this 24th day of June, 2008.

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3 Respectfully Submitted,

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ATTORNEYS FOR PLAINTIFFS

DEMAND FOR A JURY TRIAL

Plaintiffs by and through counsel, respectfully request that this matter be set
for a jury trial. Spokane, Washington designated for place of trial.

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Attached Exhibit List:

- Exhibit A Interagency Guidelines on Opioid Dosing for non-Cancer Pain
- Exhibit B List of Pain Management Specialists published with Interagency Guidelines
- Exhibit C Medical Quality Assurance Commission Guidelines for Management of Pain, Approved 18 April 1996
- Exhibit D Letter from Dr. Merle Janes to his Pain Patients
- Exhibit E Findings of Fact and Conclusions of Law dated May 22, 2008 re: Alan Hunt