STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: Richard S. Wilkinson, MD,
Master Case No.: M2022-196
Document: Final Order

Regarding your request for information about the above-named practitioner; attached is a true and correct copy of the document on file with the State of Washington, Department of Health, Adjudicative Clerk Office. These records are considered Certified by the Department of Health.

Certain information may have been withheld pursuant to Washington state laws. While those laws require that most records be disclosed on request, they also state that certain information should not be disclosed.

The following information has been withheld: **NONE**

If you have any questions or need additional information regarding the information that was withheld, please contact:

Customer Service Center
P.O. Box 47865
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STATE OF WASHINGTON
DEPARTMENT OF HEALTH
WASHINGTON MEDICAL COMMISSION

In the Matter of: RICHARD S. WILKINSON, MD, Credential No. MD.MD.00016229, Respondent.	Master Case No. M2022-196 FINDINGS OF FACT, CONCLUSIONS OF LAW, AND FINAL ORDER

APPEARANCES:

Richard S. Wilkinson, the Respondent, by
Silent Majority Foundation, per
Karen Osborne and Peter Serrano, Attorneys at Law

State of Washington, Washington Medical Commission (Commission), by
Office of the Attorney General, per
Kristin G. Brewer, Senior Counsel

PANEL: Claire Trescott, MD, Panel Chair
Mary Curtis, MD
Robert Pullen, Public Member

PRESIDING OFFICER: Mathew R. Herington, Review Judge

A five-day hearing was held in this matter during April 3-7, 2023, regarding allegations of unprofessional conduct. License placed on PROBATION WITH CONDITIONS.

ISSUES

Did the Respondent commit unprofessional conduct as defined by RCW 18.130.180(1), (4), and (13)?

If the Commission proves unprofessional conduct, what are the appropriate sanctions under RCW 18.130.160?

SUMMARY OF PROCEEDINGS

At the hearing, the Commission presented the testimony of: Scott Lancaster; Jeremy Hutchins; Steven Richards; John Maxwell; Jasper Fernandez; Raymond Scott McClelland; Anna Wald; and Dawn Nolt.

The Respondent testified on his own behalf and additionally presented the testimony of: Mike Piechota; Akiko Kato; Janis Burke; Patient E; Cathy Cockrum; Jennifer Munoz; David Arnold; Felicia Rosenow; and Frank Shallenbeger, III.

The Presiding Officer admitted the following exhibits:

Exhibit D-1: The Respondent's Credential Verification;

Exhibit D-2: Letter of Cooperation dated December 1, 2020;

Exhibit D-3: Amended Letter of Cooperation dated December 29, 2021;

Exhibit D-4: The Respondent's response to Letter of Cooperation with attachments dated January 21, 2022;

Exhibit D-5: Letter of Cooperation dated February 24, 2022;

Exhibit D-6: The Respondent's response to Letter of Cooperation dated March 21, 2022;

Exhibit D-7: Complaint to Washington Medical Commission dated August 19, 2021;

Exhibit D-8: Yakima Valley Memorial records for Patient A;

Exhibit D-9: The Respondent's records for Patient A;

Exhibit D-10: Yakima Valley Memorial records for Patient B;

Exhibit D-11: a. The Respondent's records for Patient B received in November 2021 in response to Letter of Cooperation and Records Request for the Respondent's clinic (Inv.325-447);

b. Additional records received on February 13, 2023, from the Respondent for Patient B included in the Respondent's response to Commission's Request for Production (Respondent Produced RFPS 171);

Exhibit D-12: Yakima Valley Memorial records for Patient C;

Exhibit D-13: a. The Respondent's records for Patient C received in January 2022 (Inv.868-872);

b. Additional records received on February 13, 2023, from the Respondent for Patient C included in the Respondent's response to Commission's Request for Production (Respondent Produced RFPS 174);

Exhibit D-14: Statement from Dr. Steven Richards dated February 17, 2021;

Exhibit D-15: Statement from Akiko Kato, ND, dated March 10, 2022;

Exhibit D-16: Akiko Kato, ND, records for Patient D;

Exhibit D-17: Yakima Valley Memorial records for Patient D;

Exhibit D-18: a. The Respondent's records for Patient D received in January 2022, in response to Letter of Cooperation and Records Request for the Respondent's clinic;

b. Additional records received on February 13, 2023, from the Respondent for Patient D included in the Respondent's response to Commission's Request for Production (Respondent Produced RFPS 146-150 and 170);

Exhibit D-19: Complaint to Washington Medical Commission dated September 10, 2021;

Exhibit D-20: Yakima Valley Memorial records for Patient E;

Exhibit D-21: a. The Respondent's records for Patient E received in January 2022, in response to Letter of Cooperation and Records Request for the Respondent's clinic;

b. Additional records received on February 13, 2023, from the Respondent for Patient E included in the Respondent's

response to Commission's Request for (Respondent Produced RFPS 167-168);

Exhibit D-22: Statement from Dr. Shristi Kunwar dated January 19, 2022;

Exhibit D-23: Statement from Dr. Jasper Fernandez dated December 15, 2021;

Exhibit D-24: Complaint to Washington Medical Commission dated December 18, 2021;

Exhibit D-25: Yakima Valley Memorial records for Patient F;

Exhibit D-26: a. The Respondent's records for Patient F received in January 2022, in response to Letter of Cooperation and Records Request for the Respondent's clinic;

b. Additional records received on February 13, 2023, from the Respondent for Patient F included in the Respondent's response to Commission's Request for Production (Respondent Produced RFPS 158-166 and 173)

Exhibit D-27: Statement from Dr. John Maxwell dated February 7, 2022;

Exhibit D-28: Yakima Valley Memorial records for Patient G;

Exhibit D-29: a. The Respondent's records for Patient G received in January 2022, in response to Letter of Cooperation and Records Request for the Respondent's clinic;

b. Additional records received on February 13, 2023, from the Respondent for Patient G included in the Respondent's response to Commission's Request for Production (Respondent Produced RFPS 151-157 and 172);

Exhibit D-30: Declaration by Paralegal Gabrielle Prebula dated March 22, 2023, with attachments (updated);

Exhibit D-31: The Respondent's protocol to help fight flu or colds and COVID protocol;

Exhibit D-32: Curriculum Vitae for Dr. R. Scott McClelland;

Exhibit D-33: Curriculum Vitae for Dr. Dawn Lynn Nolt;

Exhibit D-34: a. Curriculum Vitae for Dr. Anna Wald;
b. Report of Dr. Anna Wald, dated March 1, 2023;

Exhibit D-35: Curriculum Vitae for Jeanine Guidry, PhD;

Exhibit D-36: FLCCC Alliance COVID-19 Care Providers;

Exhibit D-37: FLCCC Alliance I-Mass Prevention & At Home Treatment of Distribution Protocol for COVID-19;

Exhibit D-38: Why you should Not Use Ivermectin to Treat or Prevent COVID-19 – FDA article updated as of December 10, 2021;

Exhibit D-39: Merck Statement on Ivermectin use During the COVID-19 Pandemic – Merck article dated February 4, 2021;

Exhibit D-40: Coronavirus (COVID-19) Update: FDA Revokes Emergency Use Authorization for Chloroquine and Hydroxychloroquine – FDA article dated June 15, 2020;

Exhibit D-41: AMA Opinion, Code of Medical Ethics, 2.3.2 Professionalism in the Use of Social Media;

Exhibit D-42: Order of the Secretary of Health, Order 20-03 (June 24, 2020);

Exhibit D-43: Proclamation by the Governor Amending and Extending Proclamation 20-05 and 20-60 (June 24, 2020);

Exhibit D-44: CDC – Interim Public Health Recommendations for Fully Vaccinated People – updated as of April 27, 2021;

Exhibit D-45: The Respondent's Response to Commission's Requests for Admission;

Exhibit D-46: The Respondent's Response to Commission's Request for Production of Documents;

Exhibit D-47: The Respondent's Correspondence with the FLCCC Alliance;

Exhibit R-61: Amended Transcript of Hearing on Motion to Dismiss *Robert L. Apter, et al. v. Department of Health and Human Services, et al. 3:22-cv-00184*;

Exhibit R-62: Dr. Wilkinson's letter responding to the letter of cooperation with exhibits; and

Exhibit R-63: Washington Medical Commission *COVID-19 Misinformation*. Available at: https://wmc.wa.gov/sites/default/files/public/COVID-19/COVID-19%20Misinformation%20Position%20Statement.pdf.

The following exhibits were provided to the panel only *after* the panel had determined that the Respondent had committed violations as alleged in the Statement of Charges:

Exhibit D-50: Stipulation and Agreed Order Directing Corrective Action, Washington Medical Disciplinary Board, *In the Matter of Disciplinary Action Concerning Richard Wilkinson, M.D.,* Docket No PM 4114, dated March 18, 1988; and

Exhibit D-51: Stipulation to Informal Disposition, Washington Medical Quality Assurance Commission, *In the Matter of the License to Practice as a Physician and Surgeon of Richard Stanley Wilkinson, MD,* Program No.94-09-0045MD, dated March 7, 1997.

I. FINDINGS OF FACT

1.1 The Respondent was granted a license to practice as a physician and surgeon in the state of Washington on November 15, 1977. The Respondent's license is currently active. The Respondent is not board certified.

1.2 At all times relevant to this case, the Respondent practiced medicine in a clinic that he owned. From June 2020 through at least May 2022, the Respondent identified himself as a licensed physician, promoted medical services he provided to

patients in his clinic, and published a web site (blog) in which he provided medical information to the public.

Background on COVID-19 and ivermectin

1.3 SARS-CoV-2 is a coronavirus that causes COVID-19, an infectious respiratory disease that spreads mainly from person to person through respiratory droplets produced when an infected person coughs, sneezes, or talks. Adults 65 years and older and people of any age with underlying medical conditions are at higher risk for severe illness. On January 22, 2020, the Centers for Disease Control and Prevention (CDC) identified the first U.S. reported case of coronavirus in the state of Washington. Since then, nearly one million people in the U.S. have reportedly died because of COVID-19.

1.4 The Food and Drug Administration (FDA) has approved ivermectin tablets for use in humans for the treatment of some parasitic worms and approved ivermectin topical formulations for the treatment of external parasites such as head lice and scabies, and for skin conditions such as rosacea. Ivermectin is approved in the United States under the brand name STROMECTOL and is sold by Merck & Co. Inc. (Merck). The FDA has not approved ivermectin to treat SARS-CoV-2 infections that cause COVID-19.

1.5 On February 4, 2021, Merck released a statement regarding the use of ivermectin to treat COVID-19. In the statement, Merck indicated that its scientists "continue[d] to carefully examine the findings of all available and emerging studies of ivermectin for the treatment of COVID-19 for evidence of efficacy and safety." However, Merck indicated that its analysis as of that date had identified: "[n]o scientific basis for a

potential therapeutic effect against COVID-19 from pre-clinical studies"; "[n]o meaningful evidence for clinical activity or clinical efficacy in patients with COVID-19 disease"; and "[a] concerning lack of safety data in the majority of studies." Exhibit D-39.

The Respondent's Public Statements

1.6 The Respondent made numerous false and misleading statements on his blog regarding the COVID-19 pandemic, COVID-19 vaccines, and public health officials. These statements—which in context can only be characterized as constituting the practice of medicine—were harmful and dangerous to individual patients, generated mistrust in the medical profession and in public health, and had a widespread negative impact on the health and well-being of the community.

1.7 Much of the information that the Respondent spread via his blog was not factual, scientifically grounded, or consensus driven. However, due to their specialized knowledge and training, licensed physicians possess a high degree of public trust and therefore have a powerful platform in society. Physicians also have an ethical and professional responsibility to practice medicine in the best interests of their patients and must share information that is factual, scientifically grounded, and consensus-driven for the betterment of the public. When physicians spread inaccurate information and rely on their status as licensed physicians to bolster their message, it is especially harmful as it threatens the health and well-being of the community and undermines public trust in the profession and established best practices in care. *See* Exhibit D-41. Here, the Respondent spread inaccurate information via his blog, relying on his status as a physician to spread the misinformation.

1.8 The Respondent's false statements on his blog included the following:

1.8.1 The COVID-19 pandemic is a scam;

1.8.2 Polymerase chain reaction (PCR) testing and the use of masks to reduce the spread of COVID-19 infection are useless;

1.8.3 Public health entities, including the Food and Drug Administration, the Washington State Department of Health, and the Yakima County Health Department, are providing false information and are not to be trusted;

1.8.4 Ivermectin is effective in preventing or treating a COVID-19 infection; and

1.8.5 COVID-19 vaccines are dangerous and kill people, comparing the push for vaccination with the murder of Jewish people in Nazi-era Germany.

Patient A and Patient B

1.9 Patient A and B were a married couple. As of August 2021, Patient A and Patient B were both 84 years old and had both been treated by the Respondent for many years.

1.10 On the morning of August 11, 2021, the daughter of Patient A and Patient B called the Respondent's office and told a staff member that both Patient A and Patient B had been sick with fevers for the previous three days. The daughter asked for help in preventing Patient A and Patient B from getting a COVID-19 infection.

1.11 Later in the day on August 11, 2021, the Respondent called and spoke to Patient B.[1] The Respondent prescribed Patient A and Patient B the following

[1] It is unclear from the Respondent's records whether the Respondent also spoke to Patient A at the same time. The Respondent failed to separate Patient A and Patient B in the medical records.

medications: ivermectin, 15 mg daily for three days, then every other day; azithromycin, 5-day dose pack 250 mg; budesonide 0.5 mg/2 mL via nebulizer; and methylprednisolone 4 mg. The Respondent noted in the medical record that the daughter of Patient A and Patient B was not present during the phone call and instructed staff to call the daughter at the end of the day. The Respondent did not physically see Patient A or Patient B at that time.

1.12 The Respondent did not document an appropriate history or medical decision-making regarding Patient A. The documented assessment consists of merely a billing code for four conditions, including COVID-19. The Respondent did not document a sufficient rationale for prescribing any of the medications he prescribed. The Respondent did not document that he obtained informed consent from Patient A for his treatment regimen. Appropriate informed consent would include: a discussion of the nature and character of the proposed treatment; a discussion of the possible alternative treatments for a COVID-19 infection; and a discussion of the recognized risks, as well as the potential complications and anticipated benefits of taking ivermectin for a COVID-19 infection. This would also include documentation that the Respondent informed Patient A that the FDA has not approved ivermectin for a COVID-19 infection and that the prescribing of ivermectin for COVID-19 is off-label. Further, there is no record of the Respondent providing Patient A with evidence supporting the off-label use of ivermectin.

1.13 The Respondent did not create a separate chart note for Patient B for the August 11, 2021, phone call and the prescribing of the medications. The Respondent did not document a physical examination of Patient B. Furthermore, the Respondent did not

document a sufficient rationale for prescribing any of the prescribed medications. Like with Patient A, the Respondent did not document that he obtained informed consent from Patient B for his treatment regimen.

Patient C

1.14 As of August 2021, Patient C was 17 years old. Patient C had a history of hypertension, obesity, and asthma.

1.15 On August 28, 2021, Patient C was experiencing a fever, cough, body aches, and shortness of breath. Although Patient C had an inhaler for his asthma, it was not helping him at that time. In addition, both Patient C's father and mother had been recently diagnosed with COVID-19 and Patient C had not been vaccinated against COVID-19. Consequently, Patient C's mother took him to a hospital emergency department.

1.16 At the hospital, Patient C was diagnosed with COVID-19. He was found to be hypertensive, but a chest x-ray was normal. As a result, Patient C was discharged with the following medications: albuterol, benzonatate, ibuprofen, losartan, and ondansetron.

1.17 After being discharged, Patient C continued to experience shortness of breath. On August 30, 2021, Patient C's mother brought him back to the hospital emergency department. Patient C's mother explained to the hospital staff that Patient C's oxygen saturation levels had decreased to 89 percent at home. Patient C was stabilized, determined not to be in respiratory distress, and was then discharged home with the following medications: dexamethasone, ibuprofen, and acetaminophen.

1.18 On August 31, 2021, Patient C's mother took him to the Respondent's clinic. At that time, Patient C was complaining of a bad cough, fever, and a COVID-19 infection that was not improving. The Respondent conducted a physical examination of Patient C, but there is no evidence that he took Patient C's vital signs. The Respondent prescribed the following medications to Patient C: ivermection,18 mg daily for four days, then every other day; zinc, 200 mg daily; budesonide; nebulized hydrogen peroxide; a Medrol dose pack; nattokinase, three capsules daily; and minocycline, 100 mg twice a day. The Respondent did not document his medical decision-making or a sufficient rationale for prescribing any of the above medications to Patient C. The Respondent did not document that he obtained informed consent from Patient C or his mother for the treatment regimen. There is no record of the Respondent providing Patient C or his mother with evidence supporting the off-label use of ivermectin. Similarly, there is no record of the Respondent providing Patient C or his mother with a warning that inhaled hydrogen peroxide does not have any effect on a COVID-19 infection and is dangerous.

1.19 Later in the day of August 31, 2023, Patient C was suffering from an increased cough and shortness of breath. Patient C's oxygen saturation at home was 85 percent. Consequently, Patient C's mother took Patient to the hospital emergency department again.

1.20 At the hospital emergency department, Patient C was hypertensive, had a pulse of 108, and had oxygen saturation levels between 88 and 92 percent. Patient C was given supplemental oxygen, which led to both the hypertension and increased pulse resolving. At the hospital, the treating physician discussed with Patient C's mother

whether or not Patient C should be admitted to the hospital or discharged home with supplemental oxygen due to Patient C's fluctuating oxygen saturation levels. Ultimately, Patient C's mother chose to have Patient C discharged home. Upon discharge, Patient C was provided with instructions that he should return to the hospital if he required more than two liters of oxygen by nasal cannula.

1.21 As Patient C was still suffering from shortness of breath at home, Patient C's mother brought him back to the hospital emergency department. Patient C reported that his oxygen saturation levels dropped to between 83 and 85 percent while sleeping, and improved with movement to 91 percent. Patient C again was hypertensive, had an increased pulse, and had a fever. Patient C was admitted to the hospital with a diagnosis of hypoxia and COVID-19 infection. Two days later, Patient C was discharged home with increased supplemental oxygen, dexamethasone, albuterol, losartan, acetaminophen, and ibuprofen.

Patient D

1.22 Patient D was male, 65 years of age as of October 2021. Patient D had a prior history of tobacco use and had not been vaccinated against COVID-19. After experiencing shortness of breath and flu-like symptoms for several days, Patient D was taken to the emergency department of a hospital on the evening of October 27, 2021.

1.23 At the hospital, Patient D's oxygen saturation was only 85 percent. However, his levels improved when given supplemental oxygen and dexamethasone. Patient D tested positive for COVID-19 and was diagnosed with acute respiratory failure with hypoxia due to viral pneumonia. Patient D was offered treatment with remdesivir

and baricitinib in the emergency department, but he refused those medications. Instead, Patient D and his wife requested that he be given ivermectin, indicating that they had a supply of ivermectin at home. The emergency department providers refused to provide ivermectin to Patient D for a COVID-19 infection. The next afternoon, Patient D left the emergency department against medical advice.

1.24 After leaving the hospital, Patient D went to see the Respondent on October 28, 2021. In the chart note, the Respondent indicated that Patient D was taking ivermectin. Nevertheless, the Respondent prescribed ivermectin, 18 mg per day for five days, then once per day "until doing better." Exhibit D-18a. It is unclear from the chart note what "until doing better" means. In addition, the Respondent prescribed azithromycin, prednisone, nebulized budesonide, heparin, zinc, melatonin, and vitamin C to Patient D.

1.25 The Respondent's documented assessment for Patient D on October 28, 2021, consisted only of a billing code for COVID-19. Overall, the Respondent's recordkeeping for Patient D's care was deficient. The Respondent did not document a sufficient rationale for prescribing any of the medications that he prescribed to Patient D. The Respondent did not document that he obtained informed consent from Patient D for his treatment regimen. The Respondent did not document an appropriate history, a physician examination, or medical decision-making for Patient D. Furthermore, there is no record of the Respondent providing Patient D with evidence supporting the off-label use of ivermectin.

1.26 On November 3, 2021, Patient D returned to the hospital emergency department. At that time, Patient D was experiencing shortness of breath, cough, fever, muscle pain, and headache. Patient D's oxygen saturation level was 90 percent. He was diagnosed with acute hypoxic respiratory failure and was admitted to the hospital. Patient D told hospital staff that he had been taking ivermectin and supplemental oxygen at home, but that his symptoms had worsened.

1.27 On November 14, 2021, Patient D died in the hospital. Patient D's cause of death was pneumonia due to the COVID-19 virus.

Patient E

1.28 Patient E was female, approximately 56 years of age as of September 2021. Patient E had not been vaccinated against COVID-19. On September 8, 2021, Patient E went to a hospital emergency department complaining of abdominal pain, nausea, dizziness, fever, and anorexia. Patient E indicated that she had been experiencing oxygen saturation levels in the 80s at home.

1.29 At the hospital, Patient E was diagnosed with COVID-19. Patient E was given intravenous fluids and Zofran. Patient E was offered monoclonal antibodies, but declined the offer. Nevertheless, Patient E's vital signs improved, and she was discharged home from the hospital later that day. Upon discharge, Patient E was instructed to follow up with her primary care provider and to return to the hospital if her condition worsened.

1.30 Later in the day on September 8, 2021, Patient E had a virtual medical visit with the Respondent via Zoom. However, the medical record does not indicate that it was

a virtual visit. During the visit, Patient E told the Respondent that she had previously been at the hospital with COVID-19 and was not doing well. Patient E told the Respondent that she had been offered monoclonal antibodies at the hospital but that she had declined them. Patient E did report to the Respondent that she had been taking ivermectin, vitamin D, zinc, and nebulized hydrogen peroxide. The Respondent prescribed ivermectin, 18 mg twice per day for four days, then one tablet per day. The Respondent also prescribed nebulized budesonide (three times per day), zinc, azithromycin, and twice daily aspirin.

1.31 The Respondent did not document an appropriate history or medical decision-making for Patient E. Like the records for Patient D, the documented assessment for Patient E consisted only of a billing code for COVID-19. The Respondent did not document a sufficient rationale for prescribing any of the medications that he prescribed to Patient E. The Respondent did not document that he obtained informed consent from Patient E for her treatment regimen. Here, appropriate informed consent would have included a discussion of the possible alternative treatments for COVID-19 infection, including monoclonal antibodies (which would have reduced Patient E's chances of becoming seriously ill and requiring a return to the hospital). Furthermore, there is no record of the Respondent providing Patient D with evidence supporting the off-label use of ivermectin.

1.32 On September 9, 2021, Patient E returned to the hospital emergency department complaining of shortness of breath, coughing, fatigue, fever, and chills. She was diagnosed with acute hypoxic respiratory failure and pneumonia due to COVID-19 and was admitted to the hospital. In the hospital, Patient E received dexamethasone and

supplemental oxygen; Patient E was able to be discharged from the hospital six days later.

Patient F

1.33 Patient F was male, 91 years of age as of December 2021. On December 3, 2021, Patient F had a virtual medical visit with the Respondent via Zoom. However, the medical record does not indicate that it was a virtual visit. Patient F's spouse (Patient G) was also present virtually during this visit. Prior to this visit, the Respondent had never seen or treated Patient F.

1.34 During the virtual visit, Patient F and his spouse reported that Patient F had been exposed to COVID-19 on Thanksgiving, that several family members had COVID-19, and that Patient F had a cough and a fever that had gone as high as 103 degrees Fahrenheit. Patient F also reported that his oxygen saturation level just prior to the visit was 92 percent, and that it had gone as low as 82 percent earlier that morning. However, Patient F denied trouble breathing or shortness of breath at the time of the visit.

1.35 The Respondent noted in the chart that Patient F had been taking ivermectin paste on a daily basis. Ivermectin paste is a veterinary formulation intended for use by non-humans and is dangerous when used by humans. In fact, Patient F reported that he was having "a lot of diarrhea" and his spouse indicated that on one occasion he had "almost a 'seizure' or the shakes." Exhibit D-26a. Nevertheless, the Respondent did not advise Patient F not to take ivermectin paste.

1.36 The Respondent diagnosed Patient F with a COVID-19 infection. The Respondent prescribed ivermectin, 15 mg twice daily for five days, then once per day

"until doing pretty well." Exhibit 26a. However, the Respondent did not indicate in the chart what "until doing pretty well" meant. The Respondent did tell Patient F to go to the hospital if his condition got significantly worse. In addition, the Respondent prescribed supplemental oxygen, prednisone, Singulair, vitamin C, vitamin D, zinc, Tylenol, azithromycin, and melatonin. Nevertheless, the Respondent did not document a sufficient rationale for any of the medications that he prescribed to Patient F.

1.37 The Respondent did not document Patient F's medical history or what medications Patient F was taking (other than the ivermectin paste). However, Patient F had numerous medical problems including dementia, hypertension, and atrial fibrillation. In addition, Patient F had an indwelling, double-chamber pacemaker. Patient F also was on a blood thinning medication. Although the combination of prednisone and a blood thinner leads to an increased risk of bleeding, the Respondent did not document this risk. The Respondent's documented assessment consisted only of a billing code for COVID-19. Furthermore, the Respondent did not ask Patient F if he was vaccinated against COVID-19. Overall, the Respondent's documentation of his medical decision-making process for Patient F was inadequate.

1.38 In his chart note, the Respondent wrote "informed consent re ivermectin." Exhibit D-26a. However, the Respondent did not adequately document obtaining informed consent from Patient F. There is no record of the Respondent providing Patient F with evidence supporting the off-label use of ivermectin.

1.39 In the following days, Patient F was directed by the Respondent to receive higher and higher doses of oxygen at home. Eventually, this reached a flow rate of 24

liters per minute. The Respondent did not document the rationale for this, nor did he document his medical decision-making process.

1.40 Finally, on December 10, 2021, Patient F was taken to a hospital emergency department with respiratory distress. At the hospital, Patient F's oxygen saturation was 62 percent, and he was placed on bilevel positive airway pressure. Patient F was admitted to the hospital with a diagnosis of acute hypoxic respiratory failure due to COVID-19 pneumonia. He was given dexamethasone and albuterol, but his family refused treatment with baricitinib. Patient F's condition worsened, and he died on February 17, 2021.

Patient G

1.41 Patient G was female, 87 years old as of December 2021. Patient G was married to Patient F. On December 8, 2021, she went to the Respondent's clinic complaining of fever and low oxygen saturation levels. However, Patient G was not experiencing shortness of breath at that time.

1.42 Patient G reminded the Respondent that her husband (Patient F) had a COVID-19 infection. She also let the Respondent know that she had been taking ivermectin paste. Based on Patient G's symptoms and the fact that her spouse had COVID-19, the Respondent assumed that Patient G also had COVID-19. The Respondent prescribed ivermectin, 15 mg twice daily for five days, then once per day "until doing pretty well." Exhibit D-29a. However, the Respondent did not indicate in the chart what "until doing pretty well" meant. In addition, the Respondent prescribed prednisone, budesonide, Singulair, vitamin A, vitamin C, vitamin D, zinc, cimetidine, and

promethazine. The Respondent did not document a sufficient rationale for prescribing any of these medications.

1.43 The Respondent did do a physical examination of Patient G. However, the Respondent did not take an appropriate medical history. Particularly concerning is that the Respondent did not document any drug allergies that Patient G may have had. The Respondent did not document that he obtained informed consent from Patient G for her treatment regimen. Like with other patients, there is no record of the Respondent providing Patient G with evidence supporting the off-label use of ivermectin.

1.44 On December 11, 2021, Patient G went to a hospital emergency department with shortness of breath. At that time, Patient G's oxygen saturation level was 86 percent. At the hospital, Patient G tested positive on a COVID-19 test. She was admitted to the hospital with acute hypoxic respiratory failure due to Covid-19 pneumonia. In the hospital, she was given dexamethasone and supplemental oxygen. She did request ivermectin, but the hospital providers did not provide any to her. After six days, Patient G recovered enough to be released from the hospital.

Credibility Findings

1.45 Scott Lancaster, Jeremy Hutchins, Steven Richards, John Maxwell, and Jasper Fernandez: These witnesses were all physicians who also treated Patients A through G. None of these witnesses had any reason to lie about their experiences and all these witnesses were extremely credible. Although there are medical charts in the record, these witnesses provided additional information and context that was helpful to the panel members. This additional information and context highlighted the

consequences of the Respondent's actions. The experiences of these witnesses also demonstrated to the panel how far removed the Respondent was from the appropriate standard of care for COVID-19 patients.

1.46 Raymond Scott McClelland, Anna Wald, and Dawn Nolt: These three witnesses provided expert testimony on behalf of the Commission. All were highly qualified with respect to the issues at dispute in this hearing. For example, all were physicians that had master's degrees in public health in addition to their medical degrees. In addition, all were board certified in either adult infectious disease or pediatric infectious diseases. All had multiple years of experience treating patients with infectious disease. This included studying and treating patients with COVID-19. As a result, all of the witnesses were familiar with current research on COVID-19. The panel members gave great weight to the testimony and were able to use the information from these expert witnesses in combination with their own experience, competency, and specialized knowledge while evaluating the evidence.

1.47 Janis Burke, Patient E, Cathy Cockrum, Jennifer Munoz, and Felicia Rosenow: All of these individuals were either patients, friends of patients, or family of patients. All provided insights into interactions between the patients and the healthcare system, including interactions with the Respondent's. This enabled the panel to better understand the lived experience of the patients. However, this testimony was not helpful in making a determination as to whether or not the Respondent committed unprofessional conduct as alleged in the Statement of Charges.

1.48 David Arnold and Akiko Kato: These two individuals provided healthcare services to at least some of the Respondent's patients. David Arnold is a pharmacist, and Akiko Kato is a naturopathic physician. Both were credible as to the actions that they took in providing their patient care, with their own associated philosophies. However, the testimonies of these two were not helpful in determining whether or not the Respondent committed unprofessional conduct as alleged in the Statement of Charges.

1.49 Frank Shallenbeger, III: Dr. Shallenberger provided expert testimony on behalf of the Respondent. Dr. Shallenberger works in Nevada and specializes his practice in integrative medicine. He has treated about 120 COVID-19 patients but admitted that he was not aware of the standard of care in Washington. He testified that nebulized hydrogen peroxide for COVID-19 patients was effective and safe; however, he was not aware of any research studies on that topic. He had reviewed the treatment protocols that the Respondent utilized for Patients C and E, finding them to be appropriate. Contrary to the weight of medical evidence, he does not recommend COVID-19 vaccines to his patients.

Dr. Shallenberger was much less credible than the Commission's expert witnesses. In general, he was less knowledgeable about the most up to date research on treatment of COVID-19 patients. In addition, he has been disciplined by medical licensing authorities in both Nevada and California. This included a reprimand in Nevada for failing to report disciplinary action in California. Consequently, the panel gives little weight to his testimony.

1.50 The Respondent: It was apparent that the Respondent was very biased toward his own points of view. The Respondent took positions on COVID-19 based on his own interpretations of the data and then was closed to evaluating alternate viewpoints. However, it is necessary that physicians remain skeptical of their own interpretations and must remain aware of a constantly evolving body of evidence. When there is no longer support for a given hypothesis, it must be reevaluated in light of the data. Here, the Respondent failed to conform his COVID treatment to what the evidence showed was appropriate at the time. Consequently, the Respondent's rationale for the care he provided was insufficient and not credible. Thus, the Respondent failed to meet the standard of care for a Washington physician.

II. CONCLUSIONS OF LAW

2.1 The Commission has jurisdiction over the Respondent and subject of this proceeding. RCW 18.130.040.

2.2 The Washington Supreme Court has held the standard of proof in disciplinary proceedings against physicians is proof by clear and convincing evidence. *Nguyen v. Department of Health*, 144 Wn.2d 516, 534 (2001), *cert. denied,* 535 U.S. 904 (2002).

2.3 The Commission panel members used their experience, technical competency, and specialized knowledge in evaluating the evidence in this case. *See* RCW 34.05.461(5).

2.4 Unprofessional conduct is defined in RCW 18.130.180(1) as follows:

> The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether

> the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder or applicant of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter 9.96A RCW.

2.5 An act of moral turpitude is one that violates commonly accepted standards of good morals, honesty, or justice. *See In re Hopkins*, 59 Wn.569 (1909). Actions and convictions "relat[e] to" a profession, when they indicate unfitness to bear the responsibilities of, and to enjoy the privileges of, the profession. *Haley v. Medical Disciplinary Board*, 117 Wn.2d 720, 731 (1991). Conduct may indicate unfitness to practice the profession either by: (1) raising concerns that the individual may use the professional position to harm members of the public; or (2) by tending to lower the standing of the profession in the public's eyes, thereby affecting the quality of public health. *Haley v. Medical Disciplinary Board*, 117 Wn.2d 720, 738 (1991).

Here, the Respondent's presentations presented an extremely unbalanced look at COVID-19, downplaying the seriousness of COVID-19. The claims that medical records were falsified by hospitals undermines trust in the healthcare system and may delay patients from seeking necessary care. Similarly, the Respondent's posts about masks were likely to lead to people being less likely to wear masks when they should have been. The Respondent also significantly misrepresented information about COVID vaccines. This included claims that COVID vaccines could cause birth defects and infertility, and

that somehow COVID vaccines were not really vaccines. In addition, the Respondent's comparison of COVID vaccines to the mass murder of Jewish people in the Holocaust was objectively untrue and patently offensive.

The Respondent has clearly violated commonly accepted standards of honesty. All of this behavior raises concerns that the Respondent may use his professional position as a physician to harm members of the public. It also tends to lower the standing of physicians in the eyes of the public. Consequently, his actions "relate to" the medical profession. Consequently, the Commission has proved by clear and convincing evidence that the Respondent committed unprofessional conduct as defined in RCW 18.130.180(1).

2.6 Pursuant to RCW 18.130.180(4), unprofessional conduct includes:

> Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;

As amply demonstrated in the Findings of Fact above, the Respondent failed to meet the standard of care for Patients A, B, C, D, E, F, G, and H. This included failure to provide appropriate care for the treatment of COVID-19, failure to keep appropriate medical records, and failure to get informed consent for the treatment that the Respondent provided (including a persistent failure to engage in an informative discussion of the off-label use of ivermectin with his patients). Consequently, the Commission has proved by clear and convincing evidence that the Respondent has committed unprofessional conduct under RCW 18.130.180(4).

2.7 Pursuant to RCW 18.130.180(13), unprofessional conduct includes:

> Misrepresentation or fraud in any aspect of the conduct of the business or profession;

2.8 As noted above, the Respondent's presentation contained multiple falsehoods about COVID-19. The Respondent knew (or as a reasonably prudent physician, should have known) that much of the information he was presenting about COVID-19 was a misrepresentation of the true facts. Consequently, the Commission has proved by clear and convincing evidence that the Respondent violated RCW 18.130.180(13).

2.9 The Commission requests that the panel issue an order that places the Respondent on probation for five years and includes: (1) practice restrictions; (2) a clinical competency assessment and a requirement to subsequently complete all recommendations arising therefrom; (3) annual compliance appearances before the Commission; (4) annual compliance audits; (5) completion of continuing education; and (6) payment of a fine.

The Respondent contended that the Statement of Charges be dismissed, arguing that the Commission failed to prove the allegations. In addition, the Respondent argued that the Commission is attempting to regulate speech in a way that is prohibited by the U.S. Constitution.

2.10 In determining appropriate sanctions, public safety must be considered before the rehabilitation of the Respondent. RCW 18.130.160.

2.11 The Respondent's conduct falls in Tier B of the Practice below standard of care schedule. WAC 246-16-810. Tier B is appropriate because the Respondent's

conduct both caused moderate patient harm *and* caused a risk of severe patient harm.[2] The panel considered the following aggravating factors when determining the sanction in this matter: the Respondent engaged in the dissemination of false information; there were multiple patients involved in the unprofessional conduct; the Respondent has prior disciplinary history; and the Respondent misrepresented his disciplinary history during the investigative process. The panel considered the following mitigating factors when determining the sanction in this matter: the Respondent's long history of medical practice reveals a potential for successful rehabilitation. In taking into consideration the aggravating and mitigating factors, the panel has determined that sanctions at the maximum range of the sanctions schedule are appropriate.

III. ORDER

3.1 The Respondent's license to practice as a physician and surgeon in the state of Washington is placed on PROBATION for a period of at least five (5) years.

3.2 Practice Restrictions. During the probationary period, the following practice restrictions will be in effect:

A. The Respondent is restricted from prescribing ivermectin for non-FDA-approved indications to patients.

B. The Respondent is restricted from prescribing medication or prescribing care to patients without first: (1) establishing a physician-patient relationship by seeing the patient either in-person or via real-time video; (2) taking the patient's history and

[2] The panel determines that Tier C does not apply here because it is not clear that the Respondent's actions directly caused severe patient harm or death.

conducting an appropriate examination of the patient; (3) obtaining informed consent; and (4) appropriately documenting all of this in the patient's medical record.

3.3 Clinical Competency Assessment. Within six (6) months, the Respondent must undergo a clinical competency evaluation that includes an assessment performed by the Physician Assessment and Clinical Education (PACE) program at the University of California San Diego School of Medicine. The Respondent will contract with PACE to conduct the clinical competency evaluation. The Commission, at its discretion, may approve an alternative clinical competency assessment program to conduct the assessment.

A. The assessment must include screening examinations, including at a minimum a history and physical, as well as cognitive and psychological screening. The assessment must also include reviews of the Respondent's:

1. Actions that resulted in this case;
2. Ability to conduct an appropriate history and physical examination of patients and incorporate the information gained into an assessment and plan;
3. Reasoning and decision-making;
4. Knowledge and understanding of diagnosing and treating infectious disease;
5. Ability to interpret medical literature, differentiate between peer reviewed medical literature and other types of medical literature,

and appropriately implement treatment options from the different types of medical literature;

6. Ability to counsel patients on treatment options while relying on evidence-based medicine;
7. Ability to discern the difference between evidence-based medicine and treatment modalities that lack evidence of efficacy; and
8. Ability to identify his knowledge gaps and implement appropriate responses to any such area of deficiency.

B. The Respondent must provide PACE with any release for information that is requested and must unconditionally cooperate with PACE during the evaluation. The Respondent must sign a waiver of confidentiality and a release to permit PACE and the Commission to share information. The Commission will provide PACE with records from the Commission's investigative files that the Commission deems appropriate. The Respondent must authorize PACE to provide a comprehensive written report, including any third-party evaluation reports, to the Commission. The Respondent must ensure that PACE provides its report to the Commission.

C. The Respondent must follow all recommendations in PACE's evaluation report, including recommendations for educational and other remediation, medical or other treatment, additional evaluations indicated by the assessment's screening examinations, and re-assessment after completion of remediation. PACE will

make specific recommendations regarding whether Respondent is able to practice as a physician without unreasonable risk of harm to patients, with or without imposition of remedial conditions, oversight, or training. The Respondent is not allowed to dispute any of the statements or recommendations in the PACE report. The recommendations may be incorporated into a Modified Order. The Commission is not foreclosed from taking additional action against the Respondent's license based on the PACE recommendations.

D. The Respondent shall send proof of enrollment, evaluation, and completion of the program to the Commission's Compliance Unit at medical.compliance@wmc.wa.gov.

3.4 Continuing Medical Education (CME). The Respondent must successfully complete continuing medical education (CME) courses in the following topics. All courses must be pre-approved by the Commission or its designee:

A. Medical record-keeping;

B. Medical decision-making, which includes a review of how to chart the decision making-process; and

C. Informed consent.

All these CME courses must be in addition to mandatory continuing education hours required for license renewal. The Respondent must complete the coursework within six (6) months of the effective date of this Order. The Respondent shall provide the Commission with course certificates within one (1) month of completion.

3.5 Compliance Audit. The Respondent must permit a representative of the Commission, or a pre-approved designee, to make announced visits to the Respondent's practice on an annual basis to conduct a compliance audit. The compliance audit will include a review of the Respondent's records, and compliance with this Order. The representative will randomly select records of the Respondent's patients to determine if the Respondent is in compliance with this Order. The compliance audits may also include inspection of office records, medication logs, generation of Prescription Monitoring Program profiles for all patients, outside pharmacy records, and interviews of the Respondent and other staff. Any costs associated with these compliance audits will be borne by the Respondent. The Respondent must fully cooperate with the representative during the compliance audit.

3.6 Personal Appearances. Within twelve (12) months of the effective date of this Order, the Respondent will personally appear at a date and location determined by the Commission, or as soon thereafter as the Commission's schedule permits. Thereafter, the Respondent will make personal appearances annually or as frequently as the Commission requires unless the Commission waives the need for an appearance. The Respondent must participate in a brief telephone call with the Commission's Compliance Unit prior to the appearance. The purpose of appearances is to provide meaningful oversight over the Respondent's compliance with the requirements of this Order. The Commission will provide reasonable notice of all scheduled appearances.

3.7 Personal Reports. The Respondent will submit written personal reports directly to the Commission. The Respondent will submit the first report within thirty days

from the effective date of this Order and will submit a report every six (6) months thereafter unless the Commission determines that they should be submitted less frequently and the Respondent is notified in writing. Personal reports will include: a declaration attesting that the Respondent is in compliance with all terms and conditions of this Order; a status report regarding any terms and conditions not yet completed; current professional responsibilities and activities; personal activities as they relate to practice as a physician; and any ongoing efforts to implement improvements into the Respondent's practice that may be relevant to the Findings of Fact outlined in this Order.

3.8 Fine. Within nine (9) months of the effective date of this Order, the Respondent will pay fifteen thousand dollars ($15,000) to the Commission. The fine will be paid by certified check or money order, made payable to the Department of Health, and mailed to: Washington Medical Commission, Department of Health, P.O. Box 1099, Olympia, Washington, 98504-1099.

3.9 Modification. The Respondent may not seek modification of this Order for five (5) years from the effective date of this Order.

3.10 Change of Address. The Respondent shall inform the program manager and the Adjudicative Service Unit, in writing, of changes in his residential and/or business address within 30 days of such change.

3.11 Assume Compliance Costs. The Respondent shall assume all costs of complying with all requirements, terms, and conditions of this Order.

3.12 Failure to Comply. Protecting the public requires practice under the terms and conditions imposed in this Order. Failure to comply with the terms and conditions of

this Order may result in suspension and/or revocation of the Respondent's license after a show cause hearing. If the Respondent fails to comply with the terms and conditions of this order, the Commission may hold a hearing. At that hearing, the Respondent must show cause why his license should not be suspended. Alternatively, the Commission may bring additional charges of unprofessional conduct under RCW 18.130.180(9). In either case, the Respondent will be given notice and an opportunity for a hearing on the issue of non-compliance.

3.13 Protective Order: The Washington Supreme Court has identified five factors to consider before closing part of a proceeding or sealing part of a court record. These balancing factors are:

1. The proponent of closure and/or sealing must make some showing of the need therefor.

2. Anyone present when the closure (and/or sealing) motion is made must be given an opportunity to object to the suggested restriction.

3. The court, the proponents, and the objectors should carefully analyze whether the requested method for curtailing access would be both the least restrictive means available and effective in protecting the interests threatened.

4. The court must weigh the competing interests of the public against the interests that would be guarded by a protective order.

5. The protective order must be no broader in its application or duration than necessary.

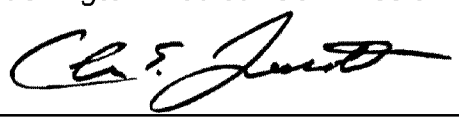
Seattle Times Co. v. Ishikawa, 97 Wash.2d 30 (1982).

Pursuant to WAC 246-11-400, a "presiding officer may issue a protective order at his or her discretion:...(2) To preserve confidentiality related to health care records or provider-client information; [and] (3) To protect examination processes." Pursuant to an

oral order issued by the Presiding Officer in advance of the hearing, the Respondent's previously proposed exhibits R1 through R15 are SEALED because they contain unredacted patient names.

Dated this 12th day of August, 2023.

Washington Medical Commission



CLAIRE TRESCOTT, MD
Panel Chair

CLERK'S SUMMARY

Charge	Action
RCW 18.130.180(1)	Violated
RCW 18.130.180(4)	Violated
RCW 18.130.180(13)	Violated

NOTICE TO PARTIES

This order is subject to the reporting requirements of RCW 18.130.110, Section 1128E of the Social Security Act, and any other applicable interstate or national reporting requirements. If discipline is taken, it must be reported to the National Practitioner Data Bank.

Either party may file a **petition for reconsideration**. RCW 34.05.461(3); 34.05.470. The petition must be filed within 10 days of service of this order with:

Adjudicative Service Unit
P.O. Box 47879
Olympia, WA 98504-7879

and a copy must be sent to:

Department of Health Medical Program
P.O. Box 47866
Olympia, WA 98504-7866

The petition must state the specific grounds for reconsideration and what relief is requested. WAC 246-11-580. The petition is denied if the Commission does not respond in writing within 20 days of the filing of the petition.

A **petition for judicial review** must be filed and served within 30 days after service of this order. RCW 34.05.542. The procedures are identified in chapter 34.05 RCW, Part V, Judicial Review and Civil Enforcement. A petition for reconsideration is not required before seeking judicial review. If a petition for reconsideration is filed, the above 30-day period does not start until the petition is resolved. RCW 34.05.470(3).

The order is in effect while a petition for reconsideration or review is filed. "Filing" means actual receipt of the document by the Adjudicative Service Unit. RCW 34.05.010(6). This order is "served" the day it is deposited in the United States mail or is otherwise properly electronically transmitted. RCW 34.05.010(19).

For more information, visit our website at: http://www.doh.wa.gov/Hearings

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: Richard S. Wilkinson, MD
Master Case No.: M2022-196
Document: Statement of Charges

Regarding your request for information about the above-named practitioner; attached is a true and correct copy of the document on file with the State of Washington, Department of Health, Adjudicative Clerk Office. These records are considered Certified by the Department of Health.

Certain information may have been withheld pursuant to Washington state laws. While those laws require that most records be disclosed on request, they also state that certain information should not be disclosed.

The following information has been withheld:

> The identity of the complainant if the person is a consumer, health care provider, or employee, pursuant to RCW 43.70.075 (Identity of Whistleblower Protected) and/or the identity of a patient, pursuant to RCW 70.02.020 (Medical Records - Health Care Information Access and Disclosure)

If you have any questions or need additional information regarding the information that was withheld, please contact:

> Customer Service Center
> P.O. Box 47865
> Olympia, WA 98504-7865
> Phone: (360) 236-4700
> Fax: (360) 586-2171

You may appeal the decision to withhold any information by writing to the Privacy Officer, Department of Health, P.O. Box 47890, Olympia, WA 98504-7890.

STATE OF WASHINGTON
WASHINGTON MEDICAL COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon of: **RICHARD S. WILKINSON, MD** License No. MD.MD.00016229 Respondent.	**No. M2022-196** **STATEMENT OF CHARGES**

The Executive Director of the Washington Medical Commission (Commission) is authorized to make the allegations below, which are supported by the evidence contained in Commission file number 2021-9863, 2021-10393, 2021-10901, 2021-11600, 2021-13535, and 2021-15189. The patients referred to in this Statement of Charges are identified in the attached Confidential Schedule.

1. ALLEGED FACTS

1.1 On November 15, 1977, the state of Washington issued Respondent a license to practice as a physician and surgeon. Respondent's license is currently active. Respondent is not board certified.

Summary

1.2 Respondent made numerous false and misleading statements on his public web site regarding the COVID-19 pandemic, COVID-19 vaccines, and public health officials that were harmful and dangerous to individual patients, generated mistrust in the medical profession and in public health, and had a wide-spread negative impact on the health and well-being of our communities. Respondent also provided negligent care to Patients A, B, C, D, E, F, and G to prevent or treat COVID-19 infections. For some of all of these patients, Respondent prescribed medications that are not indicated for a COVID-19 infection, failed to properly document adequate justification for the treatment in the medical record, failed to take a history or perform a physical examination, and failed to obtain appropriate informed consent.

Background

1.3 SARS-CoV-2 is a coronavirus that causes COVID-19, an infectious a respiratory disease that spreads mainly from person to person through respiratory

droplets produced when an infected person coughs, sneezes, or talks. Adults 65 years and older and people of any age with underlying medical conditions are at higher risk for severe illness. On January 22, 2020, The Center for Disease Control and Prevention (CDC) identified the first reported U.S. case of coronavirus in Washington State. Since then, nearly one million people in the U.S. have reportedly died because of COVID-19.

1.4 The United States Food and Drug Administration (FDA) has approved ivermectin tablets for use in humans for the treatment of some parasitic worms and approved ivermectin topical formulations for the treatment of external parasites such as head lice and scabies, and for skin conditions such as rosacea. The FDA has not approved ivermectin to treat severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infections that cause coronavirus disease 2019 (COVID-19).

1.5 Additionally, in the United States, the primary manufacturer of ivermectin, Merck & Co, Inc., issued guidance to clinicians regarding use of ivermectin in treating COVID-19. In Merck's statement to clinicians, it states that it has concluded ivermectin has no scientific basis for a potential therapeutic effect against COVID-19, no meaningful evidence for clinical activity or clinical efficacy in patients with COVID-19, and a lack of safety data in the clinical studies that have been conducted with COVID-19 patients.

1.6 The FDA has approved chloroquine phosphate for the treatment of malaria, and has approved hydroxychloroquine sulfate for the treatment of malaria and auto-immune conditions such as lupus and rheumatoid arthritis. On June 15, 2020, the FDA revoked the emergency use authorization that permitted chloroquine phosphate and hydroxychloroquine sulfate to be used to treat certain hospitalized patients for COVID-19. The FDA based its decision on emerging scientific data showing that these medications did not have an anti-viral effect, and that they posed a risk of serious cardiac adverse events and other potential serious side effects.

Public statements

1.7 Due to their specialized knowledge and training, licensed physicians possess a high degree of public trust and therefore have a powerful platform in society. Physicians also have an ethical and professional responsibility to practice medicine in the best interests of their patients and must share information that is factual, scientifically grounded, and consensus-driven for the betterment of public health. When

physicians spread inaccurate information, and rely on their status as licensed physicians to bolster their message, it is especially harmful as it threatens the health and well-being of our communities and undermines public trust in the profession and established best practices in care.

1.8 At all times relevant to this case, Respondent practiced medicine in a clinic that he owned. From June 2020 through at least May 2022, Respondent maintained a public web site on which Respondent identified himself as a licensed physician, promoted medical services he provided to patients in his clinic, and published a blog in which he provided medical information to the public. Between June 2020 and May 2022, Respondent made numerous false and misleading statements in his blog regarding the COVID-19 pandemic, COVID-19 vaccines, and public health officials. Among the numerous false and misleading statements Respondent made, or quoted others as making, were the following:

1.8.1 The pandemic is a scam;

1.8.2 Polymerase chain reaction (PCR) testing and the use of masks to reduce the spread of COVID-19 infection are useless;

1.8.3 Public health entities, including the U.S. Food and Drug Administration, the Washington State Department of Health, and the Yakima County Health Department, are providing false information and are not to be trusted;

1.8.4 Ivermectin and hydroxychloroquine are effective in preventing or treating a COVID-19 infection; and

1.8.5 COVID-19 vaccines are dangerous and kill people, comparing the push for vaccination with the murder of Jewish people in Hitler's Germany.

1.9 Respondent's public false and misleading statements regarding the COVID-19 pandemic, COVID-19 vaccines, and public health officials are harmful and dangerous to individual patients, generate mistrust in the medical profession and in public health, and have a wide-spread negative impact on the health and well-being of our communities.

Patient A and Patient B

1.10 On the morning of August 11, 2021, the daughter of Patient A and Patient B, both 84 years of age, called Respondent's office and told a staff member that both Patient A and Patient B were sick with fevers for the past three days. Respondent had been treating Patient A and Patient B, husband and wife, for many years. The daughter asked for help to prevent Patient A and Patient B from getting a COVID-19 infection. Respondent called and spoke to Patient A and Patient B later that day. After speaking with Patient A and Patient B on the phone, Respondent prescribed to both Patient A and Patient B the same medications: ivermectin, 15mg daily for three days, then every other day; azithromycin 5-day dose pack 250 mg; budesonide 0.5 mg/2 mL via nebulizer; and methyl-prednisolone 4 mg. Respondent prescribed these medications without seeing or physically examining Patient A and Patient B. Respondent noted in the medical record that the daughter of Patient A and Patient B was not present for this phone call, and instructed staff to call the daughter at the end of the day to coordinate the care.

1.11 Respondent did not document an appropriate history or medical decision-making regarding Patient A. The documented assessment consists of merely a billing code for four conditions, including COVID-19. Respondent did not document a sufficient rationale for prescribing any of the medications he prescribed. Respondent did not document that he obtained informed consent from Patient A for his treatment regimen. Appropriate informed consent would include a discussion of the nature and character of the proposed treatment; a discussion of the possible alternative treatments for a COVID-19 infection, and a discussion of the recognized risks, the potential complications and anticipated benefits of taking ivermectin for a COVID-19 infection. Appropriate documentation of informed consent would also include documentation that Respondent informed Patient A that the FDA has not approved ivermectin for a COVID-19 infection, that the prescribing of ivermectin for an unapproved condition is off-label, and that Respondent provided Patient A with evidence supporting the off-label use of ivermectin.

1.12 Respondent did not create a chart note for his treatment of Patient B for the August 11, 2021, phone call and Respondent's prescribing of the medications. Respondent did not document a sufficient rationale for prescribing any of the

medications he prescribed. Respondent did not document that he obtained informed consent from Patient B for her treatment regimen. Appropriate informed consent would include a discussion of the nature and character of the proposed treatment; a discussion of the possible alternative treatments for a COVID-19 infection, and a discussion of the recognized risks, the potential complications and anticipated benefits of taking ivermectin for a COVID-19 infection. Appropriate documentation of informed consent would also include documentation that Respondent informed Patient B that the FDA has not approved ivermectin for a COVID-19 infection, that the prescribing of ivermectin for an unapproved condition is off-label, and that Respondent provided Patient B with evidence supporting the off-label use of ivermectin.

1.13 On August 15, 2021, both Patient A and Patent B went to the emergency department at a local hospital complaining of seven days of coughing, fevers, body aches, weakness, fatigue. Both Patient A and Patient B told the emergency department personnel that they both tested positive for a COVID-19 infection earlier in the week. Both Patient A and Patient B were admitted to the hospital and diagnosed with hypoxia respiratory failure caused by a COVID-19 infection. Both Patient A and Patient B spent the next eight days in the hospital and were both discharged on August 23, 2021.

Patient C

1.14 On August 28, 2021, the mother of Patient C, 17 years of age, took Patient C to the emergency department of a local hospital. Patient C had a fever, cough, body aches, and shortness of breath. Patient C had a history of hypertension, obesity, and asthma. Patient C used an inhaler for his asthma, but it was not helping him breathe. Both Patient C's mother and father were recently diagnosed with a COVID-19 infection. Patient C was not vaccinated. In the emergency department, Patient C was found to be hypertensive and had a COVID-10 infection. A chest x-ray was normal. Patient C was discharged from the emergency department with albuterol oral inhaler, benzonatate, ibuprofen, losartan, and ondansetron.

1.15 On August 30, 2021, Patient C's mother brought Patient C back to the hospital emergency department because Patient C had shortness of breath. Patient C's mother reported that Patient C's oxygen decreased to 89% at home. Patient C was found to be in no respiratory distress, was stabilized, and was discharged with dexamethasone, ibuprofen and acetaminophen.

1.16 On August 31, 2021, Patient C's mother took Patient C to see Respondent complaining of a bad cough, fever and a COVID-19 infection that was not getting better. Respondent prescribed 14 tablets of ivermectin 18 mg a day for four days, then every other day; zinc 200 mg a day; budesonide, nebulized hydrogen peroxide; a Medrol dose pack; nattokinase, three capsules daily; and minocycline 100 mg twice a day. Respondent did not take Patient C's vital signs or perform a physical examination of Patient C. Respondent did not document medical decision-making, or a sufficient rationale for prescribing any of the medications he prescribed to Patient C. Respondent did not document that obtained informed consent from Patient C or his mother for his treatment regimen. Appropriate informed consent would include a discussion of the nature and character of the proposed treatment; a discussion of the possible alternative treatments for a COVID-19 infection, and a discussion of the recognized risks, the potential complications and anticipated benefits of taking ivermectin for a COVID-19 infection. Appropriate documentation of informed consent would also include documentation that Respondent informed Patient C and his mother that the FDA has not approved ivermectin for a COVID-19 infection, that the prescribing of ivermectin for an unapproved condition is off-label, that Respondent provided Patient C with evidence supporting the off-label use of ivermectin, and that inhaled hydrogen peroxide has no effect on a COVID-19 infection and is dangerous.

1.17 That evening, Patient C's mother took Patient C back to the hospital emergency department because Patient C was suffering from increasing cough, shortness of breath, and an oxygen reading at home of 85%. Emergency department providers found Patient C to be hypertensive, had a pulse of 108, and that Patient C's oxygen saturation level ranged from 88% to 92%. Patient C was given supplemental oxygen and felt significant improvement; both his fever and his tachycardia resolved. Because of the intermittent hypoxia, the treating physician discussed with the mother whether Patient C should be admitted to the hospital or discharged home with supplemental oxygen. Patient C's mother chose to have Patient C discharged. Patient C was discharged with instructions that if he required more than two liters of oxygen by nasal cannula, he should return to the hospital for re-evaluation and likely admission.

1.18 On September 2, 2021, Patient C's mother took Patient C back to the hospital emergency department with shortness of breath. Patient C was febrile,

hypertensive and had tachycardia. Patient C reported his oxygen saturation at home dropped to 83-85% while sleeping, and with movement improved to 91%. Patient C was admitted to the hospital with a diagnosis of hypoxia and pneumonia due to a COVID-19 infection. Patient C was discharged two days later with increased supplemental oxygen, dexamethasone, albuterol, losartan, acetaminophen and ibuprofen.

Patient D

1.19 In the late evening on October 27, 2021, Patient D, 65 years of age, was taken by ambulance to the emergency department of a local hospital with shortness of breath and flu-like symptoms for several days. Patient D's oxygen saturation in the ambulance was 85%, but improved when given supplemental oxygen and IV dexamethasone in the emergency department. Patient D, who was not vaccinated, tested positive for a COVID-19 infection in the emergency department. Patient D was diagnosed with acute respiratory failure with hypoxia due to viral pneumonia from a COVID-19 infection. Patient D received supplemental oxygen and IV dexamethasone, but refused treatment with remdesivir and baricitinib. Patient D and his wife instead requested that Patient D be given ivermectin and explained that Patient D had a supply of ivermectin, hydroxychloroquine, and azithromycin at home that was prescribed by a naturopathic physician. Emergency department providers told Patient D and his wife that they would not provide ivermectin for a COVID-19 infection. At approximately 2 pm the next day, Patient D left the hospital against medical advice with a diagnosis of hypoxia and a COVID-19 infection.

1.20 Later that afternoon, Patient D went to see Respondent. In his chart note, Respondent states that Patient D was taking ivermectin. Respondent prescribed ivermectin 18 mg twice per day for five days, then once per day "until doing better." Respondent did not document what "until doing better" means. Respondent also prescribed azithromycin, prednisone, nebulized budesonide, heparin, zinc, melatonin, and vitamin C 2000mg every two hours.

1.21 Respondent did not document an appropriate history, a physical examination, or medical decision-making regarding Patient D. The documented assessment consists of merely a billing code for COVID-19. Respondent did not document a sufficient rationale for prescribing any of the medications he prescribed. Respondent did not document that he obtained informed consent from Patient D for his

treatment regimen. Appropriate informed consent would include a discussion of the nature and character of the proposed treatment; a discussion of the possible alternative treatments for a COVID-19 infection, and a discussion of the recognized risks, the potential complications and anticipated benefits of taking ivermectin for a COVID-19 infection. Appropriate documentation of informed consent would also include documentation that Respondent informed Patient D that the FDA has not approved ivermectin for a COVID-19 infection, that the prescribing of ivermectin for an unapproved condition is off-label, and that Respondent provided Patient D with evidence supporting the off-label use of ivermectin.

1.22 On November 3, 2021, Patient D returned to the hospital emergency department with shortness of breath, an oxygen saturation level of 90%, cough, fever, muscle pain and headache. Patient D told hospital personnel that based on Respondent's advice, he was not vaccinated against COVID-19, and had been taking ivermectin and supplemental oxygen at home, but his symptoms had worsened. Patient D was diagnosed with acute hypoxic respiratory failure. Patient D died in the hospital on November 14, 2021. The cause of death was pneumonia due to COVID-19 virus.

Patient E

1.23 In the early morning of September 8, 2021, Patient E went to the emergency department of a local hospital complaining of abdominal pain, nausea, dizziness, fever of 103.6, anorexia, and oxygen saturation readings at home in the 80s. Patient E was not vaccinated and was diagnosed with a COVID-19 infection. Patient E was given IV fluids and Zofran for nausea. Patient E was offered monoclonal antibodies, but refused. Patient E's vital signs improved, and she was discharged home with instructions to rest and quarantine for 14 days, to follow up with her primary care provider, and to return if her symptoms worsened.

1.24 Later that day, Patient E had a virtual visit with Respondent stating that she went to the hospital the night before, was diagnosed with a COVID-19 infection, and is not doing well. Respondent's record of this visit does not indicate that the visit was a virtual visit rather than an in-person visit, but Respondent told the Commission that he saw Patient E virtually via Zoom. Patient E told Respondent that she refused treatment with monoclonal antibodies. Patient E told Respondent she had been taking ivermectin, vitamin D, zinc, and nebulized hydrogen peroxide. Respondent prescribed to Patient E

ivermectin 18 mg twice per day for four days, then one tablet per day. Respondent also prescribed budesonide 0.5mg/2cc one vial in nebulizer, three times a day, zinc, azithromycin, and aspirin twice a day.

1.25 Respondent did not document an appropriate history or medical decision-making regarding Patient E. The documented assessment consists of merely a billing code for COVID-19. Respondent did not document a sufficient rationale for prescribing any of the medications he prescribed. Respondent did not document that he obtained informed consent from Patient E for her treatment regimen. Appropriate informed consent would include a discussion of the nature and character of the proposed treatment; a discussion of the possible alternative treatments for a COVID-19 infection, including the benefits of returning to the hospital to receive monoclonal antibodies which would reduce the risk of becoming seriously ill and requiring admission to the hospital; and a discussion of the recognized risks, the potential complications and anticipated benefits of taking ivermectin for a COVID-19 infection. Appropriate documentation of informed consent would also include documentation that Respondent informed Patient E that the FDA has not approved ivermectin for a COVID-19 infection, that the prescribing of ivermectin for an unapproved condition is off-label, and that Respondent provided Patient E with evidence supporting the off-label use of ivermectin.

1.26 Late in the evening on September 9, 2021, Patient E went back to the hospital emergency department complaining of worsening shortness of breath, coughing, fatigue, fever, and chills. Patient E was admitted to the hospital with a diagnosis of acute hypoxic respiratory failure and pneumonia due to the COVID-19 infection. Patient E was given dexamethasone and supplemental oxygen. Patient E was discharged from the hospital six days later.

Patient F

1.27 On December 3, 2021, Patient F, 91 years of age, had a virtual visit via Zoom with Respondent. Respondent's record of this visit does not indicate that the visit was a virtual visit rather than an in-person visit, but Respondent told the Commission that he saw Patient F virtually via Zoom. The wife of Patient F was present with Patient F during the virtual visit with Respondent. Respondent had never seen or treated Patient F prior to this virtual visit. Respondent's record of this visit states that Patient F was exposed to COVID on Thanksgiving, that several family members of Patient F had

COVID, and that Patient F had a cough and a fever that had gone as high as 103. Respondent's record states that Patient F had no shortness of breath or trouble breathing, but ten minutes prior to the visit, his oxygen saturation level was reported to be 92%, and earlier in the morning it was reported to be 82%.

1.28 Respondent noted that Patient F had been taking ivermectin paste on a daily basis and was having "a lot of diarrhea." Respondent noted that the wife of Patient F said that Patient F one night had "almost a seizure or the shakes." Ivermectin paste is a veterinary formulation intended for use in animals and is dangerous when used by humans. Respondent did not advise Patient F not to take ivermectin paste.

1.29 Respondent diagnosed Patient F with a COVID-19 infection and prescribed ivermectin 15 mg twice per day for five days, then once per day "until doing pretty well." Respondent did not document what "doing pretty well" means. Respondent also prescribed supplemental oxygen, prednisone, Singulair, vitamin C, vitamin D, zinc, Tylenol, azithromycin, and melatonin. Respondent instructed Patient F and his wife to go to the hospital if he got significantly worse.

1.30 Respondent did not document a medical history of Patient F. At the time of the virtual visit with Respondent, Patient F suffered from dementia, hypertension, atrial fibrillation, and had an indwelling, dual-chamber pacemaker. Respondent did not document that Patient F had any of these conditions. Respondent did not ask Patient F whether he was vaccinated against COVID-19. Respondent did not document any medical decision-making. The documented assessment consists of merely a billing code for COVID-19. Respondent did not document a sufficient rationale for prescribing any of the medications he prescribed.

1.31 In the chart note, Respondent wrote "informed consent re ivermectin." Respondent did not adequately document his obtaining of informed consent from Patient F. Appropriate documentation of informed consent would include documentation of a discussion of the nature and character of the proposed treatment; a discussion of the possible alternative treatments for a COVID-19 infection; and a discussion of the recognized risks, the potential complications and anticipated benefits of taking ivermectin and the other medications for a COVID-19 infection. Appropriate documentation of informed consent would also include documentation that Respondent informed Patient F that the FDA has not approved ivermectin for a COVID-19 infection,

that the prescribing of ivermectin for an unapproved condition is off-label, and that Respondent provided Patient F with evidence supporting the off-label use of ivermectin.

1.32 On December 10, 2021, Patient F was taken by ambulance to the emergency department at a local hospital with respiratory distress. Upon arrival at the hospital, Patient F had an oxygen saturation level of 62%, and was immediately placed on bilevel positive airway pressure. Patient F was admitted to the hospital with a diagnosis of acute hypoxic respiratory failure due to COVID-19 pneumonia. Patient F was outside the window for treatment with remdesivir, and was given dexamethasone and albuterol. Patient F was offered treatment with baricitinib, but the family refused. Patient F's condition continued to decline. The family decided not to continue with the bilevel positive airway pressure and Patient F died on December 17, 2021.

Patient G

1.33 On December 8, 2021, Patient G, 87 years of age, went to see Respondent complaining of fever, low oxygen saturation, but no shortness of breath. Patient G told Respondent that her husband has a COVID-19 infection. Patient G told Respondent she was taking ivermectin paste. Ivermectin paste is a veterinary formulation intended for use in animals and is dangerous when used by humans. Respondent did not advise Patient G not to take ivermectin paste. Based on Patient G's symptoms and her husband's COVID-19 infection, Respondent assumed Patient G had a COVID-19 infection and prescribed ivermectin, 15 mg twice per day for five days, then once per day "until doing pretty well." Respondent did not document what "doing pretty well" means. Respondent also prescribed vitamin A, vitamin C, vitamin D, zinc, budesonide, prednisone, Singulair, cimedtidine, and promethazine.

1.34 Respondent did not document an appropriate history, a physical examination, or medical decision-making regarding Patient G. The documented assessment consists of merely a billing code for COVID-19. Respondent did not document a sufficient rationale for prescribing any of the medications he prescribed. Respondent did not document that he obtained informed consent from Patient G for her treatment regimen. Appropriate informed consent would include a discussion of the nature and character of the proposed treatment; a discussion of the possible alternative treatments for a COVID-19 infection, and a discussion of the recognized risks, the potential complications and anticipated benefits of taking ivermectin for a COVID-19

infection. Appropriate documentation of informed consent would also include documentation that Respondent informed Patient G that the FDA has not approved ivermectin for a COVID-19 infection, that the prescribing of ivermectin for an unapproved condition is off-label, and that Respondent provided Patient G with evidence supporting the off-label use of ivermectin.

1.35 On December 11, 2021, Patient G went to the emergency department at a local hospital complaining of shortness of breath. Patient G's oxygen saturation level was found to be 86%. Patient G was not vaccinated and tested positive for a COVID-19 infection. Patient G was given supplemental oxygen and dexamethasone, and admitted to the hospital with acute hypoxic respiratory failure due to COVID-19 pneumonia. Patient G requested ivermectin, but was declined. Patient G was released from the hospital six days later.

2. ALLEGED VIOLATIONS

2.1 Based on the Alleged Facts, Respondent has committed unprofessional conduct in violation of RCW 18.130.180 (1), (4), and (13), which provide:

> **RCW 18.130.180 Unprofessional conduct.** The following conduct, acts, or conditions constitute unprofessional conduct for any license holder under the jurisdiction of this chapter:
>
> (1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. ...
>
> ...
>
> (4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;
>
> ...
>
> (13) Misrepresentation or fraud in any aspect of the conduct of the business or profession;
>
> ....

2.2 The above violations provide grounds for imposing sanctions under RCW 18.130.160.

3. NOTICE TO RESPONDENT

The charges in this document affect the public health and safety. The Executive Director of the Commission directs that a notice be issued and served on Respondent as provided by law, giving Respondent the opportunity to defend against these charges. If Respondent fails to defend against these charges, Respondent shall be subject to discipline and the imposition of sanctions under Chapter 18.130 RCW.

DATED: June 7, 2022.

STATE OF WASHINGTON
WASHINGTON MEDICAL COMMISSION

Melanie de Leon

MELANIE DE LEON
EXECUTIVE DIRECTOR

ROBERT W. FERGUSON
ATTORNEY GENERAL

Kristin G Brew

KRISTIN G. BREWER, WSBA # 38494
SENIOR COUNSEL

CONFIDENTIAL SCHEDULE

This information is confidential and is NOT to be released without the consent of the individual or individuals named below. RCW 42.56.240(1)

Patient A

Patient B

Patient C

Patient D

Patient E

Patient F

Patient G

[redacted]