STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: Ryan N. Cole
Master Case No.: M2022-207
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
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
DEPARTMENT OF HEALTH
WASHINGTON MEDICAL COMMISSION

In the Matter of: **RYAN N. COLE,** License No. MD.MD.00048229, Respondent.	**Master Case No. M2022-207** **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND FINAL ORDER**

APPEARANCES:

Ryan N. Cole, the Respondent, by
Garrett Richardson, PLLC, per
Nancy J. Garrett, Attorney at Law

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

PANEL: Claire Trescott, MD, Chair
Diana Currie, MD
Ed Lopez, PA-C

PRESIDING OFFICER: Matthew R. Herington, Review Judge

A five-day hearing was held in this matter from September 25-29, 2023, regarding allegations of unprofessional conduct. License placed on OVERSIGHT.

ISSUES

Did the Respondent commit unprofessional conduct as defined by RCW 18.130.180(1), (4), (13), and (22)?

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

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SUMMARY OF PROCEEDINGS

At the hearing, the Commission presented the testimony of: Rebecca Lynn Johnson; Anna Wald; David Charles Pate; Leslie Enzian; and Eric Scholten.

The Respondent testified on his own behalf and additionally presented the testimony of: Pierre Kory; and Kelli Cole.

The Presiding Officer admitted the following exhibits:

Exhibit D-1: Updated Curriculum Vitae of Leslie Enzian, MD;

Exhibit D-2: Report of Leslie Enzian, MD, dated December 19, 2022;

Exhibit D-3: Report of Leslie Enzian, MD, dated January 30, 2023;

Exhibit D-5: Curriculum Vitae of Anna Wald, MD, MPH;

Exhibit D-6: Report of Anna Wald, MD, MPH;

Exhibit D-7: AMA Principles of Medical Ethics;

Exhibit D-8: Code of Medical Ethics Policy 2.3.2 Professionalism in the Use of Social Media;

Exhibit D-9: Letter of Complaint with attachments filed with the Commission by David C. Pate, MD, dated September 19, 2021;

Exhibit D-11: Letter of Complaint from The American Board of Pathology, Chief Executive Officer Rebecca L. Johnson, MD, dated September 28, 2021 (with attachments);

Exhibit D-13: Email dated November 16, 2021 and attached letter (November 15, 2021) from Dr. Rebecca Johnson, Chief Executive Officer, American Board of Pathology to Commission Health Care Investigator Mike Piechota;

Exhibit D-14: Message from Dr. Ryan Cole to Valued Clients dated September 16, 2021;

Exhibit D-15: Curriculum Vitae of Ryan Cole, MD;

Exhibit D-16: www.myfreedoctor.com webpage MyFreeDoctor.com Free Doctor consults all 50 states web archive dated June 9, 2021;

Exhibit D-17: Letter of Cooperation dated January 6, 2022;

Exhibit D-18: Response to Letter of Cooperation dated February 7, 2022;

Exhibit D-18a:Curriculum Vitae Ryan Cole, MD;

Exhibit D-18b:FLCCC I-Mask+ Treatment Protocol for Covid-19 Prevention and Early Outpatient (Version 18-October 12, 2021);

Exhibit D-18c:Ivermectin Use for Covid-19: Mechanisms of Action, Overview by Dr. Ryan Cole;

Exhibit D-18d:National Institutes of Health Table 2e 2021 Characteristics of Antiviral Agents that are Approved or Under Evaluation for the Treatment of Covid-19;

Exhibit D-18e:Overview Statement by Dr. Cole;

Exhibit D-19: FLCCC I-MASK+ Prevention & Early Outpatient Treatment Protocol Version 10, April 26, 2021;

Exhibit D-20: FLCCC I-MASS Prevention and at Home Treatment Mass Distribution Protocol for Covid-19 Version 1, May 10, 2021;

Exhibit D-21: The Respondent's records for Patient A (REDACTED VERSION FILED AUGUST 31, 2023);

Exhibit D-22: The Respondent's records for Patient B (REDACTED VERSION FILED AUGUST 31, 2023);

Exhibit D-23: The Respondent's records for Patient C (REDACTED VERSION FILED AUGUST 31, 2023);

Exhibit D-24: The Respondent's records for Patient D (REDACTED VERSION FILED AUGUST 31, 2023);

Exhibit D-25: Order of the Secretary of Health, Order 20-03 (June 24, 2020) https://www.governor.wa.gov/sites/default/files/Secretary_of_Health_Order_20-03_Statewide_Face_Coverings.pdf;

Exhibit D-26: Proclamation by the Governor Amending and Extending Proclamation 20-05 and 20-60 (June 24, 2020) https://www.governor.wa.gov/sites/default/files/proc_20-60.pdf;

Exhibit D-27a:Why You Should Not Use Ivermectin to Treat or Prevent COVID-19 – FDA, updated as of March 5, 2021 https://www.fda.gov/consumers/consumerupdates/why-you-should-not-use-ivermectin-treat-or-prevent-covid-19;

Exhibit D-27b:Merck Statement on Ivermectin use During the COVID-19 Pandemic, February 4, 2021 https://www.merck.com/news/merck-statement-on-ivermectinuse-during-the-covid-19-pandemic/;

Exhibit D-28: CDC - Interim Public Health Recommendations for Fully Vaccinated People – Updated as of April 27, 2021 http://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html;

Exhibit D-29: Video – KTVB I Haven't Slept Since Yesterday Morning (December 17, 2020);

Exhibit D-30: Video - BitChute – Covid Mistakes (March 4, 2021) and Certified Transcript;

Exhibit D-32: Video - Idaho Freedom Foundation, Capitol Clarity Week 8 Presentation (March 24, 2021);

Exhibit D-33: Video – Truth Be Told – The Truth About Covid-19 Lockdowns and mRNA Vaccines (June 22, 2021) and Certified Transcript;

Exhibit D-34: Video – America's Front Line Doctors (AFLDS) White Coat Anniversary Summit, The One Year Anniversary Summit Sessions: The Science, Ryan Cole, MD "Covid-19 Vaccines & Autopsy" (July 27, 2021) and Certified Transcript;

Exhibit D-35: Video – Peace Valley Charter School Board Meeting (August 26, 2021) and Certified Transcript;

Exhibit D-36: Video – AFLDS #StoptheMandate (August 2021) and Certified Transcript;

Exhibit D-37: Video - Central District Board of Health Candidate Interviews and Discussion (August 9, 2021) and Certified Transcript;

Exhibit D-39: Audio – Nate Shelman Podcast (October 14, 2021) and Certified Transcript;

Exhibit D-40: Video – Informed Dissent- Dr. Ryan Cole – Long Covid- The Stickiness of Science (March 7, 2023);

Exhibit D-41: Appropriate Use of Telemedicine, Washington Medical Commission Guideline, dated October 3, 2014;

Exhibit D-42: Telemedicine and Continuity of Care, Washington Medical Commission Policy Statement, dated March 16, 2018;

Exhibit D-43: Impact Statement from David Pate, MD, dated March 14, 2022, pursuant to RCW18.130.057(3);

Exhibit R-8: January 6, 2022, Letter from Commission Requesting Response to Complaints;

Exhibit R-9: February 7, 2022, the Respondent's Response to Complaints;

Exhibit R-10: December 14, 2022, Letter from Commission for Additional Information;

Exhibit R-11: January 30, 2023, Response to Commission's Request for Additional Information;

Exhibit R-12: February 14, 2023, Second Letter from Commission for Additional Information;

Exhibit R-13: March 7, 2023, Response to Commission's Second Request for Additional Information;

Exhibit R-15: The Respondent's AMA Profile;

Exhibit R-16: Investigation 10232 Report;

Exhibit R-17: Investigation 10232 IAR;

Exhibit R-19: Investigation 10853 Report;

Exhibit R-20: Investigation 10853 IAR;

Exhibit R-22: Investigation 11434 Report;

Exhibit R-23: Investigation 11434 IAR;

Exhibit R-24: Investigation 11434 IAR 2;

Exhibit R-25: Investigation 11662 Report;

Exhibit R-26: Investigation 11662 IAR;

Exhibit R-27: Investigation 11729 Report;

Exhibit R-28: Investigation 11729 IAR;

Exhibit R-29: Additional Investigation Subpoena and Correspondence to Medici and Successor;

Exhibit R-30: Additional Investigation Correspondence to Patients;

Exhibit R-31: Additional Investigation IAR;

Exhibit R-32: Additional Investigation IAR 2;

Exhibit R-33: Additional Investigation Request for Additional Investigation;

Exhibit R-34: Additional Investigation Memorandum Regarding Further Investigation;

Exhibit R-35: Additional Investigation Second Memorandum Regarding Further Investigation;

Exhibit R-37: National Institutes of Health Covid-19 Treatment Guidelines (June 2021);

Exhibit R-41: FLCCC Alliance I-MASK Protocols for Prophylaxis and Early Treatment (2021);

Exhibit R-42: FDA Label Ivermectin;

Exhibit R-47: UW Medicine Treatment Guidelines for SARS-CoV-2 Infection/COVID-19. September 2020;

Exhibit R-48: FDA, *Why You Should Not Use Ivermectin to Treat or Prevent COVID-19*, archived website. (June 21, 2021). *Last Accessed* on May 31, 2023, at https://web.archive.org/web/20210621143844/https://www.fda.gov/consumers/consumer-updates/why-you-should-not-use-ivermectin-treat-or-prevent-covid-19;

Exhibit R-64: Washington State Health Care Authority, *Apple Health (Medicaid) telemedicine & telehealth brief*. (Last Revised April 23, 2020). *Last Accessed* May 31, 2023, at https://www.hca.wa.gov/assets/billers-and-providers/apple-health-telemedicine-telehealth-brief-COVID19-20200428.pdf;

Exhibit R-65: Washington Medical Commission, *Guideline: Appropriate Use of Telemedicine* (Approved October 3, 2014). *Last accessed* on May 31, 2023, at https://wmc.wa.gov/sites/default/files/public/documents/MD2014-03TelemedicineGuideline_approved10-3-14.pdf;

Exhibit R-66: Excerpts July 28, 2022, Letter to Commission; and

Exhibit R-67: Three journal articles—Duration of SARS-CoV-2 mRNA vaccine persistence and factors associated with cardiac involvement in recently vaccinated patients; Autopsy-based histopathological characterization of myocarditis after anti-SARS-CoV-2-vaccination; and Letter to the Editors: "Autopsy-based histopathological characterization of myocarditis after anti-SARS-CoV-2-vaccination" by C. Schwab et al.

In addition, the panel members were presented with redacted copies of the Respondent's Answers to Commission's First Requests for Admission.

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 June 21, 2007. The Respondent has been board certified in anatomic and clinical pathology by the American Board of Pathology at all times relevant to this matter.

1.2 At all times relevant to this matter, the Respondent owned and operated an independent medical laboratory.

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 aerosols or 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, over 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 SARS-CoV-2 infections that cause COVID-19. In the United States, the primary manufacturer of ivermectin is Merck & Co., Inc. (Merck).

1.5 Merck has issued guidance to clinicians regarding the use of ivermectin in treating COVID-19. In Merck's statement to clinicians, it states that it has concluded from pre-clinical studies that ivermectin has "[n]o scientific basis for a potential therapeutic effect against COVID-19." In addition, Merck's statement noted that there is "[n]o meaningful evidence for clinical activity or clinical efficacy in patients with COVID-19 disease," as well as "[a] concerning lack of safety data in the majority of studies." Exhibit D-27b.

1.6 There is no generally accepted reliable and reproducible evidence that ivermectin is effective in treating or preventing COVID-19.

The Respondent's Public Statements

1.7 Due to their specialized knowledge and training, licensed physicians possess a high degree of public trust. That public trust is essential to the effective delivery of medical care. Knowingly false statements or those made in reckless disregard of the truth erode the public's trust in physicians and their medical treatment and advice. As a result, public health is injured.

1.8 Here, it is apparent that the Respondent has disregarded the body of COVID-related evidence found in the medical literature. He then misrepresented that evidence when he presented only one side of it to the public.

1.9 Since March 2021, the Respondent has been a frequent speaker at public and private forums and on news shows and podcasts discussing the COVID-19 pandemic. During these presentations, the Respondent identified himself as a licensed and highly trained physician. However, the Respondent has also engaged in a pattern of dishonesty. In particular, the Respondent has made numerous demonstrably false and/or misleading statements in these presentations regarding the COVID-19 pandemic, COVID-19 vaccines, the use of ivermectin to treat COVID-19, and the effectiveness of masks. As examples, the Respondent has made the following statements:

- COVID-19 is a completely survivable virus for most people that are not in elderly, high-risk categories;
- "Children survive [COVID-19] at a hundred percent;"
- Asymptomatic spread of COVID-19 is "infinitesimally small;"
- Ivermectin is "a known antiviral medication;"
- Ivermectin decreases the COVID-19 death rate by 68 to 90 percent and acquisition by 86 to 88 percent;
- "A hundred percent of world [ivermectin] trials have shown benefit;"
- The COVID-19 vaccination is "an experimental biological gene therapy immune-modulatory injection" and "a fake vaccine…the clot shot, needle rape;"
- "mRNA trials in mammals have led to autoimmune disease;"
- Fifty percent of health care workers are not getting the COVID-19 vaccination;
- The COVID-19 vaccination has caused more deaths than COVID-19 and has killed children;
- The COVID-19 vaccination only reduced the risk of getting COVID-19 by one percent;
- "Natural immunity [against COVID-19] is a broad immunity much broader than a vaccine immunity;"
- The spike protein found in the COVID-19 vaccinations is a toxin that crosses the blood brain barrier;
- The COVID-19 vaccination can lead to cancer and infertility;

- "Normal [vitamin] D levels decrease [individuals'] COVID symptom severity and risk for hospitalization by 90 percent;"
- "Aspirin decreases [COVID-19] hospitalization by 44%;"
- Early use of hydroxychloroquine decreases hospitalization and death due to COVID-19;
- There is no evidence that masks prevent the spread of COVID-19; and
- Masks can increase retained carbon dioxide in people's bodies, which can cause brain fog and inflammation.

1.10 The Respondent's public false and misleading statements regarding the COVID-19 pandemic, COVID-19 vaccines, the use of ivermectin to treat COVID-19, and the effectiveness of masks 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.

1.11 In his presentations, the Respondent has frequently cited that he has three years of experience in family medicine. However, this experience does not appear in his CV or in his licensure file with the Commission. In fact, the Respondent's actual experience in family medicine was limited to moonlighting that he engaged in while completing his anatomic and clinical pathology residency. As the Respondent completed his anatomic and clinical pathology residency in 2001, this limited family medicine experience was approximately 20 years ago.

1.12 The Respondent has publicly implied that the death of a Boise-area surgeon was due to the COVID-19 vaccine even though the surgeon died of a heart attack six months after getting vaccinated.

1.13 In a written statement to the Commission dated February 7, 2022, the Respondent stated that he has not advised patients or the general public to not get the

COVID-19 vaccine. Based on the content of the Respondent's statements made in public presentations, this written statement was a misrepresentation of the facts.

Treatment of Patients A, B, C, and D

1.14 Beginning in June 2021, the Respondent provided direct care to several patients via telemedicine using the website MyFreeDoctor.com. This involved a virtual platform that relied on instant message chat instead of a phone call or video; thus, the Respondent could neither see nor hear the patients. A disclaimer on the platform stated that ivermectin was not approved by the FDA, but that evidence supported its use.

1.15 On June 30, 2021, the Respondent treated Patient A for COVID-19 using MyFreeDoctor.com. Prior to that date, the Respondent had never treated Patient A in any capacity. Prior to chatting with the Respondent, Patient A self-disclosed information in response to the platform's pre-screening questions. Specifically, she indicated that she: had tested positive for COVID-19; was seeking ivermectin; was not vaccinated; and had symptoms that included cough, shortness of breath, and fatigue. Patient A also answered questions about her current medication usage, her health history, her family's health history, her medication allergies, and her height and weight. After stating that he had reviewed Patient A's information, the Respondent prescribed ivermectin to Patient A without seeing or physically examining her. The Respondent prescribed 21 mg of ivermectin daily for five days and authorized one refill.

1.16 On July 1, 2021, Patient A used MyFreeDoctor.com to follow up with the Respondent. Specifically, Patient A asked about ivermectin dosing and indicated that her preferred pharmacy would not fill the ivermectin prescription. Consequently, the

Respondent called in a lower dose of ivermectin to a different pharmacy. The Respondent instructed Patient A to "take 7 pills today and tomorrow, even though the bottle says 4. Day 3 take the rest. Then refill. Take 7, 7, 6 again." *See* Exhibit D-21. The medical records do not list the new dosage of ivermectin that Respondent prescribed or the number of refills that were authorized.

1.17 At no time, did the Respondent ever ask Patient A about the severity of her symptoms, when the symptoms began, when Patient A tested positive for COVID-19, or whether Patient A was experiencing fevers. The Respondent did not document a detailed history or an appropriate medical decision-making process for Patient A. The Respondent did not document a sufficient rationale for prescribing the medication he prescribed. The Respondent did not document that he obtained informed consent from Patient A for this treatment or warn Patient A that the virtual platform they were using did not allow for an informed diagnosis. Finally, the Respondent did not advise Patient A about isolation guidelines and appropriate vaccinations.

1.18 On June 30, 2021, the Respondent treated Patient B using MyFreeDoctor.com. Prior to that date, the Respondent had never treated Patient B in any capacity. Patient B was a 69-year-old woman. Of note for additional COVID-19 risk factors, Patient B was obese, with a body mass index (BMI) of 35. Patient B also worked with seniors. Patient B indicated that she was seeking treatment because she was interested in the prophylactic "I-MASS" protocol.

1.19 Prior to chatting with the Respondent, Patient B self-disclosed information in response to the platform's pre-screening questions. Specifically, she indicated that

she: did not have COVID-19; was seeking ivermectin; and was not vaccinated. Patient B also answered questions about her current medication usage, her health history, her family's health history, her medication allergies, and her height and weight. The Respondent prescribed ivermectin to Patient B without seeing or physically examining her. Specifically, the Respondent instructed her to take 18 mg of ivermectin weekly, authorized a 28-day supply, and authorized two refills. In addition, the Respondent recommended that Patient B take 400 mg of magnesium citrate and 100 mcg of vitamin K2 daily and to double her dose of ivermectin if she tested positive for COVID-19 in the future.

1.20 The Respondent did not document a detailed history or an appropriate medical decision-making process for Patient B. The Respondent did not document a sufficient rationale for prescribing the medication he prescribed. The Respondent did not document that he obtained informed consent from Patient B for this treatment or warn Patient B that the virtual platform they were using did not allow for an informed diagnosis. The Respondent also failed to address: Patient B's increased risk of hospitalization and severe COVID-19 disease due to her age and elevated BMI; the benefits of vaccination; and standard precautions against contracting and transmitting COVID-19.

1.21 On July 6, 2021, the Respondent treated Patient C using MyFreeDoctor.com. Prior to that date the Respondent had never treated Patient C in any capacity. As the reason for seeking treatment, Patient C stated that she had been suffering from energy issues since experiencing flu-like symptoms in February 2020 and that she at times felt like she was having a heart attack. Patient C stated that she wanted

an ivermectin prescription because she did not want a COVID-19 vaccine; she also indicated that she may have previously had COVID-19.

1.22 Prior to chatting with Respondent, Patient C self-disclosed information in response to the platform's pre-screening questions. Specifically, she indicated that she: may have had COVID-19 or the flu in February 2020; was seeking ivermectin; and was not vaccinated. Patient C also answered questions about her current medication usage, her health history, her family's health history, her medication allergies, and her height and weight.

1.23 The Respondent then prescribed ivermectin to Patient C without seeing or physically examining her. Specifically, the Respondent instructed Patient C to take 18 mg weekly, authorized a 28-day supply, and authorized two refills. The Respondent also recommended that Patient C take 4000 IU of vitamin D3, 400 mg of magnesium citrate, and 100 mcg of vitamin K2 daily. The Respondent additionally recommended that Patient C familiarize herself with the I-MASK supplement protocols. The Respondent recommended that Patient C double her dose of ivermectin and take it daily, take 30,000-50,000 IU of vitamin D daily for three days, 80 mg of aspirin daily for two weeks, and consider a nightly melatonin tablet if she were to test positive for COVID-19 in the future. The Respondent also stated that ivermectin may help Patient C with the energy issues she had been experiencing since her February 2020 illness.

1.24 The Respondent assumed that Patient C had long COVID despite a lack of prior diagnosis and lack of symptoms consistent with that diagnosis. The Respondent did not consider a broader differential diagnosis for Patient's C low energy, obtain a

detailed history, conduct a physical examination, or order laboratory testing. The Respondent also failed to inquire about Patient C's cardiac symptoms. The Respondent did not document a detailed history or an appropriate medical decision-making process for Patient C. The Respondent did not document a sufficient rationale for prescribing the medication he prescribed. The Respondent did not document that he obtained informed consent from Patient C for this treatment or warn Patient C that the virtual platform they were using did not allow for a sufficiently informed diagnosis.

1.25 The Respondent stated that he would prescribe a steroid for Patient C if ivermectin did not help. This was in spite of the fact that steroids are not a standard treatment for low energy of unknown etiology.

1.26 The pharmacies that Patient C's ivermectin prescription was sent to did not fill it. However, when Patient C tried to follow up with the Respondent he never responded.

1.27 On July 2, 2021, the Respondent treated Patient D for COVID-19 using MyFreeDoctor.com. Prior to that date, the Respondent had never treated Patient D in any capacity.

1.28 Prior to chatting with the Respondent, Patient D self-disclosed information in response to the platform's pre-screening questions. Specifically, she indicated that she: had tested positive for COVID-19 approximately one week before the appointment; was seeking ivermectin; was not vaccinated; and had symptoms that included a cough, sinus congestion, loss of smell, diminished taste, and fatigue. Patient D additionally reported that she had previously had a fever and body aches. Patient D also answered

questions about her current medication usage, her health history, her family's health history, her medication allergies, and her height and weight.

1.29 Even though he had not seen or physically examined her, the Respondent prescribed both ivermectin and prednisone to Patient D. In particular, the Respondent prescribed 18 mg of ivermectin for five days and authorized one refill. The Respondent prescribed 20 mg of prednisone for two days, 10 mg of prednisone for four days, and 5 mg of prednisone for four days; the Respondent also authorized one refill. The Respondent told Patient D that he prescribed prednisone (which is a steroid typically used to treat inflammation) because it helps with the loss of smell and taste, as well as fatigue. The Respondent also recommended that Patient D take the supplements listed in the I-MASS protocol.

1.30 On July 5, 2021, the Respondent prescribed a budesonide-formoterol inhaler to help with Patient D's cough. The Respondent did so without seeing or physically examining Patient D.

1.31 The Respondent did not adequately inquire about Patient D's symptoms or inquire about other potential symptoms of COVID-19. The Respondent did not inform Patient D of the side effects of steroids. The Respondent did not inquire about wheezing or shortness of breath or listen to Patient D's lungs prior to prescribing budesonide-formoterol. The Respondent did not document a detailed history or an appropriate medical decision-making process for Patient D. The Respondent did not document a sufficient rationale for prescribing the medications he prescribed. The Respondent did not document that he obtained informed consent from Patient D for the prescribed treatments

or warn Patient D that the virtual platform they were using did not allow for a sufficiently informed diagnosis. In addition, the Respondent failed to provide timely follow-up care when requested by Patient D.

1.32 From the description of the MyFreeDoctor.com website, it is clear that the virtual chat format that was utilized does not comply with the standard of care for conducting a physical examination of a patient.

Credibility Findings

1.33 The Commission panel used its experience, competency, and specialized knowledge to evaluate the evidence, including the expert witness testimony. RCW 34.05.461(5).

1.34 Anna Wald: Dr. Wald had a master's degree in public health in addition to a medical degree, and was board certified in infectious disease. Furthermore, she had multiple years of experience treating patients with infectious diseases. This included studying and treating patients with COVID-19. Consequently, Dr. Wald was intimately familiar with the current research on COVID-19 as well as the state of the research earlier in the pandemic. The panel members gave great weight to her testimony and were able to use the information from this expert witness in combination with their own experience, competency, and specialized knowledge while evaluating the evidence. Dr. Wald was very credible.

1.35 Leslie Enzian: Dr. Enzian's knowledge, skill, experience, training, and education in the areas of internal medicine made her an expert that was helpful to the panel in understanding the evidence related to Patients A through D. Dr. Enzian's

testimony on the proper uses of telemedicine was especially relevant. The panel was able to combine Dr. Enzian's opinion with its own experience, competency, and specialized knowledge in evaluating the care that was provided to Patients A through D. Dr. Enzian's testimony convincingly demonstrated that the use of MyFreeDoctor.com did not meet the standard of care for telemedicine and that the Respondent failed to meet the standard of care when treating Patients A, B, C, and D. Dr. Enzian was very credible.

1.36 Pierre Kory: Dr. Kory testified that the Respondent met the standard of care when treating Patients A, B, C, and D. However, several factors severely damaged Dr. Kory's credibility. First of all, he admitted that he agreed to testify before even reviewing the patient records. Secondly, Dr. Kory was a creator of the I-MASS protocol that the Respondent was following. However, it was apparent from all the expert testimony and admitted evidence that the protocol did not adhere to evidence-based standards. Finally, Dr. Kory is friends with the Respondent. It was obvious that this relationship tainted Dr. Kory's testimony in favor of the Respondent. As a result, Dr. Kory's testimony was not objective and not helpful to the panel.

1.37 The Respondent: Many of the facts alleged in the Statement of Charges were not disputed by the Respondent. For example, the Respondent did not dispute that he made most of the public statements that he was alleged to have made. However, the Respondent testified that he believed the statements were true or—if not true at the time of the hearing—were true at the time that he made them. However, it was clear that the Respondent was making his own interpretations of the available COVID-19 data and was then closed to evaluating alternate viewpoints as more evidence became available. This

is problematic, as the nature of medical practice requires that physicians remain skeptical of their own interpretations and be 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. It is also critical that physicians be aware of the consensus of the medical community and be able to pass that information along in a non-biased way to members of the public—even when disagreeing with that consensus. Here, the Respondent knew that the statements he was making were not consistent with the consensus of the medical community. Yet, he failed to provide this important piece of information when he was making public statements.

With regard to the care provided to Patients A, B, C, and D, there can be no reasonable dispute that the care provided was insufficient. What makes this worse is that the Respondent was dishonest about his education and experience in family medicine in presentations that he gave. Unfortunately, the Respondent still misrepresented his family medicine education and experience even during the testimony during the hearing. All in all, this dishonesty severely damaged the Respondent's credibility. However, even if the Respondent had been more credible, his lack of recent education and experience in the provision of direct patient care also means that the Panel must give little weight to his testimony.

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 RCW 18.130.180(1) defines unprofessional conduct 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.

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).

2.5 Here, the Respondent engaged in multiple acts of dishonesty when he made numerous demonstrably false and/or misleading statements in these presentations regarding the COVID-19 pandemic, COVID-19 vaccines, the use of ivermectin to treat COVID-19, and the effectiveness of masks. *See* Finding of Fact 1.9.

The behavior in the Respondent's presentation raises concerns that the Respondent may use his professional position as a physician to harm members of the public. There can be no legitimate dispute that it also tends to lower the standing of physicians in the eyes of the public. Consequently, his actions "relate to" the medical profession. As a result, 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 demonstrated by Findings of Fact 1.14-1.32 above, the Respondent failed to meet the standard of care for Patients A, B, C, and D. This failure to meet the standard care created an unreasonable risk that the patients may be harmed. 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;

As noted above, the Respondent's presentations 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. In fact, the Respondent continued to engage in this misrepresentation during the hearing itself. Consequently, the Commission has proved by clear and convincing evidence that the Respondent violated RCW 18.130.180(13).

2.8 Pursuant to RCW 18.130.180(22), unprofessional conduct includes:[1]

> Interference with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representative, or by the use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding or any other legal action, or by the use of financial inducements to any patient or witness to prevent or attempt to prevent him or her from providing evidence in a disciplinary proceeding;

Here, the Respondent interfered with the investigation by willfully misrepresenting facts. Specifically, the Respondent did so when he provided a written statement to the Commission stating that he had not advised patients or the general public to refrain from getting the COVID-19 vaccine. *See* Finding of Fact 1.13.

2.9 The Commission requests an order requiring that the Respondent be monitored for five years and that he: (1) be restricted from prescribing medications to patients or being allowed to practice primary care; (2) be allowed to have the restrictions

[1] As of April 27, 2023, RCW 18.130.180(22) has been renumbered to RCW 18.130.180(21). *See* 2023 c 192. However, the text of the statute has not changed.

lifted only if he completes necessary training; (3) be required to pay a $5,000 fine; and (4) complete additional continuing medical education.

The Respondent argues the Commission's requested sanctions are too onerous. Respondent argues that patients he treated never suffered harm. He further argues that his presentations did not constitute the practice of medicine and, in any event, he only made statements that he believed to be true.

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

2.11 Here, the Respondent's conduct falls in Tier B of the standard of care schedule. WAC 246-16-810. Tier B is appropriate because the Respondent's patient care of Patients A, B, C, and D caused a risk of moderate to severe patient harm. The panel considered the following aggravating factors when determining the sanction in this matter: gravity of the acts given the ongoing COVID-19 pandemic; misrepresentation of the Respondent's credentials; and his public statements brought ill repute upon the medical profession. The panel considered the following mitigating factors when determining the sanction in this matter: no prior disciplinary history.

III. ORDER

3.1 The Respondent's license to practice as a physician and surgeon in the state of Washington is RESTRICTED AND PLACED ON OVERSIGHT.

3.2 Practice Restrictions.

A. The Respondent is restricted from engaging in the practice of primary care medicine and from prescribing medications for patients.

B. The Respondent's practice of medicine is restricted to the practice of pathology.

3.3 The Respondent may petition the Commission to lift the above restrictions. The Respondent may only do so after completing a Commission-approved reentry course in family medicine. Any determination to lift the practice restrictions will be at the sole discretion of the Commission.

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. COVID-19;

B. Pulmonary and respiratory diseases;

C. Medical record-keeping; and

D. Telehealth.

All the above 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 PROBE. Within three (3) months, the Respondent shall complete the PROBE program offered by the Center for Personalized Education for Physicians (CPEP). The Respondent shall provide the instructor(s) of the course with a copy of this Order prior to the beginning of the course. The Respondent shall permit CPEP to communicate with the Commission regarding his participation in the course. Within one

(1) month after completing the PROBE program, the Respondent shall provide proof of attendance and unconditional pass from the PROBE program and shall provide the Commission with a copy of the essay that the Respondent writes as a part of the course.

3.6 Paper. Within nine (9) months, the Respondent must submit a paper to the Commission addressing professionalism, truthfulness, and honesty in medicine. The paper shall consist of a minimum of one thousand (1,000) words, contain a bibliography, and refer to any relevant CME completed related to the paper. The paper shall also indicate how the Respondent intends to apply what he learned in his practice. The Respondent should be prepared to discuss the subject matter of the written paper(s) with the Commission at the initial personal appearance. The paper must be provided to the Commission in both electronic and printed format to the address below:

1. Medical.compliance@doh.wa.gov

2. Compliance Officer
Washington Medical Commission
P.O. Box 47866
Olympia, Washington 98504-7866

3.7 Fine. Within nine (9) months of the effective date of this Order, the Respondent will pay five thousand dollars ($5,000) 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.

3.8 Personal Appearances. The Respondent must personally appear at a date and location determined by the Commission within six months after the effective date of this Order, or as soon thereafter as the Commission's schedule permits. Thereafter,

the Respondent must 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 the 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.

3.9 Modification. Subject to the terms and conditions set forth above, the Respondent may not seek modification of this Order for five years from its effective date.

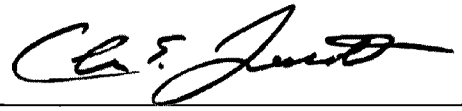
3.10 Change of Address. The Respondent shall inform the program manager and the Adjudicative Service Unit, in writing, of changes in his residential and/or business address within 30 days of such change.

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.

Dated this 4th day of January, 2024.

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
RCW 18.130.180(22)	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 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: Ryan N. Cole, MD
Master Case No.: M2022-207
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:

> Investigative, law enforcement, and crime victim information is exempt from public inspection and copying pursuant to RCW 42.56.240(1).

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: **RYAN N. COLE,MD** License No. MD.MD.00048229 Respondent.	**No. M2022-207** **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 2021-10232, 2021-10853, 2021-11434, 2021-11662, and 2021-11729. The patients referred to in this Statement of Charges are identified in the attached Confidential Schedule.

1. ALLEGED FACTS

1.1 On June 21, 2007, the state of Washington issued Respondent a license to practice as a physician and surgeon. Respondent's license is active. Respondent is board certified in anatomic pathology and clinical pathology.

Summary

1.2 Respondent made numerous false and misleading statements during public presentations regarding the coronavirus disease 2019 (COVID-19) pandemic, COVID-19 vaccines, the use of ivermectin to treat COVID-19, and the effectiveness of masks 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, and D to prevent or treat COVID-19 infections. For 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. Respondent also provided inadequate opportunity for follow-up care, treated patients beyond his competency level, and did not advise patients about standard treatment guidelines and preventative measures.

Background

1.3 Severe acute respiratory syndrome coronavirus 2 (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 United States case of coronavirus in Washington state. Since then, over 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 SARS-CoV-2 infections that cause 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. There is no reliable evidence that ivermectin is effective in treating or preventing COVID-19.

1.6 Due to their specialized knowledge and training, licensed physicians possess a high degree of public trust. That public trust is essential to effective delivery of medical care. Knowingly false statements or those made in reckless disregard for the truth, such as the medical disinformation statements by Respondent listed below, erode the public's trust in physicians and their medical treatment and advice, and thereby injure public health.

1.7 At all times relevant to this case, Respondent, an anatomical and clinical pathologist, ran an independent medical laboratory that he owns. He also provided direct care to patients via telemedicine through the website MyFreeDoctor.com. Since approximately March 2021, Respondent has been a frequent speaker at public and

private forums and on news shows and podcasts discussing the COVID-19 pandemic. During these presentations, Respondent identified himself as a licensed and highly trained physician. Since approximately March 2021, Respondent has made numerous demonstrably false and misleading statements in these presentations regarding the COVID-19 pandemic, COVID-19 vaccines, the use of ivermectin to treat COVID-19, and the effectiveness of masks. Among the numerous false and misleading statements Respondent made were the following:

1.7.1 COVID-19 is a completely survivable virus for most people that are not in elderly, high-risk categories;

1.7.2 "Children survive [COVID-19] at a hundred percent;"

1.7.3 Asymptomatic spread of COVID-19 is "infinitesimally small;"

1.7.4 Ivermectin is "a known antiviral medication;"

1.7.5 Ivermectin decreases the COVID-19 death rate by 68 to 90 percent and acquisition by 86 to 88 percent.

1.7.6 "A hundred percent of world [Ivermectin] trials have shown benefit;"

1.7.7 The COVID-19 vaccination is "an experimental biological gene therapy immune-modulatory injection" and "a fake vaccine…the clot shot, needle rape;"

1.7.8 "mRNA trials in mammals have led to autoimmune disease;"

1.7.9 Fifty percent of health care workers are not getting the COVID-19 vaccination;

1.7.10 The COVID-19 vaccination has caused more deaths than COVID-19 and has killed children;

1.7.11 The COVID-19 vaccination only reduced the risk of getting COVID-19 by one percent;

1.7.12 "Natural immunity [against COVID-19] is a broad immunity much broader than a vaccine immunity;"

1.7.13 The spike protein found in the COVID-19 vaccinations is a toxin that crosses the blood brain barrier;

1.7.14 The COVID-19 vaccination can lead to cancer and infertility;

1.7.15 "Normal [vitamin] D levels decrease [individuals'] COVID symptom severity and risk for hospitalization by 90 percent;"

1.7.16 “Aspirin decreases [COVID-19] hospitalization by 44%;”

1.7.17 Early use of hydroxychloroquine decreases hospitalization and death due to COVID-19;

1.7.18 There is no evidence that masks prevent the spread of COVID-19; and

1.7.19 Masks can increase retained carbon dioxide in people’s bodies, which can cause brain fog and inflammation.

1.8 Respondent’s public false and misleading statements regarding the COVID-19 pandemic, COVID-19 vaccines, the use of ivermectin to treat COVID-19, and the effectiveness of masks 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.

1.9 Respondent has engaged in additional false, misleading, and inflammatory behavior in public forums since March 2021. He frequently cites that he has three years of experience in family medicine in presentations, which does not appear in his CV or in his licensure file with the Commission. He has also publicly blamed the death of a Boise-area surgeon on the vaccine despite the fact that the surgeon died of a heart attack six months after getting vaccinated.

1.10 In a written statement to the Commission dated February 7, 2022, Respondent stated that he has not advised patients or the general public to not get the vaccine, contrary to the statements described in paragraph 1.7 above.

Patient A

1.11 On or about June 30, 2021, Respondent treated Patient A for COVID-19 over a virtual telemedicine platform. Respondent had not previously treated Patient A in any capacity. Respondent used a platform that relied on instant message chat instead of a phone call or video. This chat format does not comply with the standard of care for conducting a physical examination of a patient. Prior to chatting with Respondent, Patient A self-disclosed information in response to the platform’s pre-screening questions including that she had tested positive for COVID-19 positive and was seeking ivermectin; was not vaccinated; and had symptoms that included a cough, shortness of breath, and fatigue. Patient A also answered questions about her current medication usage, her health history, her family’s health history, medication allergies, and height

and weight. A disclaimer on the platform stated that ivermectin was not approved by the FDA, but that evidence supported its use. After stating that he had reviewed Patient A's information, Respondent prescribed ivermectin to Patient A without seeing or physically examining her.

1.12 On or about July 1, 2021, Patient A followed up with Respondent to ask about dosing and because her preferred pharmacy would not fill the prescription. Respondent had originally prescribed 21 mg of ivermectin daily for five days and authorized one refill. Respondent called in a lower dose to a different pharmacy. Respondent then instructed Patient A to "take 7 pills today and tomorrow even though the bottle says 4. Day 3 take the rest. Then refill. Take 7 7 6 again." The medical records do not list the new dosage of ivermectin that Respondent prescribed or the number of refills.

1.13 Respondent did not ask Patient A about the severity of her symptoms, when they began, when she tested positive for COVID-19, or whether she was experiencing fevers. Respondent did not document a detailed history or an appropriate medical decision-making for Patient A. Respondent did not document a sufficient rationale for prescribing the medication he prescribed. Respondent did not document that he obtained informed consent from Patient A for this treatment and the technology did not allow for an informed diagnosis. Finally, Respondent did not advise Patient A about isolation guidelines and vaccination.

Patient B

1.14 On or about June 30, 2021, Respondent treated Patient B, a 69-year-old female with a body mass index (BMI) of 35 who works with seniors, over a virtual telemedicine platform. Respondent had not previously treated Patient B in any capacity. Respondent used a platform that relied on instant message chat instead of a phone call or video. This chat format does not comply with the standard of care for conducting a physical examination of a patient. Patient B sought treatment because she was interested in the prophylactic "I-MASS"[1] protocol. Prior to chatting with Respondent,

[1] The I-MASS protocol was developed by the Front Line COVID-19 Critical Care Alliance (FLCCC). The prevention protocol for adults over 18 years old and 90 pounds includes taking 18 mg of ivermectin every seven days, 2000 IU of vitamin D3 daily, and 1 daily multivitamin tablet. The I-MASS protocol for active COVID-19 infections includes taking 6 mg melatonin for five days, 80 mg aspirin daily, and using anti-septic mouthwash three times a day.

Patient B self-disclosed information in response to the platform's pre-screening questions including that she did not have COVID-19, was seeking ivermectin, and was not vaccinated. Patient B also answered questions about her current medication usage, her health history, her family's health history, medication allergies, and height and weight. A disclaimer on the platform stated that ivermectin was not approved by the FDA, but that evidence supported its use. Respondent prescribed ivermectin to Patient B without seeing or physically examining her, instructing her to take 18 mg weekly, authorizing a 28-day supply, and granting two refills. He also recommended that Patient B take 400 mg of magnesium citrate and 100 mcg vitamin K2 daily and to double her dose of ivermectin if she tested positive for COVID-19.

1.15 Respondent did not document a detailed history or an appropriate medical decision-making for Patient B. Respondent did not document a sufficient rationale for prescribing the medication he prescribed. Respondent did not document that he obtained informed consent from Patient B for this treatment and the technology did not allow for an informed diagnosis. Respondent also failed to address Patient B's increased risk of hospitalization and severe COVID-19 due to her age and elevated BMI, the benefits of vaccination, and standard precautions against contracting and transmitting COVID-19.

Patient C

1.16 On or about July 6, 2021, Respondent treated Patient C over a virtual telemedicine platform. Patient C stated that she had had energy issues since experiencing flu-like symptoms in February 2020 and feeling like she was having a heart attack. Respondent had not previously treated Patient C in any capacity. Respondent used a platform that relied on instant message chat instead of a phone call or video. This chat format does not comply with the standard of care for conducting a physical examination of a patient. Patient C stated that she wanted an ivermectin prescription because she did not want a COVID-19 vaccine and may have previously had COVID-19. Prior to chatting with Respondent, Patient C self-disclosed information in response to the platform's pre-screening questions including that she did may have had COVID-19 or may have had the flu in February 2020, was seeking ivermectin, and was not vaccinated. Patient C also answered questions about her current medication usage, her health history, her family's health history, medication allergies, and height

and weight. A disclaimer on the platform stated that ivermectin was not approved by the FDA, but that evidence supported its use.

1.17 Respondent prescribed ivermectin to Patient C without seeing or physically examining her, instructing her to take 18 mg weekly, authorizing a 28-day supply, and granting two refills. He also recommended that Patient C take 4000 IU of vitamin D3, 400 mg of magnesium citrate, and 100 mcg vitamin K2 daily, as well as familiarizing herself with the I-MASK[2] supplement protocols. Respondent recommended that, if Patient C were to test positive for COVID-19, she should double her dose of ivermectin and take it daily, take 30,000-50,000 IU of vitamin D daily for three days, 80 mg of aspirin daily for two weeks, and consider a nightly melatonin tablet. Respondent also stated that ivermectin may help Patient C with the energy issues she had been experiencing since her February 2020 illness.

1.18 Respondent assumed that Patient C had long COVID-19 despite a lack of diagnosis and lack of symptoms consistent with that diagnosis. He did not consider a broader differential diagnosis for her low energy, obtain a detailed history, conduct a physical examination, or order laboratory testing. Respondent also failed to inquire about Patient C's cardiac symptoms. Respondent did not document a detailed history or an appropriate medical decision-making for Patient C. Respondent did not document a sufficient rationale for prescribing the medication he prescribed. Respondent did not document that he obtained informed consent from Patient C for this treatment and the technology did not allow for an informed diagnosis.

1.19 Respondent later stated that if ivermectin did not help Patient C, Respondent would prescribe a steroid for her to try. Steroids are not standard treatment for low energy of unknown etiology. Additionally, the pharmacies Patient C's ivermectin prescription was sent to did not fill it. When Patient C tried to follow up with Respondent, he never responded.

Patient D

1.20 On or about July 2, 2021, Respondent treated Patient D for COVID-19 over a virtual telemedicine platform. Respondent had not previously treated Patient D in

[2] The I-MASK protocol was developed by FLCCC. The supplement protocol for prevention includes daily doses for vitamin D3, 1,000-2,000 mg vitamin C, 250 mg quercetin, 30-40 mg zinc, and 6 mg melatonin.

any capacity. Respondent used a platform that relied on instant message chat instead of a phone call or video. This chat format does not comply with the standard of care for conducting a physical examination of a patient. Prior to chatting with Respondent, Patient D self-disclosed information in response to the platform's pre-screening questions including that she had tested COVID-19 positive approximately one week before the appointment and was seeking ivermectin; was not vaccinated; and had symptoms that included a cough, sinus congestion, loss of smell, diminished taste, and fatigue. Patient D had previously had symptoms that included a fever and body aches. Patient D also answered questions about her current medication usage, her health history, her family's health history, medication allergies, and height and weight. A disclaimer on the platform stated that ivermectin was not approved by the FDA, but that evidence supported its use.

1.21 Respondent prescribed 18 mg ivermectin for five days and authorized one refill. Respondent also prescribed 20 mg of prednisone for two days, 10 mg prednisone for four days, and, and 5 mg prednisone for four days and authorized one refill. Respondent did not see or physically examine Patient D before writing these prescriptions. Respondent stated that he prescribed prednisone, a steroid typically used to treat inflammation, because prednisone helps with taste and smell loss as well as fatigue. Respondent also recommended that Patient D take the supplements listed in the I-MASS protocol. On or about July 5, 2021, Respondent prescribed a budesonide-formoterol inhaler to help with Patient D's coughing again without seeing or physically examining her.

1.22 Respondent did not adequately inquire about Patient D's symptoms or inquire about other potential symptoms of COVID-19, inform Patient D of the side effects of steroids, or inquire about wheezing or shortness of breath or listen to Patient D's lungs prior to prescribing budesonide-formoterol. Respondent did not document a detailed history or an appropriate medical decision-making for Patient D. Respondent did not document a sufficient rationale for prescribing the medications he prescribed. Respondent did not document that he obtained informed consent from Patient D for this treatment and the technology did not allow for an informed diagnosis. Respondent also did not provide timely follow-up care when requested by Patient D.

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2. ALLEGED VIOLATIONS

2.1 Based on the Alleged Facts, Respondent has committed unprofessional conduct in violation of RCW 18.130.180 (1), (4), (13), and (22), 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. 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 ensuring disciplinary hearing of the guilt of the license holder 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;
> …
> (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;
> …
> (22) Interference with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representative, or by the use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding or any other legal action, or by the use of financial inducements to any patient or witness to prevent or attempt to prevent him or her from providing evidence in a disciplinary proceeding;
> … .

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

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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: jANUARY 9, 2023.

STATE OF WASHINGTON
WASHINGTON MEDICAL COMMISSION

MELANIE DE LEON
EXECUTIVE DIRECTOR

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

[redacted]