SUPERIOR COURT OF THE STATE OF WASHINGTON
IN AND FOR BENTON AND FRANKLIN COUNTIES

MICHAEL K. TURNER, an individual, RICHARD S. WILKINSON, an individual, RYAN N. COLE, an individual, and RENATA S. MOON, an individual Plaintiffs, v. WASHINGTON MEDICAL COMMISSION, Defendant.	CASE NO.: _____ COMPLAINT FOR INJUNCTIVE AND DECLARATORY RELIEF

I. INTRODUCTION

An excerpt from Notes on the State of Virginia by Thomas Jefferson (1784):

Was the government to prescribe to us our medicine and diet, our bodies would be in such keeping as our souls are now.

The Washington Medical Commission has chosen to "prescribe our medicine and diet," a form of tyranny that Thomas Jefferson never expected to encounter. Revised Code of Washington ("RCW") Section 18.130 authorizes Respondent Washington Medical Commission ("WMC") to

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PASCO, WA 99301

"adopt, amend, and rescind such rules as are deemed necessary to carry out this chapter" and to "adopt standards of professional conduct or practice." RCW 18.130.050(1) and (14). Petitioners do not dispute this authority; rather, Petitioners challenge such rules when adopted under the guise of a non-binding *Statement* as occurred on September 22, 2021, when the WMC, through a Special Meeting with limited notice[1, 2] and without opportunity for public comment,[3] the Washington Medical Commission ("WMC") adopted a position statement on *COVID-19 Misinformation* ("Statement" or "Position Statement"). *See:* Exhibit 1. No attendance roster of this Meeting was published. The Statement, a gross overreach of the Commission's regulatory authority, is the adoption of an enforceable standard of care. That standard is an official extension the WMC's "support[] [of] the position taken by the Federation of State Medical Boards (FSMB) regarding COVID-19 vaccine misinformation."[3]

The WMC has access to two types of Statements, an *Interpretive Statement,* and a *Policy Statement.* An *Interpretive Statement* is defined as "Interpretive statement means a written expression of the opinion of an agency as to the meaning of a statute or other provision of law, of a court decision, or of an agency order," whereas *Policy Statement* is defined as "Policy statement means a written description of the current approach of an agency to implementation of a statute or other provision of law, of a court decision, or of an agency order, including where appropriate the

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[1] Governor Jay Inslee declared a COVID-19 State of Emergency on February 29, 2020; the WMC could have issued a rule any time in the 18 months preceding the issuance of the Statement but chose not to. *See: Proclamation 20-05, COVID-19.* Available at: https://www.governor.wa.gov/sites/default/files/proclamations/20-05%20Coronavirus%20%28final%29.pdf. Last accessed July 10, 2023.

[2] Meeting notice available at: https://wmc.wa.gov/meetings/special-meeting-covid-19-misinformation-statement. Last accessed July 10, 2023.

[3] Washington Medical Commission Special Meeting, September 21, 2021. "While this meeting is open to the public, we will not be taking public comment or responding to questions during this meeting." Available at: https://www.youtube.com/watch?v=P5qDoNWfdhI. Last accessed: February 2, 2023.

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agency's current practice, procedure, or method of action based upon that approach." RCW 34.05.010(8), (15). These statements are advisory only, and agencies are *encouraged* to convert them into rules. RCW 34.05.230.

In this case, the WMC is using the statement as an enforceable rule although it was not adopted with the procedures for such a rule. The Statement implements a specific standard of care and asks the public and practitioners to instigate a complaint if they think a physician or physician assistant is violating the Statement. The WMC has enforced the statement through the mechanism of the Uniform Disciplinary Act ("UDA"). The Statement, acting as a rule, was adopted and implemented outside the WMC's legal rulemaking processes violating the Administrative Procedures Act. Thus, the Statement is null and void requiring this court to enjoin it and to issue a declaratory judgment declaring the Statement *void ab initio*.

II. JURISDICTION AND VENUE

0. Venue is proper in Yakima County as Plaintiff Turner resides in Franklin County and has his principal place of business, Michael Turner, MD, PLLC., is in Benton County. Additionally, Benton County is the county in which the complained of action occurred when the WMC charged Dr. Turner for prescribing Ivermectin for patients while practicing at Michael Turner, MD, PLLC. *See:* RCW 34.05.514(1)(b); RCW 4.92.010(1), (2).

III. PARTIES

Plaintiffs

1. **Plaintiff Dr. Michael Turner** is a resident of Pasco, Washington and maintains a medical license in Washington. Dr. Turner has been licensed to practice as a physician in Washington since March 2009. Dr. Turner's license is issued and regulated by the Commission. Dr. Turner is the owner of Michael Turner, MD, PLLC.

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2. The Commission received complaints regarding statements Dr. Turner made about early COVID-19 treatment and about the fact that he was treating patients with ivermectin. These complaints led to the Statement of Charges ("SOC") M2022-194 (attached to Turner Decl., Exh. 1.).

3. SOC M2022-194 was issued on May 1, 2023. The SOC accuses Dr. Turner of not meeting the standard of care for COVID intervention by prescribing ivermectin to his patients. SOC ¶¶ 1.12.2, 1.14.1, 1.19.2.

4. Since the Commission has made the investigations of Dr. Turner public, including the publication of SOC M2022-194, Dr. Turner has suffered reputational harm, been unable to acquire medical licenses in other states, has been defamed by news outlets, and had his place of practice put in jeopardy.

5. **Plaintiff Dr. Richard Wilkinson** is a resident of Yakima, Washington and maintains a medical license in Washington. Dr. Wilkinson has been licensed to practice as a physician and surgeon in Washington since 1977; Dr. Wilkinson's license is issued and regulated by the Commission. Dr. Wilkinson is the owner of Wilkinson Wellness Clinic in Yakima, WA. Wilkinson Decl., ¶ 2.

6. The Commission received complaints regarding statements Dr. Wilkinson made regarding COVID-19 on his blog maintained on the Wilkinson Wellness Clinic website (https://wilkinsonwellness.com/blog) and for his treatment of patients who had tested positive for COVID-19 with ivermectin. These complaints led to SOC M2022-196. Exhibit 2: SOC No. M2022-196.

7. SOC No. M2022-196 was issued on June 7, 2022, and addresses Dr. Wilkinson's public COVID-19 blog statements as follows: "Respondent's public false and misleading statements regarding the COVID-19 pandemic, COVID-19 vaccines, and public health officials are harmful and

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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." *Id.*

8. SOC. No. M2022-196 also addressed the Food and Drug Administrations ("FDA") approval and labeling of ivermectin and hydroxychloroquine. SOC No. M2022-196, ¶¶ 1.4, 1.6. This SOC also accused Dr. Wilkinson of not meeting the standard of care for COVID intervention by prescribing ivermectin to his patients. SOC ¶¶ 1.10, 1.16, 1.20, 1.241.29, 1.33, 2.1.

9. Dr. Wilkinson's hearing before the Commission on SOC No. M2022-196 finished on April 7, 2023.

10. Since the Commission has made the investigations of Dr. Wilkinson public, including the publication of SOC No. M2022-196, Dr. Wilkinson has suffered reputational harm and lost his right his to free speech Under Article I, Section 5 of Washington Constitution. His reputation has been accosted and trampled through the Commission's "misinformation" and "disinformation" campaign that culminated in the Statement. Wilkinson Decl., ¶ 7.

11. **Plaintiff Dr. Ryan Cole** is a resident of Idaho and maintains medical licenses in nine states including Washington; Dr. Cole's Washington license is issued and regulated by the Commission. Cole Decl. ¶ 3. Prior to COVID-19, Dr. Cole's Washington license allowed him to service Washingtonians who sent skin biopsies to Dr. Cole for laboratory review. Dr. Cole practices in Idaho but was contacted by Washington residents via telehealth seeking assistance with COVID-19 treatment throughout the pandemic. Dr. Cole is the former owner of Cole Diagnostics, a medical diagnostic laboratory located in Boise, ID. Id., at ¶ 4.

12. Dr. Cole Received his medical degree from Virginia Commonwealth University-Medical College of Virginia, in 1997, then attended a Residency in Anatomic and Clinical Pathology at the Mayo Clinic in Rochester, MN form 1997-2001, which was followed by a Surgical Pathology

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Fellowship (Chief Fellow) at the Mayo Clinic from 2001-2002. Dr. Cole then completed a Dermatopathology Fellowship (Chief Fellow) at the Ackerman Academy of Dermatopathology, Columbia University from 2002-2003. Id., at ¶ 2, Exh., 1.

13. Prior to the COVID-19 pandemic and the Commission's adoption of the Statement, Dr. Cole was never disciplined by the Commission. Since the adoption of the Statement, Dr. Cole has been the target of many complaints, several of which have been investigated by the Commission. These investigations include, but are not limited to Files No.: 2021-10232, 2021-10853, 2021-11434, 2021-11662, 2021-11729, which, upon information and belief, culminated in the Commission's Statement of Charges ("SOC") No.: 2022-207, issued on January 10, 2023. Exh. 3, SOC No. 2022-207. Dr. Cole is represented by legal counsel (not present counsel) to defend SOC 2022-207; a hearing date has not been set.

14. Statement of Charges No.: 2022-207 alleges that Dr. Cole:

> [M]ade 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. SOC No.: 2022-207, at 1.

16. The SOC and other investigations have negatively impacted Dr. Cole and his practice as Dr. Cole has been required to dissolve his Pathology practice, Cole Diagnostics. In 2019 (pre-

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pandemic), Dr. Cole had an offer to sell Cole Diagnostics at the price of $12,000,000, which was subsequently rescinded as revenue declined and due to the negative press on Dr. Cole. Id., at ¶ 12.

17. Prior to the COVID-19 pandemic, Dr. Cole held contracts with several national and regional insurance carriers; however, the negative implications of the board reports and the associated media attention, in-network contracts with St. Luke's Health Partners, Pacific Source, Mountain Health Co-op, and Cigna were terminated after Commission's publication of the Charges against Dr. Cole.

18. Since the Commission has made the investigations of Dr. Cole public, including the publication of SOC No. No 2022-207, Dr. Cole has lost several of these contracts, including the following contracts. Id., at ¶ 4. Pre-pandemic, in 2019, Cole Laboratories had a net income of $2,102,165; the net income for 2020 increased to $3,341,732 with a maintenance of the value of diagnostic services and an increase of revenue for COVID-19 testing; the 2021 net income decreased to $2,530,107; and the 2022 net income decreased to a loss of $13,403. Id., at ¶ 4; Exh. 2. The 2021 decreases in net income were primarily related to the loss of revenue associated with COVID-19 testing, and the 2022 income loss was due to the lost insurance contracts. Id.

19. Prior to the dissolution of Cole Diagnostics, Dr. Cole anticipated working 10 more years and would have sold Cole Diagnostics at the conclusion of that period. Assuming a conservative annual revenue stream of $2,000,000 (based on the 2019-2021 net income) and factoring in the potential sales of Cole Diagnostics at the $12,000,000 offer, Dr. Cole would have had a total net income of $32 million at the conclusion of ten years, including the sales of Cole Diagnostics. Id., at ¶ 13.

20. Aside from these damages, Dr. Cole has suffered reputational harm, having lost his Fellow status from the College of American Pathologists; has been informed that the American

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PASCO, WA 99301

Board of Pathology has corresponded with states where Dr. Cole holds a license, to support disciplinary actions against Dr. Cole based his public statements related to COVID-19; and Dr. Cole lost his position as President Elect for Independent Doctors of Idaho. Dr. Cole has also suffered a loss of his rights under the Washington Constitution Article I, Section V, Freedom of Speech, which reads: "Every person may freely speak, write and publish on all subjects, being responsible for the abuse of that right."

21. His right to free speech has been accosted and trampled through the Commission's "misinformation" and "disinformation" campaign based on the Statement. Id., at ¶ 14.

22. Dr. Cole has suffered other damages, including $50,000 in attorney fees spent in the defense of his license; limitations on his ability to practice medicine as discussed, above, and because of the time and effort spent in the defense of his license; difficulty in hiring and retaining employees due to the threats and difficult working conditions stemming from the opposition to Dr. Cole's positions; and undue stress on Dr. Cole's marriage and family for the personal and professional attacks he has suffered (including death threats) since he first openly advocated for early COVID-19 treatment. Id., at ¶ 15.

23. **Plaintiff Dr. Renata Moon** is a resident of Idaho and was issued a license by the Commission to practice as a physician since July 2004. Dr. Moon also maintains licenses in other states. Dr. Moon has a board certification in Pediatrics and Pediatric Hospital Medicine from the American Board of Pediatrics and has practiced as a pediatrician for over 25 years. Dr. Moon has never had any actions against any state medical license, nor has Dr. Moon ever been named as a defendant in any medical malpractice suit. Dr. Moon has held clinical teaching positions at Baylor College of Medicine in Texas, the University of Washington School of Medicine, and Washington State University's Elson S. Floyd College of Medicine.

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25. On January 6, 2023, Dr. Moon, under duress, sought to relinquish her Washington State Medical license, despite having no complaints against her, because she was speaking out against certain COVID public policies, such as vaccination of healthy children for a disease that was unlikely to have a negative impact on them even if they contracted it. She had witnessed investigations against colleagues following statement made over concerns about the safety and efficacy of the COVID-19 vaccines. Dr. Moon's license remained in effect until its expiration on March 27, 2023, with a 90-day grace period following that. Dr. Moon elected not to renew her license as she felt coerced to surrender her license due to the aforementioned investigations.

26. Dr. Moon felt coerced to surrender a valuable property interest in her license based on the Medical Commission's policy of investigating and charging physicians for speaking out against government policy on COVID-19. This chilling of speech affects her ethical obligations to fully inform her patients regarding the safety of a product, and thus interferes with her practice of medicine.

26. Dr. Moon suffered reputational damage. Her current employer, Washington State University – a public university, felt obligated to inform her that based on her public statements, they were obligated to report her to the Washington Medical Commission. Dr. Moon received a communication from her employer, Washington State University, on June 29, 2023, informing her that her contract would not be renewed.

Defendant

27. The Washington Medical Commission (the "WMC") is the Washington State Agency charged with "establishing, monitoring, and enforcing qualifications for licensing, consistent standard of practice, continuing competency mechanisms, and discipline." RCW 18.71.003. The WMC developed and adopted the challenged Position Statement. The Position Statement is an

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PASCO, WA 99301

"Agency Action" as defined in RCW 34.05.010(3) or a "Rule" as defined in RCW 34.05.010(16). Alternatively, the Statement could be interpretate as an "Interpretative Statement" as defined in RCW 34.05.010(8).

IV. FACTS

28. The Washington Medical Commission is the state agency charged with investigating physicians and physician's assistants for unprofessional conduct; the WMC held this authority prior to its adoption of the challenged Statement.

29. As a state agency, the WMC has the power and obligation to adopt rules in accordance with the APA for the purpose of enforcing its statutory powers under RCW 18.71, RCW 18.71A, and RCW 18.130.

30. The WMC adopted the Position Statement on September 21, 2021, without public comment or input from the regulated community or the public, and stated at the commencement of the meeting, in which the Statement was adopted, that public comment would not be allowed.

31. The Statement provides that, "Treatments and recommendations regarding this disease that fall below standard of care as established by medical experts, federal authorities and legitimate medical research are potentially subject to disciplinary action."[4]

32. The statement goes on to incorporate speech as part of the standard of care: The WMC supports the position taken by the Federation of State Medical Boards (FSMB) regarding COVID-19 vaccine misinformation. The WMC does not limit this perspective to vaccines but broadly applies this standard to all misinformation regarding COVID-19 treatments and preventive measures such as masking. Physicians and Physician Assistants, who generate and spread COVID-

[4] https://wmc.wa.gov/news/covid-19-misinformation-position-statement. Last accessed: July 10, 2023.

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5238 OUTLET DR.
PASCO, WA 99301

19 misinformation, or disinformation, erode the public trust in the medical profession and endanger patients.[5]

33. The incorporation of speech is based on the following statement from the FSMB:

> Physicians who generate and spread COVID-19 vaccine misinformation or disinformation are risking disciplinary action by state medical boards, including the suspension or revocation of their medical license. Due to their specialized knowledge and training, licensed physicians possess a high degree of public trust and therefore have a powerful platform in society, whether they recognize it or not. They 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. Spreading inaccurate COVID-19 vaccine information contradicts that responsibility, threatens to further erode public trust in the medical profession and puts all patients at risk.[6]

34. The Position Statement explicitly adopts a standard of care which is based on experts and information beyond of the State of Washington: "The WMC relies on the U.S Food and Drug Administration approval of medications to treat COVID-19 to be the standard of care."[7]

35. The Position Statement also threatens action against a practitioner who violates such standard:

> "The WMC will scrutinize any complaints received about practitioners granting exemptions to vaccination or masks that are not based in established science or verifiable fact. A practitioner who grants a mask or other exemption without conducting an appropriate prior exam and without a finding of a legitimate medical reason supporting such an exemption within the standard of care, may be subjecting their license to disciplinary action. . . . The public and practitioners are encouraged to use the WMC complaint forms when they believe the standard of care has been breached."[8]

36. The Position Statement has both legal and punitive effects as Plaintiffs and other medical professionals (*See: In RE: Scott C. Miller, PA*, No. M2021-272) have experienced.

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[5] *Id.*
[6] *Id.*
[7] *Id.*
[8] *Id.*

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37. To sanction/punish the medical professionals under the Statement, the Commission finds fault with the professionals' speech or conduct as it relates to the Statement *vis-à-vis* COVID-19, and then uses the mechanism of the Uniform Disciplinary Act ("UDA") to enforce the statement by claiming the Doctor or Physician Assistant committed Unprofessional Conduct pursuant to RCW 18.130.180.

38. Unprofessional Conduct is defined in RCW 18.130.180 and includes issues such as: "moral turpitude, dishonesty, or corruption relating to the practice of the person's profession" (1); "Misrepresentation or concealment of a material fact" for licensing issues (2); "advertising which is false, fraudulent, or misleading"(3); "Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed." (4); "Misrepresentation or fraud in any aspect of the conduct of the business or profession" (13); and several other practices.

39. RCW 18.130.180(1), (4), and (13) are the primary mechanisms used to enforce the standard of care under the position statement.

40. In none of these sections of RCW 18.130.180 does it state that a medical professional may not deviate from an administrative standard adopted ad hoc that was established based on undefined and unspecified "experts, federal authorities and legitimate medical research." On the contrary, the standard of care adopted by the legislature states explicitly that, "The use of 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." RCW 18.130.180(4).

SILENT MAJORITY FOUNDATION
5238 OUTLET DR.
PASCO, WA 99301

41. The WMC's Position Statement is a complete reversal of a Statement the WMC adopted a short 18 months prior from the WMC's *Pandemic Regulatory Intent*, which conforms more accurately to the legislatures intent when it adopted RCW 7.70.040. It reads, in part:

> **[R]egulatory agencies must support the front-line practitioners.** We recognize there are shortages of equipment and that difficult to impossible decisions must be made. . . Under these conditions, practitioners need support, not fear of regulatory action. . . Under these circumstances, practitioners deserve and have the support of the WMC. Practitioners should not fear for their well-intentioned actions. During this crisis, the WMC will focus on the intent of the practitioner and the realistic availability or non-availability of possible alternatives. Put another way, when assessing complaints related to practitioner's work we will consider the difficult circumstances and choices they are facing. The WMC wants you to focus on treating the patient in front of you to the best of your ability.[9]

42. The legislature intent in adopting RCW 7.70.040 was to limit liability for those acting in good faith to treat COVID-19 when resources were limited, such as early treatments to keep people from needing stressed hospital resources.[10]

43. The distinction between the Plaintiffs and other medical professional who were not investigated and charged under the Statement is that Plaintiffs dissented politically, scientifically and medically from health officials on various matters related to COVID. When threats to Plaintiffs' licenses and practices by the Commission as well as criticism by politicians and from mainstream and social media personalities could not silence these Plaintiffs, the Commission threatened and took

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[9] *WMC Pandemic Regulatory Intent*, available at: https://wmc.wa.gov/news/wmc-pandemic-regulatory-intent. Adopted March 25, 2020. Last accessed: Jul 10, 2023. (Emphasis added.)

[10] RCW 7.70.040(2)(a)(i) "The health care provider failed to exercise that degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he or she belongs, in the state of Washington, acting in the same or similar circumstances, taking into account whether the act or omission:

(B) Was due to a lack of resources including, but not limited to, available facility capacity, staff, and supplies, directly attributable to the COVID-19 pandemic"

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5238 OUTLET DR.
PASCO, WA 99301

punitive action, based on the Position Statement. This is simply due to Plaintiffs' disagreement with the mainstream policies for the treatment of COVID-19.

44. The Statement concludes by encouraging reporting of medical professionals that failed to adhere to its requirements, "[t]he public and practitioners are encouraged to use the WMC complaint forms when they believe the standard of care has been breached. Encouraging the public to make anonymous complaints against medical practitioners is the mechanism by which the Commission instigates an investigation and enforcement action against Physicians and Physician's assistants.

V. CAUSES OF ACTION/CLAIMS FOR RELIEF

COUNT I -- The Position Statement Violates The Washington Administrative Procedures Act, Revised Code Of Washington Section 34.05, Et Seq.

(The Position Statement Constitutes a Rule and was Adopted Without Proper Notice and Comment and Outside of the Requirements of RCW 34.05.230 in Violation of the Administrative Procedures Act; the Statement Provided No Comment Period and was Adopted Without Compliance with Statutory Rule-Making Procedures)

45. The allegations contained in all previous and paragraphs and paragraphs following this section are incorporated herein by reference and are re-alleged as set forth in full.

46. The Statement is a rule as it: (1) has "general applicability;" (2) the violation of which subjects a person to a penalty or administrative sanction; and (3) "establishes, alters, or revokes any qualification or requirement relating to the enjoyment of benefits or privileges conferred by law." RCW 34.05.010(16).

47. The Statement applies to all medical professionals licensed by the Washington Medical Commission and has been used to discipline medical professionals.

48. The Statement adds "new requirement[s] to an already well-defined regulation" by requiring physician speech and treatment methodologies to comport with the Commission's ill-

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5238 OUTLET DR.
PASCO, WA 99301

defined COVID-19 narrative. Such requirements constitute "a 'rule' subject to the formal rule making procedures." *Providence Physician Servs. Co. v. Dep't of Health,* 196 Wash. App. 709, 726-27, 384 P.3d 658, 667 (2016); *Citing Failor's Pharmacy v. Dep't of Soc. & Health Servs.*, 125 Wn.2d 488, 886 P.2d 147 (1994). RCW 7.70.040, which adopted a standard of care for COVID-19 related treatment pre-existed the Statement, and the Statement did nothing more than add ill-defined requirements to the well-defined regulation.

49. The requirement not to spread "misinformation" or "disinformation;" subjective terms created by the Commission for its regulation of medical professionals during the COVID-19 pandemic prescribed by the Statement; the Statement's associated encouragement of reporting complaints to the WMC; and the Statement's threat to "subject [licensees] to disciplinary action," constitute a Rule, which was without comment in violation of the Administrative Procedures Act. RCW 34.05.010(16).

50. At least one other entity of the State of Washington – Washington State University – considers this an obligatory reporting requirement for speech which violates the Statement.

51. The Statement violates the Administrative Procedures Act because it was adopted without compliance with statutory rule-making procedures. RCW 34.05.570(2)(c).

52. The Statement violates the Administrative Procedures Act because it violates constitutional provisions. RCW 34.05.570(2)(c).

53. The Washington Administrative Procedure Act obligates the grant of relief when an agency has acted ultra vires, or outside of its statutory authority or jurisdiction. RCW 34.05.570(3)(b).

54. As a Policy Statement, as defined by the WMC, the Statement is a "written description of the current approach of an agency to implementation of a statute or other provision of

SILENT MAJORITY FOUNDATION
5238 OUTLET DR.
PASCO, WA 99301

law, of a court decision, or of an agency order, including where appropriate the agency's current practice, procedure, or method of action based upon that approach."[12]

55. The APA provides that "Current interpretive and policy statements are advisory only. To better inform and involve the public, an agency is encouraged to convert long-standing interpretive and policy statements into rules." Policy Statements are not and cannot be enforceable.

56. Under the conditions outlined in Paragraphs 46-55, the WMC has treated the Statement as a rule in all facets except for compliance with the rulemaking process. Thus, the Statement is a Rule.

57. The Statement was adopted in contravention of the APA requirement to publish interpretive or policy statements in the Washington State Register, and the challenged Statement was not. See: RCW 34.05.230(1) and (4). The Statement was not published in this manner violating the APA.

COUNT II -- Violation of Article I, Section 5 of Washington State Constitution (Washington Constitution, Article I, Section 5)

58. The allegations contained in all previous paragraphs are incorporated herein by reference and are re-alleged as set forth in full.

59. Washington Constitution Article I, Section V, *Freedom of Speech*, reads: "Every person may freely speak, write and publish on all subjects, being responsible for the abuse of that right."

59. Aside from the WMC's failure in the rulemaking process as alleged above, the most critical flaw in the Statement is its prohibition on certain speech as the Statement prohibits misinformation and disinformation that is otherwise not incidental to conduct.

SILENT MAJORITY FOUNDATION
5238 OUTLET DR.
PASCO, WA 99301

60. This statement was used and relied upon by practitioners, the public, and the State of Washington to chill the speech and interfere with the conduct of medical professionals throughout the COVID-19 pandemic.

61. "The broad language of art. I, § 5 has been found to warrant greater protection for speech, both spoken and written, in some contexts. [...] Moreover, art. I, § 5 mentions only the right to speak, write and publish." *Id.* (cleaned up.).

62. "The Washington Constitution is less tolerant of overly broad restrictions on speech than the federal First Amendment and finds that regulations that sweep too broadly chill protected speech prior to publication, and thus may rise to the level of a prior restraint, while the United States Supreme Court considers the overbreadth doctrine strong medicine, employing it only as a last resort." *Soundgarden v. Eikenberry*, 123 Wn.2d 750, 753, 871 P.2d 1050, 1052 (1994).

63. "Prior restraints are presumptively unconstitutional unless they deal with non-protected speech." *State v. Coe*, 101 Wn.2d 364, 372, 679 P.2d 353 (1984)." *State v. Noah*, 103 Wn. App. 29, 41 (Wash. Ct. App. 2000).

64. Content-based regulations target speech based on its communicative content. "As a general matter, such laws are presumptively unconstitutional and may be justified only if the government proves that they are narrowly tailored to serve compelling state interests." *Nat'l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361, 2371 (2018); *Sheehan v. Gregoire*, No. C02-1112C, at *1 (W.D. Wash. May 22, 2003) ("the First Amendment precludes the government from proscribing speech because it disapproves of the ideas expressed. *R.A.V. v. City of St. Paul,* 505 U.S. 377, 382 (1992).").

SILENT MAJORITY FOUNDATION
5238 OUTLET DR.
PASCO, WA 99301

65. In Washington State, even content-neutral time, place, and manner restrictions must meet strict scrutiny and be narrowly tailored to serve a compelling government interest. *State v. Noah*, 103 Wn. App. 29, 41 (2000).

65. "The Washington Supreme Court applies a federal analysis when confronting Article I, Section 5 challenges to restrictions on commercial speech." *Nat'l Fed'n of Retired Persons v. Ins. Comm'r*, 120 Wash.2d 101, 119, 838 P.2d 680 (1992); *see also, Ino Ino, Inc. v. City of Bellevue*, 132 Wash.2d 103, 116, 937 P.2d 154 (1997). Thus, this Court should "incorporate[] Plaintiffs' Washington Constitution claim." *Ballen v. City of Redmond*, No. C03-2580P, 2004 U.S. Dist. LEXIS 31358, at *11 (W.D. Wash. June 15, 2004; *Aff'd.* Ballen v. City of Redmond, 466 F.3d 736 (9th Cir. 2006)).

66. The Statement has chilled the speech of all Plaintiffs even to the point of relinquishing a license based on threat of discipline for speech. Plaintiffs have lost valuable property and their reputations have been harmed by the Washington Medical Commissions actions in promulgating this facially speech-based statement.

67. The Plaintiffs' speech is protected speech. "In the marketplace of ideas, few questions are more deserving of free-speech protection than whether regulations affecting health and welfare are sound public policy." Conant v. Walters, 309 F.3d 629, 634 (9th Cir. 2002)

68. The chilling of Plaintiffs speech causes the Position Statement to rise to the level of prior restraint and is therefore unconstitutional.

69. There is no compelling government interest in limiting medical dissent by doctors, nor is it narrowly tailored, making the position statement unconstitutional.

70. The Position Statement does not serve a substantial interest nor is it a necessary means, making the position statement unconstitutional.

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VI. RELIEF REQUESTED

Plaintiffs respectfully request that this Court grant the following relief:

A. Stay all underlying proceedings related to each Plaintiff's charges in full (respectively, Cole: SOC No. 2022-207; Wilkinson: SOC No. M2022-196; Turner: SOC No. M2022-194, or in part, as related to: (1) enforcement of the challenged Statement; (2) COVID-19 "misinformation" and/or "disinformation;" (3) claims that the Plaintiff's speech resulted in "mistrust" for, or otherwise impacted, the medical community or the community(ies) at large; and/or (4) the use, application, prescription, or treatment of persons with Ivermectin or Hydroxychloroquine;

B. Stay all other disciplinary proceedings by the WMC for medical professionals as related to the Statement or against professionals who: (1) expressed opinions on COVID-19, the COVID-19 vaccines, and Ivermectin or Hydroxychloroquine treatment; or (2) who or treated COVID-19 patients with such medicines, resulting in discipline from the WMC;

C. Issue Attorney's fees, costs, and expenses;

D. Reinstate Dr. Moon's license free of any investigations based on COVID-19; and

E. A Declaratory Judgment entered:

1. Declaring the Statement violates the Washington State Constitution Article 1, section; and
2. Declaring that the Statement violates Washington State Administrative Procedures Act as the rule violates the US and Washington Constitutional principles, was adopted without compliance of statutory rule-making procedures;

F. A stay of all Washington Medical Commission proceedings pursuant to RCW § 34.05.550, involving allegations or Charges for the prescription of Ivermectin for the treatment of

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COVID-19 or for the dissemination of "misinformation" or "disinformation" related to the treatment of COVID-19; and

G. Any other legal or equitable relief to which Plaintiffs may be entitled.

Dated this 11th Day of July 2023.

SILENT MAJORITY FOUNDATION

/s/Simon Peter Serrano
Simon Peter Serrano, WSBA No. 54769

/s/Karen L. Osborne
Karen L. Osborne, WSBA No. 51433

5238 Outlet Dr.
Pasco, WA 99301
(509)567-7083
pete@smfjb.org
karen@smfjb.org

Counsel for Plaintiffs

Brian Anderson WSBA # 39061
for Karen L. Osborne &
Simon Peter Serrano

CERTIFICATE OF SERVICE

I hereby certify, under penalty of perjury under the laws of the state of Washington, that on this date a true and correct copy of this Complaint for Injunctive and Declaratory Relief on the Washington Attorney General's Office, as Counsel for the Washington Medical Commission were served via electronic mail, as required by the Washington Attorney General on its website, *Electronic Service of Original Summons & Complaint* (https://www.atg.wa.gov/electronic-service-original-summons-complaint), at: **serviceATG@atg.wa.gov**.

DATED this of 11th day of July 2023, at Camas, Washington.

/s/Karen L. Osborne
Karen L. Osborne, WSBA No. 51433

SILENT MAJORITY FOUNDATION
5238 Outlet Dr.
Pasco, WA 99301

Attorney for Plaintiffs

JOSIE DELVIN
BENTON COUNTY CLERK

JUL 12 2023

FILED

SUPERIOR COURT OF THE STATE OF WASHINGTON
IN AND FOR BENTON AND FRANKLIN COUNTIES

MICHAEL K. TURNER, an individual, RICHARD WILKINSON, an individual; RYAN N. COLE, and an individual; RENATA S. MOON, an individual; Plaintiffs, v. WASHINGTON MEDICAL COMMISSION, a Washington State Agency, Defendant	No. _____ GR17 AFFIDAVIT RE: FAXED MATERIALS

I, Brian Anderson, Attorney, with Anderson Law, PLLC, declare and state the following:

The attached is a digital transmission of the Plaintiffs' Complaint for Preliminary Injunction and Declaratory Relief submitted by Simon Peter Serrano, attorney for Plaintiffs, in the above-entitled matter.

The attached document, prepared for filing this 12th day of July, 2023, and consisting of 53 pages, including this affidavit page, has been examined and determined by me to be complete and legible.

Dated: 7/12/2023

COPY

Silent Majority Foundation
5238 Outlet Dr.
Pasco, WA 99301

EXHIBIT 1

COVID-19 Misinformation

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

The Washington Medical Commission's (WMC) position on COVID-19 prevention and treatment is that COVID-19 is a disease process like other disease processes, and as such, treatment and advice provided by physicians and physician assistants will be assessed in the same manner as any other disease process. Treatments and recommendations regarding this disease that fall below standard of care as established by medical experts, federal authorities and legitimate medical research are potentially subject to disciplinary action.

The WMC supports the position taken by the Federation of State Medical Boards (FSMB) regarding COVID-19 vaccine misinformation. The WMC does not limit this perspective to vaccines but broadly applies this standard to all misinformation regarding COVID-19 treatments and preventive measures such as masking. Physicians and Physician Assistants, who generate and spread COVID-19 misinformation, or disinformation, erode the public trust in the medical profession and endanger patients.

The WMC will scrutinize any complaints received about practitioners granting exemptions to vaccination or masks that are not based in established science or verifiable fact. A practitioner who grants a mask or other exemption without conducting an appropriate prior exam and without a finding of a legitimate medical reason supporting such an exemption within the standard of care, may be subjecting their license to disciplinary action.

The WMC bases masking and vaccination safety on expert recommendations from the U.S. Centers for Disease Control and Prevention (CDC) and the Washington State Department of Health (DOH).

The WMC relies on the U.S Food and Drug Administration approval of medications to treat COVID-19 to be the standard of care. While not an exhaustive list, the public and practitioners should take note:

- Ivermectin is not FDA approved for use in treating or preventing COVID-19
- Hydroxychloroquine (Chloroquine) is not FDA approved for use in treating or preventing COVID-19

The public and practitioners are encouraged to use the WMC complaint forms when they believe the standard of care has been breached.

###

The Washington Medical Commission promotes patient safety and enhances the integrity of the medical profession through licensing, rulemaking, discipline, and education. Learn more about the commission at WMC.wa.gov. Follow the WMC on Facebook and Twitter.

Special meeting where the WMC adopted this position statement: https://youtu.be/P5qDoNWfdhI

EXHIBIT 2

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]

EXHIBIT 3

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;
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> ... .

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

MELANIE DE LEON
EXECUTIVE DIRECTOR

Kristin G Brewer

KRISTIN G. BREWER, WSBA # 38494
SENIOR COUNSEL

CONFIDENTIAL SCHEDULE

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Patient A

Patient B

Patient C

Patient D