STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: Scott C. Miller, PA
Master Case No.: M2021-272
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 Assistant of **SCOTT C. MILLER, PA** License No. PA.PA.60427988 Respondent.	**No. M2021-272** **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 file numbers 2020-12052, 2021-5907, 2021-5911, 2021-5924, 2021-6372, 2021-6533, and 2021-9342. The patients referred to in this Statement of Charges are identified in the attached Confidential Schedule.

1. ALLEGED FACTS

1.1 On December 16, 2013, the State of Washington issued Respondent a license to practice as a physician assistant. Respondent's license is currently active.

Misrepresentation on original license application

1.2 In August 2012, while Respondent was licensed and was practicing in the state of California, the California Physician Assistant Board initiated an investigation of Respondent.

1.3 In February 2013, an investigator for the California Physician Assistant Board interviewed Respondent as part of the investigation.

1.4 On or about September 19, 2013, Respondent completed and signed an application to the Commission for a physician assistant credential. The completed application was received by the Commission on or about October 28, 2013.

1.5 On Section 2 of the application, the Respondent marked the box designated "No" in response Question #13:

> To the best of your knowledge, are you the subject of an investigation by any licensing board as to the date of this application?

1.6 On or about March 14, 2014, the California Physician Assistant Board issued a Citation Order to Respondent. The Citation Order found that Respondent was

providing medical care without supervising physician authorization, writing drug orders for controlled substances without conducting physical examinations and without supervising physician authorization, and failing to document and maintain medical records for patients.

1.7 In a response to the Commission's investigator dated October 12, 2020, Respondent stated that he had disclosed the existence of the Physician Assistant Board of California investigation to the Commission in his application.

1.8 Additionally, Respondent provided two documents to the investigator that purported to indicate disclosure of the Physician Assistant Board of California investigation to the Commission. The two documents were not copies of any material received by the Commission in connection with Respondent's 2013 application to the Commission. Respondent's 2013 application to the Commission does not reflect the existence of the Physician Assistant Board of California investigation.

Misleading representations regarding the efficacy of non-FDA-approved treatments and mask use

1.9 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, approximately 709,000 people have reportedly died because of COVID-19. The CDC has set guidelines regarding mask use for public safety because masks have proven to decrease community spread. One of the most common ways for COVID-19 to spread is through contact with viral particles called virons, which exit a host body in droplets. *Id.* Masks provide a barrier for those droplets, limiting the suspended particles that travel around in airflow and are easily inhaled. .

The Center for Disease Control and Prevention (CDC) has set guidelines regarding mask use for public safety. On April 27, 2021, the CDC stated that anyone who is unvaccinated and older than two should wear a mask in indoor places. That was the guidance in place on May 10, 2021.

1.10 On July 24, 2020, the Washington State Secretary of Health issued Order 20.03 mandating face coverings for everyone in public indoor settings. That mandate was in place on May 10, 2021.

1.11 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).

1.12 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.

1.13 On May 10, 2021, during a school board meeting in Camas, WA, Respondent, while not wearing a mask, identifies that he has a "pediatric practice in Washougal". Respondent made the following remarks:

> Outside of my what I do I don't know a single person who's died. . . I've treated 350 COVID patients. Do you know there's treatment? Like these blank stares. Do you know there's treatment? I treat people every day. I had 90 COVID patients come into my clinic last month, treated all of them. ivermectin cures. Vitamin D, vitamin C, it actually cures if anybody cared to look at the data.
>
> …
>
> Masking kids. . .what are these people doing there's kids outside with masks on. My wife just got back from Texas and nobody is wearing masks. . . it can't be the information, it can't be the science a whole bunch of other people know the science and aren't doing this. Our kids could go to school I wrote them mask exemptions… I will not allow them to wear a mask. I didn't allow them to wear a mask when we went to

the airport and got on a plane. I guess some of us know the science on that.

Treatment of patients with non-FDA approved medication

Patient A

1.14 On or about May 19, 2021, Patient A contacted Respondent's pediatric clinic seeking treatment. Patient A was 39 years old at the time of seeking care from Respondent. Respondent spoke on the phone with Patient A for 22 minutes. Patient A reported, over the phone, that he tested positive for COVID-19. Patient A reported congestion, cough, headache, and fatigue that began on or around May 14, 2021, as well as a fever that had resolved at the time he sought treatment from Respondent. Patient A denied shortness of breath.

1.15 Respondent documented in chart notes that Patient A reported he was positive for COVID-19.

1.16 Respondent advised Patient A to start or modify his intake of supplements on the following regimen:

A. Vitamin D 20,000 iu daily
B. Acetylcysteine 1000 mg three times a day
C. l-glutathione 500 mg two times a day
D. Vitamin C 1,000 mg every hour "or until bowel tolerance"
E. Zinc 100 mg daily
F. Melatonin 5 mg every hour during the day "if tolerated" with an initial nightly dose of 20 mg with a following 30 mg nightly dose
G. Quercetin 500-800 mg two times a day
H. Aspirin 325 mg daily
I. Selenium 200 mcg daily

1.17 In addition to the supplements listed above in Paragraph 1.12, Respondent prescribed the following medications to Patient A:

A. ivermectin 24 mg, first dose on date of prescription, followed by 24 mg one week later and then 24 mg one month later
B. Dexamethasone 12 mg daily for five days
C. Azithromycin 500 mg on the date of prescription followed by 250 mg daily for five days

1.18 Prior to prescribing ivermectin to Patient A, Respondent failed to verify Patient A's self-reported COVID-positive test and to perform a physical exam of Patient A. Additionally, Respondent calculated the dosage solely based on Patient A's reported weight without any clinical data to support the dosage as therapeutic. Finally, Respondent failed to counsel Patient A on the possible interaction between ivermectin and dexamethasone and did not order follow-up testing to monitor and address possible impact on Patient A's hepatic function.

Patient B

1.19 On or about September 1, 2021, Patient B sought care from a hospital emergency department due to acute hypoxemic respiratory failure after eight days of symptoms related to COVID-19. Patient B was admitted to the hospital's intensive care unit because he was hypoxic on arrival. Medics stated that Patient B was unresponsive with unreadable stats when they arrived to transport him to the hospital. Patient B was unvaccinated.

1.20 On September 3, 2021, Patient B declined intubation against medical advice and left the hospital against medical advice, but in accordance with Respondent's advice to pursue treatment with ivermectin. Respondent never examined Patient B.

1.21 Patient B was at serious risk of harm when he left the hospital. Medical staff informed Patient B that he would likely not survive if he was discharged.

1.22 On September 4, 2021, while patient B was out of the hospital, Respondent prescribed ivermectin to Patient B for the stated purpose of treating "head lice." Respondent instructed Patient B to "take 9 tablets orally day one and repeat in one week if head lice not resolved." Respondent misrepresented that the purpose of the prescription for ivermectin was to treat head lice.

1.23 On or about September 4, 2021, Patient B's wife called 911 to have an ambulance return him to the hospital because he was in respiratory distress. Upon return, Patient B had acute hypoxic respiratory failure and needed to be sedated and intubated.

1.24 On September 12, 2021, Patient B expired.

Patient C

1.25 On September 10, 2021, Patient C stated on a YouTube show that the Respondent had prescribed her and Patient B ivermectin and that she had taken it for COVID-19. She also stated that the Respondent was her doctor and had treated over 900 patients with ivermectin. Patient C was unvaccinated at the time she contracted COVID-19.

Patient D

1.26 On or about July 19, 2021, Patient D sought care from a hospital emergency department due to low oxygen, fever, and nausea. Patient D came into the hospital after she "ran out of her home oxygen." Patient D was unvaccinated.

1.27 Prior to admission, on July 11, 2021, Respondent was treating Patient D with ivermectin and he sent her an oxygen tank, which she was self-administering oxygen.

1.28 On or about July 27, 2021, Patient D expired.

Disrupting the therapeutic alliance with hospital providers and patients by harassing hospital staff and misleading patients about the efficacy of non-FDA-approved treatments and directing them against standard of care treatments

1.29 Based on Respondent's representations about the efficacy of ivermectin to treat COVID-19, Patient C began contacting the hospital asking that they administer ivermectin and vitamins to Patient B. Ivermectin is not part of the hospital protocol in treating COVID-19 patients. Ivermectin is not part of the NIH protocol for treating COVID-19 patients. These protocols are not considered standard of care treatment for COVID-19.

1.30 On or about September 7, 2021, the hospital's medical director and clinical risk management director spoke by phone with Patient C and a person identifying himself as Patient C's brother to discuss modalities of treatment and requests for high dose vitamin therapy in conjunction with ivermectin. Patient C requested the hospital meet with her and with the medical doctor who had been prescribing the vitamins and ivermectin. On September 8, 2021, the hospital received a demand letter from a law firm on behalf of Patient B to start ivermectin. On or about September 9, at approximately 1:00 a.m., Respondent joined a phone call with Patient C and a nurse in the intensive care unit at the hospital to discuss Patient B's care. The

same day at approximately 8:25 a.m. Pt. C called again expressing dismay about the hospital's refusal to prescribe ivermectin and threatening legal action. Later that day around 3:00 p.m., the clinical risk management director for the hospital contacted Patient C's brother who seemed "suddenly amnesic" about the prior conversation with him requesting the hospital speak with Patient B's doctor. At about 3:12 p.m. the clinical risk management director contacted Patient C and asked the name of the provider treating Patient B and prescribing ivermectin to him. Patient C hesitated but ultimately identified Respondent as Pt. B's doctor and acknowledged that Respondent had never seen or examined Patient B.

1.31 In multiple instances during the phone call with the nurse, Respondent demanded to speak with the physician who was monitoring the hospital's intensive care unit. When told the physician was not available because the physician was monitoring care for Patient B as well as twenty-three other intensive care unit patients, Respondent's conduct turned abusive and inappropriate:

> Hang on. That's it? She has twenty-four critically ill patients to manage? That's cake because she's not managing them, she's not actively managing them. She is managing them the way she is managing [Patient B] – which is nothing. . . . So my question is how is she managing [Patient B]? Is she giving him high-dose methylprednisolone to give him a chance to get off the ventilator or is she keeping him on six milligrams of dexamethasone that I'd give a five-year-old with croup? My question is what is she doing to actively help him live?"

The nurse told Respondent that Patient B was under a hospital-approved regimen. In response, Respondent said:

> That's why they die. That's why . . . you go home sad. Because they're doing the exact same thing with COVID patients. Well, guess what? He doesn't have COVID anymore. He's COVID-negative, he has an intense inflammatory response that is destroying his organs and lungs and he is on a child's dose of dexamethasone. So, if you're managing every single patient in the COVID ward exactly the same . . . nobody's doctoring them, no one is treating their symptoms. Interleukan-6, and Interleukan-17 and TNF-alpha, the last thing through his body and you're giving him dexamethasone?

The conversation culminated with the following exchange between Respondent and the nurse:

> RESPONDENT: I'm Scott Miller. We know what you're doing. Well, not you. You're a pawn, but you know what's happening. . . . I want you to carry this guilt because this is disgusting. I have advocated for patients in your hospital for the last year and I hear the same thing every time. And let just tell you what, [Patient B] deserves to have care that will allow him to go home.
>
> NURSE: We are doing everything we can.
>
> RESPONDENT: No. No, you're not. You're not doing anything. There has been no change in his protocol. He is on the same protocol as everybody else.

After the call with the nurse concluded, Respondent told Patient B that the physician "didn't give a shit" about Patient B. The recorded portion of the call then concluded with Respondent asking Patient B's spouse, Patient C, to delete the recording.

1.32 While Patient D was under the hospital's care, Respondent repeatedly contacted and pressed hospital staff, calling with Patient D's son, to change course of treatment to include a different steroid regime. Respondent communicated this recommendation to Patient D's son who contacted the hospital three times to request that Patient D be given ivermectin.

1.33 Patient D, who was too late in her disease course to receive Remdesivir, declined Tocilizumab based on Respondent's advice to Patient D's son.

1.34 On or about July 17, 2021, Patient E sought care from a hospital emergency department due to symptoms related to COVID-19. He was unvaccinated.

1.35 Patient E's family, on direction from Respondent, filed a request for an emergency injunction to have ivermectin administered to Patient E.

1.36 Patient E's spouse explained to hospital staff that her children had pressed her to go this route after Respondent advised them to do so. She had not met the attorney, nor Respondent. Respondent had never treated Patient E or examined him.

1.37 Patient E's family later withdrew the request.

1.38 Patient E was never Respondent's patient.

1.39 On or about August 2, 2021, Patient E expired.

1.40 On or about July 25, 2021, Patient F sought care from a hospital emergency department after his sister found him on the floor unable to walk to the door due to weakness and other COVID-19 symptoms. Upon arrival patient was notably hypoxic after seven days of symptoms. Patient F was unvaccinated.

1.41 On or about July 31, 2021, Patient F's daughter called the hospital with Respondent also on the phone. Patient F introduced the Respondent as Patient F's brother. Respondent recommended changing antibiotics to doxycycline and adding Cyproheptadine. The provider explained that there was no indication for these medications and Respondent identified himself as the Respondent himself, rather than Patient F's brother.

Threatening statements about hospitals and physicians who treat COVID-19 patients

1.42 On or about September 23, 2021, the Commission's investigator received a series of screenshots of Respondent's comments on his Facebook page. The comments were, again, abusive and inappropriate. Examples of the Respondent's comments included:

> FOR COMMUNITY USE ONLY; and to Legacy Salmon Creek hospital system providers that haven't suckled from the teeth of evil.
>
> I have offered solutions, treatments, protocols, that would virtually ensure all of your ICU patients being able to go home to their loved ones. I have spent countless times, with many, many hours on the phone with your nurses, daytime doctors, and twice your on-call doctors, twice, because after calling every 30 minutes throughout the night, night after night, week after week, month after month, trying to get an on-call doctor to make a few simple changes that would . . . Anyways, there are 24+ human beings in the ICU at Peace Health Southwest, every one of them being treated with the antipathy and disdain that we wouldn't wish on my enemies. I KNOW you, I know your doctor's names, I have spoken to you, I have desperately pleaded with you, I have offered the evidence-based medicine that would have saved the lives that you chose to terminate. Your names will be well known

> very soon, so our community knows who is responsible for these crimes against humanity. And Dr. Lee, you are directly responsible for the death of a woman that had so much more to give. You told me, you specifically told me that you could not make any changes to her protocol and that I would have to run that by the pulmonologist. So I spent 24 minutes, based on my dictation records, going around and round with Dr. Gupta, and he finally relented and put in the orders to change her medication that would have preserved her life. But you refused, you would not allow the medications to be given. I wonder how much "they" are paying you to kill people in our community.
> Yes, this is a legacy memo, but peace health is far more deadly.
> . . .
> To extubate a human being that is fully alive, fighting for their life, but apparently didn't have the still untested injection and they give an order for a 33-year-old woman to extubated, I'm sorry, murdered, because, I don't know, they're insurance had been maxed out and so they needed to make room for another victim.
> Let me please make something crystal clear with this memo that a hospital system put out, they specifically and intentionally chose to undermine all of science. Ivermectin is a miracle[.]
> . . .
> If needed, I am pretty sure that I could at least get a few of them to show up at Legacy Salmon Death and educate The executioners that release this internal . . .

1.43 On or about September 11, 2021, Respondent participated in an interview about COVID-19 treatments where he stated, "We need maximum pressure on PeaceHealth. Legacy isn't great either, but PeaceHealth is notorious."

<u>Uncooperative with the Commission's investigation</u>

1.44 On or about August 23, 2021, Respondent provided answers to the Commission's Letter of Cooperation where he provided unhelpful and misleading answers:

> 1. Have you advised patients to not wear masks? If so, what, if any risks and benefits did you discuss for each patient?

To this Respondent stated he advises families to follow CDC guidelines. However that is inconsistent with his statements at the Camas School Board meeting on May 10, 2021, where he explained that "the science" doesn't support a public health need for people wearing masks on airplanes.

> 2. Have you advised patients to disregard public health guidelines and to avoid social distancing? If so, please explain your rationale for providing this advice and any risk/benefits discussed with patients.

Respondent denied this, but that is inconsistent with his statements at the Camas School Board meeting on May 10, 2021. He stated that when patients came into his office and explained recent COVID outbreaks in their schools, he showed them pictures of himself and his "buddies in Montana, skiing, in a bar, with live music- listening to live music." He stated he has been begging parents to unenroll their children from schools because the school district sent a letter asking parents to speak to their children about keeping others safe and healthy by wearing a mask, social distancing, and limit gatherings.

> 3. Have you prescribed patients ivermectin for diagnosis of COVID-19?

Respondent answered "No," and explained that he had "NOT prescribed patients ivermectin 'for diagnosis of COVID-19'."

1.45 On or about August 31, 2021, Respondent provided answers to investigator's Letter of Cooperation and in his response stated:

> This complaint was not brought by the patient, the complaint was almost completely void of facts, and there seems to be little interest in the very small group of people, none of them patients of my practice, and their desire to try to negatively affect the carrier [sic] of one of the most dedicated providers in our state.
>
> I am very concerned about the lack of hospital system's interest in life saving therapies, rather continuing to implement treatments that have yielded over 700,000 thousand lives lost. I am curious why I am being investigated for using medications that I have used ubiquitously to treat

> lice and scabies, croup, and pneumonia. And I am wondering if the board has any interest on the rapid resolution of symptoms that my patient experienced.

1.46 In August 2021, in response to an LOC that included questions about Respondent prescribing ivermectin to Patient A, Respondent left a voice message for the investigator and stated the following: "I don't know how to answer the question; they are irrelevant because I treated him correctly. Do you want the truth or just what I see on TV? I need help to guide me through this silliness."

2. ALLEGED VIOLATIONS

2.1 Based on the Alleged Facts, Respondent has committed unprofessional conduct in violation of RCW 18.130.180(1), (2), (4), (6), (13), (16), 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 ensuing 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;
>
> (2) Misrepresentation or concealment of a material fact in obtaining a license or in reinstatement thereof;
> …
>
> (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;
> …

(6) Except when authorized by RCW 18.130.345, the possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diversion of controlled substances or legend drugs, the violation of any drug law, or prescribing controlled substances for oneself;

…

(13) Misrepresentation or fraud in any aspect of the conduct of the business or profession;

…

(16) Promotion for personal gain of any unnecessary or inefficacious drug, device, treatment, procedure, or service;

…

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

… .

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

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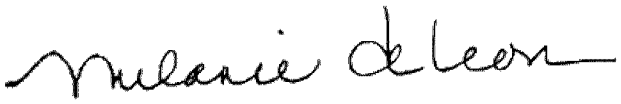
3. NOTICE TO RESPONDENT

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

DATED: October 8, 2021.

STATE OF WASHINGTON
WASHINGTON MEDICAL COMMISSION



MELANIE DE LEON
EXECUTIVE DIRECTOR

ROBERT W. FERGUSON
ATTORNEY GENERAL

KRISTIN G. BREWER, WSBA NO. 38494
SENIOR COUNSEL
ARI ROBBINS, WSBA No. 54201
ASSISTANT ATTORNEY GENERAL

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