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:
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> (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;
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> …
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> (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;
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> …
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> (13) Misrepresentation or fraud in any aspect of the conduct of the business or profession;
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> …
>
> (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
EXECUTIVE DIRECTOR

KRISTIN G. BREWER, WSBA # 38494
SENIOR COUNSEL

CONFIDENTIAL SCHEDULE

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

Patient A

Patient B

Patient C

Patient D