STATE OF MAINE
BOARD OF LICENSURE IN MEDICINE

IN RE:	
Meryl J. Nass, M.D. Complaint Nos. CR21-191, CR21-210 & CR22-4	**Licensee's Closing Argument**

This case is about censorship. The Board of Licensure in Medicine (BOLIM) began investigating Dr. Nass in late 2021 for spreading so-called misinformation about COVID-19. (*See, e.g.*, Bd. Staff. Ex. ("BSE") 3-7, 19, 25-27, 34-61.) On January 11, 2022, without affording Dr. Nass due process or reviewing an accurate history of Dr. Nass or the complaints, the BOLIM suspended Dr. Nass from the practice of medicine and ordered her to undergo a neuropsychological examination—permitted under the statute *only* if the complaint suggests that an individual may be unable to practice "by reason of mental illness, alcohol intemperance, excessive use of drugs, narcotics or as a result of a mental or physical condition interfering with the competent practice of medicine." 32 M.R.S. § 3286. No such allegations were made. The BOLIM then brazenly tried to discipline Dr. Nass for speech, claiming (among other things) that that her speech constituted "disruptive" behavior. (BSE 1, 3 (containing misinformation-related allegations); *see also* Amended Notice of Hearing (Mar. 22, 2022).)

But, like any governmental body or officer, the BOLIM is constitutionally prohibited from wielding the state's police power to silence speech with which it disagrees. Despite its political opinions, the BOLIM is not a Truth Ministry empowered to regulate the thoughts of its licensees. After Dr. Nass moved to dismiss the misinformation grounds for discipline as violating her free speech rights (Licensee Mot. Dismiss (Sept. 9, 2022)), Board Staff was left with no choice but to abandon its overtly unconstitutional misinformation-related grounds for discipline.

But, seeking to sidestep the First Amendment, Board Staff still presses forward with de minimis or technical alleged violations—an obvious effort to "get" Dr. Nass on something else. Despite the paltriness of the remaining alleged misconduct, the BOLIM voted without deliberation, on October 11, 2022, to keep Dr. Nass suspended until the end of the hearing, with the BOLIM chair turning a blind eye to her own significant conflicts of interest. Dr. Nass remained (and remains) illegally suspended for 20 months, despite numerous requests to lift the suspension. The BOLIM and Board Staff then conducted the longest adjudicatory hearing in BOLIM history over the course of eleventh months; flouted its own expert witness guidelines to pay an underqualified and ineligible doctor as much as 400% of the maximum allowable rate for experts; and provided false information to another Maine state agency to get the money used to prosecute Dr. Nass (LE 224)[1]. Ultimately, Board Staff and the BOLIM created a public spectacle by pretending that this unprecedented 11-month hearing is about the quality of Dr. Nass's medical care, when it is in fact about censorship and making an example out of Dr. Nass. The hearing is indeed a "spectacle"—but not by Dr. Nass's hand.

Argument

I. Dr. Nass is a highly qualified doctor, with expertise in pandemics and biological warfare, who cares deeply for her patients.

Dr. Meryl Nass practiced medicine in Ellsworth, Maine until she was suspended. (Tr. 116:3-14.) She matriculated at the Massachusetts Institute of Technology (MIT) before finishing high school. (Tr. 119:24-120:3.) She graduated from MIT with a degree in biology and went on to graduate from medical school in 1980. (Tr. 120:4-12.)

[1] Specifically, the BOLIM provided disinformation to the Maine Division of Procurement Services in its Blanket Contract (CTB) Justification and Amendment Forms by stating expert reviewers are paid a maximum of $125 or $175 per hour and listing the total amount of Dr. Jeremy Faust's June 6/2022 invoice ($10,500), while the BOLIM was actually paying Dr. Faust $500 per hour.

Early in her career, Dr. Nass became involved with the anthrax disease and later with the anthrax vaccine. (Tr. 120:11-18.) She did a great deal of writing on the subject, and testified before Congress on bioterrorism, the anthrax vaccine, and Gulf War Syndrome. (Tr. 120:13-24, 125:18-127:11, Licensee Exhibit (LE) 1.) In fact, the American Journal of Public Health requested that she write a paper about the anthrax vaccine program, ultimately entitled *The Anthrax Vaccine Program, An Analysis of the CDC's Recommendations for Vaccine Use*, AMERICAN JOURNAL OF PUBLIC HEALTH, Vol. 92, No. 5, May 2022. (Tr. 121:21-122:7; LE 2.) That paper showed how normal FDA standards were not followed in the approval process for the anthrax vaccine, causing many people to suffer. (Tr. 122:8-22.) Dr. Nass went on to testify before six different Congressional committees and successfully participated in litigation with a group of soldiers leading to the revocation of the anthrax vaccine license. (Tr. 122:19-125:10; LE 3, 4.) A unanimous vote of the Maine Legislature created the Commission to Improve the Lives and Health of Members of the National Guard, of which Dr. Nass was a member and then chair. (Tr. 125:9-17.)

Describing her medical practice, Dr. Nass testified that she is a doctor willing to take the difficult patient that other doctors avoid:

> I am a doctor who takes care of the patients that . . . no other doctors want to deal with because you can't make money on them, they're hard to treat, they're hard to diagnose, and so my practice has been, a lot of it for 20 years or more, taking care of patients with chronic fatigue syndrome, fibromyalgia, Gulf War syndrome, chronic Lyme disease, et cetera[.]

(Tr. 130:20-131:2.) Dr. Nass has never had a patient complaint, including throughout this case. (Tr. 156:18-157:16.)

II. Board Staff failed to prove that Dr. Nass is unfit to practice medicine [Grounds I and II].

Grounds I and II require Board Staff to prove that Dr. Nass is incompetent to practice medicine, by either (i) "engaging in conduct that evidences a lack of ability or fitness to discharge the duty owed . . . in providing care to Patients 1, 2, and 3[,]" (Ground I) or (ii) "engaging in

conduct evidencing a lack of knowledge or inability to apply principles and skills to carry out the practice for which the licensee is licensed in providing care to Patients 1, 2, and 3[,]" (Ground II). Thus, under either theory, Board Staff must do more than just identify instances where it contends that Dr. Nass did not meet the applicable standard of care, or that her performance fell below what might be expected of an ordinary, fallible doctor. Instead, Board Staff must prove that Dr. Nass's conduct was so poor to evidence that Dr. Nass lacks the ability, fitness, or knowledge to practice medicine or discharge her duties. 32 M.R.S. § 3282-A(2)(E). Each of Board Staff's arguments to that end are meritless.

A. Prescribing hydroxychloroquine or ivermectin to treat COVID-19 is not evidence of incompetence.

Especially when considering the state of evolving medical science during the fight against a novel disease, prescribing ivermectin and hydroxychloroquine to treat COVID-19 did not demonstrate incompetence in the practice of medicine. Again, the BOLIM need not decide whether ivermectin and hydroxychloroquine are effective at treating COVID-19. Instead, the question is whether Dr. Nass's belief that the benefits of prescribing ivermectin and hydroxychloroquine outweighs the risks is so outlandish to establish incompetence. 32 M.R.S. § 3282-A(2)(E). The evidence at hearing proved that the answer is a resounding no: expert evidence, and information provided by Dr. Nass to the BOLIM before her suspension and during the hearing, reveal that both ivermectin and hydroxychloroquine are highly effective when used at appropriate times in appropriate doses. Not only were Dr. Nass's beliefs reasonable, but they were also correct.

The parties called competing expert witnesses on the efficacy of hydroxychloroquine and ivermectin: Dr. Harvey Risch for Dr. Nass and Dr. Jeremy Faust for Board Staff.

Dr. Risch is a professor emeritus of epidemiology and senior research scientist at the Yale School of Public Health. (Tr. 1140:19-22.) He has published more than 400 peer reviewed papers

that have been cited close to 50,000 times by other scientific papers. (Tr. 1162:2-17.) On top of publishing peer reviewed papers, Dr. Risch served as a reviewer for the Canadian Medical Association, the British Journal of Cancer, the Annals of Oncology, and the New England Journal of Medicine. (Tr. 1158:6-1160:20.) Dr. Risch also created Yale's pharmacoepidemiology course, "which is the study of drugs, vaccines and devices and their antecedent conditions and risks and benefits . . . of those agents." (Tr. 1152:20-11:53:2.) Dr. Risch has trained generations of epidemiologists. (Tr. 1156:7-10.) His impressive Curriculum Vitae is Licensee Exhibit 151D.

Board Staff chose not to cross-examine Dr. Risch, nor did it introduce evidence suggesting bias, predisposition, or any other issues. Dr. Risch's testimony stands unchallenged.

Board Staff's expert witness, Dr. Faust, lacks credentials in epidemiology. (Tr. 808:9-10, 812:5-13.) When asked about peer reviewed publications, Dr. Faust could only identify a few. (Tr. 650:13-25.) On cross-examination, Dr. Faust admitted that one of those so-called "articles" was just a short letter published in the British Medical Journal, and that he did not know if the letter was peer reviewed or not (despite testifying under oath that it was peer reviewed). (Tr. 851:5-855:5.)

Dr. Faust spends just 600 to 800 hours per year employed as an emergency room doctor and has no idea how much of his income derives from that work. (Tr. 646:19-647:13, 843:18-21.) Much of Dr. Faust's time is spent writing for "MedPage" as an independent contractor. (Tr. 841:14-842:12.) Dr. Faust dodged questions about how much of his income comes from MedPage and stated, "I do not know the answer to that question" when asked if MedPage provides more than half of his income. (Tr. 842:10-21.) He also issues a newsletter called Inside Medicine and, again, testified that he does not know how much he earns from that publication. (Tr. 845:1-22.)

In his testimony and writings admitted into evidence, Dr. Faust revealed himself to be an opinionated and prolific advocate against ivermectin and hydroxychloroquine for treatment of COVID-19, referring to peers with opposing views as "ivermectin worshipers," "zealots," and "grifters." (Tr. 861:22-864:10, 875:13-21.) Dr. Faust tried to explain these attacks by saying what he really meant is that these people suffer from confirmation bias. (*Id.*) Ironically, while accusing his opponents of confirmation bias, Dr. Faust reduced his hourly rate from $650-$850 per hour to $500 per hour because he "firmly believes in [Board Staff]'s cause[.]" (LE 237B.) In short, Dr. Faust is a part-time emergency room doctor who came to this case with a predetermined conclusion.

In 2020, Dr. Risch, along with about 50 co-authors, published a paper entitled *Multifaceted Highly Targeted Sequential Multi-Drug Treatment of Early Ambulatory High Risk SARS-CoV-2 Infection*. (Tr. 1163:3-20; LE 50.) The paper described treatment protocols for clinicians to use with hydroxychloroquine for early outpatient COVID-19 care. (Tr. 1164:21-8.) Dr. Risch explained that the zinc ion interferes with the virus replication enzyme, but the challenge is to get the zinc ion into the cell, and hydroxychloroquine does just that. (Tr. 1166:12-1167:11.)

Dr. Risch also published a paper, *Early Outpatient Treatment of Symptomatic High-Risk COVID-19 Patients*. (Tr. 1167:12-1168:11.) The importance of studying high-risk patients is that low-risk patients generally manage the infection without intervention, while the goal is to prevent high-risk patients from developing an illness requiring hospitalization. (Tr. 1168:12-1169:9.) Dr. Risch also participated in a Brazil study, published in Travel Medicine and Infectious Disease, which found that hydroxychloroquine reduced the risk of hospitalization by half in high-risk patients. (Tr. 1169:10-1172:2.)

Much of the medical literature claiming to show lack of efficacy of hydroxychloroquine is either fatally flawed (such as commencing treatment too late or using incorrect doses) or failed to evaluate outpatient use. (Tr. 1173:2-1174:17.) Studying hospital patients, Dr. Risch explained, doesn't make sense because one cannot study the risk of hospitalization by looking at hospitalized patients; one must look at outpatient use.

> A medication that works for the [initial] flu-like illness has no relationship one way or the other to treating the hospital respiratory distress pneumonia [ARDS] which is a different illness needing different treatments and different management. And so these papers were flooding the lay airwaves, so to speak, trying to assert that hydroxychloroquine "didn't work," when what was being said about how it didn't work was smeared or omitted because all of the papers that actually looked at outpatient use and the outcomes of hospitalization show benefit.

(Tr. 1173:16-1174:1.) And it was not just Dr. Risch's May 2020 paper; there have been nine other controlled clinical trials of early hydroxychloroquine treatment, all showing benefit. (Tr. 1174:1-17.) While there have been competing studies with different conclusions, those studies did not start hydroxychloroquine within the first few days of symptoms and were not looking at the outcomes of hospitalization or mortality. (Tr. 1173:2-1174:17.) Instead, those studies evaluated days with symptoms, viral presence in sequential nasal epithelial testing, or other endpoints that are of "pretty low importance" compared to people being hospitalized or dying from the illness. (Tr. 1173:2-1174:17.)

For example, a journal article relied on by Dr. Faust, *A Randomized Trial of Hydroxychloroquine as Postexposure Prophylaxis for COVID-19*, was flawed by how it defined the high-risk group and choosing the outcome of developing COVID-19 after exposure, not whether hydroxychloroquine given after onset of illness prevented hospitalization or mortality. (Tr. 1174:18-1175:1176:5.) Another study, *Effect of Hydroxychloroquine in Hospitalized Patients with COVID-19*, is not relevant because it did not deal with outpatient use. (Tr. 1176:6-16.)

Dr. Risch also rebutted Dr. Faust's claim that, because hydroxychloroquine has been shown in randomized trials to be ineffective at treating COVID-19, exposing a patient to that particular therapy presents only the possibility of harm without the possibility of meaningful benefit. (Tr. 1192:10-15.) As Dr. Risch explained, Dr. Faust's opinion begins with an incorrect premise. The randomized trials purporting to show that hydroxychloroquine did not show benefit,

> were largely done in hospital setting or in low-risk people which had virtually no outcomes of hospitalization and mortality. And so . . . the studies that Dr. Faust was presumably referring to are ones that essentially don't bear on the question at hand and are uninformative on that basis and cannot be considered high-quality studies. It might be high quality the way you think you carry it out, but if it's meaningless for what you're studying, it's not a high-quality study.

(Tr. 1192:19-1193:11.) Dr. Risch also explained that those sources pointing to perceived risks of hydroxychloroquine use were flawed. (Tr. 1218:15-1222:18.) Indeed, neither Dr. Faust nor Dr. Thomas Courtney (Board Staff's other expert) testified that there are any remarkable safety risks associated with standard doses of hydroxychloroquine or ivermectin, and each of them agreed that both medications are generally regarded as safe. (Tr. 877:4-7, 892:21-22, 961:1-17, 965:4-11 (Dr. Faust), Tr. 534:21-11, 616:15-24 (Dr. Courtney).) Dr. Marik elaborated that ivermectin is probably one of the safest medications on the planet with over 4 billion doses dispensed. (Tr. 1470:10-1473:2.) He also testified that hydroxychloroquine is "exceedingly safe" when used in the appropriate dosing range. (Tr. 1473:3-1476:10.) Dr. Nass also discussed the safety of hydroxychloroquine and ivermectin, pointing out that the two developers of ivermectin received a Nobel prize for it, and explained how ivermectin was developed from a bacterial isolate called Avermectin. (Tr. 119:2-17, 179:5-181:20.)

Dr. Risch's report on hydroxychloroquine, marked as LE 151-B, explains how studies were selected, his reasoning about why some studies are irrelevant, and shows a 43 percent reduced risk of hospitalization with hydroxychloroquine based on the selected high quality studies. (Tr. 1197:8-

1218:14 (summarizing his report); LE 151-B.) As to Dr. Faust's criticism that what Dr. Risch did was not a meta-analysis, Dr. Risch responded, "Well, he's wrong. He's conflated the idea of writing a scientific paper with writing a scientific brief for a lay audience or . . . a halfway-knowledgeable audience epidemiologically speaking." Tr. 1195:5-13.) Dr. Risch continued to explain that he gathered every possible study that might bear on the question at hand, reviewed absolutely everything he could find, and omitted those that were flawed or off topic. (Tr. 1195:9-24.) Dr. Risch stated, "I'm happy to address what sources I used to find those studies" (Tr. 1195:18-19), but Board Staff tellingly (and perhaps wisely) chose not to accept that challenge and performed no cross-examination.

Dr. Risch also testified about ivermectin and his reports, *Ivermectin Based Prophylaxis and Risk of COVID-19* (LE 151-A), and *Ivermectin Based Early Outpatient Treatment and Risk of COVID-19 Hospitalization Mortality* (LE 151-C). (Tr. 1222:19-1249:10.)

The first ivermectin report (LE 151-A) concluded that prophylactic ivermectin appears to reduce the risk of getting COVID-19 by somewhere between 71-82%, depending on what kind of statistical analysis is used. (Tr. 1223:11-16.) After a summary introduction, the paper explains why some studies were methodologically inadequate. (LE 151-A at **2-3), why others adequately bear on prophylactic ivermectin use and risk of symptomatic COVID-19 (LE 151-A at **4-6), and provides a meta-analysis of the nine compliant studies, making it "readily apparent" that prophylactic use of ivermectin has shown risk reduction for subsequent infection (LE 151-A at **6-10). (Tr. 1223:11-1228:22 (discussing LE 151-A).)

The second ivermectin report (LE 150-C) concluded that ivermectin used for outpatient treatment reduces the risk of hospitalization 42-45% and reduces the risk of mortality 28-46%. (Tr. 1229:12-1230:5, LE 150-C.) This paper identified thirteen studies that examined ivermectin

outpatient treatment against the risk of COVID-19 hospitalization (LE 151-C at **2-3); explained why four of those studies are excluded due to various deficiencies (LE 151-C at **3-4); explained why nine of those studies were valid for use in the meta-analysis, and why three other studies are also included (LE 151-C at **4-8); and, finally, conducts a meta-analysis of hospitalization risk (LE 151-C at **8-9). (Tr. 1229:12-1236:22.) The paper also conducts the same analysis of ivermectin based treatment on the risk of COVID-19 mortality. (LE 151-C at **9-14; Tr. 1236:23-1238:8.)

Dr. Risch's three reports, marked as LE 151-A, B, and C, are his own work product written without assistance or influence of Dr. Nass or others. (Tr. 1238:9-17.) He was not talked into becoming a "firm[] believe[r] in our cause," as Dr. Faust was by the BOLIM's former Medical Director, Dr. Kenji Saito. (LE 237B).

At best, Board Staff has shown that there exists disagreement about the efficacy of hydroxychloroquine and ivermectin for COVID-19. Some (like Dr. Risch) say those medications help; others (like Dr. Faust) say they don't.[2] And some take neutral positions. (Tr. 888:21-890:2 (Dr. Faust agreeing that the NIH took a neutral position on ivermectin).) The proverbial "battle of the experts" vindicates the conclusion that Dr. Nass's belief that ivermectin and hydroxychloroquine helps treat COVID-19 does not demonstrate incompetence. Indeed, COVID-19 is a novel virus "that scientists have only been studying for a few years, and about which scientific conclusions have been hotly contested." *Høeg v. Newsom*, U.S. Dist. LEXIS 13131, at *24 (E.D. Cal. Jan. 25, 2023). As expert witness Dr. Steven Katsis explained in his report, disciplining a physician for prescribing medications based on appropriate belief there is clinical

[2] Notwithstanding his own belief that hydroxychloroquine is not effective in treating COVID-19, Dr. Faust was not able to recommend for or against prescribing it, answering "I don't think I said that" when asked, "Therefore, doctors can't prescribe it?" (Tr. 891:8-893:8.)

benefit is "well outside the Board's purview[,]" especially "in the face of an emerging pandemic where established modalities of care are ever changing." (LE 154B.) To that point, Dr. Nass testified extensively on the body of research supporting her use of ivermectin and hydroxychloroquine and provided the BOLIM with supporting documentation. (*See*, *e.g.,* Tr. 186:3-197:23, 324:23-330:9, 335:19-339:19.) So, ivermectin's and hydroxychloroquine's proven record of safety, paired with evidence of its efficacy in numerous studies, is fatal to Board Staff's claim that prescribing those medications for treatment of COVID-19 evidences incompetence in the practice of medicine.

B. The FDA's opinions about ivermectin and hydroxychloroquine are irrelevant.

The Third Amended Notice of Hearing points out that the FDA does not support the use of ivermectin or hydroxychloroquine for treatment of COVID-19 (Third. Am. Not. Of Hrg. ¶¶ 14-15.) But the evidence proved this point irrelevant. Board Staff's own patient care expert witness, Dr. Courtney, testified that medications like ivermectin and hydroxychloroquine may be prescribed off label and neither the FDA nor any other federal agency has the authority to regulate how doctors practice with their patients. (Tr. 539:20-540:19; *see also* Tr. 1086:7-15, 1115:20-25 (Dr. Faust testifying about off-label prescriptions).) Nor does any BOLIM rule prohibit off-label prescribing or otherwise require that doctors follow National Institute of Health (NIH) or FDA guidance. (Tr. 542:14-544:1.) In fact, as Dr. Marik explained, anywhere from 40% to 50% of drugs used in hospitals are off label. (Tr. 1470:10-1471:15.) Dr. Courtney agreed it was "perfectly permissible under the current standards of medical practice" for Dr. Nass to exercise her discretion to provide an off label use of ivermectin to two people requesting the medication. (Tr. 551:14-553:20.) Most recently, on August 8, 2023, an attorney with the Department of Justice who was representing the FDA during oral arguments before the United States Court of Appeals for the

Fifth Circuit in *Apter, et al. v. Department of Health and Human Services, et al.*, Case No. 22-40802, stated, "[h]ere, the FDA was not regulating the off-label use of drugs . . . The FDA explicitly recognizes that doctors do have the authority to prescribe ivermectin to treat COVID."

C. Dr. Nass Provided Excellent Care to Patients 1, 2, and 3.

i. Patient 1.

Patient 1 is 71 years old, has been married to her husband Tim for 47 years, and has one son, Joel. (Tr. 1280:10-19.) Before retirement, Patient 1 worked as a licensed clinical professional counselor focusing in corrections and trauma. (Tr. 1280:20-1281:9.) She received an undergraduate degree from the University of Maine in Farmington, her counseling degree from the University of Southern Maine, and received a drug and alcohol clinical supervisor's degree. (Tr. 1281:10-1282:2.) She is unvaccinated, having made that decision well before meeting Dr. Nass. (Tr. 1282:3-1284:21.)

Patient 1 met with Dr. Nass by phone on September 28, 2021. (Tr. 1281:22-1285:16; BSE 9 at 0048.) She informed Dr. Nass that she was unvaccinated and that she did not want to be treated with Remdesivir if she eventually became ill. (Tr. 1285:17-1286:23; BSE 9 at 0048) Patient 1 was not taking medications other than a vitamin supplement, had no health conditions, and was interested in ivermectin in case she became ill with COVID-19. (Tr. 1285:22-1286:6, 1287:5-1288:9; BSE 9 at 0048). Dr. Nass prescribed Patient 1 ivermectin with instructions that, if she became ill, she should contact Dr. Nass. (Tr. 1287:20-1288:9; BSE 9 at 0048.) When doing so, Dr. Nass disclosed and explained to Patient 1's satisfaction the risks and benefits of the medication; provided ample time for Patient 1 to ask questions and answered all questions; and provided information that Patient 1 found satisfactory. (Tr. 1288:10-1291:7; *see also* Tr. 271:7-273:12.) In Patient 1's own words, "I found her to be knowledgeable and professional, and she certainly

answered any questions or concerns that I had at that time. I wouldn't have gone forward otherwise." (Tr. 1298:8-12.)

Dr. Nass chose ivermectin because she felt that Patient 1 only required one medication, ivermectin had fewer drug interactions, and it also worked in the later stages of illness. (Tr. 118:4-19.)

Patient 1 developed COVID-19 symptoms in early December (Tr. 1291:13-19.) She had her son and husband contact Dr. Nass, each of whom had authority from her to do so. (Tr. 1291:20-1292:11, 1319:19-1320:1; *see also* Tr. 278:20-279:1.) She spoke with Dr. Nass on Friday, December 17, 2021 while "on the upswing," and learned from Dr. Nass how long she should remain in quarantine. (Tr. 1294:12-1295:11; BSE 9 at 0048 (notation reading, "12/17 Just beginning to turn a corner Day 11. Doesn't need additional rx").) Unfortunately, two days later, Patient 1's condition began to worsen. (Tr. 1295:12-1296:2; BSE 9 at 0049.) Responding on a Sunday, Dr. Nass told Patient 1 to go to the hospital. (Tr. 1296:3-11.) As Dr. Nass documented in Patient 1's record, "go in to Pen Bay ER." (BSE 9 at 0049.) Patient 1 was admitted December 19, 2021 and discharged December 25, 2021. (Tr. 1302:11-15.)

To that end, Patient 1 had no concern that Dr. Nass somehow delayed referring her to the hospital—indeed, the evidence showed that Dr. Nass immediately referred Patient 1 to the hospital when her condition worsened, and "really work[ed] hard to convince [Patient 1] that she needed to go to the ER." (Tr. 1295:12-1297:4; *see also* Tr. 273:13-275:23.) Dr. Courtney agreed that Dr. Nass's decision to refer Patient 1 to the emergency department "was a good one based on these statements that she made about her status[;]" that Dr. Nass's decision was appropriate based on the information provided by the patient; and that there was no lack of documentation with respect

to Patient 1. (Tr. 593:18-602:20.) Considering that December 19, 2021 was a Sunday, many doctors would not have been available to consult with Patient 1. (Tr. 281:21-282:11.)

In sum, Dr. Nass provided Patient 1 with excellent, prompt, and responsive medical care. This included appropriate treatment planning via telehealth, as explained by Dr. Pierre Kory, so that Patient 1 would be prepared if she became ill with COVID-19. (Tr. 1556:21-1560:11; LE 153I at **1-3.) In contrast, Dr. Martindale at Pen Bay chose to insult Patient 1 by accusing her of taking "horse-paste," and going out of her way to "use[] that language at every opportunity she had." (Tr. 1300:3-1302:10.) Similarly, Board Staff did not bother speaking to Patient 1, subpoenaed her records without her knowledge or consent, and scoured Patient 1's protected health information for the illegitimate purpose of drumming up new disciplinary claims against Dr. Nass.

ii. Patient 2.

Patient 2 is a pastor at the Maine Street Baptist Church in Brunswick. (Tr. 1344:7-9.) He has been married to his wife, Angela, for 30 years. (Tr. 1401:3-7.) Patient 2 was unvaccinated because, on a personal level, he was not comfortable with the new technologies. (Tr. 1345:11-20.) Like Patient 1, Patient 2 made the decision to be unvaccinated before ever meeting Dr. Nass. (Tr. 1345:21-23.) Patient 2 was also very concerned about being treated with Remdesivir if he ultimately became ill because he understood that Remdesivir could cause kidney issues, and both of his parents had died after dealing with renal failure. (Tr. 1360:2-1361:4.) "I was very much concerned about that being a course of treatment that I . . . did not want." (*Id.*)[3]

[3] Patient 2 ultimately went to Mid-Coast Hospital with written instructions that he did not want to be treated with remdesivir; however, the hospital administered it to him nonetheless without authorization. (Tr. 309:8-323:21.) So, while the BOLIM seeks to punish Dr. Nass for not adequately obtaining informed consent to telehealth services with patients who were knowingly on the phone with her, it is (to our knowledge) *not* pursuing a healthcare provider who disregarded explicit patient instructions that he did not want to receive a medication.

Patient 2 located Dr. Nass on the FLCC website when researching physicians who would prescribe alternative medicines. (Tr. 1345:24-19.) He was already taking ivermectin prophylactically against COVID-19, as prescribed by a physician in Texas, but wanted to find a Maine doctor. (Tr. 1345:20-1348:2, 1402:9-1403:16.) Patient 2 and his spouse were both looking for someone willing to look at alternatives besides just being vaccinated. (Tr. 1404:2-16.)

Patient 2 and his spouse met with Dr. Nass by phone on September 2, 2021. (Tr. 1348:3-20, 1350:22-1351:1, 1405:24-2; BSE 20 at 0232.) They discussed their medical conditions, their medical histories, the medications they were on, and other health-related conditions (Tr. 1348:2-1349:24; BSE 20 at 0232.) In doing so, Patient 2's spouse had Patient 2's authority to communicate with Dr. Nass about his health and health conditions. (Tr. 1349:25-1350:1; 289:23-290:7.) At the end of the consultation, Dr. Nass provided Patient 2 and Patient 2's spouse with prescriptions for ivermectin, such that it would be taken at the onset of any symptoms. (Tr. 1349:14-1350:17, 1406:24-1407:23.) Dr. Nass discussed the process used to arrive at the prescription; provided ample opportunity for Patient 2 to ask questions; and issued the prescription once all questions had been answered to the patient's satisfaction. (Tr. 1351:24-1353:9, 1406:6-1408:25.) As explained by Dr. Kory, particularly considering Patient 2's comorbidities, Dr. Nass's early treatment of Patient 2 was appropriate to ensure a timely initiation of therapy should he become ill. (LE 153I at *3.) Dr. Nass viewed Patient 2 as a high-risk patient if he ever contracted COVID-19. (Tr. 219:6-20, 290:11-20.)

Patient 2 eventually became ill with COVID-19 and had his spouse contact Dr. Nass on December 11, 2021, as Dr. Nass had requested he do if he fell ill. (Tr. 1353:10-1354:10, 1411:6-1413:21, BSE 20 at 0232; Tr. 290:23-291:5.) By then, he had been experiencing symptoms for five or six days, but thought it was a cold. (Tr. 219:24-220:3.) It had been determined that Patient

2 had COVID-19 from a home test, which came back positive. (Tr. 1355:1.) Dr. Nass's medical note from December 11, 2021 noted, "[Patient 2] is high risk + needs HCQ RX. Must ↓ diltiazem + watch for hypoglycemia." (BSE 20 at 0232.) Dr. Nass also described that the plan was to prescribe three weeks of hydroxychloroquine and azithromycin. (Tr. 1355:2-13; BSE 20 at 232.) Dr. Nass believed that those medications would benefit Patient 2. (Tr. 220:10-221:4; 291:6-292:8.) Patient 2's spouse had authority to communicate with Dr. Nass about Patient 2 during the initial consultation and throughout his illness. (Tr. 1412:1-7.)

Patient 2 did not, however, take the hydroxychloroquine due to concerns about nausea. (Tr. 1415:4-1417:4.)

On December 15, 2021, Dr. Nass texted with Patient 2's spouse, who said that Patient 2 was considering monoclonal antibodies and asked, "[d]o you see any reason he shouldn't try them?" (BSE 21 at 0234.) Dr. Nass responded, "Hard to say. It's experimental and if you are injured by them there is no recourse. *But if he needs them he should get them*." (BSE 21 at 0235.) No evidence was admitted disputing the accuracy of Dr. Nass's response.

That evening, at 7:30 p.m., Dr. Nass spoke again with Patient 2's spouse about Patient 2's condition, and told her that Patient 2 needed to get a chest x-ray. (BSE 20 at 0230.) As a practical matter, according to Dr. Courtney, the only place to get a chest x-ray at 7:30 p.m. is the emergency room. (Tr. 606:8-609:18.) And if that was indeed the advice, Dr. Courtney continued, Dr. Nass did the right thing. (Tr. 609:19-13; *see also* Tr. 567:13-16 (Dr. Courtney's testimony that he could not say that Dr. Nass discouraged Patient 2 from going to the hospital).) Patient 2's spouse testified that Dr. Nass, in fact, "advised that we go to the emergency room to get that [the chest x-ray] done because I could not get that done at urgent care or any other place without a doctor's order." (Tr. 1420:12-1421:9.) Dr. Nass likewise testified that she recommended Patient 2 go to the hospital.

(Tr. 225:21-226:20.) "I told him he needed to go to the ER. I definitely wanted a chest x-ray to be done." (Tr. 226:10-17.)

To this point, Dr. Courtney agreed that Dr. Nass's records for Patient 2 provides the reader with a "reasonably good picture of what's happening" with Patient 2's illness, and that Patient 2's medical record was not missing any information. (Tr. 602:24-603:10, 604:12-606:7.).)

Patient 2 arrived at Mid-Coast Hospital the next morning, December 16, 2021 at 10:34 a.m. (BSE 23 at 0246.) As Patient 2 explained, "[m]y hesitance to go to the hospital had nothing to do with Dr. Nass or any recommendation from her at that point. As a matter of fact, to go get the x-ray was her suggestion, you know, so going to the hospital ended up being something that was really motivated from her perspective." (Tr. 1362:1-7.) Once Patient 2 arrived at Mid-Coast Hospital, Dr. Courtney agreed that the responsibility for his care shifted from Dr. Nass to Mid-Coast Hospital. (Tr. 610:2-8, 613:21-614:6.) Overall, Dr. Nass provided excellent and responsive care to Patient 2, directing him to go to the emergency department when appropriate. (Tr. 288:11-309:1.)

iii. Patient 3

Patient 3 is a mother of four. (Tr. 1434:9-25.) Her oldest is twelve and her youngest is a 19-month-old little girl. (*Id.*) She is married and is a full-time mother and homemaker. Before her last child, she worked as a court clerk with the judicial branch in Ellsworth. (Tr. 1434:9-1435:9) Neither she nor her husband are vaccinated—again, a decision made "long before" meeting Dr. Nass. (Tr. 1435:10-1436:10.)

At 9:00 p.m. on Monday, September 20, 2021, Patient 3 received a call telling her that her COVID-19 test taken the previous day was positive. (Tr. *Id.*) At the time, she was six months pregnant. (Tr. 1436:8-10.) She could not reach her midwife, and the nurse who was on duty told

her that there was "no medication" that they could give her to help her symptoms, and that she should just take Tylenol until things got worse. (Tr. 1436:11-1437:4.)

Left without answers, Patient 3 began looking at the FLCC website to find a doctor who could see her via teleconference and help her before the infection became more severe, considering her pregnancy. (Tr. 1437:5-20.) "We were worried about that[,]" Patient 3 explained. (*Id.*)

Patient 3 found Dr. Nass on the FLCC website. (Tr. 1437:10-22.) The next morning, Patient 3's husband called on her behalf, because Patient 3 was very sick on the couch, and he put her on speakerphone so they could speak. (Tr. 1437:23-1438:6.) During the call, Patient 3's husband explained that Patient 3 was pregnant, sick, and had tested positive for COVID-19. (Tr. 1438:7-14.) Dr. Nass took her information and set a later appointment that day. (*Id*.)

At the appointment, Patient 3's husband answered Dr. Nass's call, placed the phone on Patient 3's chest, and let Patient 3 talk with Dr. Nass. (Tr. 1438:15-1440:21.) Patient 3 explained that she was pregnant, talked about her medications, and discussed other information. (*Id*.) Dr. Nass learned that Patient 3 was taking montelukast, which was not prescribed, and told her to stop taking it because it was not safe for pregnant women. (*Id*.) Dr. Nass prescribed Patient 3 hydroxychloroquine and azithromycin to treat her COVID-symptoms. (*Id*.) As with Patients 1 and 2, Dr. Nass explained risks and benefits; provided ample opportunity to ask all questions; and prescribed the medication after all questions were answered. (*Id.*; *see also* Tr. 264:6-267:19.)

Patient 3 consented to being treated solely over the phone rather than being seen in person. (Tr. 1438:15-1440:21, 1452:23-1453:4.) Dr. Courtney agreed that, considering Patient 3 had been seen at urgent care before calling Dr. Nass and was sent home (Tr. 627:21-629:5), it was appropriate for Dr. Nass to treat Patient 3 via telehealth. (Tr. 629:6-630:4.) Dr. Courtney likewise agreed with Dr. Nass that hydroxychloroquine is safe in pregnancy (Tr. 616:11-24), and concluded

that Dr. Nass had sufficient information in her medical record of September 2, 2021 to prescribe hydroxychloroquine, based on the information Patient 3 provided. (Tr. 618:24-6; BSE 29.)

Patient 3 began hydroxychloroquine that evening. (Tr. 1440:2-1441:6.) "When I woke up [the next day], I felt significantly better. At that point it just felt like a, like a lighter sinus infection, but the symptoms improved at least 50%." (Tr. 1441:7-11.) Later that day, Patient 3's midwife finally called Patient 3 back and said that she wanted to get Patient 3 set up for a monoclonal antibody infusion. (Tr. 1441:12-19.) Patient 3 explained that she had taken hydroxychloroquine and was already feeling better, but the midwife was "very stunned, very shocked[,]" and still wanted to set up the monoclonal antibody infusion even though Patient 3 was improving. (Tr. 1441:20-1442:16.) A nurse from Blue Hill Hospital called Patient 3 later that afternoon to schedule the infusion for Thursday, and Thursday morning she went and had the infusion. (Tr. 1442:17-22.)

Patient 3 got "very nauseous and very sick" during the infusion, and her body "grew very cold . . . and tired." (Tr. 1442:23-1443:24.) It was bad enough that the nurses kept her longer. (Tr. *Id*.) When Patient 3 returned home later that day, she "got significantly worse" and her husband became "very, very worried because I couldn't even sit up straight. I was so tired and my body was so cold, and I was just in so much pain that I physically could not sit up. I had to lay down and my husband was very concerned." (*Id*.) This lasted all of Thursday and into Thursday evening, and prompted Patient 3's husband to worry that she might develop pneumonia. (*Id*.)

Patient 3 finally began feeling better on Friday. (Tr. 1443:25-1444:3.) She felt as if the hydroxychloroquine helped her symptoms. (Tr. 1444:4-10.) Although Dr. Courtney speculated otherwise, he has no evidence supporting that thought. (Tr. 616:25-617:10.). Patient 3 later gave birth without complications. (Tr. 1444:11-22.)

Board Staff contacted Patient's 3's midwife to ask questions about Dr. Nass's treatment of Patient 3 (BSE 27), but never contacted Patient 3 herself. (Tr. 1445:4-23.) Nor did Board Staff tell Patient 3 that the Board would be subpoenaing her confidential medical records to use against Dr. Nass; indeed, Patient 3 only learned that Board Staff subpoenaed her records when Dr. Nass's attorney told her. (*Id.*) And, in an extreme invasion of Patient 3's privacy, Board Staff subpoenaed the medical records of Patient 3's hospitalization to give birth and admitted them into evidence. (BSE 29.)

III. Dr. Nass Complied with Telemedicine Rules [Grounds IV – VI, XIII, IX].

The Third Amended Notice of Hearing puts forward various grounds for discipline based on alleged violations of Maine's telemedicine rules. None have merit.

First, Governor Mills suspended the telemedicine rules during the COVID-19 pandemic, and they were not active when Dr. Nass treated these three patients.

Second, Board Staff failed to prove that Dr. Nass failed to adhere to appropriate standard of care and ethics with respect to telemedicine, or that she failed to conduct an appropriate interview. (Grounds IV and V.) The only expert witness Board Staff called on this issue was Dr. Courtney, who by his own admission has never used telemedicine to treat patients for COVID-19. (Tr. 405:5-7.) On cross-examination, he agreed that Dr. Nass met appropriate standards for establishing a telehealth relationship. (Tr. 544:20-549:21, BSE 116.) In any event, Part I.C of this closing argument, together with testimony offered by Dr. Nass, the three patients, and Dr. Nass's experts, explains how Dr. Nass met the appropriate standard of care in treating Patients 1, 2, and 3, including an appropriate medical interview.

Dr. Marik added that Dr. Nass provided appropriate care for the patients via telehealth. (Tr. 1482:17-1495:19; *see also* Tr. 257:17-267:2). Board Staff at times asked its experts about whether Dr. Nass's statements deviated from the standard of care. But, other than those experts'

disagreement about the efficacy of ivermectin and hydroxychloroquine, those experts could not opine on any specific acts or omissions suggesting that Dr. Nass failed to meet the standard of care, for telehealth or otherwise.

Third, Board Staff failed to prove that Dr. Nass did not obtain informed consent (Ground VI). Board Staff's theory on informed consent is limited to a narrow issue: whether the patients provided informed consent related to telehealth services. (Tr. 569:12-19 (AAG Willis's explanation of the basis of Ground VI, as stated during an objection).) Thus, the issue is not whether the patients provided informed consent with respect to the prescriptions provided, but whether they provided informed consent to receiving telehealth services.

Board Staff appears confused about which issue required informed consent. There was no evidence admitted suggesting that the patients were not aware they were receiving telehealth services and not in-person services. To the contrary, each patient testified that they understood that they were being treated via telehealth. And when asked about informed consent, Board Staff's own expert, Dr. Courtney, said, "I don't personally have a strong opinion about it." (Tr. 626:10-15.) Dr. Nass also offered patients who were not ill an in-person examination in lieu of telehealth, but Patients 1 and 2, neither of whom was ill at the initial consultation, chose phone visits instead of office visits. (Tr. 252:22-254:1.) These patients *chose* telehealth, just as they *chose* to have their family members participate in their care. To say that these three patients, each of whom was on the phone with Dr. Nass, did not provide informed consent to telehealth or to a shared consultation with their relatives is absurd.

Fourth, as discussed in Part I.C.i and ii, Board Staff failed to prove that Dr. Nass did not escalate care when appropriate (Ground VIII). Instead, it was proven that Dr. Nass immediately referred both Patient 1 and 2 to the hospital when appropriate.

Fifth and finally, Board Staff failed to prove that Dr. Nass somehow violated telemedicine rules by prescribing via telemedicine (Ground IX). Board Staff's expert, Dr. Courtney, testified that prescribing medication via telemedicine is permitted and that he sometimes prescribes without an in-person examination. (Tr. 549:22-556:5.) Considering that Board Staff's own expert blessed this practice and engages in it himself, it would be arbitrary and capricious for the BOLIM to hold otherwise.

IV. Dr. Nass's medical records complied with the law, and she adhered to confidentiality requirements. [Grounds XI – XIII].

First, as to documentation of informed consent (Ground XI), each patient testified that they provided informed consent to receiving treatment via telehealth. Notably, Board Staff introduced no evidence of what information it believes that Dr. Nass failed to convey. And, as Dr. Marik explained, Board Staff's theory is "an absurdity" because "[t]he patients wanted a telemedicine consult, they initiated it, so it goes without speaking that that's what they wanted. It would have been doubly redundant to have documented the obvious." (Tr. 1505:18-1506:1.)

Second, as to the completeness of the records (Ground XII), Board Staff failed to designate an expert on this issue. Dr. Nass testified accurately that (i) there is no evidence in the case about what the standard is for documentation; (ii) she did not know where to look for such standards, and (iii) that the only documentation standards that she is aware of are those associated with billing, such as Medicare standards and those adopted by insurance companies. (Tr. 375:5-377:15.)

Although the Hearing Officer erred by letting Dr. Courtney testify about medical recordkeeping—a topic about which he was not designated—his testimony ultimately corroborated Dr. Nass's. He was unable to identify what information was missing from any of the patient records, and often conceded that Dr. Nass's records were sufficient to support the treatment provided. Nor did he establish what the standards are for medical recordkeeping or point to any

law or rule providing fair notice to practitioners of what the standard even is. *Balian v. Bd. of Licensure in Med.*, 1999 ME 8, ¶¶ 15-16, 722 A.2d 364 (due process violated where the standard the practitioner allegedly violated is not admitted into evidence); *see also State v. McCurdy*, 2010 ME 137, ¶¶ 15-21, 10 A.3d 686 (due process violated where there is no law or rule giving those regulated fair notice of the standards to which they will be held). Disciplining Dr. Nass for having allegedly inadequate records is thus not only contrary to evidence and the testimony of Board Staff's own expert, it also violates due process. *Balian,* 1998 ME 8, ¶¶ 15-16, *McCurdy*, 2010 ME 137, ¶¶ 15-21.

Third and finally, as to confidentiality (Ground XIII), Board Staff failed to prove that Dr. Nass violated a duty of confidentiality by speaking with the patients' family members. As Dr. Nass's testimony and the testimony of the patients established, consent to communicate with the patients was given and was obvious from the circumstances, where family members were often present on the phone. Even Dr. Courtney agreed that spouses communicating information about a patient happens "all the time[.]" (Tr. 604:3-11.) And, having practiced medicine for 40 years, Dr. Marik found it "astonishing" that Board Staff is claiming that communicating with an authorized family representative is somehow improper. (Tr. 1488:18-1489:18.) As he explained, communicating with family can be essential to medicine; it is something that doctors do every day. (*Id*.) Dr. Kory pointed out that that the need to speak with Patient 2's spouse was especially justified because Patient 2 was "acutely ill and deteriorating," and Patient 2 and his spouse jointly participated in the early planning visit in September. (LE 153I at 4.) The claim that Dr. Nass violated a duty of confidentiality is absurd.

V. Dr. Nass stood up for her patient against a pharmacist who was trying to interfere with the patient's medical care [Ground XIV].

Board Staff is prosecuting Dr. Nass because she stood up for her patient. No law or enforceable rule authorizes pharmacists to inject themselves into the doctor-patient relationship by second guessing a doctor's judgment or demanding to know a patient's diagnosis. Facing a pharmacist wanting to play doctor, Dr. Nass did what she needed to do to get a patient a potentially lifesaving medication.

Patient 2 was a "high-risk patient" if he contracted COVID-19. (Tr. 219:4-20.) He had met with Dr. Nass in September 2021 but, because there was a restriction in Maine on giving hydroxychloroquine prophylactically, Dr. Nass could not prescribe it at that time. (Tr. 219:4-20.) In December, Dr. Nass was informed that Patient 2 had become very ill with COVID-19, determined that he would benefit from hydroxychloroquine and azithromycin, and prescribed it. (Tr. 220:21-:221:4.) The pharmacist called Dr. Nass to demand Patient 2's diagnosis. (Tr. 221:5-22.) As established above, hydroxychloroquine is an FDA approved medication which can be used off-label and is safe and effective to treat COVID-19.

Understanding that pharmacists had been bullied into not dispensing legally appropriate medication such as hydroxychloroquine (Tr. 221:6-22.), Dr. Nass had to "either do my best for the patient and put myself at risk . . . or I could withhold the drug and I'd be safe and the patient would be at more risk." (Tr. 222:3-7.) She chose the patient, consistent with the oath she took when graduating medical school. (Tr. 222:3-14, 227:5-22.) And after choosing the patient, she immediately notified the Board about what had happened in hopes that her experience would quell the hysteria over prescribing legal medication and encourage the powers that be to let doctors be doctors. (Tr. 222:3-25.)

Yes, Dr. Nass misinformed a pharmacist of a diagnosis when responding to a question that the pharmacist had no right to ask, about a prescription the pharmacist had a duty to fill, because Dr. Nass reasonably believed that doing otherwise placed her ill patient's life in jeopardy. In doing so, Dr. Nass complied with all laws pertaining to prescribing practices, while the pharmacist was interfering with the doctor-patient relationship. As explained by expert witness Dr. Katsis, Dr. Nass was "inappropriately queried about the indications for prescribing [h]ydroxychloroquine[,]" and it was perfectly allowable for Dr. Nass to prescribe hydroxychloroquine to treat an active COVID-19 infection under the Board of Pharmacy statement. (LE 154B at *3.) The BOLIM should applaud, not condemn, Dr. Nass for standing up for her patient when he needed her most. The violation, if any, is de minimis and justified.

VI. Board Staff's Other "Alleged Violations" Are Meritless [Grounds XVIII – XIX].

A. Dr. Nass had no duty to respond to the notice of complaint in CR23-4 or the "25 questions" letter [Ground XVIII].

Dr. Nass did not violate 32 M.R.S. § 3282-A(2)(R) by not responding to the notice of complaint or the "25 questions letter." (Bd. Staff. Open. Stat. at *4 (explaining the basis for Ground XVIII).)

i. Notice of Complaint

The BOLIM waived any requirement for a response to CR23-4 by issuing a notice of hearing and setting the matter for an adjudicatory hearing. "Waiver is 'a voluntary or intentional relinquishment of a known right and may be inferred from the acts of the waiving party.'" *Blue Star Corp. v. CKF Props., LLC*, 2009 ME 101, ¶ 26, 980 A.2d 1270 (quoting *Interstate Indus. Unif. Rental Serv., Inc. v. Couri Pontiac, Inc.,* 355 A.2d 913, 919 (Me. 1976)). "If a party in knowing possession of a right acts inconsistently with the right or that party's intention to rely on it, the right is deemed waived." *Id.*

Under the governing statutes, when investigating a complaint, the BOLIM shall notify the licensee of the content of the complaint as soon as possible, and the licensee must respond within 30 days. 32 M.R.S. § 3282-A(1). After reviewing the complaint and response, if the BOLIM ultimately determines that the complaint is true or of sufficient gravity to warrant further action, the BOLIM can (i) enter a consent agreement, (ii) accept a voluntary surrender, or (iii) "[i]f the board concludes that modification or nonrenewal of the license is in order, the board shall hold an adjudicatory hearing in accordance with Title 5, chapter 375, subchapter 4." 32 M.R.S. § 3282-A(1)(C). The purpose of the physician's response, then, is to enable the BOLIM to decide whether to continue investigating, set the matter for an adjudicatory hearing, or handle the matter through some other mechanism.

Here, however, the BOLIM chose to skip that process by issuing a notice of an adjudicatory hearing on CR23-4 before Dr. Nass's response to the complaint was due. (BSE 125 (stating the date of the initial notice of hearing as January 24, 2021).) Having already decided it was pursuing an adjudicatory hearing, the BOLIM chose to invoke the machinery of the Administrative Procedure Act. Of course, the BOLIM could have instead waited for a response on CR23-4, received it, and then decided fairly and impartially whether an adjudicatory hearing was appropriate, but the BOLIM was not interested in that measured approach. Instead, it jumped to the final and worst-case option under 32 M.R.S. § 3282-A(1) of scheduling an adjudicatory hearing with respect to CR23-4. And in doing so, the BOLIM waived any requirement that Dr. Nass respond to the complaint. *Blue Star Corp.., LLC*, 2009 ME 101, ¶ 26.

Also, Dr. Nass should not be found to have violated 32 M.R.S. § 3282-A(2)(R) because, in not responding, she was reasonably relying on the advice of prior counsel, who even filed a lawsuit against the BOLIM, negating the argument that she willfully failed to respond to the complaint.

See generally State v. Flynn, 2015 ME 149, ¶ 23, 127 A.3d 1239 (discussing the advice of counsel defense).

Just as the lawyers representing the parties are not doctors trained in medicine, Dr. Nass and BOLIM members are not lawyers trained in law. Faced with a suspended license, Dr. Nass timely sought legal advice, was having her lawyers manage whether she had a legal obligation to respond, was told she did not have to respond to the complaint, and so-advised Board Staff through counsel and in her later testimony. (Tr. 104:6-9, 106:12-108:2.) Because she was reasonably relying on the advice of her lawyers, she did not willfully fail to respond to the notice of complaint in CR23-4.

ii. 25-Questions Letter.

Although raising it in their opening statement, Board Staff later abandoned the theory that Dr. Nass should be disciplined for not responding to the 25-questions letter. (Bd. Staff. Resp. to Licensee's Second Mot. to Vacate at 3, n.3 (Apr. 26, 2023) (asserting that Ground XVIII is not based on the 25-questions letter).) Nonetheless, in the interest of completeness, the 25-questions letter is not a "complaint notification" under Section 3282-A(2)(R). A complaint notification does just what the name implies—it notifies the licensee of the substance of a complaint against them. The 25-questions letter, in contrast, simply "requests" that Dr. Nass answer a series of questions. (BSE 98.)

Plus, nothing in Section 3282-A authorizes the BOLIM to propound interrogatories to a licensee, as it sought to do here. Again, when the response to the 25-questions letter was due, the BOLIM had already suspended Dr. Nass and invoked the Administrative Procedure Act by issuing a notice of hearing. If the BOLIM felt the need to conduct discovery after punishing Dr. Nass, as it was doing with the 25-questions letter, the proper channel was requesting leave from the hearing officer—not trying to bully Dr. Nass by exceeding its statutory authority.

B. Subpoenas [Ground XIX].

Board Staff's effort to prosecute Dr. Nass for not responding to the subpoenas is meritless for several reasons.

First, the BOLIM waived and forfeited its authority to enforce or issue subpoenas by voting to set the matter for an adjudicatory hearing. The subpoenas bear docket numbers CR21-191, CR22-210, and CR22-4, with a production date of January 27, 2022. (BSE 94, 95, 96.) But before the response was due, on January 24, 2022, the BOLIM issued a notice of hearing on those same three complaint numbers. (BSE 125 (stating the date of the notice of hearing).) By issuing a notice of hearing, the BOLIM transformed the matter from an investigation into an adjudicatory hearing under Title 5, chapter 375, subchapter 4. 32 M.R.S. § 3282-A(1)(C)). By transforming this matter into an adjudicatory hearing, the BOLIM chose to subject itself to the Maine Administrative Procedure Act, including 5 M.R.S. § 9060.

Under 5 M.R.S. § 9060, subpoenas are only authorized where they relate to "any issue of fact in the proceeding[,]" 5 M.R.S. § 9060(1), and may be quashed "upon a finding that the testimony or the evidence whose production is required does not relate with reasonable directness to any matter in question, or that a subpoena for the attendance of a witness or the production of evidence is unreasonable or oppressive or has not been issued a reasonable period in advance of the time when the evidence is requested[,]" 5 M.R.S. § 9060(1)(C). The two subpoenas did not relate to any fact at issue. Instead, those subpoenas seek, "[y]our patient appointment calendar from July 1, 2021 to the present[,]" "a list of all patients you have seen and treated (in-person and via telehealth) from July 1, 2021 to the present[,]" and "complete medical records" for two patients *other than* Patients 1, 2 and 3. (BSE 95-96.) None of this is relevant to any of the allegations in any of the notices of hearing.

Second, Dr. Nass mounted a legal challenge to the subpoenas, which remained pending before the Hearing Officer until recently. With that matter being unresolved when the Third Amended Notice of Hearing was issued, and Dr. Nass's duty to respond unestablished, Dr. Nass cannot be disciplined for not responding to the subpoenas.

Third, like the response to the Notice of Complaint (discussed in Part V.A.i), Dr. Nass was reasonably relying on the advice of counsel in not responding to the subpoenas. (Tr. 109:11-110:15, 111:24-112:10, 330:24-332:25.) This decision was especially understandable because, after providing patient records to the BOLIM earlier, the BOLIM allowed parts of those records to be released to the newspapers. (Tr. 332:23-25.)

Finally, Dr. Nass should not be disciplined for not responding to two subpoenas issued by a board that is abusing its subpoena power in violation of Dr. Nass's free speech rights. When the subpoenas were issued, the BOLIM was already overtly trying to punish Dr. Nass for exercising her free speech rights. By demanding that she produce her entire appointment calendar for a six-month period, the BOLIM was harassing Dr. Nass, invading the privacy of patients who may not wish to have their sensitive and personal medical information pawed all over by lawyers and bureaucrats, and trying to drum up other grounds for discipline for a pretextual prosecution. This misconduct violates due process and fundamental fairness in every sense of the words.

Conclusion

In its September 9, 2023 decision in *Missouri v. Biden*, criticizing governmental efforts to censor disfavored speech about COVID-19, the Fifth Circuit Court of Appeals wrote:

> [t]he Supreme Court has rarely been faced with a coordinated campaign of this magnitude orchestrated by federal officials that jeopardized a fundamental aspect of American life. Therefore, the district court was correct in its assessment—"unrelenting pressure" from certain government officials likely "had the intended result of suppressing millions of protected free speech postings by American citizens." We see no error or abuse of discretion in that finding.

Case No. 23-30445, slip op. at 61-62 (5th Cir. 2023).[4]

The situation here is worse. It is well-established that government agencies like the BOLIM have no right to control discourse by censorship, coercion, or retaliation. *See, e.g.*, *Bantam Books, Inc. v. Sullivan*, 372 U.S. 58, 68 (1963); *Backpage.com, LLC v. Dart*, 807 F.3d 229, 235 (7th Cir. 2015). Whereas cases like *Biden* often involve veiled threats, in this case, the BOLIM and Board Staff weaponizes their tremendous licensing power against a disfavored speaker. They have directly punished Dr. Nass for her speech by suspending her medical license; ordered Dr. Nass to submit to an unjustified neuropsychological examination with the BOLIM's chosen expert at her cost; and retaliated against Dr. Nass by pushing through a pretextual prosecution of baseless and de minimis allegations. By making an example of Dr. Nass, the BOLIM has sent the message that any licensee publicly questioning the BOLIM's preferred view on COVID-19 risks their license, reputation, and livelihood. One would hope that, in the twenty-first century, scientific discourse about a novel and rapidly evolving disease of which we know little would be embraced and not condemned.

Dated: September 15, 2023

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[4] Available at https://www.ca5.uscourts.gov/opinions/pub/23/23-30445-CV0.pdf.