COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES

HOUSE HEALTH COMMITTEE HEARING

STATE CAPITOL
IRVIS OFFICE BUILDING
ROOM 515
HARRISBURG, PENNSYLVANIA

MONDAY, DECEMBER 13, 2021

IN RE: COVID-19 TREATMENT OPTIONS

BEFORE:

HONORABLE KATHY RAPP, MAJORITY CHAIRWOMAN
HONORABLE DAN FRANKEL, MINORITY CHAIRWOMAN
HONORABLE TIMOTHY BONNER
HONORABLE STEPHANIE BOROWICZ
HONORABLE JIM COX (V)
HONORABLE JOHNATHAN HERSHEY
HONORABLE DAWN KEEFER
HONORABLE KATE KLUNK
HONORABLE ANDREW LEWIS
HONORABLE CLINT OWLETT
HONORABLE BRAD ROAE
HONORABLE PAUL SCHEMEL
HONORABLE TIM TWARDZIK
HONORABLE DAVID ZIMMERMAN
HONORABLE JESSICA BENHAM
HONORABLE STEPHEN KINSEY
HONORABLE BRIDGET KOSIEROWSKI
HONORABLE RICK KRAJEWSKI
HONORABLE BENJAMIN SANCHEZ (V)

JEAN DAVIS REPORTING
POST OFFICE BOX 125 • HERSHEY, PA 17033
Phone (717)503-6568

COMMITTEE STAFF PRESENT:

MICHAEL D.I. SIGET, JD, MPA, EXECUTIVE DIRECTOR AND LEGAL COUNSEL, REPUBLICAN CAUCUS
MAUREEN BEREZNAK, RESEARCH ANALYST, REPUBLICAN CAUCUS
LORI CLARK, ADMINISTRATIVE ASSISTANT II, REPUBLICAN CAUCUS
ERIKA FRICKE, EXECUTIVE DIRECTOR, DEMOCRATIC CAUCUS
DYLAN LINDBERG, RESEARCH ANALYST, DEMOCRATIC CAUCUS
PATRICK O'ROURKE, RESEARCH ANALYST, DEMOCRATIC CAUCUS
DEVIN MERCADO, LEGISLATIVE ASSISTANT, DEMOCRATIC CAUCUS

JEAN M. DAVIS, REPORTER
NOTARY PUBLIC

I N D E X

TESTIFIERS

P R O C E E D I N G S

*** * ***

MAJORITY CHAIRWOMAN RAPP: Good morning.

Welcome to the hearing on therapeutics and House Bill 1741 sponsored by Representative Dawn Keefer.

Before we begin, I would like to say that I'm very happy to report that the Committee did prevail with the Pennsylvania Supreme Court on the constitutionality of the Secretary of Health's orders. So we are very happy that the Constitution prevailed in the State of Pennsylvania.

Today we are looking at hearing information on the therapeutic side of vaccines. I have had a lot of people, constituents, as I'm sure my colleagues have had, on the COVID-19, what can I do besides being vaccinated, and as we know now, even our citizens across the state who have received the vaccine are still contracting COVID.

So from the very beginning, I had constituents contacting my office, okay, I can wash my hands. I can quarantine. I can wear a mask. There surely has to be something else. You know, what can I do to stay healthy? And even, you know, trying to stay healthy, we know that that is not going to prevent you from possibly contracting COVID.

But certainly we have heard, since this whole issue started, numerous times daily, you know, about what to

do, washing your hands, you know, social distancing, wear a mask, which anybody is still free to do. If you feel comfortable wearing a mask and social distancing and staying away from your family, isolating yourself, you are free to do that. But what other steps can we take? And that is the purpose for our meeting today.

We have some great presenters, I think, sharing with us. We know that there are people who are at higher risk, those who smoke, those who are obese. And certainly our citizens can take steps to stop smoking, to lose weight. But the question is, what else can our citizens of Pennsylvania do to take precautions and stay healthy?

So we have good people on our panels today. I hope that you will learn something today.

And at this point in time, I will ask the members -- as this is a hearing, we don't take attendance, but we usually ask the members to at least identify themselves and announce where they are from.

After we do that, Representative Frankel, I will give you a chance for a few remarks.

MINORITY CHAIRMAN FRANKEL: Thank you.

MAJORITY CHAIRWOMAN RAPP: But at this point in time, Representative Frankel, if you would like to start, sir, and just say your name and your district so that the public knows who is attending today.

MINORITY CHAIRMAN FRANKEL: Thank you, Madam Chair.

I'm Representative Dan Frankel from the 23rd District, which is in Allegheny County in the city of Pittsburgh.

REPRESENTATIVE KRAJEWSKI: State Representative Rick Krajewski, 188th District, west and southwest Philly.

REPRESENTATIVE KOSIEROWSKI: State Representative Bridget Kosierowski, Lackawanna County right outside of Scranton, Pennsylvania.

REPRESENTATIVE SCHEMEL: Paul Schemel representing portions of Franklin County.

REPRESENTATIVE KEEFER: Representative Dawn Keefer from York and Cumberland Counties.

REPRESENTATIVE TWARDZIK: Representative Tim Twardzik from Schuylkill County, the 123rd.

REPRESENTATIVE ZIMMERMAN: Representative Dave Zimmerman, 99th District, Lancaster County.

REPRESENTATIVE BENHAM: Representative Jessica Benham, 36th District, Allegheny County.

REPRESENTATIVE BONNER: Tim Bonner, 8th District, Mercer and Butler Counties.

REPRESENTATIVE BOROWICZ: Stephanie Borowicz, 76th District, Clinton and Centre Counties.

REPRESENTATIVE ROAE: Representative Brad Roae,

Crawford County and Erie County.

MAJORITY CHAIRWOMAN RAPP: Thank you, members.

We do have a member attending virtually, Representative Sanchez.

Representative, thank you for being with us today albeit virtually.

Representative Frankel, did you have a few quick comments, sir?

MINORITY CHAIRMAN FRANKEL: Thank you, Madam Chair.

First, I'd like to take a moment to acknowledge how momentous it is that we are able to have a conversation, not just about the danger of the public health posed by COVID-19 but also the treatment options available to help mitigate that peril.

A year and a half ago when we knew so much less about the virus, how it spread, what symptoms were, it would have given us some peace to know that we could be talking about treatments now. I have endless gratitude for the scientists and the doctors who have worked around the clock to find ways to prevent the death and devastation of COVID.

Hopefully we'll continue to see new treatment options for COVID-19. Ultimately, some will start out promising and prove fruitless; others may have less auspicious beginnings but turn out working. Understanding

will hopefully continue to evolve.

Even while I'm ecstatic about all the innovation and advancing science, I'm concerned that natural scientific uncertainty and frustration with the pace of advancements has created an opening for blighted misinformation. We know that misinformation, particularly as it relates to the risks and benefits of vaccines, is having a dramatic impact on COVID mortality. We see it in reports from hospitals.

Geisinger, which is overflowing, reported that 90 percent of their patients are unvaccinated. The legislation we're considering as part of this hearing would prevent state licensing boards from disciplining providers for prescribing any nonstandard medication treatment for coronavirus infections so long as the drug is FDA approved.

That means this bill would allow providers to act with total impunity, zero oversight when it comes to drug prescribing for coronavirus. Pharmacists would be forced to fill the prescription without regard to their own professional judgment about safety of the medication, its interaction with other drugs or any anything else.

Remember, OxyContin is an FDA-approved drug. So is methylprednisolone. Also important, COVID-19 is a coronavirus but so are many of the viruses that cause the common cold. So presumably under this legislation, doctors would be immune from discipline even if they prescribed

OxyContin to cure someone's runny nose.

People will always seek medication that may not work, whether that's out of misinformation or desperation. Should they get it just because they want it? What if it could hurt them? Should doctors be allowed to exploit patients and to get paid to give them treatments that could harm them with impunity? These are the questions I will have in mind while listening to the testimony. And I'm eagerly looking forward to hearing our testifiers' perspectives.

Thank you, Madam Chair.

MAJORITY CHAIRWOMAN RAPP: Thank you, Chairman Frankel.

At this point in time, I would invite our two panel members for our first panel. Dr. Denise Johnson, who is our Pennsylvania Physician General.

Dr. Johnson, we are very pleased that you are here today.

DR. DENISE JOHNSON: Thank you.

MAJORITY CHAIRWOMAN RAPP: And Lisa Robin, who is the Chief Advocacy Officer for the Federation of State Medical Boards.

Dr. Johnson, I believe that Lisa Robin is with us virtually.

If you would like to just remain standing and,

Lisa, if you would please raise your right hand. It is now our policy for those that testify at hearings that you are sworn in.

(Witnesses sworn en masse.)

MAJORITY CHAIRWOMAN RAPP: Thank you so much.

At this point in time, Dr. Johnson.

DR. DENISE JOHNSON: Can you all hear me okay now?

MAJORITY CHAIRWOMAN RAPP: Yes.

DR. DENISE JOHNSON: Okay. Thank you.

As you have said, you've all received a copy of the written testimony. I'm just going to go over some of the highlights here.

As all of you know, the Sars-CoV2 virus that causes COVID-19 has upended all of our lives over the past year and a half, almost going on two years. It has affected every aspect of our lives, not only our social lives but our emotional lives, our physical lives, financial lives, and especially our health.

We are learning more and more about the virus every day. And there's so much that we still don't know but continue to learn. We know that people with underlying conditions are at more risk for the virus, but we also have not been consistently able to predict who will get sick.

I'm sure all of you have heard anecdotes of people who have no known underlying conditions who also get sick with the virus. It has been very unpredictable.

Again, you've heard scientists have been working, hundreds of scientists, probably thousands, all across the globe to investigate new treatments or old treatments that may have an impact for COVID-19. In studying these new treatments or old treatments, we need to decide whether or not the actual treatment causes an improvement or an impact on COVID. And that's why it takes rigorous study to determine whether or not there's benefit.

We also need to look at the risks and the side effects of the medications or the treatments to make sure that the benefits of this treatment is outweighed by the risk that it might cause. Certainly individuals can take responsibility for their own health. Again, as you've heard, eating a healthy diet, making sure that you have fruits and vegetables, fiber, make sure that you are controlling your weight, make sure that you're not smoking, getting enough rest, getting enough exercise, and also decreasing stress.

We also know that the vaccines can prevent, as we've heard, many different illnesses certainly for COVID-19. So here is what's in the evidence and the studies have shown that we can do in terms of COVID-19.

So first for prevention. Again, we know that we have had effective vaccines that are having a significant impact especially on severe COVID-19 hospitalizations and deaths even in the face of the new variants. We know that these vaccines have been administered to hundreds of millions of people and we've got good data on the effectiveness and the safety of these vaccines.

Also along the lines of prevention recently authorized is ADZ. And that's the new medication or the new drug by AstraZeneca. This is meant for people who have immunocompromised conditions and they're not able to mount a response with the vaccine. It's not an alternative to the vaccine, but there's some people because of their underlying condition who are not able to mount an immune response.

And so this treatment would be given in injections every six months to prevent COVID-19. These are people who have not tested positive, maybe have not been exposed but are at high risk for severe disease. And now there's a treatment available for prevention of these individuals.

There are also, of course, as you've heard, nonpharmacological measures that we can take like masking, social distancing, avoiding crowded indoor places with poor ventilation to prevent and avoid COVID-19.

So I want to talk a little bit more about

treatment. So one of the areas of treatment is postexposure. So in individuals who are at high risk for severe disease, there is an option to get postexposure treatment, people who have been exposed to COVID but have not yet tested positive but are at high risk for disease and avail themselves of postexposure treatment that is delivered with a monoclonal antibody therapy.

So we have three different monoclonal antibody therapies right now for use. The first one is the REGEN-COV. It's the monoclonal antibodies by Regen. There is also the Bamlanivimab from Eli Lilly. And there's Sotrovimab from GlaxoSmithKline. So individuals who are at high risk for COVID after they have been exposed and avail themselves of an infusion of monoclonal antibodies can prevent the development of COVID-19.

So people who have been exposed and have tested positive, especially those who are at high risk, also can get monoclonal antibody therapy. The monoclonal antibodies are manmade proteins that act as the antibodies in your system that can help clear the virus and help you to prevent severe disease for COVID-19.

These studies of the monoclonal antibodies have shown that early administration of monoclonal antibodies in high-risk individuals after they test positive can decrease the risk for hospitalization by 70 percent. These

monoclonal antibodies need to be given early in the course of the illness. They seem to be most effective especially when given within five to seven days of symptom onset but certainly before ten days to clear the virus. And once the virus has caused the extensive damage to the cells that COVID-19 can do, then these treatments are really not as effective.

Other treatments for hospitalized patients are the Remdesivir antiviral by Gilead and then dexamethasone, a steroid that we've used for many years but can help to decrease the inflammatory effects that the virus has caused.

So there have been no over-the-counter treatments or supplements that have been proven to prevent or to treat COVID-19. We know that some of these treatments that we have need to be given early in the course of treatment so that patients who become positive or who are candidates for the postexposure really need to have these treatments as quickly as possible. If there's a delay in terms of getting these treatments, then they won't be as effective .

Anecdotally, seeing patients coming in to the hospitals, we often see that somewhere around a week after symptom onset is when patients tend to have the decrease in oxygen. Once those patients have decreasing oxygen and they have severe symptoms, the monoclonal antibody therapies and these early therapies that we have don't work.

Also coming online for early treatment are two oral antiviral medications that we expect to be authorized quite soon. So the molnupiravir from Merck as well as the Paxlovid from Pfizer are oral antiviral agents that need to be given within five days of symptom onset. Research has shown that they can decrease the risk for hospitalization in people who are at risk by somewhere between 30 to 50 percent. Again, these need to be given very early and really seem to be more effective three to five days after symptom onset.

So in summary, vaccines are by far the most effective measure that we have to prevent COVID-19, especially severe illness and hospitalization and death. And we have seen great evidence that they are working even in view of the variants that we have seen of late.

Patients need to be aware of the treatments, especially because the treatments are effective early on after symptom onset. A delay means that people will not have the opportunity to avail themselves.

Thank you for this opportunity to come before you today. I am open for your questions. Thank you.

MAJORITY CHAIRWOMAN RAPP: Thank you, Dr. Johnson.

We will have Lisa Robin present her testimony. And if you want to remain there, ma'am, then after she

concludes her testimony, then the members will ask questions at this time.

Thank you.

DR. DENISE JOHNSON: Thank you.

MAJORITY CHAIRWOMAN RAPP: All right. Thank you so much.

Lisa, if you would like to proceed with your testimony, please.

MS. LISA ROBIN: Yes. Thank you.

Good morning, Chairwoman Rapp and members of the Committee. I'm Lisa Robin, Chief Advocacy Officer with the Federation of State Medical Boards. On behalf of the FSMB, I would like to take this opportunity to express our opposition to House Bill 1741.

The FSMB is an national, nonprofit organization, representing the 70 state medical and osteopathic licensing and disciplinary boards of the United States, its territories, and the District of Columbia. These boards are generally referred to as state medical boards. The FSMB supports these boards as they engage in their statutory mandate of protecting the public's health, safety, and welfare through the proper licensing, disciplining, and regulation of physicians and, in many states, other health care professionals.

The FSMB develops and maintains policies and

guidelines based on regulatory best practices and, since 1956, has maintained current guidance for medical practice acts and the corresponding structures and functions for the authority and operations of effective state medical boards. Accordingly, the FSMB is well-positioned to comment on HB 1741.

State medical boards play a vital role in protecting patients and they must have the requisite resources and authority in order to do so. If passed, House Bill 1741 would set a dangerous precedent for medical regulation generally by hindering the ability of state medical boards to fulfill this role.

While the FSMB does not comment on any particular treatment or disease outlined in this bill, we are extremely concerned about the overall impact HB 1741 would have on patient safety in Pennsylvania. The proposed legislation could put patients in jeopardy by undermining the ability of a State Medical Board to properly assess the standard of care and take appropriate action as necessary.

The fundamental role of medical regulation has been delegated to the states and confirmed by the Supreme Court. States carry out this responsibility by creating medical boards comprised of appointed physicians and public members that have the requisite medical expertise and oversight authority needed to carry out their regulatory

responsibilities.

These public officials are charged with overseeing the practice of medicine, including administering licensing processes, investigative and adjudicatory processes as well as providing guidance for licensees on best practices or specific medical activities.

Boards are tasked to receive, evaluate, and act upon complaints regarding the quality of care and the professional conduct of their licensees. The ultimate goal is to foster the professional practice of medicine and protect the public from improper and substandard care.

Restricting a state medical board's authority to assess the quality of patient care, as this bill would, limits recourse for patients that have suffered harm.

The FSMB urges the Committee to recognize that it is vitally important that state medical boards retain full authority to protect the public interest by initiating disciplinary action against medical professionals when necessary and appropriate.

Thank you.

MAJORITY CHAIRWOMAN RAPP: Thank you.

At this time, we'll start with questions.

Dr. Johnson, I appreciate your testimony. And I know you didn't get to -- well, I guess you did get to complete it.

For either one of you, if you would like to answer. In part of your testimony, Dr. Johnson, that you didn't get to was the supplements, the zinc, the vitamins, and, you know, Hydroxychloroquine and the Ivermectin. Now, we all -- everybody in Pennsylvania, our constituents, they all have social media, most of them. So we've heard, you know, almost nightly since Day 1, you know, from the CDC, from the Department of Health. But we've also -- people have a tendency today to do their own research on social media or whatever.

And we believe in freedom here in Pennsylvania and that includes freedom regarding your health care. And so many of my constituents are, indeed, using supplements, whether it's vitamin C, vitamin D3, zinc. Many people today are seeking physicians who will prescribe Ivermectin, Hydroxychloroquine, and others.

And I believe that people have the right to do that because now we are starting to hear side effects of the vaccines. We're starting to hear that even people who are vaccinated are coming down with the virus.

So why would you be opposed to promoting, which I haven't seen from the Department of Health or CDC, our citizens across the nation taking supplements to build up their immune system. This is really what citizens are trying to do. How can I build up my immune system to help

prevent the virus from affecting me or any of my family? And I think that's where our citizens are coming from. They want to build up their immune system. They believe in preventive medicine. And to me, that is what I'm hearing from my constituents.

Feel free, either one of you, to respond.

DR. DENISE JOHNSON: Well, thank you, Chairwoman.

I'd be glad to respond. I think that you are absolutely right. People can take supplements. People should take individual responsibility to build up their health. There's nothing wrong with seeking to improve your health and to maintain your health.

What is very important is to make sure that people understand that they are fully informed. So the level of evidence is something that sometimes it's difficult for the individual just seeing an article to know but that's why we have scientists at the CDC and others that really rigorously review the evidence to see, again, whether or not this treatment that we are taking or the supplement actually has an impact.

Many times you can take -- if you take something and you get better, it doesn't necessarily mean that that made you get better. We need rigorous scientific study to make sure that there's a cause and effect.

But what people also need to know is that

supplements are not an alternative to the treatments that we have. There's not the level of evidence to show that those supplements can prevent or treat COVID-19. Again, people are free to pursue those but they need to be fully informed in terms of what the benefit would be.

MAJORITY CHAIRWOMAN RAPP: Thank you, Dr. Johnson.

Unfortunately, a lot of citizens do not believe that the medical community, whether it's the CDC or the Department of Health, is fully informing them. And that's why we're looking at Representative Keefer's piece of legislation.

Representative Frankel, would you like to ask the first question from your side?

MINORITY CHAIRMAN FRANKEL: Sure. I have a number of questions. So maybe we could go around.

MAJORITY CHAIRWOMAN RAPP: Yes, please. If we could please limit to one question per member if you have a question and keep it brief. That would be wonderful.

MINORITY CHAIRMAN FRANKEL: Okay.

Well, first of all, I want to thank you, Dr. Johnson, for being here. I took a look at your testimony. There's a lot more to it.

One of the concerns is that, you know, talking about some these alternative treatments that have not been

approved by these medical boards takes our eye off the ball with respect to vaccination status.

What are the trends in hospitalization and death as related to vaccination status? And secondly, the second part, since I just have a little bit of time here, does the Department of Health put any limitation on the use of Ivermectin or Hydroxychloroquine and, if so, why?

DR. DENISE JOHNSON: Okay. Well, first of all, I think, as we're all aware of the news reports, Pennsylvania is certainly suffering with a surge of COVID-19 cases. We have seen the peak of our cases during this pandemic last year around the December/January timeframe. But the peak that we have now has already surpassed what we had in the spring. And those numbers are still continuing.

I'm sure all of you know that our hospitals have become overwhelmed. Last year when we had the peak of COVID patients, we didn't also have the other respiratory illnesses or the other delayed treatment for chronic conditions that we have. So now our hospitals are at capacity and really feeling the strain.

As mentioned before, we have seen that still, even with the variants circulating, the people that are hospitalized are mainly those people who are unvaccinated. And so even though there's recommendations now for boosters for the vaccinated, we do know breakthrough cases, the

majority of cases that we're seeing are in those that are unvaccinated.

So the second question in terms of the Department of Health and non-approved treatments, the Department of Health does not weigh in on what the medical care is. I think that's proven and already mentioned that that is the purview of the medical boards in terms of the practice of medicine and what is appropriate.

As I'm sure all of you are aware, standards of care change as we get more information, as we do more research. And so it really takes a fluid medical board to be able to determine what is appropriate medical treatment. The Department of Health has not weighed in on that.

MINORITY CHAIRMAN FRANKEL: Thank you.

MAJORITY CHAIRWOMAN RAPP: At this time, the next question from the members will be Representative Dawn Keefer. And she is the prime sponsor of House Bill 1741.

Representative Keefer.

REPRESENTATIVE KEEFER: Thank you.

Thank you, both, for coming and talking to me about -- talking with us regarding this legislation and preventive care or treatment for COVID.

There were two years -- almost two years into this and we're still limited on preventive outpatient treatment for COVID. So that's really what my impetus was

for my legislation is, why are we taking things off the table? Like you said, it's fluid. So we need some kind of a process that remains fluid because science is ever evolving. We continue to do studies. We continue to get new information.

So my question actually is for Ms. Robin. You said that, you know, your job is -- you try to protect the standard of care and make sure that, you know, people are acting -- or your physicians are acting ethically and that they're meeting those standards. But do you ever take a position against an FDA standard of care?

For example, currently the standard of care that they have is Remdesivir. And that had negative -- had limited studies, much more limited actually than even Ivermectin. But it still proceeded as a standard of care. And as we continue to get information on how they're implementing that, it's being used at the wrong time and there's limited efficacy in that. And then Olumiant, which is very concerning because it's a black box warning on it as well and could cause blood clots. And we're dealing with a disease that we know does cause blood clots. So do you ever come out and say, you know what, that's not a standard of care that, you know, we can endorse?

MS. LISA ROBIN: Well, thank you for the question.

The Federation does not set the standard of care or comment on a particular medication. We are really here today to talk about the remedy that a patient would have if a patient went to the medical board with a complaint that the medical board would be barred from doing any sort of investigation of that complaint and looking at the standard of care in that particular instance.

REPRESENTATIVE KEEFER: But it's that standard of care, if you guys deem that standard of care to be, you know, compromising to the patient's care -- so if the doctor is -- I'm just going to continue to use this standard of care and that's because it's already been approved and then that way I'm covered with insurance. You never push back on anything like that, you know, as long as it follows the rules, it's not -- it's not an issue of concern?

MS. LISA ROBIN: Well, the Federation is a non-governmental body. Those decisions would be made by the individual medical boards that are a part of the state agency. And they would be authorized to look at the standard of care and determine whether they believe that that standard of care was met.

It really would not be under the purview of our organization to comment on anything that would have to do with a particular standard of care or for any particular medications.

We really are just here to talk about that these boards should be authorized to be able to look at that so patients have a remedy with the board and that they are not prohibited from looking at the complaints that would be submitted by an individual patient.

REPRESENTATIVE KEEFER: Right. And I believe what we are talking about is when physicians are being penalized by a board, not because of a patient, per se, but because of a practice that, you know, may not follow a standard of care but maybe an FDA-approved off-label drug use. So it's, you know, really when we are intermingling government and our medical profession, that's where it gets hairy because we're not doctors. We're not medical professionals. So when we start interfering in that line and we now have taken away doctors' abilities to treat patients and meet the patients where their needs are, I thought that your organization was more of an intermediary on that level. But that's not the case?

MS. LISA ROBIN: No. Actually physicians are allowed to prescribe drugs for off-label use. And this is -- this is not a question. But our position is if harm does occur that the patient should have the recourse to be able to go to their own State Medical Board to look at that care that was rendered. Boards are complaint driven and they are bound to investigate those complaints and make a

determination. Many would not lead to any sort of discipline.

REPRESENTATIVE KEEFER: All right. Thank you.

I'll let others ask questions.

MAJORITY CHAIRWOMAN RAPP: Thank you, Representative Keefer.

Representative Kinsey, I'm not sure where you are. Oh, there you are, sir.

REPRESENTATIVE KINSEY: Thank you, Madam Chairwoman.

Ms. Robin, I have a question for you. You mentioned that the Federation is not a governmental body. And you also just recently talked about the patient -- ensuring that the patient has a remedy with the board. So my question to you is, do you think that this bill will limit a patient's ability to seek recourse in the event that they had a bad outcome or harm was caused if this bill was passed?

Also, do you think that this bill might put patients at risk and, if so, what precedent do you think that it might set if this bill is passed?

MS. LISA ROBIN: Thank you.

Yes. Our concern really lies in the precedent that this bill would set forth medical regulation generally. Patients need to have recourse in the event of harm. And

boards were established to receive complaints from the public or from peers or other information sources and then to investigate those claims to protect the public.

If the public has no recourse with their state and the boards are created by the state in the interest of the public, not really in the interest of the profession, boards do, you know, protect the integrity of the profession and make sure that there is accountability.

But we believe that this bill would set a precedent by barring the board from even investigating any complaint if the patient is harmed due to some sort of treatment regardless if it's this issue or something in the future.

REPRESENTATIVE KINSEY: Great. I want to thank you for your testimony.

And thank you, Madam Chair, for allowing me to ask a question.

MAJORITY CHAIRWOMAN RAPP: Thank you, Representative. You can ask a question anytime, sir.

REPRESENTATIVE KINSEY: Thank you.

MAJORITY CHAIRWOMAN RAPP: Representative Borowicz.

REPRESENTATIVE BOROWICZ: Thank you, Chairwoman.

So many directions I could go here.

Thank you, both, for being here. I appreciate

your testimonies.

Real quick. To refer back to the question that was just asked. So is there recourse for patients if there is harm from the vaccine right now, from the COVID vaccine? Is there also recourse for patients that have any harm due to them from the vaccine?

MS. LISA ROBIN: Well, the State Medical Board would look at complaints from patients from the care that was given by a licensee. I don't know that an adverse reaction to the vaccine would be from the care of a physician or not. But a patient can certainly file a complaint on any issue that they feel that they were wronged by.

REPRESENTATIVE BOROWICZ: Okay. My next question -- sorry. I know you said only one. But if I could just do one more on the monoclonal antibodies.

I agree with you. We've seen a huge success rate. I'm not a doctor obviously, but just through people and my constituents receiving monoclonal antibody treatment has been very successful.

I have a friend that received monoclonal antibodies, a Z-Pak, and Ivermectin. Within 24 to 48 hours, she was feeling much better, a little fatigue for about, you know, eight to ten days but no fever, no cough. And so this has proven monoclonal antibodies is a great treatment. But

I don't see it widespread in Pennsylvania.

Is there specific qualifications that someone must have to be able to receive this treatment? Because that's not going on in other states and it seems to be that you have to qualify in Pennsylvania. I have several friends that have been denied this lifesaving treatment. Is there a process? Do you have to qualify in Pennsylvania? And what can we do to change that to make this more widely available?

DR. DENISE JOHNSON: Well, thank you, Representative, for that question.

Certainly, as you say, the monoclonal antibody therapy has really been phenomenal in terms of how it helps patients. Monoclonal antibodies initially were in quite limited supply. And so the initial qualifications were people who were at high risk for severe COVID. As we had more available than people who were at high risk that could even receive them for was exposure prophylactic.

Really the public needs to know that monoclonal antibodies are available. And on the CDC website and the -- I'm sorry. I think the HHS website you can find a location near to you that has monoclonal antibodies and then you can seek that.

The providers make the determination based on what the underlying conditions are for patients and so patients who are at higher risk. But there are also

organizations that have had some difficulty administering the treatment. They have to find space to do this for people who are coming in who are actively COVID positive. So our hospitals right now are struggling with being overwhelmed. Being able to allocate staff to be able to man the sites, being able to give monoclonal antibodies has been challenging. But monoclonal antibodies are available across the state but there can be some limitation at the facility.

REPRESENTATIVE BOROWICZ: Qualifications, like you don't have to qualify to get this or you are not denied because, you know, your BMI is low. So there are specific qualifications; is that what you're saying?

DR. DENISE JOHNSON: Well, first of all, you have to get it within the timeframe. So the monoclonal antibodies work the best if they are given before five to seven days but definitely before ten days. So after that time, someone would not qualify. And they would prioritize people that have higher risk. People who have no risk at all, they would prioritize them.

REPRESENTATIVE BOROWICZ: I'd like to see, you know, in Pennsylvania -- Florida can do it and Texas. We need to make it widely available here for people, especially with the surge that we have been having, so there's no reason in Pennsylvania that we cannot have that widely available for every citizen in Pennsylvania if needed.

Thank you.

MAJORITY CHAIRWOMAN RAPP: Thank you, Representative.

Thank you, Dr. Johnson.

I was just handed an article from our counsel. And this is an article from -- it was updated December 23rd, 2020. And obviously any of you can research this on social media. You can't sue Pfizer or Moderna if you have severe COVID vaccine side effects. The government likely won't compensate you for damages either.

I'm sure there are other articles out there if anyone wants to research whether or not you can sue for damages regarding the vaccine.

Thank you.

Representative -- I know I'm going to mispronounce your name again -- Kosierowski. I hope that's close enough.

REPRESENTATIVE KOSIEROWSKI: You did a wonderful job. Kosierowski. Very good.

Thank you, Madam Chair.

My question is for you, Dr. Johnson. And thank you, both, for being here this morning.

I'm a big fan of preventive care. We know preventive care works. We know when patients practice those measures we know that they can help. And collaborative care

with the doctor and a patient I believe is always best.

But how concerning is it when we talk so much about social media and getting guidance and getting information on social media. I'm concerned for the true guidelines that physicians use, like peer review research and clinical trials and data, proven data, reviewed by people like epidemiologists and molecular biologists and critical care docs and, you know, infectious disease doctors that are on the front lines here. That's where we learn about side effects. And that's where we learn about effectiveness. And that's where we learn about safety of these types of treatments.

So I'm just concerned about the credibility that we as a Commonwealth now have in our true scientists and true docs and physicians that are treating COVID-19 and those that are in the hospital with the patients that are non-vaccinated and in our hospitals now.

And I just -- it's an information question that I have for you. How concerned are you and our Department of Health about this?

DR. DENISE JOHNSON: Well, thank you, Representative.

I'm not sure if I can answer your question completely. But I think that, as you point out, there are a lot of sources of information. And it can be difficult for

an individual person to really critically analyze that information. And that's what the medical profession really depends on. Physicians and providers need to be able to have access to the information. And they need to be able to convey to patients the weight of the evidence of the different recommendations so that patients are able to make an informed choice.

So it is the responsibility of the provider to let patients know what treatments are approved and not approved and why they are approved or not approved and what the risks and benefits would be to them. A patient has the right to that information. And it is really required for them to be able to make an informed choice. So that responsibility lies with the provider again to give credible information to the patients to be able to make that decision.

REPRESENTATIVE KOSIEROWSKI: Thank you very much, Doctor.

MAJORITY CHAIRWOMAN RAPP: Thank you, Representative.

Thank you, Doctor.

Representative Zimmerman.

REPRESENTATIVE ZIMMERMAN: Thank you, Madam Chair.

I appreciate the testimony this morning. So I'd

like to ask Dr. Johnson a question on the two drugs that are being made available through Merck and Pfizer. Are they FDA approved and are they both steroids or are they differing drugs from each other and are they available today and, if so, where?

DR. DENISE JOHNSON: Thank you, Representative.

So they are in the process of being approved. I know that the FDA is considering the molnupiravir, and Paxlovid is not yet approved. So we anticipate that they will be approved soon. They are antiviral agents so they help to decrease the viral replication. They're not steroids or anything like that but work sort of like Tamiflu so that it will help to decrease the replication of the virus.

Once those are approved or authorized, then they would be available. We anticipate that once they become available though, they will be in limited supply until that supply can be built up. But they are not yet available but we anticipate hopefully by the end of the year they will be.

REPRESENTATIVE ZIMMERMAN: Thank you very much.

Thanks, Madam Chair.

MAJORITY CHAIRWOMAN RAPP: Thank you, Representative Zimmerman.

Representative Krajewski.

REPRESENTATIVE KRAJEWSKI: Thank you, Madam

Chair.

My question is for the Physician General but, Ms. Robin, feel free to chime in as well.

In your professional capacity, Dr. Johnson, would you ever recommend supplemental treatments, viral or antibody treatments you've already covered, for someone who is in generally good health over taking the vaccine for COVID-19 prevention? And then as a follow-up to that, given that we know that the vaccine is our greatest tool in disease prevention against COVID-19, what role do you believe the pharmaceutical companies have in promoting vaccination?

DR. DENISE JOHNSON: Well, thank you, Representative.

First of all, we know that the vaccines are safe and effective and they are saving lives. And there has been no treatments that we've seen that offer the same level of protection as vaccines. So there's no supplement or other over-the-counter treatments that would even come close to the effectiveness of the vaccine.

Because we know that the vaccines are so effective and because we know that any risks of the vaccines are way outweighed by the benefits, we recommend vaccines. And I think that pharmaceutical companies and others should recommend vaccines, again, because they are the best

protection that we have had. And again, we have a mountain of evidence that has proven again that they are effective. They are saving lives.

REPRESENTATIVE KRAJEWSKI: Thank you.

MAJORITY CHAIRWOMAN RAPP: Thank you, Representative.

Representative Owlett.

REPRESENTATIVE OWLETT: Thank you.

Thank you, Dr. Johnson, for being here. I wanted to talk a little bit about the monoclonal antibodies again. I realize that you shared that's a great treatment. I'm curious. Is there any information about that on the Department of Health's website, about the treatment options, locations, where people could access that at all?

When you were talking about it, I pulled up my iPad just to look real quick. I'm not finding anything. So is there anything on the DOH website about monoclonal antibodies?

DR. DENISE JOHNSON: There are. And we can get you where exactly it is on the website. But there are.

REPRESENTATIVE OWLETT: Okay. Is there a map of where those sites are in the state?

DR. DENISE JOHNSON: I'm not sure. I'll need to check on that. I know that there's a national locator for monoclonal antibodies. I'm not sure if that is a link, but

we can get that information.

REPRESENTATIVE OWLETT: Okay. That would be great.

I pulled up Florida. And it was, like, bam, first. It was right on the front page. Right there you could find 14 locations at least. And I'm just not seeing it here in Pennsylvania. I'm curious if it's available in all 67 counties of the Commonwealth. So if you could get that information to us, that would be great.

Thank you.

DR. DENISE JOHNSON: Thank you.

MAJORITY CHAIRWOMAN RAPP: Thank you, Representative Owlett.

Thank you, Dr. Johnson.

Representative Keefer for the second time as the sponsor of the bill.

REPRESENTATIVE KEEFER: Thank you, Madam Chair.

I just wanted to note that even with 1741 it does not provide blanket immunity for physicians. That's not anything -- there's nothing in that legislation that prevents a suit based on malpractice regardless of what the role of the standards are. So any other interpretation of that is not accurate. A patient would still have recourse on that.

But getting back to treatment, clarifying the

vaccine breakthroughs we do have, treatments we still don't have. There was a question asked about monoclonals and where people are getting information, because I've had a couple constituents actually attack me for not promoting them more. But the fact is is that they are not available for everyone because you have to be in a specific category to receive that; is that accurate?

DR. DENISE JOHNSON: Yes. I mean, there's a timeframe. And people who are at a higher risk are prioritized.

REPRESENTATIVE KEEFER: Yes. So I had somebody within the first couple of days go in but she wasn't old enough. She didn't have any other risk factors so they would not give it to her. So we don't have all these treatments for everybody. And I'm not confident that the cases that we're seeing in the hospitals where we're getting the numbers saying 80 percent are unvaccinated is accurate. Because I continue to get calls from patients who say, I just got out of the hospital. And my chart was marked that I was unvaccinated, but I'm vaccinated.

One was because he was eligible for a booster and didn't have it yet. And he said he wasn't eligible. He had gone to get it. And another one when they challenged it they said, well, you weren't vaccinated through our system and we weren't able to verify your vaccination in the State

System so it just goes in as unknown.

So I'm going to assume all of those are getting reported up to the State then as unknown or unvaccinated. And we still can't get all the data from the State that we requested. That's a little confusing on how we're reporting those numbers as far as vaccinated, not vaccinated.

And it's just important because we don't have treatment and people are scared. It's continuously perpetuated in the media. So getting the right information, true informed consent. Treatments to keep people out of the hospital should be just as much of a priority as vaccinations, especially when we know the amount of breakthroughs that there are with the vaccine.

So I would just implore that we all continue to work towards prioritizing that.

Thank you.

MAJORITY CHAIRWOMAN RAPP: Thank you, Representative Keefer.

Good questions.

Any other members before I recognize Representative Frankel for a question?

Representative Frankel.

MINORITY CHAIRMAN FRANKEL: Thank you.

These questions are for Ms. Robin. We researched -- my staff took a look at this research and they

found no disciplinary actions were taken against doctors for use of off-label medications for coronavirus since early 2020. If our State Board isn't using the power to discipline in these cases, why do they need it?

MS. LISA ROBIN: Well, I think the fact that there have been no disciplinary actions doesn't necessarily mean that there hasn't been any complaints. Complaints are generally not public information and would not be public unless an investigation was completed that determined whether or not disciplinary action was appropriate.

I think that sometimes the investigation takes some time to complete so we wouldn't necessarily know that there have been complaints. But we do know that, even if there have been no actions that patients, in the event that there is an adverse action or adverse outcome of a patient, that they should have the ability to file a complaint with their board and the board would be able to look at the care and be able to make the determination on behalf of the patient.

And we are concerned that this bill would prevent state boards from looking at that and taking any actions specific to the complaint.

MINORITY CHAIRMAN FRANKEL: Thank you.

I think it would be helpful if we had an understanding maybe of how this system of accountability

worked in a different realm, say in the opioid crisis. Maybe you can give us some background to how it has functioned.

MS. LISA ROBIN: Sure. And I think that is a pretty good example of boards and the role that they play and actually as a part of the role of the state and strategies to combat a public health issue.

So we all know the opioid crisis, the medical boards took a very active role in a number of areas by looking at guidance and policies to be able to look at the improper prescribing by individual physicians and taking actions when necessary that could range from loss of license to continuing education.

They also looked at putting in place required CMEs, or Continuing Medical Education, on prescribing and looking at the tools. State Medical Boards were very involved with the Pharmacy Boards as well as making sure that Prescription Drug Monitoring Programs were working well in the state.

So I think that they were one part of the strategy by taking their ability to take a disciplinary action, look at complaint s from patients, from patients' families. This was a good example that the medical boards really did step up and made a difference in fighting the opioid crisis.

MINORITY CHAIRMAN FRANKEL: Thank you very much. Thank you, Madam Chair.

MAJORITY CHAIRWOMAN RAPP: Thank you, Representative Frankel.

I want to thank both of our testifiers. And I have some closing comments.

Ms. Robin, you just talked about the physicians possibly being held accountable by the opioid crisis. And so that is another reason why the citizens of Pennsylvania -- we all know about the opioid crisis. And a lot of that crisis was because physicians -- and I think the world of physicians, doctors, the role that they play in our society. We have the best health care in this country. But part of the problem with the opioid crisis was the physicians prescribing the opioids.

And another thing that we hear often is anybody who works with their doctor in consultation in how to stay healthy, what to do if you're sick, what to do if you have an emergency, which I'm sure most of us have been in. We've visited the ERs. And some of us have been to the ORs.

But a lot of times we hear from certain doctors before we take certain steps, if we need a certain procedure, we need a second opinion. We need a second opinion. Not just one doctor's opinion, but a second opinion. And so we do have physicians who are stepping up

across the nation regarding other therapeutics, other treatments, preventive medicine.

And I appreciate those physicians because, as I opined, we have the right to medical freedom in our great nation and in the state of Pennsylvania. That is the base of American citizens is our freedom that we have in this country. And that includes the freedom to treat your body in consultation with your doctor, hopefully, in how to treat any -- if you want to get a second opinion, that's wonderful. But we should have the medical freedom to look at alternative medicines. A lot of people will go to health food store for vitamins before they will buy vitamins from Wal-Mart that are made in China these days.

So I appreciate both of you, your testimony, and coming here today. This is an important issue, I can assure you, to the people of Pennsylvania. And to the members sitting here, we listen to our constituents. And one thing that was asked by Representative Keefer, Dr. Johnson, is we need the data on who is contracting COVID right now. What are the numbers for people who are vaccinated? What are the numbers for people who are unvaccinated?

Because we know that a majority of people in this state right now are vaccinated. Every one of us sitting here probably know of people who have contracted or have had the virus, whether it's the variant or whatever, who all

have the vaccine. So I think that's a vital and just piece of information that we deserve. And the people of Pennsylvania deserve that information. How many people are coming down with COVID who are vaccinated? How many people coming down with COVID who are unvaccinated? I want to see that data. And I think many members here, we have a right to know.

So I would appreciate it, Dr. Johnson, if the Secretary and the Department of Health could start sharing that news as well as map information where these other treatments are available in the state of Pennsylvania, because our citizens have the right to know that information.

But I truly appreciate both of you attending here today. It's been very informative. And I think it may be something that we need to follow up on, you know, down the road. But I thank both of you for attending today and giving us this vital information. And we hope to hear more information that we requested through this hearing.

Thanks to both of you very much.

DR. DENISE JOHNSON: Thank you.

MS. LISA ROBIN: Thank you.

MAJORITY CHAIRWOMAN RAPP: At this point in time, we're a little bit ahead of schedule but we're going to move into our second panel. And one of our testifiers on that

panel will be Dr. Robert Schmidt, Primary Care/Preventative Medicine and Complementary Medicine from Penn Highlands Family Medicine. I believe he's from Elk County.

And Dr. Chaminie Wheeler, Medical Wellness Consultant. Dr. Wheeler, welcome.

Dr. Pierre Kory, who is with the Front Line COVID-19 Critical Care Alliance, who is with us virtually. Welcome, Dr. Kory.

And Dr. Amesh Adalja, who is a Senior Scholar at Johns Hopkins Center for Health Security.

Is he with us virtually as well? Oh. Thank you, Doctor.

Our first testifier will be Dr. Schmidt after I swear you all in. If you could all please stand and raise your right hand.

(Witnesses sworn en masse.)

MAJORITY CHAIRWOMAN RAPP: Thank you.

You may be seated.

Members, I think you have the testimony in your packet.

Dr. Schmidt, you are first on the list. If you would like to proceed, sir. And welcome to the hearing.

DR. ROBERT SCHMIDT: I want to give the people some background and to the Committee on myself. I don't

have a clinical appointment at this time. I grew up in the suburbs of Pittsburgh. I went to medical school at the University of Texas Medical School in Houston. I did my residency at UPMC St. Margaret's. And I went to Elk County in 1981 and based myself somewhat. I've seen a lot. And I've been there ever since.

I initially was board certified in Family Medicine, went on as a Medical Director of the Emergency Room and became board certified in Emergency Room Medicine, then Geriatrics and Sports Medicine. I'm currently board certified in Family Medicine, clinical Epidemiology. And I have my acupuncture license. That's my background.

As far as COVID goes, you know, good things come to rural Pennsylvania late, so do bad things. In the first phases of the COVID epidemic, it was like we were watching something in a movie. We didn't have the terrible surge at first. Eventually it arrived. It was in the summer, late summer of 2020. Mostly we felt like college students coming home from campus brought it back. Doesn't really matter. We started to deal with it.

Everybody was hampered by lack of treatment, things like that. I got COVID in December of 2020. I had already done my research. I was on zinc, vitamin D and vitamin C. I was able to get hydroxychloroquine just prior to what would turn out to be the real dark underbelly of why

this bill had to be written. And that was when I got Hydroxychloroquine, took it. And then shortly thereafter it was not allowed to be dispensed by pharmacists for anything other than a rheumatological diagnosis.

It was a little bit unusual sitting around waiting to see if I was going to go down the tubes, you know, as I had COVID. I had four risk factors but I did fine. I was back to work in two weeks.

So as the pandemic took hold, at least in our area, what I started to do is more research on treatment. And this is where I became aware of Ivermectin. Hydroxychloroquine was already being widely used in Europe. We didn't tend to embrace that much, which is one of the problems with American medicine. I mean, I've been on the inside.

I was Clinical Assistant Professor at UPMC for six years. If you want to call it medicine or the establishment, if they don't endorse it, if they don't discover it, it's difficult to get things accepted. So anyhow, Ivermectin is being used all over the world with results. And anybody that says that there isn't enough information, there's been no studies, it's been studied in dozens and dozens of studies throughout the world with tens of thousands of patients showing beneficial effects, statistically significant beneficial effects, in almost

every phase of the COVID problem, the clinical illness.

So I started to study this more. And I was very busy over the summer with just some internal things of people being off. And then I was about to start to utilize it. I wasn't going to let what other people say as the truth. In fact, my first experience with fake news -- I'm not a big fake news person. I didn't like to believe that fake news exists but when a doctor in Texas came out and said that the emergency room was lined up with people with Ivermectin toxicity and then the hospitals -- hospitals don't like to back up doctors too much -- but the hospital came out and said this guy is off the charts. He doesn't work for us. This never happened. But that story was carried by every major news service in the United States. Okay.

And so then I'm saying, all right. You know, what's really going on? And then the CDC, you know, came out with its Ivermectin horse medicine toxicity story. Well, the facts are people were desperate. You can buy Ivermectin at Tractor Supply. If you aren't very good at math and you start slicing this pill up, you can take 10 or 100 times the usual dose. Well, that's not a physician-prescribed, physician-instructed therapeutic regimen. That's people desperate for treatment who make mistakes. That's the Ivermectin toxicity story.

So then late in the summer of this year, my associate that I practice with, the 20-year-old sister died of COVID. She had obesity and vitamin D deficiency. Vitamin D deficiency isn't recognized by the establishment as a risk factor but, in fact, is a risk factor. So then I said, I can't sit on the sidelines anymore and I started to prescribe Ivermectin.

But to my chagrin, the pharmacies wouldn't fill it. I mean, most physicians who want to practice medicine and get the best effects, 20 to 30 percent of all prescriptions are for off-label use. And I will say that the State Medical Board has not interfered with that.

What I found out is -- I'm not going to say diabolical, but a very, very concerning fact was the pharmacist would not fill these prescriptions for the patients. And I give my patients extensive handouts on the utilization of it, all the other things they need to do as far as supplementary medications for symptoms and then the supplements.

So I called all the pharmacists. And I said, what's going on? The three chain pharmacists said, we can't fill it. We were told if we do fill it for anything other than treating worm diseases we are at risk of our jobs and disciplinary action. That's the real reason this bill is necessary. Not that doctors are going to poison people or

do the wrong thing.

Every State Medical Board can investigate anything they want to investigate. As President of the Medical Staff at my hospital, I sat through this. They can look into anything they want to look into. The bill does not prevent disciplinary action or, you know, really negligent care. But the pharmacists wouldn't fill the prescriptions.

I went and met with the two local private pharmacists. And one, he was so small he couldn't get Ivermectin. He was not hung up on it. But the other one who I was the Medical Director for their pharmacy for about 15 years -- I'm not now -- their issue was that, one, the one co-owner was getting pressure with negative feedback from pharmaceutical organizations, peer organizations, that this was not considered standard of care, that they risk disciplinary action.

And then the one business-savvy owner of this private pharmacy said that they would get blowback and could get in really significant trouble from pharmacy benefit managers if they filled it and they bill it to insurance. So about a half hour of folding their hands and things like that, they agreed to dispense it but it would have to be for cash.

On the international market, five days of

Ivermectin at 12 milligrams per dose is about $10. They have to sell it because the cost to them and not a significant markup, it's $105 for five days. This doesn't sound like a lot. However, I have some poor people in my practice who can't afford it. And I had actually given -- I bought it and gave it to them.

So the pharmacy issue is the crux of the issue. We're not getting interfered with by the Pennsylvania Medical Board. But if you can't get the medicine into patients' hands, it doesn't matter where the roadblock is. The roadblock is there.

So I've been dispensing it since September. The one colleague and I have treated about 100 patients. It just performed up to the study expectations. The biggest thing patients have to do -- and I'll leave you with this -- is they have to get it before they get in the hospital. Uniformly across the board, it's not being used in hospitals. Patients are being refused. That's where the York case came from.

I don't like to recommend lawsuits. Doctors don't like lawsuits. But patients are going to have to take it to court if we don't get this bill through. Now, it still doesn't help you treat them in the hospital. I don't do inpatient medicine anymore. I did it for 25 years. I practice only outpatient medicine now. And from a medical

practice point of view, this is the biggest roadblock now is once the patients are in the hospital. Because Ivermectin works in all phases even outpatient and then in more severe cases because it's anti-inflammatory, antiviral, and it does things that can help in almost every stage of the disease.

So I'm going to talk about the safety I addressed. I'm going to talk about one last thing about this, a state in India. Now, India is the biggest Democracy of the world, right. There's 220 million people. That's bigger populationwise of England, France, Spain, and Italy combined, which is about the same size -- all of the states east of the Mississippi are 180 million people. So keep those statistics in mind.

So Uttar Pradesh is the name of this state. And they were hit initially by this and they wanted to do everything they could. So they instituted a mass Ivermectin utilization campaign. This was not only treating the active cases but they prophylactically treated all contacts. Now, to date -- and this is the population of 220 million. Pennsylvania's population is 12.8 million. If I'm off by 1,000 here or there, I appreciate what you said about getting statistics.

The total cases for Uttar Pradesh as of about a week ago -- and I utilize the Johns Hopkins dashboard, which is recognized as one of the best in the world tracking COVID

cases nationally, by state, by county, in the United States, and by region and states all over the world. Their total cases were 1.74 million as of about a week ago. Pennsylvania is 12.8 million. Now Uttar Pradesh is 17 times larger than Pennsylvania. Their vaccination rate -- this is on a background vaccination rate of 1 vaccine shot for COVID, 58 percent; and 36 percent for vaccination for two vaccinations. The Pennsylvania rate is probably above 85 percent for one vaccine and 65 for two. So we have more vaccine doses and patients treated. But in a country 17 times our population have about the same number of cases.

But after -- the thing to look at here is after they did their Ivermectin campaign, the case rate for Pennsylvania in the last 28 days, 168,000. The case rate for Uttar Pradesh in 28 days was 277. Deaths in the last 28 days in Pennsylvania to the best I could dig out from all these sources 2,200 deaths. Uttar Pradesh, five.

I mean, so when you take a state this size -- now let's compare it to the 180 billion people in the 28 states east of the Mississippi. If every state government got together and unanimously stated that Ivermectin was a main reason that this happened, if it could happen here, we wouldn't be having this hearing. We would all be buying stock in the companies that make Ivermectin and racing to see which state could get it the lowest.

Well, so, why do I say that? Early November of 2021, the first thing was the Indian Bar Association, okay -- this is for the whole country of 1.35 million -- billion people -- sued the chief scientist for effectively preventing Ivermectin use by saying it doesn't work. And they're suing because it resulted in innumerable deaths and manslaughter. That was in the India Press. Eight days ago in the India Press the governmental leaders of Uttar Pradesh stated -- and I quote -- Uttar Pradesh government says, early use of Ivermectin helped to keep positivity and death low. This is like all 28 states east of the Mississippi making that statement, except it wasn't here. It was in this state, which is the largest Democracy in the world. In fact, Uttar Pradesh would be 6th. If it was a country into itself, it would be tied with Pakistan, the 6th largest country in the world. This is not a small area. This is not.

So I want to close with -- in my summary and you have my summary -- doctors will always be held accountable for whatever they prescribe. The fears of the boards don't buy that. The fears of the National Federation of Boards that they won't be able to do anything, I agree with the Representative. That's not going to happen. They are going to be there looking and only allow doctors to be doctors to treat what we've always treated, assess the literature and

treat the patients and move forward to getting this pandemic under control. Vaccines are going to play a role but there's better vaccines coming out. But there's always going to need to be treatment and this medication can make a difference.

MAJORITY CHAIRWOMAN RAPP: Thank you, Dr. Schmidt. And thank you for traveling here for the hearing. I'm sure all of you have traveled a ways.

So our next testifier is Dr. Wheeler, Medical Wellness Consultant.

You may proceed.

DR. CHAMINIE WHEELER: Well, thank you.

To give a little bit of background, I am a Wellness Medical Consultant now. But for the last 18 years I have only worked in the hospital setting. I'm a pediatrician. I've done Pediatric Emergency Medicine, pediatric hospitals. I've worked for the St. Luke Health System in Pennsylvania. I worked in the emergency room in Langhorn, Pennsylvania, years ago and for Children's Hospital of Philadelphia. So those are my credentials.

And the reason I am here today is to be the patient advocate. I want to make sure that it is absolutely important that doctors are held accountable for their decisions if they take some action and if they did something that would harm a patient. We need that check and balance.

We also need our patients to be able to -- we need to be advocates for our patients, too. And our hands can be tied because we want to do what is ethically and morally right to help save a life.

And I'm here because I know physicians who have prescribed Ivermectin who have been investigated by the Pennsylvania Department of Health. I know situations -- one situation specifically that there was actually a letter sent from a prescription that went from a CVS or something like that to the patient saying, did your doctor prescribe this for you? Asking the patient to come against them. And the patient went to their primary care doctor who they trust who they have a covenant of trust, patient/physician relationship.

So this is not -- this bill is not to say that doctors can harm people and that's okay. It's to be a patient advocate, meaning if a patient is hurt, a physician should be held accountable. But also when a patient needs help, the physician needs to be able to help them.

And to add to that, throughout all of this, I have had many conversations with many physicians who are in the hospital who have not been able to prescribe Ivermectin when the patient gets admitted because it's against hospital policy. And every time a physician writes a prescription for Ivermectin, I can tell you the thought that goes in your

head, am I going to lose my medical license? And that's wrong because they are doing what they believe is in the best interest of the patient.

So for that, I am not -- it's actually really hard for my to say this. I don't know what happened to medicine, the hypocrisy in our medicine. And I want to talk about three areas that are going on.

One is that our drugs have to be FDA approved to be used; No. 2, that off-label use is uncommon, like you said, and; No. 3, that the scientific discord to be able to -- there's not one established narrative in medicine. Medicine is always called a practice because we have -- it's a practice. It's not you do A and it results in B always. We have to be able to have the timeframe between A and B to say, you know what, could we have veered this way? Could we have done this to get a better outcome? And that is medicine in practice. So those are the three areas that I want to talk about.

The first one I want to talk about as a pediatrician, I want to tell you historically only 20 percent of our drugs that we use in pediatrics is FDA approved, 20 percent. Eighty percent is not; that is, FDA approved for children. Let me just make sure I say that. And most drugs that we use in children have never been studied in children. And I don't blame that. You know,

kids are protected.

We have -- we even have drugs that were once FDA approved that have been taken off the market. And this is the drug Zantac. It was because of the carcinogenic effects of it that it was taken off the market. I can tell you in residency during my pediatric GI rotation, my attendings told me Zantac has a side effect profile of water, of water. That's what I was told. It is okay to use.

And yet, now, after -- so Zantac got its approval, FDA approval, in 1983. And it has become the world's best-selling drug by 1988. And then after 33 years of using it in the market all the way down to little neonatal NICU babies, not just in the adult population, it was pulled off the market. So drugs do not have to be FDA approved.

The other one I want to talk to you about, off-label drugs are uncommon. There are many, many classes of drugs that we use off-label all the time. There's a study. And I've given you all the sources for my studies. In 2006, 21 percent of prescriptions that are prescribed for adults is off-label use. And 78.9 percent of children discharged from a pediatric hospital were taking at least one off-label medication. In an Intensive Care Unit study, 36.2 percent of medication orders were off-label use. In a headache specialty practice, 47 percent of the prescriptions

were off-label use. So this off-label use -- and I've also given you a whole PDF of drugs listed for off-label use.

And just so the public can hear it, I want to talk about it. We use aspirin in children. It is put into our protocol and it has shown significant benefit. It is an off-label use. We use Benadryl for insomnia. That's not a -- everybody hears that. That is an off-label use. It's not indicated for insomnia.

There is Albuterol. We all know -- everybody knows Albuterol is used in asthma and helps dilate our airways. We used it in hypercalcemia. Hypercalcemia is increased potassium. It helps drive potassium into the cell and it is lifesaving. Potassium causes rhythm problems in the heart and you can die immediately from rhythm disturbance. It is a medication that we push to help get that potassium back into the intercellular environment. Off-label use. So those are just a couple things that I wanted to mention from there.

So we talked about the -- No. 1, we talked about the FDA drugs must be an FDA-approved, off-label use. And No. 3, it's basically the scientific discord where physicians aren't allowed to challenge one another. It has been honestly politicized as misinformation. So any physician that goes against the narrative that's established by our CDC and our Department of Health is considered

misinformation.

And like we have been talking about, Ivermectin, it is a Nobel Prize-winning drug, not for COVID but as an antiparasitic. It was even first used to -- even the thought of looking at it is because that scientific discord was allowed in that country that already had a mass distribution program in place for use as an antiparasitic saw less incidents of COVID cases. So that is why doctors who understand the mechanism of action, who understand these things are like, I wonder if it could be a potential.

On the website in our National Library of Congress and Medicine -- that's articles and articles and studies -- there are seven meta-analysis studies. Six of the seven meta-analysis studies -- meta-analysis meaning small study, small study, small study, all added together and you analyze all the data. So meta-analysis is a huge analysis of these studies and have shown the benefit.

And since we're talking about it, Ivermectin can prevent, like we talked about, can prevent the virus from entering the cell, from entering the nucleus of the cell, entering causing replication of the cell. Those all are the antiviral effects of Ivermectin. That is the reason why those numbers and those cases are there. And that is one part of the disease.

Like Dr. Johnson talked about, a lot of times

people get hypoxic at, you know, a week plus, Day 8, Day 10 of the natural evolution of the coronavirus illness. Well, that is true. So if we start early the antiviral effect of Ivermectin where it can prevent the replication, decrease it. Basically in any infection, infection rises, the medication we give helps decrease the rate of rise of that infection. And that's what we are trying to do as physicians is to decrease that rate of rise so the patient's body, their own immune system can take over. That's what antibiotics do. That's why an IV antibiotic is superior to an oral antibiotic because IV antibiotics can get on top of that rate of rise faster than an oral antibiotic. So that's the antiviral effect.

And then the anti-inflammatory effect like we talked about when patients become hypoxic is because of this huge storm that happens in our body that causes our chest x-rays to be white. It causes multisystem organ involvement. Those are what's responsible for the long haulers of the COVID illness caused by SARS-2 virus. All of those things so the anti-inflammatory effect that is done.

And there's actually a study on the NIH website that I gave you that actually says Ivermectin is non-epitopic specific. That is huge. Non-epitopic specific, that means like in our blood cells, if you are a Type A blood, you have -- the way I simply describe it is

that you have a little flag on your blood cell that says I'm Type A. So everybody knows that that's what it is. Well, like the Delta virus, variance is specific. It looks a tiny bit different than the coronavirus. The Omicron is a tiny bit different. The Alpha variant is a tiny bit different.

So the way that the Ivermectin is non-epitopic specific means that it has the potential for the mutation, natural mutation, that occurs in our nature to be helped in that situation. It's unethical. It is morally unethical to promote a narrative that says something that could save lives that could help people to give their bodies a fighting chance and to tell physicians if you fight for it, you're going to lose your license. And then for pharmacies to come up with these corporate policies that say it's not going to be covered when we have so much.

And so I think it was Ms. Robin from the Federation of State Medical Boards said that, you know, they have an obligation to investigate. I was investigated for my medical license. And I was investigated because the hospital, I spoke out against the mandate. They appropriately dropped my investigation but I had to hire a lawyer for it.

So this is not the doctors. I know physicians on the medical documentation on the Epic system who have written, Ivermectin not given per hospital policy, the

physicians that wanted to prescribe it absolutely. Who was tying their hands? Hospital policies that are led by our leadership because if we go outside of that narrative we are held liable.

And to say that the Federation of State Medical Boards, Ms. Robin I believe said, quote, full authority, nobody needs full authority in anything. There needs to be checks and balances at every level. Full authority is not Democracy. Their authority has to have checks and our authority has to have checks. So you can put out a statement saying that if a doctor does this, you are doing this, information and you are going against science.

I actually -- since we've talked about the opioid crisis so much, I wanted to address the opioid crisis. The opoid crisis, actually a lot of it is actually rooted in our leadership, in our authority making policies like in the hospitals that said pain scores have to be given and if the pain level was this, to prescribe this. It doesn't matter that they are on their iPhone chatting. It doesn't matter what the physician thought. But if the patient said the pain score was this, he needed a narcotic.

So I'm not saying that it's not the doctor's fault for doing this absolutely. But policies were made that were also wrong in that.

So in summary, those are the reasons. The reason

that I'm here is because I want to be a patient advocate and I want our physicians to be able to be physicians if they agree with the procedure and believe that it should be done to be able to give that medication or to do that. If they do it and outside of their -- and they cause harm, they should be held accountable for it. But they also take an oath that says do no harm. And the physicians that are taking their chances right now every day with every script they write is doing that because of the oath they took that says do no harm and they want to help people.

MAJORITY CHAIRWOMAN RAPP: Thank you, Dr. Wheeler. Thank you for being here.

DR. CHAMINIE WHEELER: Thank you.

MAJORITY CHAIRWOMAN RAPP: Our next testifier is Dr. Kory, who is with the Front Line COVID-19 Critical Care Alliance. And Dr. Kory is joining us virtually.

Dr. Kory, you may proceed when you are ready, sir.

DR. PIERRE KORY: Okay. Thank you.

Good morning. I appreciate the invitation. As much as I appreciate the invitation, it's also just a really sad topic, to be honest. I cannot overemphasize the seriousness of this legislation and of the topic that we're addressing.

Myself and my colleagues, we are not only

world-renowned experts even before COVID, we did become expert at the disease of COVID. We've studied almost every aspect and deeply studied the therapeutics. And we've come up with protocols that are actually used around the world. I've published a minimum of ten papers on the therapeutics of COVID. And I try to advocate and lecture on my expertise widely.

But the troubling thing is the former -- my colleague who just testified, she described a lot of the things that are happening on the ground. And I have to say the reason why I'm glad to be here is that it's time for the lawyers and it's time for the legislators.

I am literally done as a physician fighting inside the system that I'm sorry is so corrupt to the core. And that's the other expertise that I had to gain. It's not an expertise I had. I went into this pandemic believing in the general good faith and the benign purpose of these institutions that they had the public health's interest at heart.

And unfortunately, the main lesson I've learned is that is not true. That is not true. I see profits at the core of almost every behavior. And it is extremely troubling and it is extremely distressing. And that desire and structure and the system going after profits is now hurting physicians. You heard my colleague just describe

what it's like now to practice medicine. We're under the threat of losing our licenses if we do something as crazy and risky as prescribing a decades-old, cheap, you know, historically safe, off-label medicine. We are now subject to complaints.

And the Representative from the Federation of State Medical Boards talking about how they want to have the right to investigate us, let's be clear, she's talking about if we cause harm. That is not what's happening to many doctors around the country. We are being investigated and having our license threatened, not from causing harm, from simply doing off-label prescribing. And there's a huge difference in that. And like my colleague said, I've had to hire lawyers. And I've had to respond to complaints for doing something which before COVID had long been championed, which is the use of off-label prescribing for when there's no good alternative. That's No. 1.

And No. 2, you know, I did write my testimony. It's quite long. I kind of want to summarize it. You know, for any layperson or legislator listening, you can hear these two sides. And they seem so far apart. So we heard from my colleagues in the first hour talk about how things are proven or not proven and things are approved and not approved. Let us be clear on who gets to do that. It is the health agencies that are in power. They determine what

level of proof is sufficient. And the aberrance in how they do that is -- it's absolutely shocking what is going on.

You know, I heard questions about molnupiravir and this new drug called Paxlovid. Let me just use that to start off as an absurd example. Because if you look at my testimony that I submitted today, the written testimony, I really couched this entire topic in terms of the decades-long war on repurposed drugs. Every drug you heard mentioned today, whether it be Ivermectin or Hydroxychloroquine or fluvoxamine, falls into the category of something called a repurposed drug. Another way of defining that is off-patent, not that it is not profitable. It's not obscenely profitable. Let me be clear. You can make a profit by selling and prescribing these drugs. You just can't make obscene profits that you can when you have patent protection of a novel pharmaceutical agent.

The profits of this market in a global pandemic for these novel agents is incalculable and the forces that are trying to shove them into our guidelines is really indescribable. And so the war on repurposed drugs, which has occurred in oncology for decades, in cardiology, and in psychiatry, where they're constantly trying to foist novel agents on us that are not necessarily better than older off-patent names or even safer, that dynamic is continuing to a degree I've never seen before. And it's really

troubling because we know stuff that works on the ground. We've identified at least two dozen compounds, many of them repurposed, that work at early stages with this disease.

Not one is approved or proven. Why is that? Because the system is set up as follows: In order to get something approved or, you know, to be considered proven, you need a big pharmaceutical company to do a big somehow pristine and unassailable randomized control trial. Not that they're unassailable. They're considered to be such.

Once you have that trial, then you can go to regulatory agencies and health agencies and then get approval. Everything else, no matter how much evidence I bring forth in my lectures, whether it's, like my colleague said, dozens of studies -- and let's take Ivermectin for an example. Right now Ivermectin sits on 67 controlled trials involving 49,000 patients. Thirty-two of them are randomized controlled trials and 16 are double-blind perspective randomized controlled drugs. Almost every single one shows benefit.

In summaries of those, the benefits are massive not only in prevent -- and I heard earlier in the hour that there's nothing else but vaccines that work to prevent transmission. That is absolutely a ludicrous statement. That's what they want you to believe. That is not true. There are alternatives to vaccines and there's a lot of

trials showing that, not only epidemiologic but also perspective to trials.

That evidence base is so massive. That's why that makes this conversation absurd, absurd. Because any evidence I bring, you know what those in power can do? They do this all the time. They use the following terms -- and these are really -- these are terms you need to listen for and key in on. You hear terms like insufficient evidence, low-quality trials, small trials. And many of these trials are coming from foreign lands and they're not to be trusted and not to be believed. I see this over and over and over again.

And so this war on repurposed drugs in favor of for-profit drugs is hurting people. People are dying. Until these monoclonal antibodies came on scene, which I actually have problems with -- I do believe they're effective, but, boy, they have to be given early and there's not full access to them. And try getting them when someone falls ill on a Friday night. It's not easy. And when you give them late, I've seen patients who don't do well. The antibodies are not good for late disease.

And so they are not the panacea that we all want them to be. But there are many, many other alternatives. And they're being blocked. Not only are they being blocked but the doctors are being attacked. And here's the other

thing that no one wants to talk about. Prior to this pandemic when there was a guideline on how to treat a disease, it was called a guideline. We never heard the word mandate. Let me read to you -- let me read to you what the NIH says in their guidelines on how to treat COVID.

They essentially say in the introduction, the last paragraph, they are very clear to say that these guidelines are not mandates and they should not substitute the judgment of the physician and their judgment of the patient and patient's circumstances. No guidelines should ever supersede the expertise and knowledge of that patient at the bedside.

And yet what I've seen in COVID is that we don't do guidelines anymore. We do mandates and restrictions. It's happening in the hospitals. And now it's happening at the Medical Boards. I have never had to treat patients so deathly ill with two hands tied behind my back.

I'm an ICU specialist. I have treated patients throughout this pandemic. I get every phase of the disease, early, middle, and late. I have seen hundreds of patients coming to my ICU dying. You know why they're dying? They're not dying of COVID. They're dying of horrific undertreatment. They're dying of corruption from every phase of this illness, the lack of alternative or championing the repurposed drugs. They're coming

undertreated. They're coming in with late-phase disease. They get to the hospital. They're given Remdesivir, Remdesivir, which is an absolute fraud and a joke.

And if you look at my testimony -- let me bring out the core of my testimony, which is these two concepts, the dozens, many dozens of trials -- I've already talked about Ivermectin, 67 trials. Hydroxychloroquine is 200 trials. Fluvoxamine, which is the newest one that is being now distorted and suppressed by the health care system, Fluvoxamine, which is a well-known antidepressant, known to have anti-inflammatory properties, it now has, in three studies from high impact journals, one large observational control trial and two randomized controlled trials.

One of the randomized controlled trials was done by McMaster University, one of the world's top universities, highly funded large trial in Brazil, randomized control trial and showed a massive reduction in hospitalization.

Let us be clear. That is a repurposed drug. Do you guys want to guess what our health care system has done since the publication of that trial? Have they approved it? Have they recommended it? They have not. The Infectious Disease Society of America reviewed the existing evidence based on Fluvoxamine in early November and this was their opinion. It should not be used outside the context of a clinical trial. How many more trials until they recommend a

repurposed drug?

Let us contrast that with molnupiravir. Molnupiravir. Molnupiravir, which is a $700 drug that they contracted with the United States Government, they are going to sell it to the government for $700 a dose. It cost $19 to make. They are going to sell it for $700. It just got FDA approval last week.

And when they presented that data -- this is the data from molnupiravir. Number 1, the data that they presented in a press release, they gained the first half of the data a month ago. They actually blasted a press release showing that there was a 50 percent reduction in hospitalization. That's a month ago.

When they went to the FDA they showed the data that they collected after the analysis that they blasted on a press release. In the second half of that trial, placebo outperformed the drug such that the final results is that it only had a 30 percent reduction in hospitalization. I don't know why in the first half the drug did better than placebo. But the second half the placebo did better than the drug. Overall, it was minimal. It was one study. By the way, that is one study in mild patients. One single study and they got FDA approval.

Meanwhile, two large studies on moderately ill patients in India were stopped early for absolutely no

effect. And then Merck themselves did a study on hospitalized patients which they stopped early for business reasons.

So here you have a drug that has four trials, three of them failed for no efficacy, one has very minimal benefits with a lot of suspect around it and yet it meets FDA approval. Meanwhile you have Fluvoxamine, a decades-old, off-label, repurposed drug, which is sitting on a number of randomized control trials and doesn't have approval.

So when I have to hear that something is approved or proven and I'm doing stuff that is not approved or not proven, I absolutely have to laugh at this point. And that's just an example of Fluvoxamine. And I could go on and on.

What is the criteria for proof? You're telling me that 67 studies in 49,000 patients with almost every study showing some amount of benefit and then in the summaries of studies all around the world, that analysis is showing that it works not only in reduction of transmission, hospitalization, mortality and death.

You have health ministries around the world for Ivermectin. Mexico City a year ago did an early test and treatment with Ivermectin. They showed up to a 75 percent reduction in hospitalization. They emptied their hospitals.

Uttar Pradesh, probably one of history's greatest public health achievements, essentially eradicated the disease with widespread prophylaxis early treatment and postexposure prophylaxis of contacts. They literally eradicated the disease.

If you look at Japan right now, one of their top -- one of their doctors and the head of one of their major medical associations during a big surge in August said to all the doctors, start using outpatient. Clinics everywhere started to advertise that they started using Ivermectin. They have the lowest number of COVID patients in the hospital right now.

It's happened over and over and over again. You have 39 countries which recommend Ivermectin. So it somehow works outside the U.S. but it doesn't work in the U.S. And 28 percent of the world's population lives in a place where it's recommended. Yet I have to get under the threat of my medical board in order to use Ivermectin.

And Hydroxychloroquine is actually even a more colossal fraud and corruption. I don't even want to go into that because they already killed that in 2022 with numerous, numerous actions of fraudulent studies published in papers and really horrible studies that were designed to fail.

You know, when they studied Hydroxychloroquine, an antiviral, almost every single study was in the hospital

phase. Any doctor who knows anything about infectious disease knows if you're going to use an antiviral you use it in the first phase of symptoms. Once they proved it didn't work in the hospital, guess what they did to the early outpatient trials? They cancelled them. They cancelled them. Dr. Fauci cancelled two active outpatient trials of Hydroxychloroquine early treatment.

Does anyone want to guess why they cancelled those early trials? They cancelled them because they cannot have an approved medicine in that phase, in the early treatment phase. You need to keep the lanes open for molnupiravir and Paxlovid. The attacks on Ivermectin throughout media, the CDC bulletin saying that everyone is filling up ERs with overdoses and that this is a horse dewormer, it's all a PR campaign. It is what pharmaceutical companies do. They have done this for decades. It has just become -- it's just unsupportable and unconscionable.

I'm going to finish here . And that's why it's time for the lawyers and the legislators. I'm sorry if I'm upset but I'm literally fighting a war from inside a system that is rotten to its core around these novel therapeutics. They do not allow for the use or championing or advocacy for repurposed drugs. They don't make enough profit. And they present as a threat to alternative therapeutics.

And I have had it. And I'm so sick and tired of

people calling me literally crying because they need help. And then I try to prescribe them medicines because they are acutely ill. And the pharmacist says, no, we can't prescribe that. If this is for COVID, we wouldn't do it. They're all in fear and brainwashed by these agencies telling them not to do it.

And you guys don't know what it is to care for a patient when you know that every single day's delay in an effective antiviral therapy leads to a worse outcome every single day.

You know, those of us on the inside, we can't keep doing this. I mean, you have to fix the system. And this legislation would be one small step in doing that, one small step in allowing doctors to more freely practice to help their patients without these ridiculous restrictions which have never happened historically. It's called a practice of medicine. I've never even been told what medicine I should or shouldn't use. I've been told the ones that the experts think that is best to use, but I've never been restricted from using a drug that I thought was helpful.

And with that, I'm going to stop.

MAJORITY CHAIRWOMAN RAPP: Thank you, Dr. Kory.

We appreciate, you know, that you're here virtually. Thank you for your testimony.

The last testifier for the panel is Dr. Amesh Adalja, who is Senior Scholar at Johns Hopkins Center for Health Security.

Welcome, Doctor. Please proceed.

DR. ADALJA: Thank you, Chairwoman.

Chairwoman Rapp, Representative Frankel, distinguished members of the Committee, thank you for the opportunity to testify.

My name is Amesh Adalja. I'm a Senior Scholar at the Johns Hopkins Center for Health Security at the Johns Hopkins Bloomberg School of Public Health. The Center for Health Security is a public health think tank focused on infectious disease, emergencies, pandemic preparedness, and the intersection of infectious disease and national security. I have been there since 2008 since I was interning in infectious disease.

The opinions expressed here are my own and do not necessarily represent those of Johns Hopkins University. For the record, I'm a Pennsylvanian, born in Philadelphia, raised in Butler County, currently living in Pittsburgh. I'm actually in Representative Benham's district. And Representative Bonner represents part of my hometown area.

I practice infectious disease and critical care and emergency medicine both in Pittsburgh and Butler. I've seen hundreds of COVID patients throughout this pandemic in

all settings, in the Emergency Department, as an infectious disease consultant, and as a critical care specialist.

My work at the Center, I've been a national spokesperson for COVID. I've written multiple pieces on COVID and its treatment, pandemic preparedness. I testified in front of the House Foreign Affairs Committee in Washington on pandemic preparedness.

What I'm going to talk about today in my brief testimony is less about the science. I'll take questions on the science and the treatment of COVID, but I'm going to talk just about this bill and kind of what we're discussing.

And I think it's important to start out with saying the off-label use of medications approved by the FDA for indications other than their intended use is a vital mainstay of the practice of medicine. That's been true before. It's true today. And I agree with panelists that have said that off-label medication is very common and necessary.

I think it is something that should be sacrosanct and an integral part of what it is to be a medical professional. You have to use your judgment, look at the data and make decisions. Off-label use of drugs is a practice every physician engages in on a daily bases to the great benefit of patients.

I want to talk about off-label use of

medications. I draw a distinction between judicious and injudicious. Judicious means that there is some reason. There's sound medical judgment behind the use of that drug. There is some level of evidence. There is some equipoise on whether this works or doesn't work and may not necessarily be something that's been submitted for FDA approval for that indication, but you have some evidence base, something that you can look at to actually show that this may work and won't cause harm.

Now what I draw a distinction from is injudicious use of off-label prescribing. And that is often not necessarily about the drug itself. But when using a certain drug and it's accompanied by steering away a patient from something that's known to be efficacious, that's an efficacious preventive, efficacious treatment, where it's not being used complementary but used as a substitute, that's where I think there's a distinction to be drawn.

I think if a doctor, genuinely uncertain about the benefit of treatment with a specific medication, prescribes it safely, the appropriate dose, counsels the patient about it, directs the patient to other measures that should be utilized in concert, and does not view the treatment without a strong evidence base as the substitute for something where there is incontrovertible evidence, I don't think there's a place for disciplinary investigation.

And I don't think the State Medical Board would actually initiate one.

Indeed, if you talk about Ivermectin, if you look at the guidelines, the NIH guidelines say they don't recommend for or against its use. So I don't think that there should be disciplinary investigations if this is done judiciously. Where I think there is an issue is when a physician actively steers a patient away from something that's a standard of care or a preventative that's known to be effective and offers something else as a substitute, I think doctors have a professional obligation to have a good and sound medical reason when they deviate from standard of care. And I think failure to do so in some instances in which a patient can be in danger is malpractice and is unprofessional.

If State Medical Boards are to exist, they must be able to investigate unprofessional conduct by its licensees. It's one of their core functions. Shunning evidence-based practice and breaching a standard of care without biologically plausible sound reasons are actions that can and are investigated by such bodies.

I think there's room for discussion about the scope and function of medical boards. But a bill that specifies ad hoc changes to the board's purview concerning a single illness that's in the headlines right now can't be

justified. I feel it represents an intrusion of politics into medical decision-making.

Thank you for the opportunity to testify. And I'd be happy to answer your questions.

MAJORITY CHAIRWOMAN RAPP: Thank you, Dr. Adalja. And my thanks to the entire panel.

I just wanted to say my comments and then we'll begin with questions from members. I would think that the one person that the people of Pennsylvania want to trust to be in their lives right now is their physician. And it is disturbing for me to hear, you know, about what is going on. And we've been hearing it for a long time about what's going on with Ivermectin, Hydroxychloroquine, and what's going on with what many refer to Big Pharma versus what our personal health care providers would, you know, prescribe and recommend to us. That one person that we want to trust is our physician.

And I appreciate the fact that the four of you do believe in science. You believe in the science and you believe in the studies. It's just not the studies that some people want to recognize. And they don't want to recognize the science that you bring to us. So I very much appreciate your testimony.

And at this point in time Representative Zimmerman is our first questioner unless, Representative

Frankel, do you have any comments or would you like to wait until the end?

MINORITY CHAIRMAN FRANKEL: I'll save my comments until the end. I do have a questions though.

MAJORITY CHAIRWOMAN RAPP: Thank you, sir.

Representative Zimmerman.

REPRESENTATIVE ZIMMERMAN: Thank you, Madam Chair.

Thank you, guys, for your testimonies. Real good information. In my district, we've had a number of incidents of some kind of bill results with this Remdesivir. And Dr. Johnson's earlier statement or in her written statement says Remdesivir used in hospitalized patients early in the course of their illness has antiviral effects to decrease viral replication.

The question is, do you have any idea why FDA is recommending this treatment option? And also who's actually recommending against it? And again, I'll say that in my area, we've had a number of individuals that have contacted myself and had some really poor outcomes with this.

So I'd be interested in hearing from anyone that would like to respond.

DR. PIERRE KORY: I would love to respond to that. So in continuing the theme of my testimony, right, you answer a really great question. So Remdesivir is

purportedly an antiviral. If you know anything about this disease, it occurs in phases. The first early outpatient phase is what we call the viral replicative phase and it presents as a viral syndrome with all the things that viral syndromes bring, right. So cough, fever, shortness of breath, fatigue, myalgia, muscle pains. I believe mostly a lot of fatigue, sometimes congestion or sore throat.

In the unfortunate minority, some descended to what we call the pulmonary phase, which is essentially a reaction of the lungs to virus or viral particles. It's not necessarily an invasion of the virus into the lungs. But it's a hyper-inflammatory reaction. That is a later phase.

A third really important part you have to understand about COVID to understand what I think is the absurdity of Remdesivir is that viral replication, active replicating a virus that is culturable generally is not able to be cultured or found after about Day 6 or 7 of symptoms. And it varies. In maybe one instance they found it on Day 9. Most people get admitted to the hospital somewhere around Day 7, 8, 9, or 10.

So we have a system which in this country we use a very expensive $3,000-a-dose intravenous drug beginning in the nonviral replicated phase with a drug that purportedly works on stopping viral replication. Why would we do that? Because it's easy to administer that. It's an intravenous

drug. It has to be given daily. And so it's very hard to do that as an outpatient. That's No. 1.

And No. 2, if you look at the studies supporting Remdesivir, this is where it gets really, really ugly. The two trials which showed benefit, they showed extremely modest benefit and both were conducted by pharmaceutical companies. The independent trials done around the world, including the WHO -- and by the way, I do not hold the WHO any higher than the other agencies right now. The financial influences running through all of them are just astounding. But for some reason they diverged in Remdesivir. There's like almost a crack in this wall of corruption.

But the WHO trials and the Chinese trials and all the independent trials not done by pharmaceutical companies found zero benefit in the hospitalized patient with a trend to harm. The WHO does not even recommend Remdesivir for the world to use. Yet in the U.S. it's standard of care.

And I really appreciate the prior physician, Dr. Adalja's comments about judicious and injudicious use. The one thing I would caution him about his paradigm, because he kept using standard of care, what happens when the standard of care is corrupt and based on bad science? Then we're all in trouble. And that is what I'm seeing.

I'm seeing a standard of care that's being determined by those under massive financial influence.

Let's be clear. Remdesivir is the standard of care in this country in the hospitalized patient. It failed in Ebola. It had worse outcomes. It's known to have many toxic side effects yet it's routinely used. And if you're a doctor right now, try working in a hospital and saying, I don't want to give my patient Remdesivir. Do you know what kind of attacks will rain down upon you particularly from the medical staff and the administrator?

Because here's another little caveat that you guys may not know. This country -- this is how much under the influence we are of the financial industry -- we have legislation which gives a 20 percent add-on payment to all hospitals using Remdesivir. If they use Remdesivir, they get a bonus. They get a bonus. If you think I'm making this up, I'm happy to submit to the Committee the legislation does show that.

DR. ADALJA: I just have a few comments.

DR. PIERRE KORY: I don't know if I answered the question. But I did give my thoughts on Remdesivir.

MAJORITY CHAIRWOMAN RAPP: Yes. Thank you.

Doctor, if you'd like to comment.

DR. ADALJA: I have a few comments.

I do agree with Dr. Kory that Remdesivir is not a knockout punch. The benefit is very marginal. It gets people out of the hospital quicker. It is a mainstay of

treatment but I think -- I myself have refrained from using it in certain patients especially if they're very sick because I don't think it's going to even have that benefit of getting them out of the hospital. I think that it's not one of the great drugs. It was, as he said, repurposed from Ebola. It's the only thing we had early on and there was enthusiasm about it but it really hasn't been a major driver of improved outcomes.

It is something that's heavily used. I think it's because of the benefit that was shown, which is very marginal, of getting people out of the hospital faster. That's what it was really touted for. But it's not -- it shouldn't be considered the workhorse. And it has to be used appropriately. You have to dose it appropriately because there are side effects from it. But it hasn't been as promising as people thought it would be.

REPRESENTATIVE ZIMMERMAN: Thank you.

Thank you. I appreciate the responses.

Thank you, Madam Chair.

MAJORITY CHAIRWOMAN RAPP: Thank you, Representative Zimmerman.

Representative Kosierowski.

REPRESENTATIVE KOSIEROWSKI: Thank you, Madam Chair.

I have two questions, one for Dr. Wheeler and

then for Dr. Adalja.

So, Dr. Adalja, when you spoke about the usage of off-label drugs and you spoke about, you know, the importance of using it in complement with proven treatments rather than, you know, a substitute and standard of care, that other repurposed drugs -- because I know that this is all about pharmaceutical companies and, you know, doing clinical trials, not doing clinical trials, the expense of the drug. You know, are there other medicines that are treating COVID-19 patients with good outcomes that may be a cheaper form of an off-label repurposed drug?

DR. ADALJA: Sure. Thank you for that question.

So one of the mainstays of what we do do in the hospitals is the use of a drug called Dexamethasone. This is a corticosteroid. And this is a cheap, generic corticosteroid just like a steroid you might take when you get poison ivy. But what we found -- and Dr. Kory alluded to this pulmonary phase when people's -- when the viral phase is kind of over and you get this inflammation in your lungs -- one of the things you can do when a patient needs oxygen is give them Dexamethasone. And what it does is it decreases the inflammation.

And it was a drug that they did clinical trials for outside of the United States, primarily in the United Kingdom, and they saw a mortality benefit. And this cheap,

generic drug has become a workhorse. And we use it on any patient that comes into the hospital that requires oxygen we use Dexamethasone for. And I think that this has probably been the single biggest advance at least in my treatment of COVID patients when we had that in terms of improved in-hospital mortality. I think it's remarkable.

REPRESENTATIVE KOSIEROWSKI: Thank you, Dr. Adalja.

DR. PIERRE KORY: Can I make a comment on Dexamethasone?

REPRESENTATIVE KOSIEROWSKI: Yes.

MAJORITY CHAIRWOMAN RAPP: Yes, Doctor. Go ahead.

DR. PIERRE KORY: Sorry to be the -- boy, am I Mr. Negativity. I really wish I didn't have to be. But Dexamethasone is actually the one repurposed drug that has actually met the standard of care worldwide. I would like to remind the audience that I gave testimony in the Senate back in May of 2020 saying that a corticosteroid use was critical in this disease and that people were dying because of the lack of corticosteroids.

I did that at a time when every national and international health care agency was recommending against the use of corticosteroids. Those of us on the front lines who are treating this, we knew. We knew months before. And

we were screaming for it to be used.

When I testified, I endured months of attacks and condemnation and recklessness for my advocacy until it became standard of care worldwide, like Dr. Adalja said, because of one randomized control trial.

Here's my negativity. Dexamethasone at the dose in which it's used and which it's approved, they tested a dose or two. It's 6 milligrams of Dexamethasone. It is an anemic dose. It helps a few and fails the many. I see so many patients dying throughout the pandemic from insufficient use of steroids.

Does anyone want to know why they use such a low dose? Well, I can give you my very cynical guesses. And I actually have evidence to show that it's correct. They use a low dose. They needed to leave the door open for novel other anti-inflammatory medicines to enter the market.

And guess what? If you look at the NIH guidelines today, it is using this very low dose of Dexamethasone with drugs all very expensive, other anti-inflammatory drugs. I am an expert in corticosteroids in COVID-19. I have at least ten trials showing massive additional mortality benefits if you use higher doses of corticosteroids earlier. Yet our national guidelines right now is to put everyone on 6 milligrams of Dexamethasone.

I agree with my colleague that it was a game

changer. But I will tell you it's insufficient. It helps a few and fails the many. And we will never get our agencies to advocate for higher doses. They are not studying higher doses. Or when they do, they start out at minimally higher doses. There's just a trial which tested 12 verses 6. And there was a trend towards better, but that's not that much bigger of a dose.

So I just have to say that the lack of like expert doctoring -- we wait for these trials while people are dying. We wait for this big trial or for the agency to do the trial and design the trial and the dose and the drug that they want to use. And then when they decide what that is to tell us, meanwhile I got patients dying. I've got to do the best I can.

And again, I need the freedom and autonomy to be the expert that I am. I cannot be like beholden and shackled to some standard of care which is determined largely by agencies and desk jockeys, not people at the front lines. So again, it's about autonomy. We need the freedom to practice our expertise.

MAJORITY CHAIRWOMAN RAPP: Thank you, Doctor.

REPRESENTATIVE KOSIEROWSKI: I just wanted to ask the Doctor a quick question.

MAJORITY CHAIRWOMAN RAPP: Sure. Go ahead, Representative.

REPRESENTATIVE KOSIEROWSKI: So, Doctor, you just spoke about the Dexamethasone being used at 6 milligrams and not being able to give a higher dose to patients that may need it. And then you spoke about other drugs that are given in lieu of the Dexamethasone.

Just remind me because I'm not familiar. Are these drugs that you just spoke about, are they steroids? And are they much more expensive? Because I thought steroids were kind of cheap to use.

DR. PIERRE KORY: No. You're getting it very close to right. So Dexamethasone is a very cheap off-purpose decades-old drug and it is in use. And those other drugs, those are actually like cytokine blockers so they will attack one facet of the big inflammatory cascade. And they're used in conjunction with Dexamethasone.

I've got to tell you as an expert at lung disease and lung injury, I don't need the ids and abs. I just need a higher dose of corticosteroids upfront that has much wider suppressive activity and my patients would do quite well.

But you know what? The ids and abs are now, if you look at the guidelines, the ids and abs are right on there as standard of care. They want you to give the low dose steroid with the ids and abs. And those are very profitable and expensive.

REPRESENTATIVE KOSIEROWSKI: Okay. Thanks,

Doctor.

And you just answered my question about why you cannot prescribe a higher dose of Dexamethasone because that is the standard of care?

DR. PIERRE KORY: So you can but the general starting point is 6 milligrams. And you know, I see people start to go higher so doctors still can. So I will say in the hospital they do have autonomy with that but it's generally that they're all very cautious because 6 is the standard. So they might double it, which is not that much bigger of a dose.

Keep in mind so 6 milligrams of Dexamethasone is about 32 milligrams of prednisone. In my outpatient practice for an 80-year-old with emphysema or an asthmatic, I give 40 milligrams of Prednisone.

So here you have patients in advanced respiratory failure on maximum levels of oxygen support, whited-out lungs and on ventilators and they're giving less corticosteroids than I give a 24-year-old who is wheezing from a springtime asthma attack. Absurd.

REPRESENTATIVE KOSIEROWSKI: Thank you.

MAJORITY CHAIRWOMAN RAPP: Thank you, Doctor.

REPRESENTATIVE KOSIEROWSKI: And one quick question for Dr. Wheeler over here.

MAJORITY CHAIRWOMAN RAPP: Sure.

REPRESENTATIVE KOSIEROWSKI: I just have to address one thing that you said. When you talked about pain scales and the use of narcotics and opioids, having worked in pain clinics -- I'm an RN and I worked for 27 years in orthopedics. I worked in pain clinics -- you use pain scales all the time.

When you talked about the policy, whom are you referring to that said, hey, if you're a 7 on a scale of zero, no pain, you're looking great, 10, you want to jump off a bridge, you are in so much pain, when you spoke about the policy that was dictated on how much narcotics to prescribe, whom are you referring to?

DR. CHAMINIE WHEELER: That's a great question. Basically those policies were actually coming from our hospital administrators, protocols that were set in place that would have the standard set of orders that actually have, you know, basically bullet points that say scale of this, this. These are your choices. There are standard orders that are in our electronic medical records that you collect and you do this.

So if a patient is asked -- I mean, I have this often in pediatrics, you know, a child may be laughing and giggling and watching their iPad and you go in there and, are you having belly pain? And they are having a good time, whatever. And they say their pain is an 8, you know, and

you have to -- I mean, we don't do it in our hospital because our nurses are fabulous about making sure that 8 is a true 8. But often in the beginning of all of this stuff, in the beginning that 8 would get drug X because it is in our protocol.

And like so as a clinician and as an RN, you know when somebody is laughing and giggling, we use the abdominal muscle and all of that. If you are in significant pain, you would not be able to use abdominal muscles. You wouldn't want to cough because it hurts. That type of thing.

So that clinical decision-making, that judgment, is what's often hindered. And opioids is not an issue in the pediatric population. But the reason I made that is because it was brought up about it.

REPRESENTATIVE KOSIEROWSKI: Thank you.

Maybe because I was in nursing in 1990. We didn't have a clinic. We didn't have, you know, computers that already -- you know, clinical standards were out there.

DR. CHAMINIE WHEELER: And that is very true.

REPRESENTATIVE KOSIEROWSKI: We didn't use that.

DR. CHAMINIE WHEELER: When I was first in residency everything is in the electronic records and almost everything we order, there's an order set. And you click on your orders.

REPRESENTATIVE KOSIEROWSKI: Thank you.

MAJORITY CHAIRWOMAN RAPP: Thank you, Doctor.

Are you finished, Representative, then?

REPRESENTATIVE KOSIEROWSKI: Thank you.

MAJORITY CHAIRWOMAN RAPP: Representative Klunk.

REPRESENTATIVE KLUNK: Thank you, Madam Chair.

Just a question about some of the preventive side of things. What I'm hearing from constituents is, you know, they are asking, hey, I have the vaccine. I'm doing my part. But what else can I do to make sure that if I get COVID it's not as bad? Or even if they are not getting vaccinated, what can I do in my everyday life to prevent it from a medication standpoint?

And I know some of the doctors you've talked about, some of the vitamin cocktails, if you will. And what we're hearing from folks who are in the hospital who come out, those doctors who are treating those with really bad COVID are giving them, you know, vitamin D, zinc, whatever that mix might be in the hospital.

And they are telling them, hey, if you know people, get them on a regimen of taking some vitamins, taking that vitamin D, taking that zinc.

So what would you recommend to, you know, patients who are coming in, you know, for a physical, say, right now? Every year you go in for your updated physical. Are doctors or any of you looking at patients and saying,

hey, you know, the vaccine is available. Get your flu shot. But also you might consider taking a mix of these vitamins. Is anyone talking about that with patients? Is there that standard of care out there? If not, what is hindering that?

DR. PIERRE KORY: So as a member of a group of highly published physicians who have come out with protocols, we have prevention, early treatment, hospital, and long-haul COVID protocols.

We have a prevention protocol which is evidence-based. We have to go back to one of the beginning themes of this whole testimony, which is the terms of proven and approved. So are they proven or approved? There's sufficient evidence to me and I know that they work. There are dozens of trials on a number of different agents that show a drastically reduced risk of transmission and contraction of this illness if you use the following. You mentioned vitamin D.

There are now dozens of trials repeatedly showing the following: Your chances of getting the illness are higher if your vitamin D level is lower. Your chances of having a worse outcome is higher if your vitamin D level is lower. If you have a higher vitamin D level, your chances are lower of getting the disease and your chance of dying is now approaching near nil if you have a level above 50.

There's numerous trials and a lot of

sophisticated data. Yet there's no big perspective randomized control trial that our government has done. The supporting evidence to show that having an appropriate vitamin D level is overwhelming. It would be reasonable and sound medical practice to test your patients for their vitamin D level and supplement accordingly for fear that they get ill and to prevent them from having a bad outcome. It's just good medicine, whether it's proven or approved -- it's certainly not approved.

It's not in the guidelines. And I will tell you that that's another astounding behavior of allegations which they have known for decades. The FDA has data going back decades. And a huge portion of our population is vitamin D deficient, especially in low income areas, poverty-stricken areas. In the northern cities, we have endemic vitamin D deficiency especially in the winter. Why we don't have a national protocol of testing and supplementing really defies for me reason and logic. So I think that would be a reasonable thing.

Trials for other medicines -- so, for instance, Ivermectin has the largest evidence base. Every single trial that's been done that's perspectively looked at patients who are taking Ivermectin regularly in this pandemic shows a wickedly lower risk of getting the disease.

And there are many mechanisms of action which I

will spare you. I can do an hour of the science as to why that happens. But it's well-defined. Just so you know, Ivermectin is not like something that we pulled out of a hat for COVID. There's ten years of studies showing numerous mechanisms of Ivermectin as an antiviral. It essentially attaches to very tightly the protein, preventing entry. So it has very good rationale for why it would prevent transmission.

And let me bring you back, like my colleague did, to the example of Uttar Pradesh in India. In India in Uttar Pradesh it's a state of 241 million people. After the big surge of Delta in April and May which captured all of the headlines, they redoubled their program.

And their program involved over 70,000 health care workers who traveled throughout the state, 97,000 villages, all doing rapid testing. Everybody that they tested that was positive got Ivermectin treatment. Everyone in the household got postexposure prophylactics. Every health care worker took Ivermectin.

And after the months of doing that, in September, they started to find that in their last two and a half million tests, they had 201 positives, which is a positive rate of .007 percent, which is effectively zero. They reported that 67 out of 75 districts in their state had not one active case. That would be akin to our Federal

Government announcing that in 40 states of this country there was not one active case of COVID.

And that is a state that I think is historically -- a historic public health achievement. It was a massive, massive public health intervention. It's not from lack of testing. If anything, they were the highest tested state in India. It shows you the benefits of just that one drug in prevention. And there are others but those are the most profound.

So, yes, there are alternatives. And when you look at the protection -- you mentioned vaccinated versus unvaccinated. Let's be clear. There are many breakthroughs. There's magnitudes of breakthroughs with these vaccines. Prevention would work for anyone, vaccinated or unvaccinated, in addition to or for those who can't or don't want to get vaccinated. And so there are alternatives but you just don't hear about it.

In the guidelines they are very clear. They say the following: Here's three statements. Do not use any medication to prevent this disease. They call out Hydroxychloroquine specifically. Do not use Hydroxychloroquine. And do not use anything in postexposure prophylactics. They are really clear. They don't recommend anything else to help the average citizen prevent from getting this disease. That is the current NIH guidelines.

That is the standard of care.

DR. ROBERT SCHMIDT: I'd like to answer that.

So every patient that comes -- you know, I'm doing all outpatient medicine -- if they haven't been given the information already, they are given instructions on taking vitamin C, vitamin D, and zinc. That is recommended.

I give them other information about medication. And the most important thing I tell them, other than that, which is important, is that if they get diagnosed, they have to call my office immediately so they can get on Ivermectin because they are not going to get it in the hospital. And that's been relatively successful so far.

I've had three patients with massive numbers of risk factors. They have lived on Ivermectin. They still went in the hospital. So had they been able to continue it, they might have done better. They have been discharged from the hospital. This medicine is for real.

And I think the problem we're facing, which was alluded to by Dr. Kory, is what's been going on since Google, that dehumanization of our society. We are no longer people to have compassion or to help have a good life. We are profit centers to be manipulated so that -- what do you want to call them -- obscene or excessive profits can be made. When I started medicine 40 years ago, this kind of discussion never would have occurred. We would

just have started the treatment using something new off-label and you'd start doing it.

To answer the other Representative's question about repurposed drugs, when I started residency, aspirin was a main antirheumatic drug. It's main purpose was to treat arthritis. Yet as soon coronary bypass and cardiology came along, they had known about the effects and now that's basically the main purpose. You don't even use it for arthritis anymore. So the repurposing of drugs has a great history.

The only difference now is, you know, I hate to say it but it's profit. We are being prevented from treating people like we always have been treating for things that I'm discouraged to say I agree with Dr. Kory.

MAJORITY CHAIRWOMAN RAPP: Thank you, Doctor.

Representative Klunk, does that conclude your questions?

REPRESENTATIVE KLUNK: Yes, thank you.

MAJORITY CHAIRWOMAN RAPP: We did discuss a little bit about Dr. Johnson not wanting to recommend zinc or some of the others.

DR. PIERRE KORY: The studies are there, Madam Chairwoman.

MAJORITY CHAIRWOMAN RAPP: Thank you very much.

Representative Keefer, you're on the list but I'm

going to wait and give you last before Representative Frankel, if that's okay.

REPRESENTATIVE KEEFER: Okay.

MAJORITY CHAIRWOMAN RAPP: Representative Borowicz.

REPRESENTATIVE BOROWICZ: Thank you, Chairwoman Rapp.

And I appreciate you doing this. I talked to a doctor last night and they said we are the first Legislature in the state to hopefully expose what's going on behind the scenes. I appreciate you guys.

Dr. Kory, I believe that this is going to be instrumental in exposing what's really going on because if this was about treating COVID, we wouldn't have these situations. It's about control, exactly like Dr. Kory said. And that is a scary place to be in this nation.

I think Ronald Reagan said, if government can get into our health care, they can get into every aspect of our lives. And that's exactly what we're seeing right now, withholding of Ivermectin and doctors' medical licenses being threatened. It's a shame that our doctors have to be put in this position.

And I thank each one of you guys for standing up against it and doing what's right for your patients. I know it's not easy, but doing what's right is not easy. And so I

appreciate you guys. This is a real scenario and situation that we're dealing with. I do have a question after I got all passionate about that. But thank you. Thank you for being here and exposing what is really going on and the truth.

I'm hearing over and over -- I put out a post about please tell me your story -- hundreds of people writing saying, you know, my loved one had Remdesivir and then went into kidney failure. Does Remdesivir cause kidney failure? It seems like that is repetitive. And I'm not a doctor by any stretch of the imagination, but it seems like that's a repetitive repercussion or side effect from taking Remdesivir. Is it?

DR. ADALJA: I can start. So Remdesivir does have side effects that can cause a kidney injury. Sometimes it's hard to tease out whether it's the drug toxicity versus the sickness of the person itself because COVID itself can cause people to go into septic shock and have kidney problems as well. So sometimes it is, I guess, an interaction between Remdesivir and the illness. But, yes, Remdesivir does have side effects that can cause kidney disease and kidney damage.

Again, it's not the best drug to give. I think it's something that maybe gets people out of the hospital faster in the best case scenarios. But it's not the drug

that we hope for. It's not a knockout punch. And it has side effects.

DR. PIERRE KORY: I would just agree with that. I mean, yes, it is difficult in the individual patient to know what is causing the kidney injury especially later in the hospital phase.

But everything I do as a physician is some estimation based on the complete knowledge base that I possess of a risk-benefit ratio. And if you have a drug that has a high amount of side effects and you have very minimal evidence that it's truly going to alter the course of their illness, you're failing that risk-benefit ratio. And to continue to use Remdesivir blindly and dogmatically in the hospital given its side-effect profile and its minimal benefits found in trials is to me malpractice.

However, that happens to be the standard of care. But to me, as a physician at the bedside, I find it malpractice to use that drug in a hospital phase of illness given its side effects and given the sum total of the evidence which is all of the randomized control trials from around the world show no benefit. And the independent ones show a trend to harm. Standard of care in this country.

DR. CHAMINIE WHEELER: I wanted to talk to you about what you said about the trust and the medicine and the power and the control. So Dr. Johnson in her testimony here

said that the Department of Health does not, quote, weigh in on medical treatment.

However, they may not exactly say a doctor needs to do X but our Pennsylvania Department of Health on August 26th, 2021, put out a health alert against Ivermectin. This is a two-page health alert. So they do weigh in on medical treatment. This is the health alert. And in this health alert in the summary section they did say -- you know, I started with the hypocrisy in medicine, the misleading information that's given -- they talked about adverse events associated with Ivermectin misuse and overdose are increasing as shown by a rise in calls to poison control centers and people are experiencing adverse effects.

So as a physician, we get Pennsylvania Department of Health alerts with all kinds of different reasons. When we get something like this, oftentimes we're busy in clinical medicine. We will look at the summary passage. And then we'll look through the rest of it kind of quickly.

And when we look at this summary passage, that's what is highlighted. And then you look at the next page, you would assume this graph -- it's a graph that represents calls to the poison control centers since they said that in the sentence. But it's actually a graph that shows the number of increases in prescriptions to Ivermectin, not calls to the poison control centers.

And then so they had this about it and then they cite two examples of specific overdoses. And in those two specific overdoses that people needed treatment, hospitalized, one was an adult who took an injectable dose of Ivermectin that was meant for cattle, the whole dose and was hospitalized, was discharged from the hospital. And another one was an adult patient taking Ivermectin with unknown strength purchased from the Internet. Neither one of those were given by a licensed physician under their supervision for their care.

So those are the two examples the Pennsylvania Department of Health cited as evidence against physicians from prescribing Ivermectin. So I disagree with Dr. Johnson's statement that the Department of Health does not weigh in on medical treatment.

MAJORITY CHAIRWOMAN RAPP: Thank you, Doctor.

And I think that goes to what we said earlier is that people who are looking at social media, they want to build up their immune system. And so if they can obtain Ivermectin through Tractor Supply but if they are not a large animal owner, they don't realize maybe that you shouldn't take the whole tube because the tube goes by weight of your animal.

DR. CHAMINIE WHEELER: Right.

MAJORITY CHAIRWOMAN RAPP: But it's sad that that

is what they cited. And unfortunately, the mainstream media is at fault with that as well.

DR. CHAMINIE WHEELER: It is so sad because it's unfortunate that our patients feel they have to take a veterinarian formulation of a medication because physicians, their primary care physicians, will not prescribe Ivermectin for fear of losing their license. That's what happened.

MAJORITY CHAIRWOMAN RAPP: Thank you.

DR. PIERRE KORY: Can I add one point to that?

MAJORITY CHAIRWOMAN RAPP: Yes.

DR. PIERRE KORY: That CDC bulletin that went out to all the Departments of Health, the timing of that should be noted. So when the CDC moved to act -- and again I'm sorry to be so cynical but I've had to learn this truth. But the pharmaceutical industry and our health agencies are actually one in the same.

The other way you can understand everything that we've talked about in this testimony is as follows: You can only understand the policies and the recommendations to treat this disease as non-scientific, because they actually failed the science. So if they don't have scientific objectives, what objectives do they have? And I'm arguing that they are financial.

And so when you look at these objectives we have to understand them as having a primarily financial

objective. Let's look at what the CDC did with their bulletin. Do you guys know when they did that? They did that the end of August. And that's the same time where you're starting to see media mentions of these poisonings and you start to see the term horse dewormer start to populate throughout the media.

It was a concerted PR campaign and do you guys know what triggered it? I will tell you. What triggered it is that the weekly prescriptions of Ivermectin hit 90,000 a week in this country. It wasn't because of the increase in poison control calls or the poisonings. It's because the doctors were figuring this out. And it was becoming a widespread prescribed medication, 90,000 prescriptions a week.

And that's when the other side had to move. And I'm sorry but this is a war out there. It's a war for profits. And those that you're watching, the maneuvers that they took to suppress the evidence of efficacy and to malign and discredit not only this drug but those who prescribe it.

And I'm sorry but I have to be very plain and blunt. That timing of that campaign is entirely triggered by the massive rise in prescriptions amongst the U.S. physicians, period.

MAJORITY CHAIRWOMAN RAPP: Thank you, Doctor, for enlightening us with that information.

I believe that Representative Keefer is our last questioner other than Representative Frankel and myself. So Representative Keefer, because she is the sponsor of the bill, may have more than one question.

Representative Keefer.

REPRESENTATIVE KEEFER: Thank you, Madam Chairwoman.

I just want to point out that my legislation isn't specifically about Ivermectin or Hydroxychloroquine, which I do note in the legislation as examples. It's about treatment. And it's about the ability of doctors to practice medicine. It's about patient access to medical care and a patient/doctor relationship.

But that's been hijacked by government and Corporate America. And they have far exceeded their role in affordable health care. And they bastardized the whole process and compromised our access to care to the point where we are now witnessing thousands and thousands of people dying.

And going back to that corporate greed that's been, you know, the premise or suspected premise of some of the action, Merck and Pfizer collectively are making $64,000 a minute right now. So certainly there's some motivation there.

So I want to get to the point of, Dr. Adalja, you

had mentioned, you know, that the risk of my legislation is that, you know, we have intruded into an area that could, you know, compromise medicine. But the fact is that we have already intruded. We are already in knee-deep. So how do we back that up? This should be independent. It should be scientists and doctors that are figuring this out. But I would guess beyond 50 percent of bureaucracy interference of government, non-scientists, non-physicians are making medical decisions.

DR. ADALJA: So that I think is a good question. I think the politics has injected itself from the very beginning of this pandemic on both sides of the aisle. And I think that's made it very hard as anybody that's a subject matter or expert or works in the field to be able to navigate it, because people view things through whatever tribe they are in and nobody actually looks at reality.

My worry with your bill is that by singling this out it's going to make it very difficult for the State Medical Board to actually perform its function. And I think we have to draw a distinction. And I think the Medical Board should do this. They should not be going after doctors who prescribe off-label medications judiciously when they depart from standard of care -- and I take Dr. Kory's point about what standard of care means -- but when they depart from what a reasonable doctor does or what a doctor

does but they have a biological reason for doing so and they're not steering people away from things that actually have shown benefit.

So for example, if you had somebody who was prescribing Ivermectin and then telling people, don't get the vaccine because I'm giving you Ivermectin, this is going to save you, this is preferable to the vaccine, I think that's wrong. And I think you've got to be able to draw that distinction. And the State Medical Board should draw that distinction as well.

So I just worry that this bill will put the State Medical Board in a bad position.

REPRESENTATIVE KEEFER: I accept that. And I can appreciate that. And I'm happy to talk to you and work on some of the language. You know, if they are able to draw that conclusion, that saying, oh, well, you are prescribing Ivermectin in lieu of a vaccine, that that would be, you know, the deal breaker in that you have a patient/doctor relationship. So there may be a multitude of reasons why this patient can't get the vaccine or doesn't want to get the vaccine. I mean, there's a whole host of reasons why there may be this circumstance.

How does the Medical Board get in? Are they supposed to get into every one of those situations?

DR. ADALJA: No. But I think they probably get

complaints. The State Medical Board gets complaints. They take action because some patient or some other doctor writes a letter to them saying, this person, we are worried about this person. So they have to adjudicate that complaint to say does it have merit or not.

And I think if somebody is doing something off-label but in a judicious manner, I think that's one thing. But if somebody is doing it in another way where they are directing people away from things, people that maybe don't have a contraindication to be vaccinated or don't have a contraindication to get monoclonal antibodies, I think there's an issue. And that's what I worry about, drawing that distinction, so that your bill doesn't inadvertently cause bad medicine to be practiced and remove the ability of the State Medical Board to investigate when bad medicine or unprofessional conduct is going on.

REPRESENTATIVE KEEFER: And listen, this is the last thing I want to do. This is not my area of expertise to start mitigating this. But right now the cases that I have heard about as well where they are actually investigating doctors, it's not because of a complaint. It is because of the observation of the prescribing of Ivermectin. That seems to be initiated by the Board, by the prescribing. So it's not a complaint necessarily about a patient.

In fact, they had to contact the patient to see if they were, you know, aware of the prescription and, you know, did they receive informed consent? So, you know, maybe it's something about staying in your lanes. I'm not sure. But I'd be happy to continue that dialogue because somewhere we have to walk this back of where it's going.

DR. AMESH ADALJA: The line I draw is evidence of harm. That should be what the State Medical Board is acting on. And I think that there may be ways to craft the legislation or to talk to the State Medical Board about how to make that distinction between evidence and harm and injudicious use of off-label medications versus somebody that's doing it in a judicious manner even if there may not be a necessary benefit to it.

REPRESENTATIVE KEEFER: Right. I mean, if they had to start investigating every, you know, off-label use or repurposing of drugs, I mean, there's not enough people in Pennsylvania to start reviewing all of those, right?

DR. ADALJA: I agree.

REPRESENTATIVE KEEFER: I think that is it. Just one more area I just wanted to ask Dr. Wheeler about. So if a patient comes to you and they are in the throes of COVID, what course of action do you have other than sending them to the hospital to be admitted? You know, if they are not at that point where they necessarily have to be admitted, what

do you have in your toolbox?

DR. CHAMINIE WHEELER: Right. Exactly.

So when somebody gets sick, the best thing that we do have in the toolbox is to provoke their body to fight what they have. And right now our standard of care is stay home. Stay in your room. Stay locked up. And if your pulse drops, come to the hospital. That is what we are told that we need to say. But that's not what we do say because it's unethical.

So everything that promotes the healing process and promotes our immune system to be able to fight is what we need to promote. That includes rest, you know, hydration, and all of that. But it also includes taking the things that we know boost your immune system. And the fact that medications like Ivermectin that stops the replication, I mean, that's what Tamiflu does.

REPRESENTATIVE KEEFER: Right.

DR. CHAMINIE WHEELER: Tamiflu given early in its course for the flu, that's what -- and Tamiflu actually only decreases the severity of the illness. Ivermectin is to prevent our viruses from replicating, to halt the process so our body can get on top of it so it doesn't go to that Day 8 and that cytokinestorm, that inflammatory multisystem involvement. So that's all we have in our toolbox.

REPRESENTATIVE KEEFER: What you would have done

in SARS-1 that we had, right?

DR. CHAMINIE WHEELER: Yes.

REPRESENTATIVE KEEFER: Were you under these types of restrictions in SARS-1?

DR. CHAMINIE WHEELER: We have never been under this type of restriction ever. Ever. Actually most insurance companies don't cover a vitamin D lab draw -- they said it's too expensive -- unless you know that you have a vitamin D deficiency. Well, to have one, you need a lab draw. So doctors really don't. Vitamin D has been the best word in medicine for probably a good seven years because it has so many different effects of all kinds of stuff.

So no. I mean vitamin D I've told every single person, get your vitamin D. I mean, especially in our digitalized world where we stay indoors so much, our vitamin D, even if we take enough, is hardly -- it has less time to get activated by the sun to be used by our body.

So, no, we have never, ever seen this type of limitation where we can hold to our covenant and say do no harm and to help our patients. And to that there's a -- I have a personal friend, his sister actually died in the hospital at St. Luke Hospital in the ICU. They had been asked -- the family had asked to give Ivermectin, was told that it's not in their standard of care, not in their protocol, did not give it. I don't know if Dexamethasone

would have had an effect by then, how much it would impact. But they were denied that because it was not -- this is just one example. They were denied that because it was not -- Ivermectin was not FDA approved.

At the same time they were given another drug called Pulmozyme. Pulmozyme is used in cystic fibrosis patients to break up mucus plugs. Guess what? It's also not FDA approved for COVID. But in that same ICU, that was okay. So there's just such a hypocrisy. And we have got to get, like you said, walk the stuff back. Get back what is medicine, which is that patient/physician covenant, clinical picture, what's going on to be able to make that decision.

REPRESENTATIVE KEEFER: All right. And I just wanted to say. I have from a patient who was in the hospital -- and I've never seen anything put out like this before. It's from UPMC and it's treating COVID-19. And they actually have COVID-19 treatments that are approved. So they list here monoclonal, Remdesivir, steroids, heparin -- but then they also include a partial list of treatments that we do not provide -- and Ivermectin, Hydroxychloroquine, vitamins, Famotidine, IVIG, the inhaled dilators. There are a whole host of things.

And I've never seen anything where they -- why would you take things off the table at a time when there's a novel virus. We don't know. The FDA has one approved drug

-- or two, I guess, approved in hospital. Why would we take anything off the table until it's completely studied is just beyond me.

DR. CHAMINIE WHEELER: It's unethical.

REPRESENTATIVE KEEFER: Right. And I do have just also for the record from the NIH website is the COVID-19 treatment guidelines. It's table 2-E. Characteristics of antiviral agents that are approved or under evaluation for treatment of COVID-19.

And on here it has dosing regimens, adverse events, monitoring parameters, drug to drug potential, and comments. And the three antivirals that they have listed is Remdesivir, it has Ivermectin, and has nitazoxanide. And of the three only one has adverse events that have been associated with renal and liver toxicity. And that's Remdesivir. And yet they come away, you know, with the recommendation for protocols as, you know, the only one is Remdesivir.

REPRESENTATIVE KEEFER: Dr. Kory, did you have a question?

DR. PIERRE KORY: Yeah. I mean, I guess I'll just repeat that these restrictions are unheard of. So you're talking about a guideline for disease in which they say you can use this but you cannot use that. Unprecedented in medicine. I've never been told what I can't use if it's

FDA approved, used for other medicines, and if I know the mechanisms of action biologic plausibility and evidence of efficacy from trials or other countries or even my own experience, being told I can't use it.

You know, we've had for decades -- I'm an ICU and a lung specialist. We have had sepsis guidelines in many centers when they look to see how many of the doctors actually rigidly adhere to those sepsis guidelines. You'd be surprised it's like maybe 40 to 60 percent at times. People don't rigidly adhere to guidelines. But you were allowed to. I don't know where this restriction is coming from. My sense is that there's influences that are making them restrictive.

You know, one of my colleagues and founders of our expert group on COVID therapeutics, Dr. Mereck (phonetic), who is in Virginia, he also worked in a hospital where he went to attend in the ICU for a week and he got a memo. The entire system received this memo from up high from a committee that listed six different medicines that they could no longer use.

He attended in the unit that week. Every single patient that he attended to that had COVID died and they died miserable deaths. And he felt that he could not treat them and he filed a lawsuit. So there's an active lawsuit in Virginia using statutes of Right To Try and also trying

to preserve the practice of medicine and the autonomy of the physicians.

You know, what hospital has the right to tell us what we can't use if we know that it's safe and it's FDA approved? Why would we be prevented? This is all unprecedented happening in COVID. And like you said, the control of medicine is reaching heights I've never seen before and people and patients are suffering.

REPRESENTATIVE KEEFER: Thank you.

MAJORITY CHAIRWOMAN RAPP: Thank you, Doctor.

Thank you, Representative Keefer.

We are running short of time. I'll give Representative Frankel the last question. He has some closing comments and I will have some closing comments.

Representative Frankel.

REPRESENTATIVE FRANKEL: Thank you.

I had a number of questions but just one quick question for Dr. Adalja. Do you prescribe Ivermectin?

DR. ADALJA: I do not.

REPRESENTATIVE FRANKEL: Thank you.

With that, let me make a few closing comments here.

Thank you, Madam Chair.

Thank you to all the testifiers here today. It was interesting to hear Dr. Kory's testimony. I, too, have

concerns about pharmaceutical companies and their excess profits. In fact, I've got legislation about it, the Pharmaceutical Drug Advisory Board that would make sure that medications are treated like a public good.

But I'm concerned about calling the entire medical community rotten to the core. That sounds too much like politics and conspiracy than a basis for having sound policy. Our physician panel today was made up of three supporting nonstandard care and just one in support of the prevailing recommended care regimen.

Outside of this room, 96 percent of doctors followed recommendations and got vaccinated long before a single hospital required it. That means that this witness table would need another 94 seats for the physicians who support standard of care to reflect the overwhelming ratio of medical experts who follow and believe in our vaccine-led guidelines and 4 percent who do not.

This has unfortunately -- excuse me. I am not a physician. And I'm not sure the person to be -- and I'm not sure I'm the person to be arbitrating what is and isn't appropriate, safe care. I know there's a place for off-label use and innovative treatments. I also know there's a time when nonstandard care can be unsafe, harmful, and exploitive to vulnerable and terrified patients. I know that we must be able to draw a line between safe

experimental treatments and pure quackery.

I also know that with my background in insurance and policy, not medicine, I'm not the person to draw it. I'm glad we have a process of the State Medical Boards to make those decisions, whether it comes to coronavirus, cancer, or any other illness. Lawmakers in this room are wearing business attire, not white coats and not stethoscopes. We should let doctors and health professionals focus on keeping patients safe.

Thank you, Madam Chair.

MAJORITY CHAIRWOMAN RAPP: Thank you, Representative.

And I do appreciate each and every one of you who have been here today. And, yes, we could fill the room with physicians and certainly everybody in this room has different opinions on many different subjects. And I think that's probably why at the Supreme Court level, we don't want to trust just nine justices. Somehow we need to expand the court so that we have more opinions.

I wanted to thank each and every one of you here. As I said earlier, the one person you want to trust is your personal physician. And when you go to see your personal physician, you want to have trust that that doctor that you're seeing is going to prescribe to you, and even if it's not even a prescription, that they are going to recommend to

you things that you can do to stay healthy.

Now, not too long ago we really believed in preventive medicine. Now all of a sudden the only way to, you know, have preventive medicine is for everyone to receive a vaccine, you know, regardless of what you believe. I'm not an anti-vaccine by any means.

Anybody who has ever been part of a military family, you know, believe me, military families have a lot of vaccines.

Representative Pennycuick, thank you for being here today. Army veterans, you know and I know that's why you are chuckling.

I appreciate the doctors who have differing opinions. We know it doesn't take a rocket scientist to know that Big Pharma is making big bucks right now. And the information and the lack of information on how to keep yourself healthy, that preventive medicine, simply taking vitamin D that anybody can buy from any drugstore down the street. And it's just those simple things that our own Department of Health does not want to give that information I find appalling.

A very short time ago those were the kind of things that we talked about to keep your personal health care costs down, keep yourself healthy. We even had a big article in a magazine called City and State that

Representative Frankel and I were featured in. And what was the gist of the whole article? How do you keep yourself healthy today. Get out and exercise. Don't smoke. You know, don't do this. Don't do that. And do this. Do this. Get out in the fresh air. Don't isolate yourself. Get out in the fresh air. Stay healthy.

Take vitamin D, C, zinc. You know, something from your physician that you trust. We all want to be in consultation with our physicians. And there are many differing opinions. That's what our country is based on. We have a right to share our ideas, our opinions. And we can disagree and hopefully we can still get along.

So far Representative Frankel and I have still been able to come to, you know, these meetings and get along. But we have different opinions. And we know that's the same in the medical world. We have a right as citizens of this great state and nation to know if there are differing opinions than what big government wants to share with us.

So thanks. My thanks to all of you.

Members, thank you for being here today. This is a great Committee. I really appreciate the members on both sides for your questions. And we are contemplating running this bill. We are back in session in January. So if anybody wants to weigh in for or against, we're always

looking at that information.

And, sir, we do not take questions from the audience but you are free to approach me afterwards. But at this point in time, we are in Session so at this point in time, the hearing is adjourned.

Thank you.

(Whereupon, the hearing concluded.)

I hereby certify that the proceedings and evidence are contained fully and accurately in the notes taken by me on the within proceedings and that this is a correct transcript of the same.

Jean M. Davis
Notary Public