

Testimony by Andrew M. Thomas, MD, MBA, on behalf of the Ohio State Medical Association
House State and Local Government Committee
November 19, 2020

Mr. Chairman and Members of the Committee:

My name is Dr. Andrew Thomas and I am here to testify in opposition to SB 311 on behalf of the Ohio State Medical Association. I also serve as the Chief Clinical Officer and an Associate Professor of Clinical Internal Medicine at the Ohio State University Wexner Medical Center, but I am not here on behalf of the University of the Medical Center. In addition, I serve as the Zone 2 lead for the state's pandemic response.

Earlier this week, the OSMA and a number of other statewide organizations circulated a letter to this Committee stating our opposition to this legislation. SB 311 would prohibit the Ohio Department of Health from issuing mandatory statewide or regional quarantine order that apply to individuals who have not been either exposed to or diagnosed with the disease. The bill also allows the General Assembly to rescind certain ODH order through a concurrent resolution.

In that letter, we ask that the legislature reconsider moving forward with this legislation given that we are in the midst of an international pandemic with an unprecedented increase in new COVID-19 cases as well as hospitalizations and ICU stays. For example:

- During the spring and summer surges of COVID-19, Ohio topped out at just over 1,100 COVID patients in the hospital on any given day. Again this fall, we crossed the 1,100 patient mark on October 18th....but, instead of being the peak this time, we crossed 2,000 inpatients as of November 5ththen we surpassed 3,000 inpatients on November 12th and as of yesterday, November 18th, we have 3,706 Ohioans in the hospital with COVID-19. **Over the last two weeks alone, we have seen a 78.3% increase in the statewide COVID-19 hospital census and that is an increase from a time that was already at a record high for the pandemic.**
- Here in Zone 2, an area that includes 36 counties across Central, Southern and Southeastern Ohio, in the spring and summer COVID-19 surges, we peaked at a total of 354 COVID-19 inpatients in the Zone's hospitals. We crossed that previous high mark on October 29th.... but instead of being the peak this time, we crossed 400 inpatients on November 2nd.... then 500 inpatients on November 6th then 600 inpatients on November 10th then 700 inpatients on November 17th....and then 800 inpatients yesterday on November 18th.... **Over the last two weeks alone, here in the Central and Southern areas of Ohio, we have seen a 67.8% increase in the Zone COVID-19 hospital census, and that is an increase from a time that was already a record high for our Zone for the pandemic.**
- It is also important to note that yesterday, Regions 7 and 8 – the two more rural regions of Zone 2 – were also at their highest number of hospitalized COVID-19 patients at any time during the pandemic. An important fact for those of you from rural districts, in recent weeks, only 50-60% of COVID-19 patients in our Zone have been hospitalized in Franklin County hospitals. This is not like the spring or summer surges when 80% or more of the inpatients were hospitalized in the metropolitan areas of the state. If you haven't talked to the local hospital leadership in your district lately, you might want to check in with them. We have a Zone 2 surge call each weekday

morning at 9am, and the angst – and some days desperation – that I hear in the voices of many hospital leaders around Zone 2 is not the same thing that I was hearing 2 or 3 months ago. In response to local COVID surges, we have needed to transfer patients between hospitals in the Zone on a daily basis to make sure we are using our region-wide hospital capacity in an efficient manner – the farthest transfer in our Zone that I am aware of was moving a patient from Chillicothe to be admitted in Coshocton.

Over the past few weeks, nearly every hospital in the Zone has needed to implement some level of surge interventions including modifying levels staffing, pulling in nurses or providers from ambulatory clinics to work at the hospital, or, most recently, we have major hospitals in the state limiting non-urgent surgeries and procedures both to free-up staff as well as bed capacity to manage the number of current COVID-19 inpatients.

Until we see a sustained drop in new COVID-19 cases being diagnosed, we know that we will continue to see a trend of increasing hospitalizations, and the thought of another significant increase in hospitalized patients is difficult to contemplate both in terms of the toll it will take on the patients and family member of those who become ill, but also the price that the nurses, pharmacists, doctors, environmental service workers, transporters, EMS workers, and other frontline health care staff who are confronted with this stark reality on a daily basis.

In addition to the rapidly escalating number of cases and the risk of our health care system being overwhelmed, the nature of this infection also makes it very difficult to control. One of the most concerning aspects of the COVID-19 pandemic is the ability of an individual to infect another person unknowingly during the asymptomatic or pre-symptomatic phase of the infection. If the ability of ODH to only issue executive orders related to those already diagnosed with the infection or exposed to someone who is diagnosed, then we fear that there will be millions of Ohioans put at risk given the risk of asymptomatic or pre-symptomatic spread.

If we take this out of the context of COVID-19 specifically but think of future infectious pandemics that may occur – or worse yet, bioterrorism incidents that could occur with infectious agents that could be far more dangerous and transmissible than COVID-19 – the ability of the Ohio Department of Health to act swiftly based on the science and epidemiology of that particular infection should not be restrained as it would be under this piece of legislation. I'm not sure that people remember how perilously close Ohio came to an Ebola outbreak in 2014 – if you remember, the infection moved over the course of a few weeks from a couple continents away, to a couple of states away to a couple hour drive away with one of the patients from Dallas visiting her family in Akron just prior to becoming ill. If that were to happen again in Ohio or if there were a “dirty bomb” to go off in one of our cities with an infectious agent in it, I think that all Ohioans would appreciate the ability of our public health officials to provide a rapid, evidence based response to the crisis.

While many have been critical of some of the orders issued since the Spring, the Ohio Department of Health has done their best to remain consistent with the recommendations from the US Centers for Disease Control and Prevention, the White House Coronavirus Task Force and other established scientific experts in this field. ODH's orders have not been arbitrary or capricious but have followed the

science **as it was known at the time** they were issued to the best of its ability. We have just gotten to know this virus over the last 9 months in this country and continue to learn more about how to combat it on a weekly – or sometimes daily – basis. The Ohio Department of Health needs to retain the flexibility to issue orders that are consistent with the recommendations of their Federal partners and the scientific experts who are pushing forward our knowledge of the virus.

In conclusion, many critics of the ODH's work often say that "these orders are unprecedented" or "this has never been done before"....I will not read them into the record, but I will supply the committee with five documents from the University of Michigan Center for the History of Medicine's influenza archive. This is an online archive of the response of 50 cities across the United States to the influenza pandemic of 1918-1919. While COVID-19 is not the same as influenza, the 1918-1919 worldwide pandemic is the closest model we have for how a worldwide pandemic can occur in the modern age. The five documents outline the response of Cincinnati, Cleveland, Columbus, Dayton and Toledo to the pandemic over 100 years ago. As the incidence of cases rose in the state during that crisis, multiple interventions were implemented in an attempt to control the infection – things like limiting large public gatherings and events, putting limitations on the density of public transportation, closing certain schools or certain types of businesses that were considered high risk for transmission, and putting curfews in place for different types of businesses to close at different times of the day.

ODH's response to this pandemic has not been arbitrary or capricious. It has followed the recommendations of our Federal government experts, the science and epidemiology of this infection, and tried and true public health interventions that have been used for over 100 years.

Thank you for your time and your consideration of my remarks.