Chairman Schmidt, Vice Chair Deeter, Ranking Member Somani, and Members of the House Health Committee, thank you for hearing my testimony in support of HB 12, the Jeff, Dave, and Angie Patient Right to Try Act.

My name is Dr. Holly Papanek, thank you for the privilege of sharing my story.

As a board-certified internal medicine physician and hospitalist for the past 28 years, twice recognized for excellence in patient care, I was neither concerned nor frightened about volunteering to serve in the COVID unit when the outbreak struck our area in the summer of 2020. At that time, I believed the US had the finest medical care in the world and our academic research institutions and front-line physicians would work tirelessly together to create and trial, extensive creative approaches to the rapidly moving pandemic. I was confident that differing approaches would be encouraged and successes rapidly shared as the fog surrounding this impending crisis was met head-on. Much to my horror, as I cared for patient after patient, including my own family member, this did not occur in my Southwest Ohio institution or, to the best of my knowledge, anywhere else in our country.

My first cause for concern was in the summer of 2020, when I read about early therapies succeeding in less developed parts of the world but being discouraged for use in the US. I also remember exactly where I was standing on the Covid unit that Thursday in July 2020 while caring for patients through the initial SARS-CoV-2 wave when we received word that Governor Mike DeWine and the Ohio Board of Pharmacy issued an unprecedented ban of hydroxychloroquine for the treatment of COVID that was 'effective immediately' throughout my large hospital network. We were all quite astonished, as we were seeing positive results with its use in hospitalized patients who were ultimately recovering and safely discharging home. Hydroxychloroquine is a well-studied, incredibly safe medication, dispensed over-the-counter in many parts of the world. Why would our public health agencies ban its inpatient or outpatient use under the supervision of physicians in our state? This was unprecedented for a medication with such a safe profile. However, as of July 30, 2020, care options were no longer to include hydroxychloroquine, and this medication was removed from use per my hospital medication formulary. The actions directed at hydroxychloroquine were, unfortunately, just an opening act for what was to come in 2021.

2021 represents a tipping point for my career and may be deemed an inflection point for the trajectory of modern medicine.

Almost exactly one year later, my mother-in-law, Judy Papanek, in July 2021, upon her return from a trip, experienced severe shortness of breath and rushed to the hospital where I was employed. She later tested positive for the Delta strain of SARS-CoV-2.

By the time she arrived in my facility's emergency department, I was becoming increasing concerned by the hospital's strict adherence to woefully ineffective NIH guidelines that governed all care in the COVID ICU. (The US "excess deaths due to COVID 19 "were among the highest per capita in the world – Last out of 11 high income countries globally)

Judy was willing and comfortable with "standard of care", or any therapies that might benefit her. Despite my discussions with the infectious disease physician group, she was denied any "unproven" therapies. As her condition worsened, I requested multiple times that any alternatives be trialed, observing, "This regimen is not working—why not at least try something different?" My pleas were met with condescension by the critical care team, a reprimand from our group, and a verbal reminder regarding the protocols to be used in the COVID Unit.

My only offense was rationally advocating for a patient willing to explore whether promising alternatives could help. Rather than being allowed to trial a different therapy "at her own peril," Judy was subjected to the "standard of care", which included remdesivir, ventilator care, and eventually on dialysis due to failing kidneys, where she remained in a coma until her son and daughter agreed to let her pass. She deserved the right to try an alternative. She and her family were willing to release the hospital of all liability, and I was willing to be the clinician of record for the alternative therapy. However, no variance from a failing "standard of care" was permitted during that dark time. Her final gift was the donation of her body to Ohio University's Heritage

College of Osteopathic Medicine. I cannot emphasize enough what a dynamic and loving “Nanny” her six grandchildren lost that day in August of 2021.

In the aftermath, I could not, in good conscience, continue to conform to the mandated status quo. I delved deeper into alternative therapies being suppressed online, in medical journals, in the media, and by our Governor’s daily chats with “public health experts.” The Front Line COVID-19 Critical Care Alliance (FLCCC) posted continually updated evolving COVID-19 treatment protocols for both outpatient and inpatient settings. Empirical therapies, and therapies working in other parts of the world – discouraged for use in the US. The founding doctors had impeccable credentials, and their research’s clinical impact and H-scores were of the highest caliber. The protocols were flexible and more astute than anything we had been mandated to use in the COVID ICU over the previous 12 months. FLCCC guidance stood alone in the outpatient setting, as there were no recognized early treatment protocols from our public health authorities.

I tried their outpatient protocol for the first time when a dear friend messaged me after her husband was sent away from his primary care physician’s office with instructions to “stay home, isolate, and if your oxygen levels start to drop, go to the hospital. And don’t you wish you would have gotten vaccinated?” He reached out to me in desperation-barely able to breathe, with those darkening COVID eyes I had seen hundreds of times, on the cusp of needing the emergency hospital care all now feared. Fortunately, medications not allowed in my hospital, along with other less controversial components of the FLCCC protocol, were started that afternoon. His decline reversed in less than 12 hours. To this day, they both agree those pills saved his life.

After that blessed outcome, I felt led to place my name on the FLCCC website as a treating clinician. Unfortunately, it wasn’t without much trepidation, since in the eyes of most medical boards, true adherence to my professional oath in 2021 was deemed a rogue act. I internalized the protocols, made my personal cellphone available online via the FLCCC website, and treated patients from across Ohio via FaceTime. Not being in private practice, I had no way to market or bill for my services, nor did I desire to. All my COVID patients came to me frightened and desperate, vaccinated and unvaccinated, with similar stories of being turned away by my once trusted peers and newfound fears of the hospital systems I already knew so well.

During the remainder of that outbreak, after hospital shifts adhering to required protocols - my evenings and weekends were spent providing early-intervention COVID therapy via virtual health, creating paper patient charts, and searching for pharmacies to fill my prescriptions. My relationship with pharmacists has always been stellar—I value their knowledge and the second look each script receives. However, in the fall and winter of 2021, that experience diverged dramatically. Pharmacist after pharmacist at ALL the major chain pharmacies (where I had sent scripts for decades) refused to fill my “off-label usage” prescriptions, callously telling patients’ family members, “This medicine isn’t indicated for this,” or simply, “We won’t fill this script,” or on multiple occasions threatening to report me to the medical board. No collegial discussions, contraindicated research, evidence of an unsafe dose, or legal precedents were ever provided to justify this unethical disruption of medical care. No prescription I wrote ever endangered a patient or approached a toxic dose, yet none would dispense to my patients. One guilt-ridden pharmacist, working the overnight shift, privately disclosed that this refusal was “unprecedented,” but “her hands were tied by a corporate mandate, and she couldn’t discuss it further.”

Thankfully, I found a small, private pharmacy that would serve my patients. I attribute the saving of many lives to this courageous pharmacist and the FLCCC protocols. Had she also refused to provide these lifesaving medications, many more of your constituents would no longer be with us today.

By the end of 2022, I resigned from my hospitalist position, a career I had considered an honor to be part of for nearly three decades. I held the practice of medicine by Ohio’s outstanding physicians above the political agendas of our polarized world. Unfortunately, the COVID emergency proved this was not the case. Thousands of Ohioans are no longer with us due to the reckless bureaucratic, institutional, and corporate overreach that infected the practice of medicine during this dark time. The patient-doctor relationship was compromised with tragic consequences. In April 2020, 71.5% of the public trusted hospitals and their physicians; by January 2024, and rightfully so that trust had dropped to just 40.1%,

I pray the even-handed actions in this bill can begin to reverse this tide. If the precedents set during the COVID-19 emergency are not addressed at the state level by medical freedom-oriented “Right to Try” legislation like HB 12, we are all in potential jeopardy. As I said, 2021 is an inflection point for medicine—This body has the power in 2025 with the clarity of hindsight and uncovered evidence of bias and corruption to move its trajectory not to the Left or Right, but away from darkness and back toward the light.

I urge the committee to vote YES on HB 12.

Respectfully,

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