OH DOCTOR, WHERE ART THOU? PANDEMIC EROSION OF THE DOCTOR-PATIENT RELATIONSHIP

HEARING

BEFORE THE

SELECT SUBCOMMITTEE ON THE CORONAVIRUS PANDEMIC

OF THE

COMMITTEE ON OVERSIGHT AND ACCOUNTABILITY

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OH DOCTOR, WHERE ART THOU? PANDEMIC EROSION OF THE DOCTOR-PATIENT RELATIONSHIP

Thursday, September 14, 2023

HOUSE OF REPRESENTATIVES
COMMITTEE ON OVERSIGHT AND ACCOUNTABILITY
SELECT SUBCOMMITTEE ON THE CORONAVIRUS PANDEMIC

Washington, D.C.

The Subcommittee met, pursuant to notice, at 10:05 a.m., in room 2247, Rayburn House Office Building, Hon. Brad R. Wenstrup (chairman of the subcommittee) presiding.

Present: Representatives Wenstrup, Miller-Meeks, Lesko, Cloud, Joyce, Greene, Jackson, McCormick, Ruiz, Dingell, Ross, Bera, and Tokuda.

Dr. WENSTRUP. Good morning. The Select Subcommittee on the Coronavirus Pandemic will come to order.

I want to welcome everyone. Without objection, the chair may declare a recess at any time.

I now recognize myself for the purpose of making an opening statement.

Good morning and thank you all for coming here today to discuss the importance of the doctor-patient relationship and truly caring for patients.

Every patient is unique, and one-size-fits-all solutions do not work well in medicine. From early on in the pandemic, I recommended to the administration that Americans need to hear from the doctors that are actually treating COVID–19 patients and that sidelining doctors during the COVID–19 pandemic was a massive mistake.

We've lived through many things, even before the pandemic. The requirements on our EHR, the reporting requirements they're obligated to give that—all these things to take us away from patients. Prior authorization and dictating what patients' medicines are from someone who has never seen the patient. All these interruptions. Your doctor, who knows you should have been the primary partner on health and medical decisions.

Constant testing, for example, before entering a building but no testing required to enter our country over our southern border confused many Americans as to what was going on in the arena of public health. Instead, politicians with no medical background imposed mandates to be followed or to be fired.

I'll tell a quick personal story. First of all, I believe the vaccine saved hundreds of thousands of lives. I truly do. And I was very much for the emergency use, especially for those that were most vulnerable. And that should have been our priority, especially when limited.

I got the Pfizer vaccine. Months later, I got COVID, and the only reason I knew I had COVID is because I couldn't smell garlic salt when I was cooking. And I snorted the stuff, and I got nothing. I remember having chills about a week and a half before. I got better.

I was told that I needed the booster to travel to Germany. So, I asked downstairs at the Physician's Office if I could get antibody levels and T-cell levels before doing the booster. They said: We can't do T-cells, but we can do antibodies.

A strong level, as I got my results, showed that 40 was very strong. My level was 821.

Should there not have been a discussion with the doctor as to whether or not you needed a booster? Whether or not it was going to make a difference? Whether there's a possibility of a hyperimmune response? There was no such thing.

We've seen school boards not accepting notes from a physician about their students and maybe just getting one dose of Pfizer, so they don't get myocarditis. Rejected. That happened in my own district.

To be clear, this important decision, whether to get vaccinated and boosted, is the exact choice that should be between each American and their physician. Why should individuals be strong-armed into getting a vaccine that they may have little or no marginal benefit or potentially create risk for themselves? Especially without a discussion.

Ms. Dingell, on this committee, has told us many times—because she had a reaction to vaccines when she was young—that she was very concerned. She was afraid. Understandably. But she tells the story that she talked to her doctor, and they made the decision to go ahead. Well, so many Americans were not given that option. They were told: You get this, or you're fired from your job.

The sacred relationship between a doctor and a patient is directly connected with personal health outcomes. Every patient is different. Numerous studies have found that a physician's knowledge of a patient's ailments and emotional state is positively associated with the resolution of those ailments.

The doctor-patient relationship, as well as the autonomy of physicians, has been eroded in recent decades. Government interference in medicine has continually crept in and taken advantage of in times of crisis. Bureaucratic red tape and administrative burden forces physicians to spend less time treating patients.

For example, Dr. Ruiz and I have had a bill for several years to streamline—when insurance companies are saying, "You must fail first, or this is the drug you have to take," so that there's no delay in patient care, and we can resolve that.

Consolidation in the healthcare market has also brought physicians further under an umbrella of central control. More and more physicians are employees rather than employers. The pandemic rapidly accelerated these trends. As we continue to innovate and

prioritize efficiency in our healthcare system, we must also preserve the sanctity of the doctor-patient relationship.

With "do no harm" in mind, we must ensure that physicians have the autonomy to treat patients without undue interference. This is one of the great tragedies of our response to the COVID–19 pandemic. We allowed the government to censor and bully doctors, to try to get them to comply with the agreed-upon narratives pushed by unelected bureaucrats and politicians who never treated a single COVID patient, let alone studied medicine.

Doctors came under immense pressure to promote COVID–19 vaccines to everyone, regardless of whether they felt it was warranted or medically appropriate. I remember a video I saw with Dr. Fauci, and I think it was around 2004. And, in the interview, he was asked: So, if you've had the flu, do you still need the vaccine?

He said: No, no, no. No, you don't need it because you have more immunity if you've already had the flu than you'll get from the vaccine.

So, people are confused with the message.

Doctors who have prescribed off-label medications for years were suddenly vilified for doing the same during COVID–19. Today, you'll hear from one such doctor, Dr. Jerry Williams, who treated thousands of patients at his urgent care clinics, who felt the positive effects of his cures and treatments and also felt the negative effects of medical censorship.

A Federal Court of Appeals recently determined that the Biden administration violated the First Amendment by colluding with social media companies to stifle dissent about COVID–19 online. It's just what the court said.

The Federal Court also recently revived the lawsuit against the FDA for interfering in the practice of medicine by embarking on a politically motivated campaign against the FDA-approved drug ivermectin. Most medicines for animals are also human medicines, but the doses are different. And it's not fair to say they're the same.

This anti-science, anti-doctor, and government-mandated approach during the pandemic failed miserably, and it makes us less prepared to address a future pandemic. And I've done panels where people were hesitant, and they said: We just want to be educated, not indoctrinated.

We need to set this straight if we're to be successful in public health.

The Majority was in contact with a possible witness for today's hearing who is deeply passionate about these issues. That physician wanted to testify, but was too afraid that their career would be destroyed for speaking out any more than they already had. This is a problem. It's appalling that we have built a world which forces experts to choose between the government's treatment plan and the truth, or even be allowed to express their own opinion.

Rather than listen to doctors, the government censored them. The very government officials that took an oath to uphold the Constitution that protects free speech. Rather than encourage Americans to seek out the advice of a doctor, they kept doctors' offices closed and deemed your treatment as unnecessary, even if there were no cases anywhere near where you were working.

People were fearful. I understand that. But, as we look back, this is a mistake we should not make again. They imposed vaccine mandates and vilified any dissenters. We can't let these failures be repeated. We must learn from the past to succeed in the future. For many, this reality has been obvious for some time, but it appears that others still have not learned anything over the past several years.

Just this week, the CDC decided to recommend an updated COVID–19 booster for all Americans over the age of 6 months. I suspect that some of this conversation today will be focused on this decision.

My hope is that today's discussion will emphasize the importance of the doctor-patient relationship and why we must resist attempts by government or industry to take more decisionmaking power away from individuals, both doctors and patients, and put into the hands of bureaucrats.

I look forward to an on-topic, respectful discussion today about a very important issue. Thank you.

I would now like to recognize Ranking Member Dr. Ruiz for the purpose of making an opening statement.

Dr. RUIZ. Thank you, Mr. Chairman.

The relationship between a patient and their doctor is sacred. It is a cornerstone of healthcare delivery that is rooted in trust, empathy, and the oath to do no harm. As a physician, it is something that I deeply valued when I treated and cared for my patients in the emergency department, giving critical care at critical moments.

And, for our Nation's physicians who served on the front lines of the COVID–19 pandemic, as I did in previous pandemics in the emergency department, I know it is something that they deeply value, too.

And let me be clear: The physician-patient relationship is not one that occurs in spite of our government's public health institutions. Rather, it is a relationship that is complemented and fortified by the tireless work of public health officials and experts, particularly during times of crisis.

And now that we have emerged from the darkest days of this pandemic, we, as lawmakers, have a responsibility to continue equipping our Nation's doctors with the tools necessary to provide the highest quality care to patients, both now and in the event of future crises.

In order to do that, we must continue empowering collaboration between our physician and public health communities in our ongoing response to threats like COVID–19. We've seen what this collaboration can look like during the course of the pandemic.

For example, once COVID–19 vaccines became available, the Biden administration and the physician community worked together to rapidly deploy them and increase their uptake, including through commonsense policies like vaccine requirements for high-risk individuals working in high-risk situations.

These public health measures, which were enacted in support and in consultation with physicians, allowed us to safely and responsibly reunite loved ones, reopen schools, businesses, and workplaces, save lives, reduce harm, and prevent additional hospitalizations.

In fact, dozens of distinguished medical groups and leaders have gone on the record in support of these pandemic-era policies, including the physicians in the American Medical Association, the physicians in the American Academy of Pediatrics, the physicians in the American Academy of Family Physicians, the physicians in the Infectious Disease Societies of America, and more.

So, thanks to the Biden administration's leadership in successfully rolling out the country's largest vaccination program in history, we have been able to emerge from the depths of the pandemic, and now the work to keep COVID–19 at bay remains.

We must continue working to preserve and expand access to treatments that ensure Americans can recover from COVID–19 with ease. This includes antiviral therapies, for which the administration has successfully deployed thousands of test-to-treat sites and preserved widespread access even after the conclusion of the public health emergency.

Additionally, we must continue partnering with physicians to remove barriers that they and their patients may experience to treatments and medications that we know work and save lives.

Throughout the pandemic, the administration's weekly convening of clinicians across the country has equipped our Nation's providers with the resources and the latest information that they need to provide their patients with the best possible treatments and therapeutics.

And now, as we enter the fall and winter months, where cases of COVID–19 and the flu are known to rise, our government's public health officials must keep this line of communication open with patients and physicians to promote the highest quality of care.

We can achieve this goal by partnering with community-based organizations, especially those in underserved communities, to increase public health outreach and improve health outcomes from COVID–19. And, most importantly, we must work to ensure that everyone, even in the most rural and remote parts of the country, can get the care they need when they need it.

Over the last 3 years, we have made great strides in achieving this goal. Because there is no patient-doctor relationship if patients don't have doctors.

In fact, last year, congressional Democrats secured key provisions in the Consolidated Appropriations Act of 2023 to advance equitable healthcare access. This included maintaining telehealth flexibilities put in place during the public health emergency to ensure that all Medicare beneficiaries, no matter where they live, are able to access vital telehealth services, especially in areas where there are no physicians, and so this increases the opportunity to even have a doctor-patient relationship.

And let's not forget the historic reforms under the Inflation Reduction Act that put more affordable care within reach for millions of Americans, capping out-of-pocket drug costs for Medicare recipients, and saving 14.5 million Americans hundreds of dollars a month on healthcare premiums.

So, as we begin today's hearing, it is my hope that we can pursue a productive conversation about how we can work together, lawmakers and clinicians, to improve access to care, enhance trust between physicians and patients, and forge a stronger collaboration

between physicians and public health officials that will fortify our Nation from future threats.

As Ranking Member of this Select Subcommittee, my goal has always been and continues to be to identify forward-looking policies that protect the public's health and leave us better prepared for the next pandemic.

So, after a long and productive district work period that I know everybody on this committee had, I hope that today's hearing puts us on the path toward that goal.

I yield back.

Dr. WENSTRUP. I would now like to recognize Dr. McCormick for the purpose of making an opening statement.

Dr. MCCORMICK. Thank you, Chairman Wenstrup and Ranking Member Ruiz, for the special opportunity to address this committee as to my concerns, as we are doctors. We served during this entire pandemic. This is a special occasion for me.

I just rewrote my entire opening statement in the last 5 minutes, just listening to the words. The words sound great. The tools. We gave you guys the tools. There was great collaboration. They allowed us to. We removed barriers. We got more affordable healthcare. Those are all words we've heard recently by the government.

The problem is, when the tools are biased by the government, when collaboration means the government gets its way or bribes scientists or gives them grants or bonuses to change their opinion—when they say, "allows us to," that means once the government gives you permission to. When they say, "removes barriers," unless the government disagrees. When they say "affordable healthcare"—I don't know of anybody who, in America, thinks we have affordable healthcare. So, let's start there.

Beginning in March 2020, the government took over the conversation of healthcare. For the first time ever, at least in my lifetime, we had a novel virus that was killing people. And for the first time ever, the collaboration between doctors and patients was interfered with, and also doctors and doctors, and also doctors and scientists, because the government got to have the ultimate say so. There's the biggest problem.

In 2020, as a person who was involved in treating patients before we even knew what it was called, before we even knew what was going on, when we see fevers as exposed repeatedly, I was censored when I had a scientific/medical opinion. That turned out to be right, by the way, but that's inconsequential.

The fact is the government got to tell me what was right and wrong. Government officials who hadn't seen a patient in decades or at all. People who didn't have an MD, who had never seen a person in the ER, who had never treated a virus in their life, got to censor me. And some people even threatened to take away my license because I disagreed with them. Because I'm an expert, too, I felt this is the biggest problem in the whole approach.

It's not collaboration when the government gets the say-so and when they are the expert. And this goes back to our basic political philosophy. Is government the equivalent of God? Are they the moral authority? Are they equivalent of physicians and medical authority? Are they the equivalent of businessowners and get to tell

you when your business is open or closed, who you hire and fire, whether you should get vaccinated, whether you can travel? This is the fundamental difference that we are arguing today.

As a healthcare provider, and as an American citizen who has rights that are inalienable—not given to me by the government but given to me by God, in my opinion—the American people deserve to make medical decisions through the caring and informed conversations with their physician rather than through politically motivated mandates. The American people deserve a choice. The freedom of choice is as fundamental to this country as anything that ever existed.

The COVID pandemic wreaked havoc on us. We all agree on that. We know it was a horrible thing. But we can't even agree on the science of what started this pandemic without making it political.

Now, just to be clear, I'm not against someone wearing a mask. I'm not against someone getting a vaccination. I was actually one of the first people in the United States to get a vaccination, as an ER doc on the front lines seeing thousands of COVID patients. The science seemed clear to me at the time that it would have a real benefit against a novel virus from becoming ill and not being able to serve my patients. I got the vaccine willingly.

And I'm a military guy. Over 21 years in the military. I've gotten plenty of vaccinations in my time. It doesn't scare me. But, as soon as the government said, "You will." You're going to have resistance.

And, ironically, it's not just the White conservatives. It's the Black liberals. Because people don't trust the government. And, as soon as you say, "I really want you to get this," and they say, "No thank you," and you say, "No, I want you to get this."

"No, thank you."

"No, you're going to get this."

You know what the response is going to be from those people. You galvanize people. You don't attract them to something.

And that's the political nature that we made this disease. And it actually defeated the purpose of a good conversation between a physician and their patient and what would be maybe a real benefit to a vaccination.

Now, that has modified. Over time, the science has changed, so to speak. Well, the science hasn't changed, but the opinion has. The way that we use NSAIDs or steroids or different medications has changed. Now, the science changed, and we were able to do that. But ultimately, we have to let the scientists and the medical professionals, and the patients have those conversations if we're going to keep this from being a political conversation rather than a medical conversation. And that's what I'm sticking up for.

Thank you very much. And, with that, I yield.

Dr. WENSTRUP. Thank you.

I would now like to recognize Representative Ross for the purpose of making an opening statement.

Ms. ROSS. Thank you very much, Chairman Wenstrup and Ranking Member Ruiz.

And thank you to the witnesses, all of you, for being with us today.

I'd just like to take this opportunity to call attention to the hypocrisy of the Republicans in designating today's hearing topic, particularly in light of the current state of reproductive rights and reproductive healthcare in our country.

My colleagues on the other side insist that public health guidelines based on strong medical consensus and evidence from the scientific community violated the relationship between patients and doctors. I take this relationship very seriously. My father is a doctor. He raised many of the concerns about having insurance companies interfere with his doctor-patient relationships. This is not an unfamiliar topic to me.

But having this discussion while simultaneously advancing an extreme agenda to undercut reproductive healthcare and insist that elected officials know better than doctors and patients is really rich.

It appears that some of my colleagues support government encroachment on America's privacy and health as long as it aligns with their goals of dismantling access to reproductive care. States across this country have enacted draconian legislation, targeting and criminalizing doctors and reproductive health providers, encouraging vigilantism, deputizing citizens to go after individuals seeking abortion, and forcing rape victims as young as 13 to carry pregnancies to term. Somehow, in their eyes, this doesn't qualify as government overreach or interference in the doctor-patient relationship.

Over 1,500 healthcare providers in my home state of North Carolina penned an open letter in opposition to our Republican legislature's 12-week abortion ban, writing that it puts the government in charge of deciding which healthcare options are available to patients and sets a dangerous precedent that violates the sacred patient-clinician relationship.

On top of that, the North Carolina Medical Society, the North Carolina Obstetrical and Gynecological Society, and the North Carolina Academy of Family Physicians all publicly oppose the law. And, yet, despite the outcry from physicians, despite the danger to public health, despite public opposition, a bunch of extreme politicians said, "I know better."

And now, extreme Republicans eye a national abortion ban, as they attach anti-choice riders to appropriations legislation and fight to end the access to safe medication abortion nationwide. The ability for all women to make their own decisions about their healthcare is at risk. As a matter of fact, it's gone in many states.

I want to remind folks that in the Roe *v.* Wade decision, the primary opinion came from Justice Harry Blackmun, who himself represented doctors at the Mayo Clinic. He understood the importance of the doctor-patient relationship and not criminalizing healthcare.

In closing, I want to remind the committee of what Justice Ruth Bader Ginsburg wrote in her 2007 dissent in Gonzales *v.* Carhart, "Legal challenges to undue restrictions on abortion procedures do not seek to vindicate some generalized notion of privacy. Rather, they center on a woman's autonomy to determine her life's course and thus enjoy equal citizenship stature."

She argued this point at her Senate confirmation hearing as well, explaining that the decision whether or not to bear a child is cen-

tral to a woman's life, her well-being, and her dignity. It is a decision she must make for herself. And when the government controls the decision for her, she's being treated as less than a fully adult human responsible for her own choices.

If my colleagues on the other side of the aisle genuinely believe that vaccine requirements constitute government overreach, then they must acknowledge that abortion bans, and contraception restrictions enacted across this country are evidence of an even greater overreach and violate the relationship that we have with our doctors.

Thank you, Mr. Chairman, and I yield back.

Dr. WENSTRUP. Thank you.

And I want to welcome all of our attendees today.

And I do want to point out that free speech is obviously still allowed in our committees, but I would also like to remind everyone that this on-topic discussion we hope to have today is about the pandemic erosion of the doctor-patient relationship. And, out of respect for our panelists here today, that's what they prepared for. That's what they are here to discuss.

So, I hope, for the remainder of this time, that we can go ahead and hear from our panelists and ask them questions and try and find ways that we can do better, especially in the area of public health, as it relates to the doctor-patient relationship going forward.

So, our witnesses today are Dr. Jeffrey Singer. Jeffrey Singer is a senior fellow at the Cato Institute and works in the Department of Health Policy Studies. He is president emeritus and founder of Valley Surgical Clinics Ltd. and has been in private practice as a general surgeon for more than 35 years.

Dr. Azadeh Khatibi—Khatibi. Sorry.

Dr. Khatibi is a fellowship-trained physician and surgeon. She is a physician scientist, medical freedom and ethics advocate, as well as a mindfulness mentor.

Dr. Jerry Williams. Dr. Williams is a product of the university system of Georgia for both college and medical school. He is a University of North Carolina fellowship-trained child and adult neurologist, as well as the owner and founder of Urgent Care 24/7, a chain of urgent care centers, and he has practiced medicine for 32 years.

Dr. Andrea Shane. Andi L. Shane is the division chief of infectious diseases at Children's Healthcare of Atlanta and Emory University. Dr. Shane earned a medical degree from Louisiana State University School of Medicine in New Orleans, followed by residency training with an additional year as the chief resident at Albert Einstein College of Medicine in the Bronx, New York.

Thank you for being here today. Pursuant to Committee on Oversight and Accountability rule 9G, the witnesses will please stand and raise their right hands.

Do you some solemnly swear or affirm that the testimony that you are about to give is the truth, the whole truth, and nothing but the truth, so help you God?

Thank you. Let the record show that the witnesses answered in the affirmative.

The Select Subcommittee certainly appreciates you being here today, and we look forward to your testimony.

Let me remind the witnesses that we have read your written statements, and they will appear in full in the hearing record. Please limit your oral statements to 5 minutes.

As a reminder, please press the button on the microphone in front of you so it is on, and the members can hear you. When you begin to speak, the light in front of you will turn green. After 4 minutes, the light will turn yellow. When the red light comes on, your 5 minutes has expired, and we would ask that you please wrap up.

I now recognize Dr. Singer to give an opening statement.

STATEMENT OF JEFFREY SINGER, M.D.
SURGEON PRIVATE PRACTICE
SENIOR FELLOW
CATO INSTITUTE
DEPARTMENT OF HEALTH POLICY STUDIES

Dr. SINGER. Thank you, Chairman Wenstrup, Ranking Member Ruiz, and members of the subcommittee. I have submitted a longer written testimony, which I'll summarize here.

In my 40 years of private practice, I have firsthand experience of government agencies progressively intruding into physicians' clinical decisionmaking and often casting a chilling effect on what clinicians feel comfortable communicating to their patients.

Beyond the assault on their autonomy, clinicians face ethical dilemmas when concerns about job security or even if they can continue practicing their profession if they fail to adhere to orthodoxy distort their best judgment regarding what they perceive to be in their patients' best interest.

In my Cato Institute study "A Hippocratic Oath For a Free Society," I argue that physicians must always prioritize the autonomy and rights of individual patients. I call for doctors to take an oath declaring, quote: I will respect the crucial scientific advances in medicine but will always question the assumptions my profession has inherited and will judge them in the light of the latest evidence. I will respect my patient's autonomy, thoroughly explain all the diagnostic possibilities and therapeutic options as I understand them, offer my best opinion and advice from among these options, and accept their decisions.

Government, public health, and other regulatory agencies have made it increasingly difficult to honor that oath. This became much more apparent during the recent coronavirus pandemic. As I stated in my essay "Against Scientific Gatekeeping," "A problem arises when some of those experts exert outsized influence over the opinions of other experts and thereby establish an orthodoxy enforced by a priesthood. If anyone expert or otherwise questions the orthodoxy, they commit heresy. The result is groupthink, which undermines the scientific process."

During the coronavirus pandemic, most medical scientists, for instance, uncritically accepted the epidemiological pronouncements of government-affiliated physicians who were not epidemiologists. At the same time, they dismissed actual epidemiologists as "fringe" when those specialists dared to question the conventional wisdom.

In my essay, I postulate that the deference to government-endorsed positions is probably related to funding. President Eisenhower observed in his farewell address, "While the free university is historically the fountainhead of free ideas and scientific discovery, a government contract becomes virtually a substitute for intellectual curiosity."

He also wrote that, "We should be alert to the danger that public policy could itself become captive of a scientific technological elite."

Most physicians today are employed by hospitals or by large multistate corporate clinics. Many of these organizations derive significant income from government funding and government-ran programs and are thus reluctant to stray from the recommendations of government health agencies. They insist that their physicians adhere to these recommendations, even if they might personally disagree with the scientific rationale of those recommendations. Employers discourage them from communicating their reservations and concerns to their patients.

The intrusion into the practice of medicine by non-clinician public health officials and by lawmakers and bureaucrats who are untrained in medicine—yet have the hubris to tell physicians how and what they may use to treat their patients—threatens the integrity of the medical profession and indirectly imperils patients.

While the intrusion into the practice of medicine accelerated during the pandemic, it is not new. Government agencies, including law enforcement agencies, have been directly or indirectly telling doctors how to practice medicine for over 100 years to support drug prohibition.

Relatedly, starting in 2016, state lawmakers started dictating in statute the medical management of pain. That practice continues to this day even after the Centers for Disease Control and Prevention admonished lawmakers for misinterpreting and misapplying the CDC's pain management guidelines and revised them in late 2022—and revised them in late 2022. This has led to patients being undertreated for pain and doctors being afraid to treat them.

Will lawmakers or government agencies next dictate what drugs doctors use to treat high cholesterol or hypertension or diabetes?

The decades-long trend of government meddling in medicine has and will continue to erode physician autonomy and the patient-doctor relationship. But more importantly, physicians are ethically bound to respect their patient's autonomy as sovereign adults. Impeding them from informing their patients of the new diagnostic and therapeutic options and imparting their best and honest opinions to them assaults patient autonomy.

Thank you for allowing me to participate in this important hearing, and I look forward to answering your questions.

Dr. WENSTRUP. Dr. Singer, I want to give you credit because I know your written statement has a lot more to say, and I appreciate that you were able to hone that down for us today. But thank you for both your written statement and that.

I now recognize Dr. Khatibi to give an opening statement.

STATEMENT OF AZADEH KHATIBI, M.D., M.S., M.P.H.
PHYSICIAN
MEDICAL ETHICS AND FREEDOM ADVOCATE

Dr. KHATIBI. Good morning, dear members of the Subcommittee, and thank you for the gracious invitation to speak before you today.

My name is Dr. Azadeh Khatibi. I'm a board-certified physician in California.

As an Iranian-American immigrant, I'm very grateful to have spent most of my life free from living under an authoritarian regime. But, during the COVID pandemic, I recognized disturbing elements of authoritarianism. Government collusion and pressuring for censorship, chilling of American speech, abridgment of rights without good reason in justifying it, and promotion of a toxic culture of misinformation policing and othering of anyone who challenges the CDC's views.

The work of a physician is a sacred one. And, prior to COVID, our healthcare work force was already suffering from the severe problems of burnout and loss of autonomy. But the pandemic exponentially fractured the patient-doctor relationship and physician autonomy, particularly in states, institutions, and organizations which have used the momentum generated by the Federal Government to, themselves, also overreach.

Medical ethics has four pillars to which doctors must adhere for their patients: Beneficence, nonmaleficence, patient autonomy, and justice. Furthermore, doctors are expected to act as fiduciaries for patients to act in the patient's best interest.

In California, I have seen the attempt to remove physicians' basic rights, so I, along with some colleagues, have sued the Governor and the Medical Board of California.

In 2022, they passed a law that declared it unprofessional conduct for a physician and surgeon to disseminate misinformation or disinformation related to COVID–19. And it defined misinformation as false information contradicted by contemporary scientific consensus contrary to standard of care.

It was clear to me, even though it wasn't clear to the California Medical Association, that this violated doctors' right to free speech by chilling their speech and also the patients' First Amendment right to hear their doctors' speech. It was also clear that making doctors conform to scientific consensus would stunt the development of medicine by dampening scientific questioning and academic debate. Lives and liberty were at stake.

The word "consensus" in the law, which has popped up nationally on the stage after COVID, is problematic. In medical terms, consensus refers to the general opinion of doctors or groups of doctors, either in formal opinion or formal publication.

And, even when you craft formal consensus opinion, there's discussion. There's debate. There's disagreement by experts. It is natural and normal for doctors to disagree on what is best for individual patients or groups of patients. It is natural and normal.

Throughout history, doctors have had liberty to contradict consensus opinion. Consensus is always catching up to the latest emerging evidence or thought frameworks, and thus, it is always behind the cutting edge.

Multiple times as a physician and also personally for myself and for my family, I have gone against consensus opinion, formal and informal, and I believe that's one of the reasons I am alive today.

What's truly frightening about this law is that it was written to target doctors' public speech originally. Make no mistake about it. If they could have gotten away with prohibiting doctors' public speech, they would have.

In court, we argued that the law violates the First and 14th Amendments of the Constitution, and we were granted a preliminary injunction against the law. But damage to the doctor-patient relationship has already been done. Doctors are afraid to speak out. They tell me their stories.

One doctor tells patients: I'd tell you what I think, but I can't because it's illegal.

Another says: I don't speak up about dosing concerns about the vaccine that I have.

One responds to vaccine safety requirements by giving patients a list of vaccine side effects and otherwise stays silent.

Another tells patients: I can't say what I want to say because I might lose my license.

One doctor advised a group of us docs in a social setting: Don't ever write a vaccine exemption because you're going to be investigated, and you might lose your license.

Another was wrongfully terminated from his job when he started becoming more politically active. Another told me she feels like she's practicing under Communism. Doctors say that the situation has gotten, "crazy, ridiculous, bizarre." By the way, the majority of these examples are physicians I knew from before the pandemic, not after.

I'm currently involved in two lawsuits for physicians' rights, and I'm doing my part, and I look to you to do your part to lay the policy framework for wisely being responsive instead reactive, having an ethical government that shuns censorship and chilling tactics, and encourages a culture of supporting open scientific debate by trained people, no matter if they come from inside the government or outside, and even if they disagree with the government's assessment.

Last, I'm mentioning this because I think it's so important. I urge you to investigate the effects of COVID on the consistently sickest people in our population. They're about 15 to 20 percent of people, but they have about 50 percent of the diagnoses, healthcare expenditures, and office visits in the United States.

And decades of research at this point has shown that these highly sensitive individuals are more malleable to intervention. So, they actually—by the time the next pandemic comes, we could make them more physically and mentally healthier than the rest of the population with incredible healthcare costs and utilization savings benefits for the United States. So, I'm happy to talk about that as well.

Thank you so much for your time today.

Dr. WENSTRUP. Thank you, Doctor.

I now recognize Dr. Williams to give an opening statement.

STATEMENT OF JERRY WILLIAMS, M.D.
FOUNDER
URGENT CARE 24/7

Dr. WILLIAMS. Chairman Dr. Wenstrup, Ranking Member Dr. Ruiz, and Members of the Subcommittee, I am pleased and honored to testify on this Subcommittee's important work.

I am here to address the challenges that I faced as a practicing physician in the trenches during the COVID pandemic, having developed my own treatment protocol and treated over 5,500 patients, resulting in only five hospitalizations and zero deaths. Yes, zero.

To come before you and do such a thing as this in this current environment is not for faint of heart. I heard what the Chairman said about the physician who didn't come, and I understand that pressure and that concern.

This is for the man in the arena. As John Wayne said, "Courage is being afraid but saddling up anyway." Still, I almost didn't come.

But then I heard the words of one of my heroes, fellow Savanian Supreme Court Justice Clarence Thomas, who said, "I would rather die than withdraw."

The industrial-medical complex and bureaucracy demanded that I stand down. Check at the door my common sense. Two internships, one in internal medicine and pediatrics, and a residency and fellowship in child and adult neurology, but I refused. Sadly, the overwhelming majority of my colleagues did comply.

I didn't stand down then, and I won't stand down now. I'm here to speak for the 1.2 million U.S. citizens who died with COVID and the over 5.8 million others worldwide that did the same. I speak for the countless patients who now suffer from long COVID and post-vaccine injury. And, no, I am not anti-vaccine.

I speak for those that died from complications of the COVID vaccine. I speak for the family members who were refused access to their loved ones while their loved ones died in a hospital and nursing home alone. It is our duty to be the voice of others, to speak for others that cannot. It is also my First Amendment right, and I will be their voice.

In early 2020, as the pandemic was beginning, I took an inventory of the arrows in my quiver to fight the COVID–19 virus. I had one. A zinc tablet from my local pharmacy. That was it.

Realizing how unprepared I was, I immediately went to work and began researching everything I could find on coronaviruses, and I found the 2005 peer-reviewed article from the Journal of Virology on chloroquine and its effectiveness against SARS-CoV infection and spread. Considering I had nothing else, it was a start. An inexpensive, safe, well-used old drug with worldwide availability.

Simultaneously, I was working to protect my employees because it quickly became abundantly clear that we didn't have enough PPE. No one did. And you couldn't buy it at any price.

So, I found a paper from 2010 that addressed the H1N1 influenza pandemic of 2009, and it showed a reduction of flu transmission to healthcare workers by using outdoor exam rooms. So, we had the first outdoor exam rooms that I knew of anywhere.

And I was immediately attacked on social media, and I was immediately attacked by a local hospital for violating OSHA and

HIPAA by having outdoor exam rooms, which, by the way, became the standard nationally and internationally.

On March the 9th, 2020, in the journal "Clinical Infectious Diseases," an in-vitro study showed hydroxychloroquine—chloroquine's first cousin, so to speak—to be more effective than chloroquine in the inhibition of SARS-CoV–2.

I had more experience with hydroxychloroquine and was very comfortable with that medication and its safety profile, and so I immediately started preparing our first version of our treatment protocol. We never attempted to do a publishable study. Our goal was to kill this virus and save the next patient coming through the door. We never took a one-size approach fits all. We treated each patient with as much of our protocol as was appropriate and safe and our anecdotal evidence accrued.

In summary, I simply adhered to my Hippocratic oath and a basic tenet of medicine, specifically infectious disease medicine—which the medical-industrial complex and bureaucracy asked us to all forget—treat early to prevent the afflicting agents, whether bacterial, viral, fungal, or protozoal from getting a toehold.

I rolled up my sleeves and applied what I had learned, was transparent and honest with my patients, observed carefully, followed up and documented compulsively, adjusted when necessary, learned to unlearn, and refused that which was antithetical to medical science.

Thank you for the opportunity to participate in this bully pulpit.

Dr. WENSTRUP. Thank you, Dr. Williams.

I now recognize Dr. Shane to give an opening statement.

STATEMENT OF ANDI SHANE M.D., M.P.H., M.S.C.
CHIEF
DIVISION OF INFECTIOUS DISEASES
DEPARTMENT OF PEDIATRICS
EMORY UNIVERSITY SCHOOL OF MEDICINE

Dr. SHANE. Chairman Wenstrup, Ranking Member Ruiz, Members of the Subcommittee, thank you for inviting me to testify.

As a pediatric infectious disease physician, I have cared for newborns, children, and adolescents with COVID–19 and led efforts at my institutions to ensure that care was optimally provided throughout the pandemic.

The clinician-patient relationship is a foundation of our healthcare system. To earn and maintain our patients' trust and exercise beneficial medical judgment, we must stay abreast of the best available data. Our public health agencies are partners in this effort.

During the COVID–19 pandemic, physicians worked rapidly to update practices according to new information. These changes often appeared confusing and required explanations about the why behind them. These discussions involved a true investment in the clinician-patient relationship.

As a pediatrician, I have the privilege of taking care of children who are my patients and their parents who are indirectly my patients. When I think about the clinician-patient relationship before, during, and after the pandemic, I see evolution, partially driven by

the pandemic, and partially driven by the information explosion that has changed the delivery of healthcare.

Supporting population-based health measures enhances the provision of optimal care for individual patients. In addition, community-based measures that prevent infection, hospitalization, and death benefit both the individual who remains healthy as a result and the community in which they reside. Preventing hospital overcrowding and healthcare worker burnout better positions us to provide high-quality care to individual patients.

When COVID–19 vaccines first became available, there were compelling reasons to boost vaccination rates quickly based on the information that was available at that time. As a result, many healthcare professional societies supported policies requiring vaccination, particularly for healthcare workers.

But vaccine requirements are not new. Schools require—have enrollment vaccine requirements, and we require seasonal influenza vaccine requirements for healthcare. Those have been in place for many years.

Clinicians have been leaders in efforts to vaccinate the population. Infectious disease physicians have been deeply engaged in educating other clinicians about COVID–19 vaccines. We've partnered with public health agencies, community-based organizations, and the media to educate the public because we saw before us the lifesaving impact of COVID–19 vaccination.

COVID–19 therapeutics are critical in saving lives and preventing hospitalizations. Data has helped us inform the prioritization of limited COVID–19 therapies, how to optimize them, and how to manage potential adverse effects. The collaboration of public health and clinicians is critical to collect, analyze, update, and make publicly available data on COVID–19 therapeutics.

Now, the Federal Government healthcare systems, public health officials, and clinicians must work together to expand equitable access to both vaccines and antiviral therapies by increasing the use of telehealth, mobile clinics, and community health centers.

When examining the clinician-patient relationship, I cannot help but be concerned about access. People residing in 80 percent of U.S. counties do not have direct access to an infectious disease physician. Over half of our adult and pediatric infectious disease training program physicians went unfilled last year. Low compensation relative to other specialties is just one barrier.

Despite these challenges, we are committed to applying lessons learned to improve our preparedness and responses to future public health emergencies by improving surveillance, data infrastructure, laboratory capacity, communication, and research to ensure that we preserve the clinician-patient relationship that is so instrumental in our Nation's health.

It will take all of us coming together. I am grateful for this opportunity to testify. Thank you.

Dr. WENSTRUP. I want to thank you all very much.

I now recognize myself for questions.

Dr. Singer, I understand you published a study earlier this year regarding the Hippocratic oath and how it should be adapted. In this study, you note that medical schools are straying further from the traditions of their oaths. You specifically note that none of

these oaths prioritize or consistently apply a commitment to individual patient autonomy.

In your opinion, why is it important for medical school graduates to swear an oath that reveres patients' rights and autonomy?

Dr. SINGER. Thank you, Mr. Chairman.

In my study about the Hippocratic oath, I actually—even going back to the original one from Hippocrates of Kos, there tends to be—there's not enough emphasis on the fact that the patient is a sovereign adult with rights that we need to respect, and that we, as physicians, are basically consultants giving our best opinion to these patients. We're not their bosses. We don't make decisions for them. We just tell them, based on our best knowledge, what we think is the best course for them to follow.

In recent years, the Hippocratic oaths that are administered at various medical schools have strayed further and further from an oath that originally didn't give enough respect to patient autonomy, and now has gone far astray. Some of the oaths don't even discuss much about patient care.

So, what I argue is that we need to get back to focusing on what we, as physicians graduating from medical school, need to commit ourselves to, which is to respect the rights of our patients. To look at our patients in much of a way as clients, and we're their consultants. And we're ethically obligated to tell them everything we know, not to withhold information from them that they are entitled to know if we know this information, and at the end of the day, respect whatever the decision they make because they're the boss. We're the consultants.

Dr. WENSTRUP. Thank you.

I want to talk a minute about off-label treatments. It's long been understood that the FDA is not in the business of regulating the practice of medicine. This includes a physician's right to prescribe FDA-approved medications off-label, meaning that the approved drug is used outside the specific scope of the approval.

Off-label medications are critical to providing necessary care for millions of Americans, often patients who have few or no approved medications for their condition. Studies have estimated that up to 20 to 30 percent of all prescriptions are for off-label uses.

I'm a podiatrist. I often prescribe nitroglycerin. Why? For patients with Raynaud's. So, when they're going to be exposed to cold, they can put a nitroglycerin patch over their posterior tibial artery, and their foot will be perfused with oxygen and blood during that time, and therefore averting amputations. And it worked every time.

A Federal appeals court recently revived the lawsuit against the FDA which alleges the agency surpassed its authority and waded into the regulation of medicine. One such example is the FDA's now infamous tweet from August 2021. You can see the poster: "You are not a horse. You are not a cow. Seriously, y'all. Stop it."

That's from the FDA.

Let me tell you, I worked in the drugstore in high school, and I can remember a time where a medicine that, you know, we commonly dispensed—I looked at the label, and I saw the name of the patient was Spot. It was for a dog. I understood what that was about. It was a human medication that is also used for an animal.

This tweet is condescending in every single way. And it's palpable. And it's incorrect. And it's misleading. And this is coming from the FDA. Not to mention, the FDA appears to conflate the off-label usage of FDA-approved human-grade ivermectin with its veterinary counterpart.

Dr. Williams, as a child and adult neurologist, you have been using off-label medications for years prior to COVID–19. Is that right?

Dr. WILLIAMS. Yes, sir.

Dr. WENSTRUP. Including drugs like ivermectin and hydroxychloroquine?

Dr. WILLIAMS. Yes, sir.

Dr. WENSTRUP. And did you ever have a problem obtaining them for your patients prior to COVID?

Dr. WILLIAMS. Many times.

Dr. WENSTRUP. Do you believe that actions taken by the FDA or other Federal officials may have caused this?

Dr. WILLIAMS. Yes. Without question.

Dr. WENSTRUP. Dr. Singer, why is it important to preserve a doctor's right to prescribe medications off-label?

Dr. SINGER. Well, first of all, much of clinical knowledge comes from prescribing drugs off-label. We read in the medical literature much of the time comparative effectiveness studies showing how different drugs that were developed for one particular disease appear to have a use in another disease.

Especially when there's a scientific rationale for it, we doctors sometimes use it on our patients in certain clinical situations, and then we share our experiences. Sometimes as time goes on, we learn that—it turns out that it wasn't what we thought it was cracked up to be, and we pass the word along and abandon it. But other times, we find that, indeed, this is an excellent treatment, and eventually the FDA comes around and revises its recommendations for use.

But this is the way we gain scientific knowledge in the clinical field. You really can't gain knowledge unless you try different things and report on it to your colleagues.

Dr. WENSTRUP. Yes. And not to pick on you, Dr. Singer, but I look at minoxidil, which was approved for treating high blood pressure. But a side effect was hirsutism and hair growth, so dermatologists started mixing it off-label with lotion for hair growth. And now we see where that's now used commonly.

You know, I want to talk about missed appointments a little bit. Because of disruptions in care during the pandemic, the number of patients who were screened for cancer fell significantly. Correspondingly, the numbers of diagnoses also fell off. Early stage cancer diagnoses fell by almost 20 percent in 2020.

A recent study in The Lancet Oncology found that this has now led to an increase in diagnoses of deadly late-stage cancers across almost all types of cancer.

Dr. Singer, are you seeing some more trends in your field?

Dr. SINGER. Chairman Wenstrup, yes. In fact, we even saw this during the darkest days of the pandemic.

I'm a general surgeon. So, among the spectrum of diseases that I'll deal with is, for example, appendicitis or diverticulitis. We'll see

patients show up in the emergency department with very advanced cases. You know, several-day-old, ruptured appendicitis or ruptured diverticulitis or peritonitis. The kind of thing you rarely see in our, you know, developed society these days.

And, since then, too, we've seen an unusually large number of people present into our office with surgical problems that are in a much more advanced state than we're accustomed to seeing them as.

Dr. WENSTRUP. I appreciate that.

You know, in the early days, everyone was scared. So, you know, you understand how we just need to shut everything down.

But what I have concerns about is where we're looking at local levels. I mean, I even had a sheriff call me because someone who was scheduled for their painful hernia, their case was canceled at a time when, in that county, there were no cases of COVID. And he ended up taking his life because he was in so much pain. So, you know, lessons learned, I think we ought to take into consideration what's going on at a local level.

And I do want to take just the opportunity to discuss off-label again a little bit and give Dr. Khatibi and Dr. Shane both a chance to give your thoughts on the use of medications off-label in general.

Dr. KHATIBI. Certainly, in my practice of ophthalmology, we use off-label drugs all the time. If we didn't, we would actually have a lot less of an arsenal of drugs to use against diseases. So, it's an integral part of medical care, and the government shouldn't be dictating to you the off-label uses that actually aren't potentially dangerous to patients and make sense, and especially in a late-stage case or something where there's just no other options. It's a good thing to have to be able to utilize.

Dr. WENSTRUP. We passed a bill here several years ago relating to the right to try.

So, Dr. Shane?

Dr. SHANE. Thank you, Chairman Wenstrup.

In pediatrics, I have actually had several opportunities to use medications off label. Unfortunately, because many medications are not tried in children as part of clinical trials, we're often forced to do that. And so, one of the really potential ways that we can optimize that is by including children in clinical trials so we can gather data, and medications do not have to be used off label.

Thank you.

Dr. WENSTRUP. Thank you. Thank you all for your input here.

I now recognize Dr. Ruiz for questions.

Dr. RUIZ. Thank you.

Over the course of the pandemic, public health officials worked with limited and constantly evolving and changing information to keep Americans safe and implemented policies to help our Nation overcome the virus. You know, we talk about off-label uses of medication. As a physician, it's something we do, but we also do it with caution, and we do it in respect of science in search of the evidence to help us determine whether it's a sham or whether it's a real medication that has proof.

And the whole scientific process is to move us from anecdotes to the statistical realm so that we can prove and replicate that our results are not due by chance but that, within a 95 percent con-

fidence, that they are true, that they will happen, that this actually works. So, it's not anecdotal or if it just happens with this one time, it works or not, or maybe a group of 10 patients or 50 patients and we swear by it, but so that we can get to that truth.

And I do believe that all of you had mentioned something very important that was common is I wish there were more studies, or we need more studies. Or even in these off-label uses, the studies refute its use, and it really didn't work, so we stopped using them.

So, at the beginning of this pandemic, there was some anecdotes, some suggestions with bench research, perhaps, on some of these medications, but then we, with caution, said be careful; let's do more research. And then as the research developed, then there would be some recommendations, and the medical societies, the boards, the people that certify our board certifications in all of our respected fields, physicians, our colleagues, those that aren't, you know, running for office or anything, put certain parameters based on that research to give us some kind of gold standard of practice so that we can abide by.

And those, your colleagues, my colleagues, his colleagues, all of you our colleagues who are the professors in universities and the researchers gave us these recommendations and said, look, if you want to be board certified and hold up to our standards, we believe that the scientific literature will recommend this and not recommend that, and this is what we believe at this time.

At this time is always key and it's always important because we must be humble to the fact that science evolves and things change, and we're using that now to even understand long COVID, to determine what are the commonalties and how to treat it, because of symptoms, they are realizing because the science is real, and there is such a thing as a long COVID syndrome.

And so, we are evolving in that aspect, and we are evolving in understanding the science to develop more therapeutics in addition to the vaccines so that when people do have a breakthrough symptomatology, that, even after a vaccine, that they have the treatments to be able to limit the intensity and the duration of illness.

It's just science. It's what we are trained to do. It's what we want to look at to see if there is evidence about that. All of us participated in journal clubs during residency, and we learned how to analyze that science. So, this is—you know, this is what has evolved.

It's not a, you know, government conspiracy to come and suppress the physicians or the physician's ability to think independently or to interfere into the patient-doctor relationship. This is a practice amongst our colleagues of saying, well, let's look at the data. Let's look to see what is out there and, as it evolves, let's give these the recommendations.

And a clear example of that and in search of this science, our goal was to get a vaccine. We're all waiting for a vaccine to help us reduce the transmission, for many prevent getting sick, and for the rest to reduce hospitalizations and intensity and duration so that we can put kids back in schools and people back in jobs and come back to a new normal.

And so, the notion that or the general notion that the Federal Government sought to subvert physicians and erode the doctor-pa-

tient relationship during the pandemic, even with the vaccine requirement, is just not true. And it's not helpful when we know that the vaccine is are best arsenal to help eliminate the spread of a dangerous virus and to protect the public's health.

So as a physician, you know, I'd like to start by—with the COVID–19 vaccine requirements questions.

And so, Dr. Shane, why were requirements a clinically appropriate tool to boost vaccine rates, especially among high-risk individuals in high-risk settings, which is not a new notion? We've done it before in many different settings. And how have they been used in context outside of the COVID–19 pandemic to reduce the threat of other dangerous diseases in the United States?

Dr. SHANE. So, thank you very much for that question.

So, during the COVID–19 pandemic, as we know, as you mentioned, we were all waiting for a vaccine, and the reason why the mandates were so essential at that particular time was that we needed a rapid way of ensuring that people got vaccinated. And certainly, there was a lot of communication about the benefits, and with everything, there is always a risk, so communication about the risk as well.

But the mandates or the requirements were really an optimal way to ensure that the vaccine reached the most number of people, and, in addition, that requirement also allowed for improving access, which was a clear and important issue as well.

Dr. RUIZ. Thank you.

So, thanks to the policies that President Biden put in place, including these common-sense vaccination requirements, more than 230 million Americans got vaccinated, 3.2 million deaths were prevented. 3.2 million deaths were prevented, and 18.5 million hospitalizations were averted.

And when pandemic era vaccine requirements were challenged in the courts, America's leading medical societies, our colleges, the physicians that certified your practice and your training and residencies and to ensure that all of our practices are up to our current standards, including the physicians in the American Medical Associations, the physicians in the American College of Physicians, the physicians in the American Academy of Family Physicians, the physicians in the American Academy of Pediatrics, and several others all expressed strong support.

The physicians expressed strong support for these policies as a critical tool to help America overcome the pandemic.

So Dr. Shane, as a physician, do you agree with the allegations that doctors were sidelined, and that the physician-patient relationship was disregarded in the discussions surrounding COVID–19 vaccine requirements?

Dr. SHANE. So, thank you.

I do not. You know, desperate times calls for desperate measures, and the vaccine requirements were the optimal way to enhance that.

Despite the requirement, there were lots of opportunities for physicians to communicate with their patients and families to ensure that there is a good understanding of, as I mentioned in my statement, the why behind the rationale, and that is what is so important, is making sure that people understand the why and rationale.

Dr. RUIZ. And there are some patients that we would recommend not to get the vaccine. There were some contraindications based on the studies and the histories that should not get the vaccines.

Do you agree with the characterizations of COVID–19 vaccine requirements as a one-size-fits-all protocols that undermine the quality of care Americans receive from their physicians?

Dr. SHANE. No, I do not. And especially since I take care of children of many different sizes, I certainly couldn't have a one-size-fits-all approach and had to tailor all of my recommendations based on the patient and their condition.

Dr. RUIZ. You know, I would also like to address the suggestion that population-based health approaches undermine the quality of care that a physician can provide to their individual patients.

Dr. Shane, in your written testimony, you state that, quote, supporting population-based health measures does not run counter to providing optimal care for our individual patients. You note that community-based measures prevent infection, hospitalizations, and death; thereby, benefiting individuals who stay healthy as a result.

So how did population-based COVID–19 public health measures, such as masking and other mitigation measures, safeguard individuals' health during the pandemic?

Dr. SHANE. So, thank you for the question.

Those mitigation measures both had an impact on the individual and, in addition, to the community. So, when individuals are healthy, that means—individuals comprise communities and communities are healthy.

And the vaccinations were one. Masking, separation when needed, having people stay home when ill, those were all things that we had to do to flatten the curve and to make sure that we could bring ourselves back to a society that was enabled to have the normal interactions.

Dr. RUIZ. Thank you.

You know, I have both a doctorate in medicine and a master's in public health, and the practices, although overall achieved the same objective, a healthy individual, a healthy population, there are some practices for population health and the understanding of that field that's different than what we learn in medical school. And so, I think that that's why there is oftentimes a lot of confusion trying to extrapolate individual care to population care and vice versa.

And so there is a profession and a goal to keep a population safe as it relates to the individual care, and they are not incongruent, but they are different.

So, one final question for you. How does the work of our public health institutions complement, as opposed to undermine, a physician's role in providing the best care for their patients?

Dr. SHANE. So, thank you for the question.

That's actually very critical, and the clinician has a perspective, the individual perspective, and then the public health institutions have a different perspective, and so bringing those two together is the best way to ensure that we have policies and recommendations that take into account both the individual and the community.

Thank you.

Dr. RUIZ. Thank you.

And I yield back.

Dr. WENSTRUP. I now recognize Dr. Miller-Meeks for 5 minutes of questions.

Dr. MILLER-MEEKS. Thank you, Mr. Chairman. I would like to thank the SSCP for having this hearing, and I would also like to thank all of the witnesses for testifying before this Select Subcommittee today.

First let me just say for those who don't know me, I'm a physician, was a nurse prior to being a physician, was also the director of the Iowa Department of Public Health, and a 24-year military veteran. So, I have a lot of experience in all facets of medicine.

The COVID–19 pandemic dramatically altered many aspects of healthcare. As we know, hospitals and clinics were closed even though in the healthcare setting we know how to manage infectious diseases. But most notably I think what we saw was a further erosion of the doctor-patient relationship.

So as a physician and a nurse with decades of experience delivering care to patients of all ages and in various healthcare settings, I recognize the value and the reality that patient medical needs can rarely, if ever, be broad brushed. Individual needs vary drastically. These can be due to allergies, comorbidities, intolerances, various other medical factors or social factors that require a robust doctor-patient relationship, and this is something that all doctors, including my friends and physician colleagues on the other side of the aisle publicly recognize.

And let's also admit, as Dr. Wenstrup did at the start of this hearing, that there have been decades of erosion of the doctor-patient relationship from pre-authorization, step therapy, fail first therapies, even when things have already been tried, even how EHRs and standardized practices gear toward billing rather than toward actual patient assessment and care.

The use of off-label medicines. Never before have we had Governors threaten the medical licenses of individuals if, through their interactions and their medical knowledge were to prescribe a patient a certain type of medication, or boards of pharmacies to be told that those certificates would be removed.

I was and am still appalled by the multitude of COVID–19 vaccine mandates imposed by Federal, state, and local governments throughout the pandemic for exactly this reason, and I would disagree with our witness who said that there were lots of opportunities. There were not lots of opportunities.

If you were in the healthcare setting, despite over a year of having provided care to patients with PPE, you were mandated to get a vaccine or lose your job. I know of people who lost their job. If you were in the military, you were required to get a vaccine even if you were 18 or 20 years old, even if you had—your risk for getting myocarditis or pericarditis, may have, in fact, been greater than your risk of being hospitalized or dying of COVID–19.

We did not recognize infection-acquired immunity, which we have in every other type of infectious disease but not in this one. Somehow it just evaporated when it came to COVID–19.

And in our school systems, you couldn't go to school as a child if you weren't vaccinated, so excuse me if I do not believe that the doctor-patient relationship and the doctors' conversations with indi-

viduals may have said you're at low risk getting vaccinated or you've had COVID–19.

I had the same experience as Dr. Wenstrup. I was vaccinated. I gave vaccines in the 24 counties in my district, recommended for people to be vaccinated and have conversations with their provider, but nonetheless, when I was testing my antibody levels and keeping track of them because of some research that said you may decrease antibody levels with boosters, my antibody levels were high but even last December was still recommended to get the vaccine, to get a booster.

So, I'm not going to continue to pontificate, although we could go on for quite a while.

Dr. Williams, in your written testimony, you detail how you developed your own treatment protocol for COVID patients during the pandemic. And let's remember that COVID patients were told if they tested positive, come back when you're really sick, and you might die first before you come back in. So, there were no treatment protocols offered to these individuals.

So, your protocols resulted in five hospitalizations, zero deaths, despite seeing over 5,500 patients. Can you detail why this approach was effective and whether your practice would have benefited from increased government presence?

Dr. WILLIAMS. Thank you, ma'am, for the question.

I took what I was trained to do, and I applied it because we didn't have any options at that point at the beginning of the pandemic. And I dove into the research, and I found what I could find, but we all agree it was an incomplete data base. And there is the old saying, I cannot argue with anecdotal evidence. But that was all we had. That was all we had.

But then we do what we do. We practice medicine and we observe, and we adjust, and we learn and, most importantly, sometimes we unlearn.

And I was pro-vaccine. I was as anxious, and I was one of the first people to get the vaccine in my county at the behest of our county health official who called me directly because my name wasn't on the list. And I said, no, in the Marine Corps, the drill sergeant goes last. He eats last. His troops eat first. I'll go last. He said, I need you to re-think that for me. I need you to go first because there is some trepidation.

And I gladly went first. I'm twice vaccinated and once boosted, but when they started refusing to acknowledge natural immunity post infection, it was a red flag for me. And I've always maintained, and I've made this very public that it's an individual decision between the patient and their medical care provider.

My protocols took a broad stroke approach at this virus. It's almost like peeling an onion. There's multiple layers. So, we were trying to attack the virus to kill the virus using virucidal whatever we had that we felt like was safe, first do no harm.

But I was also looking at, with this silent kind of storm, what was killing these patients in the hospital. So, the inflammatory response to this virus is something that we needed to talk about more, we needed to address. So, we used, amazingly, some very simple over-the-counter medications that stabilized the mast cell

and the neutrophil. These are cells in our body that control the inflammatory response.

And we're talking about things like Claritin, loratadine, famotidine, Pepcid AC. These kinds of drugs and the supplement melatonin is a strong mast cell stabilizer. So, we were working hard to stabilize these patients' mass cells.

My goal, owning an urgent care company, was I had to address these patients that showed up at my door frightened, and some of them were very, very sick and did not want to go to the hospital. And my goal was to save each patient that came through the door and to address this virus from every direction that I could.

Dr. MILLER-MEEKS. Thank you, Dr. Williams. I hope others will allow you to expand on your testimony.

I yield back.

Dr. WENSTRUP. I now recognize Ms. Ross from North Carolina for 5 minutes.

Ms. ROSS. Thank you, Mr. Chairman.

Right now in America we're witnessing an unprecedented interference in the ability of physicians to provide the best possible care for their patients. In states across the country, politicians are practicing medicine without a license, getting in the middle of decisions that should be made by a woman and her doctor.

We've heard Republicans on this panel say that Americans need to be educated by doctors, not indoctrinated by politicians. I could not agree more.

From North Carolina to Arizona, extreme Republican legislatures at the state level have pursued draconian policies to control women's reproductive freedom in spite of approximately eight in ten American adults who believe the decision to have an abortion should be left to a woman and her doctor.

And, yes, in spite of this, we also have medical consensus from doctors all around the country. They have told us so. The American College of Obstetricians and Gynecologists led 24 medical organizations, including the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Physicians, the American Medical Women's Association, in filing an amicus brief in Dobbs versus Jackson in opposition to Mississippi's abortion ban after 15 weeks of pregnancy, writing that the ban impermissibly intrudes in the patient-physician relationship by limiting physicians' ability to provide the healthcare that the patient, in consultation with her physician, decides is best for her health.

And that Mississippi's policy places clinicians in the untenable position of choosing between providing care consistent with their best medical judgment, scientific evidence, and the clinician's ethical obligations or risk losing their medical license.

Dr. Shane, as a physician, do you agree that abortion bans intrude on a physician's autonomy to provide the best care for their patients in accordance with their medical judgment?

Dr. SHANE. Thank you for the question.

Yes, I do.

Ms. ROSS. Thank you so much.

This isn't the only example of physicians speaking out against extreme abortion bans enacted in states across America. In Ohio,

the American College of Obstetricians and Gynecologists, the American Medical Association, the Society For Maternal Fetal Medicine filed an amicus brief in opposition to the State's 6-week abortion ban, writing that the law would force clinicians to delay provided needed medical care until a patient is in a critical situation.

And by the way, on the opposing side were 18 Republican attorneys general, some might say a group of politicians, who filed a brief in support of the abortion ban. The list goes on and on.

Now, let's compare how doctors responded to public health measures implemented during the COVID–19 pandemic.

In November 2021, the American Medical Association, led by 60 organizations and more than 30 preeminent doctors, scientists, and public health leaders had a statement of support for OSHA's vaccine policies. In BST Holdings *v.* OSHA, the AMA filed an amicus brief in support of the agency's vaccine and testing policies emphasizing that COVID–19 poses a grave danger to public health and that halting the policies would irreparably harm the public interest.

In MB, parent of minor SB *v.* Knox County Board of Education, Democracy Forward filed an amicus brief on behalf of the Tennessee chapter of the American Academy of Pediatrics in support of schools making policies pointing to the significant protection that masking provides to teachers, students, and the community. The list goes on.

Dr. Shane, based on everything that I've just shared, do you agree that the vast majority of the physician community supported public health measures implemented to reduce the spread of COVID–19 and overcome the pandemic?

Dr. SHANE. Thank you for the question.

Yes. During the time of the COVID pandemic, physicians did overwhelmingly support the mitigation measures that was so life preserving and enabled people to continue to do some of the essential work like attending schools, going to businesses, and doing all of those other things very, very safely.

Ms. ROSS. Thank you very much.

And Mr. Chairman, I yield back.

Dr. WENSTRUP. I now recognize Ms. Lesko from Arizona for 5 minutes of questions.

Mrs. LESKO. Thank you, Mr. Chair.

First, I want to thank you for having this topic of discussion. I think it's an important topic.

And I also want to thank all four of you for coming to testify today in front of us. And I have to admit that I know Dr. Singer for, I don't know, like 20 years I think, 20 years. He's from Arizona, and I represent the Phoenix area and some suburbs of Phoenix in Arizona.

I would love to debate some of the extreme pro-abortion views that are going on in our country right now that support abortion up to the very last minute, but this is not the meeting to do that at. So next time I will debate that if we have a hearing on that.

Dr. Singer, on April 2, 2020, Arizona Governor, Doug Ducey, issued an executive order barring pharmacists from dispensing

hydroxychloroquine or ivermectin unless they had a prescription from a doctor saying the patient had COVID–19.

In Arizona, patients were not allowed to use these drugs for preventative measures even if a doctor prescribed it. The Governor limited the prescription to 14 days. This was the case not just in Arizona but across the country. Now, I'm not sure in the case of Arizona if—I think he did it, quite frankly, because he thought there would be a shortage of ivermectin and hydroxychloroquine.

Also, in 2021, William and Karla Salier had gotten prescriptions from a doctor in Missouri for ivermectin and hydroxychloroquine to treat their infection with COVID–19. William Salier had become seriously ill from the virus. Pharmacists at Walmart and Hy-Vee refused to fill those prescriptions. Karla Salier says the Walmart pharmacist rudely lectured her about the dangers of treating COVID–19 with ivermectin, and the Hy-Vee pharmacist said it was against corporate policy to prescribe the drugs for COVID–19.

Dr. Singer, do you think it was right for governments and pharmacies to overrule doctors?

Dr. SINGER. Thank you, Representative Lesko.

As I said in my opening Statement, this was a major problem and nowadays most pharmacies employ pharmacists, and most medical doctors are employed either by hospitals or corporate clinics who, even if they're not explicitly told by government agencies what the policy should be, they certainly feel the pressure, and they don't want to go against government agencies.

Right now, the evidence suggests that hydroxychloroquine and ivermectin are not helpful in the treatment of COVID–19, but in the early days of this pandemic, when thousands were dying on a daily basis, and we didn't know—the information was just coming in—we're still getting information. We're still learning more now than we thought we knew—there was anecdotal and observational evidence that these drugs may be effective to prevent or treat COVID–19.

It was, I would argue, the ethical thing for a physician speaking to their patient to say, I'm aware from anecdotal evidence that this may be helpful. We're talking about drugs that have a very good safety profile. They've been around for years, used for other things, and don't have a very high complication rate.

And I think it would have been unethical for the physician not to mention to the patient that this may be helpful, providing you understand that I can't guarantee it because all the information isn't in, and providing that you're willing to accept whatever risk this drug has, and then let the patient decide.

So, this became politicized, and this is kind of unprecedented because as it was mentioned earlier during the testimony, 20 percent or more of all drugs prescribed in this country are off-label prescriptions, and we don't see this kind of interference. And we physicians, as we learn, as time goes by, if we learn that the off-label use of that drug turns out not to be effective, then we stop doing it.

But if we suppress basically clinical investigation and just sharing of clinical knowledge, then you suppress the advancement of medical science.

Mrs. LESKO. Well, I agree, and so thank you very much.

Dr. Williams, do you have anything more to say on the subject? Because I know Dr. Miller-Meeks ran out of time.

Dr. WILLIAMS. Well, my colleague—thank you—she made a good point. As a pediatric subspecialist, as a child neurologist, I've had to use drug off label for my pediatric patients, for example, my entire career. I mean, we did it every single day of fellowship, for example. So, I was used to having that conversation with my patient about off-label use risk/benefit, and we make a decision—the patient makes a decision in consultation with their medical care provider, whether it's a physician, nurse practitioner, PA, et cetera. So that's part of that sacred relationship that we're here talking about today.

And also, I would ask everyone to keep in mind that early on, hydroxychloroquine had an EUA briefly for use.

Ms. LESKO. All right. Well, thank you all again.

And I ran out of time, so I yield back.

Dr. WENSTRUP. I now recognize Mr. Garcia from California for 5 minutes of questions.

Mr. GARCIA. Thank you, Mr. Chairman.

I just do want to start just by pushing back against some of the Republican claims and some from my colleagues that these abortion bans that are completely extreme and out of step are outside the scope of this hearing. Now, to use their own words, this hearing is about a " one-size-fits-all protocols promoted by politicians that eliminate the decisionmaking power of patients and physicians."

Now, we know that abortion bans have deprived women in 22 States of access to abortion and criminalized doctors seeking to provide the highest quality care to their patients. They have assaulted the reproductive freedom and bodily autonomy for more than 25 million people.

House Republicans advanced these bans before the pandemic, during the pandemic, and are continuing to do so this day. So, with all due respect, I disagree, and I think it's critical that we ensure this hearing addresses the doctor-patient relationship, especially when it comes to abortion bans.

Now, today we're also, unfortunately, enabling extremists who claim that masks are child abuse and that vaccines don't work. It's appalling, it's embarrassing, and it's endangering American lives.

Now, the House Republicans have built an entire platform around controlling women's bodies, banning health care for LGBTQ+ people, and putting corporate profits over the health of everyday Americans. As a committee, we should be coming together to protect public health and fighting to make medical care more accessible for all Americans, but instead, House Republicans are working to undermine the doctor-patient relationship and push essential health care out of reach for women, LGBTQ+ people, low-income Americans, and seniors.

Now, the truth is most doctors and medical professionals continue to support common sense guidelines about pandemic response just like they overwhelmingly support access to abortion, gender forming care, and HIV prevention. But right now, Republican leaders are working overtime to restrict every single one of these things even over the explicit protest of doctors, patients, and medical experts.

Now, over 20 Republican-led State legislatures have criminalized health care for LGBTQ+ people, forcing families to travel hundreds of miles and even flee their communities to access lifesaving medically recommended care. It's also estimated that nearly 400,000 transgender adults live in States that are considering legislation to ban health care that they actually depend on. This is almost half a million Americans.

And this doesn't stop at trans people or the broader LGBTQ+ community and their families. Far right leaders are so desperate to continue their attacks on LGBTQ+ Americans that they're targeting critical medication that prevents the transmission of HIV.

In March, an extreme Republican appointed judge in Texas struck down the Affordable Care Act's free preventative services requirement all because of a culture of vendetta against the very existence of gay people. And I know this because I, myself, am part of the community.

Now, Mr. Chairman, medical providers are pulling out of already underserved communities and Republican led States explicitly because these policies infringe on their ability to care for patients. Doctors are being threatened with legal action for simply providing safe, effective, and medically necessary health care all because extremists points of view have decided their top priority should be interfering with people's most personal medical decisions and the doctor-patient relationship.

Dr. Shane, I want to ask you, given your perspective as an expert in infectious diseases, I want to ask you about the importance of accurate science-based public health information. First of all, how important is it for government institutions to provide patients and physicians with clear and consistent public health information, especially during an ongoing pandemic?

Dr. SHANE. Thank you for the question, Representative Garcia.

It is absolutely critically important that information is available, that it is accessible, that it is interpreted and communicated to families and to patients.

Mr. GARCIA. And is it fair to say the overwhelming majority of physicians, including infectious disease doctors that you're representing today, supported efforts to get Americans vaccinated?

Dr. SHANE. Absolutely, yes, we do.

Mr. GARCIA. And I want to add also I was mayor of my city for 8 years. We have our own health department. We don't use the county system. We run one of the largest health departments in the State of California, and we pushed to get everyone vaccinated, and that was on the advice of the overwhelming majority of doctors.

So, I want to thank you, Dr. Shane, for being part of the medical community that actually worked to save lives, not to try to cause disinformation that actually got people killed during the pandemic.

I want to also ask are individuals, including political leaders, who spread misinformation about vaccines endangering public health and costing American lives?

Dr. SHANE. Thank you for the question.

Yes. Unfortunately, when misinformation is spread, that has tremendous adverse effects that impact not only the individual but the entire community.

Mr. GARCIA. Thank you.

And I want to again add that it's really unfortunate that we continue to push vaccine hesitancy not just in this committee but across the country.

And with that, Mr. Chairman, I yield back.

Dr. WENSTRUP. I now recognize Mr. Cloud from Texas for 5 minutes of questions.

Mr. CLOUD. Thank you.

And I want to thank you all for being here. Often, it's said that we're the home of the free because of the brave, and certainly our minds go to our soldiers and veterans when we hear that, and rightfully so. But as I've traveled in my district and the country, I often remind people that we only save our Nation when everybody in every walk of life stands up and is courageous.

And so, I want to thank you for being here in spite of some of the concerns that have been mentioned that's going on with doctors being ostracized and losing licenses and all those different kind of things.

I'm concerned about a trend that we've seen recently in health care where we go from America being the envy of the world when it comes to health care system, bringing innovations to the world, doing all these different kind of things. And sure, it's not a perfect system, but we certainly led the world in it to where we've seen recently a kind of massive consolidation of power.

And then that has also been a part of this separation between the doctor and patient, Obamacare being a big part of this to where we see more people on health insurance rolls and less people actually getting health care. So, it was great for the profits of the health insurance companies; not so great for the patient.

And then COVID pandemic and our response to it exacerbating that in a sense, and you've touched on a number of those things in the past, but truly the pandemic made this situation worse. We saw people silenced. We saw people dissented.

I know of public health officials that were out there spouting the CDC official line but then had a closet full of hydroxychloroquine or ivermectin for their own patients. I know of pharmacists that it's been mentioned that wouldn't fill doctor prescriptions. I was in, you know, much of my district's role, and there were hospitals that stopped doing surgeries even though there was not one single case of COVID in their district.

Even here in the House, the House physician sent out a memo giving fines for people not wearing masks, but it was just for the House. So, you could literally be in the Rotunda and subject to a fine for not wearing a mask of one half of the Rotunda, take two steps over in the same room and be totally clear even though—and how should I put this—the demographic profile of the Senate was more vulnerable to COVID.

So, this whole thing has really been bizarre, and it's caused a massive distrust from the American people when it comes to what they should expect out of it, and a lot of this consolidation of power has turned to these nice terms like consensus, which is actually a good thing, population-based or community-based health care, as opposed to focusing on the individual in front of the doctor.

And you all have given great testimony.

Dr. Khatibi, I wanted to talk to you because I was interested in how you talked about consensus and also especially you being an immigrant from an authoritarian regime. I find it interesting that when I travel, many immigrants actually understand and are more concerned even than people who have been kind of in the boiling pot of what's happening in America, kind of a frog in a boiling pot. They see what's happening when it comes to some of these concerns.

And I was wondering if you could speak to some of that and your concerns about that and, you know, especially maybe why this is happening. What do you think is behind all of this?

Dr. KHATIBI. Well, let me start off with the why. I think that as a consciousness in the United States, we're still very much in a reactive way of behaving, and we certainly saw that during COVID. People, instead of being wisely, mindfully responsive, they're just reactive. They "other". They don't listen. We've seen that here.

And what happens is then people stop thinking, and they start trying to kind of focus on ego-based protective mechanisms that then actually prevent you from thinking cognitively.

And the people who had experience living in authoritarian regimes have seen it, so they have more access to that cognitive experience because they've lived it, and so they can connect the dots more easily than someone who is just living in fight or flight and being reactive.

So, they recognize these patterns of chilling of speech, everybody kind of in a group think, the government pressuring for censorship or suspecting it and noticing that there is pressure from the government. They notice these things better, easier.

And so, I have certainly seen that in my immigrant community, that people are more weary of the American government now, and I think people are waking up a little bit and seeing what happened during COVID. People who disagreed with me a few years ago are agreeing now.

What was the first part of your question?

Mr. CLOUD. I don't recall.

Dr. Singer, you talked a lot about the cash incentive involved in it, and it seems like there is kind of almost a carrot and stick to this in the sense that the Federal dollars flowing into the system in ways have kind of messed up the incentive structure of honest feedback.

And it seems also in a sense there is also the legal recourse in that a lot of people, like the CDC, will come out and just say, oh, it's a recommendation. But you know, unspoken, if you don't follow it, that you open yourself up to lawsuit abuse; meanwhile, you know, you have these massive companies that are kind of protected from liability, specifically in the case of vaccines.

I was wondering if you could speak a little more to your concerns in that regard.

Dr. SINGER. Representative Cloud, that's a very good point. In fact, it's not limited just to the coronavirus pandemic. In general, when government agencies recommend things, it oftentimes becomes a de facto mandate because of the government agency being a source of funding or maybe having, you know, regulatory over-

sight that could be detrimental to the entities that is making recommendations to it.

So, I jokingly say that, you know, when the CDC recommends something, it's oftentimes like when Tony Soprano recommends something.

So, your point is well-taken, and I think it's just a natural phenomenon the way it is when the government gets involved in these things. I think it's unavoidable, but that contributes to a creation of distrust between the patient and the doctor because especially with the experience that we've had where there was constant changing of different recommendations, which is understandable because the information was changing. So, these recommendations had to be revised.

Patients started wondering are you, doctor, recommending this to me because you really believe this is what you think I should do, or are you recommending this to me because you're afraid you'll get in trouble if you don't recommend this to me? And that's not a healthy relationship between a patient and a doctor.

Mr. CLOUD. Thank you.

Chairman, I'll yield back.

Dr. WENSTRUP. I now recognize Ms. Tokuda from Hawaii for 5 minutes of questions.

Ms. TOKUDA. Thank you, Mr. Chair.

The entire premise of this hearing is the erosion of the doctor-patient relationship as a result of politicians telling doctors how they should treat their patients. So, let's talk about that.

It is truly hypocritical that my Republican colleagues are convening a hearing on government overreach into the doctor-patient relationship when their party is literally writing the playbook across our country on how to do exactly that all while endangering the lives of 25 million women by denying them access to abortions and forcing doctors to break their Hippocratic oath to do no harm when government denies them the ability to provide their patients with the care and treatment they need.

Since the right-wing majority of the Supreme Court overturned Roe, extreme Republican lawmakers have been tripping over themselves to pass dangerous bans and restrictions, defying the will of the majority of Americans.

According to the American College of Obstetricians and Gynecologists, and its over 57,000 members, abortion is an essential component of women's health care. Abortion is health care.

Ms. GREEN. Murdering babies.

Ms. TOKUDA. When we criminalize—excuse me, Mr. Chair. I would like some—the ability to answer my question.

When we criminalize health care, undermine a patient's ability—thank you very much.

Dr. WENSTRUP. Please, we'll have order, and I will expect that Ms. Tokuda has her right to make her comments.

Ms. TOKUDA. And I appreciate——

Dr. WENSTRUP. Everyone will get their time.

Ms. TOKUDA. Thank you. I hope so.

When we criminalize health care, undermine a patient's ability to access health care, tell doctors how they should and should not treat their patients, we have failed.

Dr. Shane, yes or no. Do abortion bans undermine any role of the doctor-patient relationship?

Dr. SHANE. Yes.

Ms. TOKUDA. Since Dobbs took effect, we have heard horrific stories of patients, and during life-threatening situations and unthinkable, emotional trauma before doctors felt they could legally provide care.

The far rights warn abortion is a direct attack on one in every four women in the United States that have received abortion care and an assault and infringement on every single person's ability to obtain the health care they need in consultation with their health care providers. These draconian bans have devastating consequences on all of our communities.

Longitudinal studies have shown us that denying access to abortion care increased household poverty, subjected individuals to long-term financial distress, bankruptcies, and even evictions. Women denied this most basic health care were often more likely to stay in violent relationships, were often left raising their children alone, and, in the most tragic cases, suffered serious health problems and life-threatening complications.

Dr. Shane, simple yes or no. Does banning basic health care, such as abortion care, harm patients?

Dr. SHANE. Yes.

Ms. TOKUDA. When abortion is banned, it severely limits a provider's ability to provide their patients with timely, high-quality access to care. It directly undermines and erodes the relationship between patients and medical professionals and, even worse, puts patients' lives at risk.

Dr. Shane, do these consequences pose an even greater threat to the doctor-patient relationship than a pandemic or public health policies like COVID–19 vaccine requirements?

Dr. SHANE. Yes, they absolutely do.

Ms. TOKUDA. As we see a rise even right now in COVID cases throughout our country and even in the halls of Congress, I urge my colleagues on the other side of the aisle to think long and hard about this subcommittee's priorities. We spent the last 2 hours discussing baseless hypocritical allegations of interference in the doctor-patient relationship during the pandemic, all the while, we have Republicans systemically damaging the doctor-patient relationship by criminalizing basic reproductive health care and inflicting harm on millions of women across our country.

I yield back.

Dr. WENSTRUP. I now recognize Dr. Joyce from Pennsylvania for 5 minutes of questions.

Dr. JOYCE. Thank you, Chairman Wenstrup and Ranking Member Ruiz for holding today's hearing. And to the witnesses for being with us today, we appreciate both your time and your testimony.

As a physician, I understand the importance of the doctor-patient relationship, and I have dedicated my career to serving my patients. More important, I understand the irreparable harm that comes from a one-size-fits-all approach to medicine. This approach was exacerbated by the coronavirus pandemic, and served the trust between the medical community and physicians and their patients was fractured.

Throughout the pandemic, public health officials consistently inserted themselves between the doctor-patient relationship in the exam room, in public service announcements, and further eroding what is a critical and a sacrosanct relationship.

Physicians' feet were often dangled above the fire if they didn't comply with the questionable COVID-era policies, with vaccine mandates, and often physicians were censored or blacklisted, and researchers in the same vein were censored or blacklisted for dissenting opinions regarding COVID vaccines, COVID data, and specific to this conversation, to patient care.

Dr. Singer, you have written about the ethical questions of COVID–19 vaccine mandates, and you have often said, and I'm quoting at this point, as a medical doctor, I enthusiastically endorse COVID–19 vaccine, and you personally had been vaccinated and will encourage others to be vaccinated. But you continued brilliantly by saying, but I will use persuasion, not coercion. Your words.

Dr. Singer, do you believe that vaccine mandates without exemption are incompatible with the Hippocratic oath or the tenets of the basic doctor-patient relationship?

Dr. SINGER. Representative Joyce, Dr. Joyce, yes, I do. I think it's actually you have no right to force someone to be vaccinated. Obviously, I believe that the vaccines saved hundreds of thousands of lives, and I got vaccinated. I got the first two shots, and I got the booster shortly thereafter, and I'm glad I did. But my role is to recommend to people, not to force people, not to compel people.

In addition, there are some people who have very good reasons to not be vaccinated. They may have allergies. They may have already had COVID, and they have natural immunity, and they are concerned about getting a reaction to a vaccine that is of a new technology and hadn't been subjected to clinical trials because there was an emergency use authorization. These are not unreasonable concerns. I need to respect those concerns.

I do need to qualify that that doesn't mean that private organizations don't have the right to have requirements. For example, if passenger cruise ships said that we will only take you on our tour if you're vaccinated, they are a private business, a private entity, and they have every right to set the terms by which they're going to allow people to come on their ship. It also might make business sense for them.

Dr. JOYCE. Let's continue this discussion, and I appreciate your candor.

As you know, the CDC just recommended the booster to all Americans over the age of 6 months. Can you expound on this recommendation, as well as your view regarding the booster?

Dr. SINGER. Well, based upon my understanding of this, I think the United States is actually an outlier here. In the UK and most European countries, they're not recommending the booster to anyone under the age of 65 unless they're in a high-risk group. And then even over 65, they're recommending that you consult your physician and talk it over with your physician.

I'm with Dr. Paul Offit in this one, the director of the Children's Hospital in Philadelphia. When you have over 90 percent, maybe close to 100 percent of young children, and you're talking about like

6-month olds who have already been exposed to the virus and have natural immunity, and they are among the lowest risk group from getting severely ill from COVID, then I don't see a justification for subjecting young, healthy people to yet another vaccine that does have, we're seeing particularly in young people, some complications, such as myocarditis.

Unless again—you have to individualize. You could have a young child that is immunocompromised, has Leukemia or something like that. That's a different story. But in general, as a general rule, I don't advocate it.

Dr. JOYCE. Finally, very simply, do you feel that vaccine mandates facilitate fracturing the patient-doctor relationship?

Dr. SINGER. I think mandating does because, first of all, it's a natural tendency for people to recoil when they're mandated even if what's being mandated is actually a good idea. People don't like being told they have to do things.

And so, when you have somebody who it's important that they have a very trusting relationship, the doctor and the patient, and the patient understands that they're being compelled to do something, I think it just undermines the relationship of trust between the doctor and the patient.

Dr. JOYCE. Thank you for your candor.

Mr. Chairman, I yield.

Dr. WENSTRUP. I now recognize Ms. Greene for 5 minutes of questions.

Ms. GREENE. Thank you, Mr. Chairman.

I find it pretty appalling that the Democrats on our committee are using this hearing to talk about the murder of unborn children, babies, people who have rights in our country due to the Constitution.

Abortion is not health care. It's not. It's murder. Health care saves lives, and that's what many doctors tried to do during the COVID tyrannical shutdowns, the censorship of doctors, and outrageous government practices that destroyed businesses, destroyed freedoms, took away freedom of religion, free speech, and killed people and continue to kill people.

And one of the reasons we're talking about doctor-patient relationships today, one of the biggest reasons that we have seen an erosion in the doctor-patient relationship is because of this, because of all the deaths reported to the VAERS system that have been ignored and not investigated.

And these are the numbers. These are the reports of deaths that started in 2021 with the COVID vaccines, and these are reports of others, but you can see the spike. And this is why people are having a hard time trusting their doctors.

I'm not vaccinated. I refused to take it.

Dr. Williams, what has been your position on vaccination? And has your position changed? And if so, why?

Dr. WILLIAMS. I commented earlier, Congresswoman, that I was one of the first people to get vaccinated in my company because I was asked to do so, and I was happy to do so. I did it unhesitatingly, but when natural immunity was being discounted and ignored, my position personally changed.

Now, my practice of medicine has been, from day one, that it's an individual's decision that they need to make informed with their health care provider, and I maintain that right now.

The recommendation of the most recent booster, though, has me astounded. It hasn't been studied in children at all, this newest booster, and to recommend everyone 6 months of age or older to do that, I just don't understand it. But I still maintain that it needs to be an individual's decision, the parent in the case of a child, or the individual patient and their provider.

Ms. GREENE. And have you been censored for sharing your experience treating your patients, what you felt was the right thing to do during COVID?

Dr. WILLIAMS. Many times. I was lifetime banned from Twitter for just simply responding that if someone needed to speak to someone from the press, that I would be happy to answer some questions. I woke up the next morning and had a lifetime ban from Twitter. Three months after Elon Musk bought the company, I got reinstated, and they asked me to rejoin the platform and apologized.

But I also was banned from YouTube for reviewing an NIH published paper on quercetin, which is a supplement, and all I did was review the paper, and I was banned from YouTube and then threatened with a lifetime ban on YouTube.

Ms. GREENE. The FDA in 2021 tweeted, you are not a horse, you are not a cow. Seriously, y'all, stop it. They were referring to the drug ivermectin.

Dr. Williams, has ivermectin ever been used by human beings?

Dr. WILLIAMS. Yes, ma'am.

Ms. GREENE. Does it have a history of use on human beings?

Dr. WILLIAMS. Yes, ma'am.

Ms. GREENE. So why did the FDA send a tweet implying that ivermectin was just a medicine for horses and cows?

Dr. WILLIAMS. I don't know. I know that the fifth circuit court a week ago last Friday took issue with that, and I think that's going to go back to the lower court and be addressed, but I don't know why they would have said that.

Ms. GREENE. Is ivermectin safe?

Dr. WILLIAMS. Yes, ma'am. In my experience, very safe.

Ms. GREENE. What about hydroxychloroquine?

Dr. WILLIAMS. It is safe. Hydroxychloroquine is—you can use hydroxychloroquine in all three trimesters of pregnancy. I mean, the most difficult patient to treat with medications is the first trimester pregnant female. So, it's a very safe drug.

But, you know, like all drugs. We use all drugs carefully. I don't prescribe Tylenol without thinking about its consequences.

Ms. GREENE. Of course not. You wouldn't do that.

But they kicked you off of Twitter just for talking about COVID.

It's been reported that 41 percent of Americans forwent receiving medical care they needed during the pandemic. What effect did this have on people missing a diagnosis of a serious illness, Dr. Williams?

Dr. WILLIAMS. You know, it's been my concern. The two things that I've thought about is how many routine colonoscopies and how many routine mammograms didn't get done, and I don't think—ob-

viously, at this point we don't know the full measure of the damage that was caused by that. It's going to be great, though.

Ms. GREENE. It will continue to be great.

What effect did vaccine mandates have on people who may not have known they had an illness that would have made taking the vaccine more dangerous?

Dr. WILLIAMS. You know, I think that that situation is where the person who is getting a vaccine needs to consult with their health care provider, and it needs to be done in an environment where there is a place to do so. You can't have a personal, confidential conversation with a pharmacist at a counter with dozens of people around, with no privacy.

And so those patients needed to go see their health care provider prior to getting a vaccination. And sadly, some people have access to care issues, and I acknowledge that, but I think those patients that you're addressing here, they shouldn't have gone to get a vaccine in a retail environment, or they needed to go to their provider and have a discussion.

Ms. GREENE. Yes, unfortunately, they weren't given a choice. Many of them were mandated to do so or they'd lose their jobs.

I've run out of time. Thank you, Mr. Chairman. I yield back.

Dr. WENSTRUP. Normally, at this time we have an opportunity for the Ranking Member to make a closing statement and then the Chair to make a closing statement. He won't be here, so I will go ahead and make a closing statement.

And I just want to start with one thing. Dr. Shane, I appreciate what you said about access to care. My district has traditionally been urban and rural, and the access to care problems are tremendous. And I will say that at the end of 2020, we did get into law in a bipartisan fashion, 1,000 new residency programs with 25 percent earmarked for rural, which hopefully will help address exactly what you're talking about.

Today was about the doctor-patient relationship, and I just want to say I said early on, and I said it to the previous administration, and I tried to say it to this administration, America needs to be hearing from the doctors who are treating COVID patients, not the politician, not the person in the lab.

There is a difference between those that write the white papers and those that put on the white coat and are seeing patients. Those experiences are real. Those are real people, and it's not just on paper, and it makes a huge difference in the delivery of care and public health in the United States of America.

I wonder today where our Surgeon General is in the conversation. I remember, when I was young, C. Everett Koop. Everyone knew who C. Everett Koop was, and we heard from C. Everett Koop. And when he spoke, he talked about why, and he had some bedside manner, which doesn't exist.

You talk about vaccine hesitancy. It doesn't help when a political candidate says, well, if it comes up under Trump, I ain't taking it, right. And at the same time, see comments, and these are quotes from the President, if you're vaccinated, you're not going to the hospital. You're not going to be in the ICU unit. You're not going to die.

What I said from the very beginning, following the trials very closely, one, I applaud the trials because normally you get between 8 and 10,000 patients in a trial. This had 30 to 40,000 brave Americans that got in these trials, and what we learned was not always what was related to the American people. What we learned was that there are certain people that are very vulnerable to dying from COVID and that many of those very vulnerable people did not get as sick, were not hospitalized, and may not have died.

That wasn't everybody but that was the tendency. That's the discussion you have with your patient.

You know, and then we see, you know, the shocking headline that there's a variant. That's not new. There's always variants. Why weren't we saying from the very beginning, by the way, there will probably be variants to this because there usually are.

We missed the boat. I mean, I hear today talk about the physicians. The physicians recommended this. Physicians recommended. Which physicians? And only certain physicians with one mindset, unfortunately, while so many other physicians were silenced.

And I heard today some say that, well, you didn't have to get it. We had to mandate it. We had to mandate it, but you didn't have to get it. Well, that's not true unless you wanted to lose your job. Then you didn't have to get it, and that's the facts.

I mean, there is a surgeon that I worked with at Walter Reed. She was being treated for breast cancer, and she was not against the vaccine, but her oncologist said, I don't think you should get that right now.

Dr. WENSTRUP. I don't think you should get that right now because it may interfere with what we're trying to do.

And the military would not accept that. And she was punished for that. She'll never get promoted. She had to get an attorney to fight this, to even stay in the Navy.

You tell me this is right? You tell me there's no interference between the doctor-patient relationship, and some people had a choice? You have to go through a heck of a battle to get your choice, I guess, on whether you get the vaccine or not.

Every doctor here today spoke about the advantage of being able to use things off-label. In one case today, I think it was insinuated that that was negligent and not thought out. I don't know one doctor that's going to use something off-label that hasn't done their research to be able to defend why they're using something off-label. And I think every one of you would agree with that. Yet it was implied that people were being dangerous. They weren't. They absolutely weren't. What was dangerous is shutting them down.

I had doctors call me. Friends of mine. We had started practice around the same time. They called me saying: I just got a call from the pharmacy board telling me I'm going to lose my license if I do this. And I haven't harmed anybody. I've only helped people. But I got a couple kids I got to get through college.

I said: Do you want to come and testify that?

No. No, because I know what will happen to me.

These are facts that America needs to know about that has been taking place in our government.

And, Dr. Khatibi, I applaud you for being able to talk about what it's like in an authoritarian regime and quickly recognizing what's

going on. And it's our job to make sure that this doesn't happen again and quits happening now. That we actually do things.

Look, I know Dr. Ruiz always says, "I was in public health." I was in public health. I was on our board of health. But I was also practicing. And the people that worked on our health board, the physicians that actually were still seeing patients, had much greater insight to what was actually going on than those that weren't. They may have the degree, but they haven't been seeing patients anymore. It was very advantageous to have that.

You know, I apologize to all of you for some of the things that happened here today because you came here to talk about how you believe it's best that we can save human lives and what our public-private partnership should look like. And I'm sorry it got off topic so much.

Dr. Dingell—excuse me, Representative Dingell—I referenced you in my opening statement. You had the option to talk to your doctor because you were scared. Many people did not get that.

It's about benefits and risk. Those are the conversations that we have to have. That wasn't taking place. That wasn't taking place.

And I just think the bedside manner has been horrific. And I think we can do a whole lot better. And it's up to us to create a path so that we must do that and must do it that way on behalf of patients.

Dr. Williams, you referenced why you are here. It was on behalf of your patients. And I would contend that the doctors that have decided to come to Congress are here on behalf of their patients as well.

A little out of order, but I would like to give Mrs. Dingell the opportunity for a closing statement.

Mrs. DINGELL. So, I just want to say that, as we do close, that I do think that the doctor-patient relationship is very important. And I think that, quite frankly, as we talk about COVID–19 in so many ways, it shined a light on problems that we have in the supply chain and our emergency preparedness. We had a problem before the COVID, and we have a problem after COVID—which is really not over, just for the record.

But that people—not everybody is as lucky as we are to have access to a doctor. There are too many people that don't have access to a doctor or have a family practice doctor.

Yesterday, I was in a meeting with a number of different areas of medicine, and it's stunning when you learn the number of—there are 5,000 infectious disease doctors in the country, period. And fewer people are going into it. And, when you talk to the neurosurgeons and that—when you go to each of the specialties, it's terrifying. So, we got to, like, work on making people want to go into healthcare. And how do we work together to give everybody—to have the access that we do?

And, you know, unfortunately, the reason that I had access to an infectious disease doctor—I talked to doctors here, but the infectious disease was because I got osteomyelitis during the pandemic and waited too long. And the doctor told me when I was in the operating room, people die when you get to the point that you get to. So, I don't want that to happen to people either.

So, we want them to be able to get—to have a doctor. To be able to go to the doctor. And I think it's a crisis that we have in this country that there are too many people that don't have access to healthcare, period.

So, you know, I could always ask you to join my fight for Medicare For All, but we won't do that right now.

I do want to push back against some of the misrepresentation that was made today that the courts have decided that the FDA inappropriately overreached into a physician's ability to describe ivermectin to treat COVID–19 patients.

While the Fifth Circuit Court has recently ruled to allow a lawsuit involving the FDA's public communications of ivermectin to proceed, this does not mean that the Federal Government subverted physician autonomy. It also does not change Federal health agencies' current science-based guidance that ivermectin is not an effective treatment for COVID–19.

Beginning in August 2021, the FDA has publicly discouraged the use of this to treat COVID–19 on social media and its website by promoting public awareness that it's not authorized or approved as a COVID–19 treatment—a COVID–19 treatment. The currently available data shows that it is—does not show it is effective at preventing or treating COVID–19, and that taking large doses of it is dangerous.

But your health provider or care provider can knowingly write a prescription. In these public materials, FDA also states, quote: If your healthcare provider writes you an ivermectin prescription, fill it through a legitimate source, such as a pharmacy, and take it exactly as prescribed.

In court, the Federal Government has represented that the FDA explicitly recognizes that doctors do have the authority to prescribe ivermectin to treat COVID, and the FDA is clearly acknowledging that doctors have the authority to prescribe it to treat COVID–19.

This is because the FDA determines which drugs are allowed to be marketed as a treatment for a specific indication but doesn't regulate how physicians prescribe approved drugs, which we talked a lot about today, and, you know, there are a lot of alternative labels. And every time somebody talked about it, I keep thinking about diabetes medicine that's being used right now for weight loss. And I won't comment on that either, but that's a very obvious use that everybody in the country knows about right now.

I just think it's—I want to work with you to make sure that we do—every person has access. I think these were complicated times when this all started. We didn't know the answers.

I'm not old, but I'm seasoned, and I remember the sugar cube and the panic in this country about polio. I mean, I was the generation after. Let's just remember when the sugar cube did come. But, you know, you had to get it to go to school. You had to have that.

And what we have to do—and you know I've said this to you before. We've got to work together. I want to work to make sure that every patient has the opportunity to have a relationship with a doctor that can know and treat the total patient. And I don't want to undermine people's confidence in public health. And there are a lot of public health scares right now.

And I'll never take a flu shot, but that doesn't mean that a whole lot of other people shouldn't have a flu shot. And we've got to help talk to people about why maybe they shouldn't take something, but why it benefits most of the population.

So, I hope—as I've said to you before, I want to work with you together on that, Mr. Chairman, and I think it's important. So, thank you, as we close this hearing.

Dr. WENSTRUP. I thank you. And I'll offer an invitation to you to support me in our path to being the healthiest Nation on the planet. That's what we should be after. Too often, we just talk about what insurance plan you have. How about we work on being the healthiest Nation on the planet?

But I want to thank all of our witnesses here today. This, to me, is—I'm passionate about this. As a physician, obviously, it's important that this committee—this subcommittee held today's hearing to better understand the sacred doctor-patient relationship and the effects of the interaction of the government getting involved with that relationship. And I think that we can have a better path forward in the future if we really listen to what has taken place and do better going into the future.

As doctors, we know the importance of holding a patient's hand and patting them on the back to let them know that we're there and that we care for them. And, when you're told you have to go get a shot in your arm, regardless of what it is, and no conversation with the physician that you know and trust, and you get it at the pharmacy or you get it from the National Guard or whatever the case may be, let there be at least the opportunity for a discussion with your physician.

We can't let ideology replace medical science. To me, it's a new twist on government overreach. It's no secret. Democrats are for larger government. Republicans are for smaller government. OK. But how far are we going to take this? And we want to know it's in the best interest of the patients overall, and that's where we're going.

We saw natural immunity ignored. We really quit talking about convalescent plasma, which early on, I saw patients in my hometown—I saw people lining up to give their blood that had COVID and donate their antibodies, basically, and other people get better. We didn't really talk about all of the above. And that, to me, is the problem. And that's what interfered between doctors and their patients.

Anyway, I thank you all for being here today. It's important. This conversation is far from over, but I'm glad we had the opportunity to discuss it today.

And, with that, I close. And my final statement is, with that, and without objection, all members will have 5 legislative days within which to submit materials and to submit additional written questions for the witnesses, which will be forwarded to the witnesses for their response.

If there's no further business, without objection, the Select Subcommittee stands adjourned.

[Whereupon, at 12:22 p.m., the committee was adjourned.]