

My name is George Lohmann, MD, FACS. I practiced medicine for over 50 years and served as the Director of Neurosurgery at Brookdale Hospital in Brooklyn, New York. Throughout my career, I treated thousands of patients, including many suffering from pulmonary infections and respiratory diseases. When COVID-19 hit, I became deeply concerned by what I was witnessing. Based on my decades of clinical experience, I knew it was not correct to leave early signs of respiratory illness untreated until hospitalization was required. Additionally, I was concerned that the treatment patients were both receiving and NOT receiving in the hospitals, was resulting in unnecessarily low success rates. Based upon these strong convictions, I treated hundreds of patients on an outpatient basis, pro bono, as I was profoundly troubled by the number of people who were dying in our nation's hospitals.

My treatment approach included, depending upon the individual patient, vitamins and supplements, ivermectin, melatonin, azithromycin (Zithromax), and nebulized budesonide. In my own clinical experience, 100% of patients I fully treated, recovered without progressing to hospitalization or death. Yet, I watched as physicians who advocated similar treatments outside the hospital protocols were criticized, censored, and, in some instances, placed in fear of professional consequences.

For me, this was not merely a professional concern. It became painfully personal when my cousin, Karl, was hospitalized with Covid. Despite the pulmonary nature of his condition, Karl's attending physician was a nephrologist. As I followed Karl's treatment, I became increasingly alarmed. He was receiving medication that I believed posed a serious risk to his kidneys, while therapies I had successfully used for patients with significant pulmonary inflammation, including nebulized budesonide (a common lung steroid) were not being administered.

I personally called Karl's attending physician. I implored him to reconsider the treatment plan and discontinue the medication I believed was contributing to renal toxicity, as it was already known at that time that Remdesivir was contraindicated for patients with kidney issues. However, my concerns were not acted upon. I then watched Karl deteriorate. His kidney function declined as his respiratory condition worsened. Even while receiving high-flow oxygen, Karl made clear he was not able to breathe properly (due to the high level of inflammation in his lungs), yet the very treatment that would have helped (Budesonide), was denied. Within days, Karl was dead.

With over five decades as a physician, few experiences have affected me more deeply. I understood that critically ill patients do not always survive, even with excellent medical care. What was so devastating about Karl's death was watching him decline while believing, based upon my training and experience, that reasonable treatment alternatives remained available and that my warnings were going unheard.

Medicine cannot become so rigid that adherence to a protocol takes precedence over the condition of the patient directly in front of the physician. Protocols should guide physicians; they

should never replace clinical judgment. When a patient is deteriorating, physicians must remain free and willing to reassess, change course, and consider reasonable alternatives.

I was also deeply troubled by a system in which financial incentives surrounding particular hospital protocols, combined with the fear physicians faced of professional repercussions for departing from those protocols, could influence medical decision-making. At a minimum, such circumstances create a profound potential conflict between institutional policy and individualized patient care.

I spent my professional life caring for patients and making difficult medical decisions. Watching my own cousin die while believing there were reasonable measures that could have saved him, is something I will carry with me for the rest of my life.