

Gerry and I were both diagnosed with COVID-19 on November 17 at a remote testing site. Our general practitioner told us to stay home and ride it out, but we were not given any additional care or guidance.

I was taken by rescue squad to Northwestern Hospital in McHenry on November 23 after my oxygen levels dropped into the 50s and I was admitted. Gerry was taken to the same hospital on November 25 after his pulse oximeter showed that his oxygen saturation had fallen into the 70s with minimal activity.

The hospital sent Gerry home that day by rescue squad with a diagnosis of COVID pneumonia and a prescription for ibuprofen. He did not meet the hospital's protocol for admission.

November 27 he called the rescue squad again and was finally admitted.

Once hospitalized, Gerry was placed on high-flow, heated oxygen delivered through a nasal cannula. He received a 10-day course of remdesivir, along with steroids, antibiotics, antivirals, Pepcid, and likely several other medications.

That was a significant part of the problem. Gerry was a wonderful and compliant patient, but he was too sick to understand what medications he was receiving or why. While we were both in the hospital, he would call me and tell me that he did not understand what was happening to him or what the medical staff was doing. Both of us asked the doctors to provide me with updates about decisions regarding his medical and pharmaceutical treatment.

However, it was McHenry Hospital's policy for doctors to determine whether a patient was "decisional." Because Gerry could carry on a conversation and identify the day of the week, they deemed him decisional. In reality, he was not capable of understanding the complex matters involved in his treatment. Both of us said so, but our concerns were ignored.

The hospital also refused to let me see Gerry or be present during his consultations, even though I was hospitalized there with him, had since been discharged, and had immunity—none of which they would recognize.

When I repeatedly asked why Gerry was getting worse, the staff kept telling me, "Sometimes things have to get worse before they get better." I asked that he receive convalescent plasma, but I was told that it was not part of the hospital's protocol. When Gerry was moved to the ICU, I immediately requested that he be transferred to another facility. McHenry's only remaining option, I was told, was intubation—placing him on a ventilator. The hospital said it wouldn't arrange a "lateral transfer."

Meanwhile, because of his difficulty breathing, Gerry was not being fed. He lost 25 pounds in three weeks weakening him further.

After he was placed on a ventilator, the hospital called to tell me that he was in kidney failure and instructed me to come say goodbye. I rushed to the hospital, and the doctors eventually agreed to transfer him to Northwestern in Chicago for ECMO treatment.

Once Gerry arrived in Chicago, doctors discovered that he had blood clots in his legs—clots that McHenry had not monitored for. All of his tests and scans had to be repeated because, according to the Chicago specialists, the quality of the imaging done at McHenry was substandard.

Gerry fought valiantly, but after two cardiac arrests, he was declared brain-dead on December 21, 2020, and ultimately passed away.

Gerry had no preexisting conditions. He was an IBEW member, fit, and healthy. He took only one medication for his thyroid. He was 63 years old and had retired that March to protect me from COVID exposure because of my asthma.