

COVID-19 Hospital Experience — Statement for the Record

I am a board-certified Internal Medicine physician who worked as a hospitalist/nocturnist caring for COVID-19 patients in Florida from **March 2020 through August 2021**. During this period, I worked at multiple hospitals, including five HCA facilities, generally in assignments lasting approximately three months. I worked extensively in Tallahassee, Lake City, Okeechobee, the Treasure Coast and the West Palm Beach area.

For approximately seven months, I predominantly worked **7:00 p.m.–7:00 a.m. nocturnist shifts**. I admitted COVID-19 patients and provided overnight cross-coverage for patients assigned to other attending physicians. This required reviewing medications, laboratory and imaging results, oxygen requirements and clinical changes, and responding to deterioration with emergency orders. For approximately five months, I predominantly worked **7:00 a.m.–7:00 p.m.** as an attending hospitalist directly responsible for treatment plans.

My concerns about COVID treatment policies began while I was actively practicing, not years afterward. HCA treatment guidance was distributed to our hospitalist group. A May 26, 2020 HCA communication stated that **hydroxychloroquine had been removed from its recommendations** and that its remdesivir section had been updated following FDA Emergency Use Authorization. I subsequently encountered pharmacy and administrative restrictions when attempting to prescribe hydroxychloroquine and ivermectin. My Raulerson Hospital progress note specifically documented that hydroxychloroquine was **“not allowed for COVID19 treatment per hospital pharmacy and HCA rules.”** Another electronic record shows an ivermectin order I entered receiving a request for clinical review by the CMO, with zero of five doses shown as administered.

I generally preferred hydroxychloroquine-based treatment when I believed it was clinically appropriate and institutional rules permitted it. I generally declined to initiate remdesivir unless a patient specifically agreed after I discussed potential risks, including renal and hepatic adverse effects, and the potential benefits and uncertainties as I understood them.

Because I worked predominantly nights for substantial periods, many remdesivir-treated patients whose deterioration and deaths I observed were patients I was **cross-covering**, rather than patients for whom I was attending of record. I monitored their treatments and responded to their deterioration overnight. My contemporaneous records subsequently described **14 deaths among 28 remdesivir-treated patients I tracked during one period**. This was an observational clinical experience and does not, by itself, establish that remdesivir caused those deaths. It was sufficiently concerning, however, that I believed it required investigation.

I reported these concerns while they were occurring. On **August 8, 2020**, I contacted FDA seeking to report suspected adverse drug reactions and concerns about remdesivir effectiveness. On August 14, I told FDA that I was covering these patients overnight and had

documented approximately 25 cases during my preceding seven workdays. FDA records document additional acknowledgements through September 6, 2020.

I also raised concerns with hospital physicians and leadership and through outside oversight channels. I ultimately lost the ability to continue working at facilities after challenging treatment restrictions and documenting my objections.

I respectfully ask Congress to obtain the **EHRs, pharmacy audit trails, HCA treatment policies, mortality data, FDA and HHS complaint records, and relevant physician and administrator communications** and independently determine what happened to these patients and to physicians who raised concerns.