

My name is Kimberly Lewis. I am a 63-year-old retired public-school teacher from Alden, New York. I am the widow of Robert F. Lewis, Jr., and I submit this statement concerning his hospitalization at Mercy Hospital in Buffalo, New York, during December 2021 and January 2022.

My husband was 60 years old when he died on January 15, 2022. He had a history of diabetes, high blood pressure, a mild heart attack in 2008, and bowel obstruction surgery in 2016, but he had recovered fully from those prior events. Before entering the hospital, he was working full-time as a computer programmer and was active in volunteer Christian ministry.

I became ill December 12, 2021, with symptoms we believed to be COVID-19. After I began improving, my husband became ill on December 24. He received treatment at home, but his condition worsened rapidly. Overnight on December 27, his oxygen levels repeatedly dropped and on December 28 he was taken by ambulance to Mercy Hospital for oxygen support and hydration.

In the emergency department, he objected to a nasal swab COVID-19 test (and vaccination) on religious grounds. They told him they would not treat him without it and discharged him. I found him, brought him back and demanded treatment. The security guard forced me to leave the hospital. They sent him to the waiting room with an oxygen tank where he lost consciousness, struck his head, and required a CT scan. He was admitted, placed in isolation, and put on high flow BiPAP. He was repeatedly told he must be treated with Remdesivir and go on a ventilator. He refused. He asked staff to contact his personal medical provider and me as his health care proxy. Those requests were repeatedly ignored.

During 18 days of hospitalization, I was allowed only four brief visits. I was told conflicting things about who could authorize visitation and about treatment decisions. My husband's attending clinicians changed many times. I repeatedly provided notice that I was his health care proxy and requested coordination with me, but this was inconsistent.

He repeatedly declined remdesivir and ventilation. We requested ivermectin, which his outside provider had prescribed before admission. They refused until day fourteen, and then only at a much lower dose than previously prescribed. Throughout the hospitalization, I was given very limited and inconsistent information by staff about his condition and treatments.

He spent increasing amounts of time on BiPAP. We were told it would be used temporarily, but he became dependent on it. He had difficulty eating and drinking because the mask was not removed. I was told he was receiving meal trays, but he reported periods without food, and I was told IV hydration would not be used. He was given only clear liquids on his trays most of the time. On day fourteen, a doctor agreed to order "full liquids." When I was finally able to visit, I observed him in wet bedding. As his contact with me and others was severely limited, I also observed that this isolation caused him to deteriorate mentally, emotionally, and physically.

Near the end of his hospitalization, clinicians urged me to authorize comfort-care measures and removal of BiPAP. On my first three visits, he indicated that he was still fighting and did not want “comfort care.” He asked for additional pain medication, which they denied until I agreed to complete the MOLST form. On my final meaningful visit, he indicated that he was ready to stop fighting and wanted more medication to relax. When I returned later after discussing the required form, I was told comfort-care medication had already been given. He died a few hours later.

I ask the Senate to recognize and investigate the effects of isolation policies, inconsistent communication, failure to honor proxy involvement, barriers to informed consent and refusal, and the inadequacy of nutrition, hydration, personalized treatment and supportive care provided to hospitalized COVID-19 patients.