

Statement of Liz Dewey Submitted for the Record

I respectfully submit this statement in memory of my husband, Kevin Dewey, who passed away on August 19, 2021, after a month-long hospitalization for pneumonia and a positive COVID-19 test. I submit this statement as a firsthand account of my family's experience and the events as I personally witnessed them or as they were communicated to me by healthcare providers.

Kevin first became ill on July 12, 2021. Believing he had a cold or sinus infection, he contacted our family physician after developing a fever of 101 degrees. Our family physician declined to see him because he was running a fever. Over the following days, he visited multiple urgent care clinics but was sent home to rest and stay hydrated. On July 19, a chest X-ray revealed pneumonia, and he was prescribed medication. Our local pharmacy did not fill the prescriptions for several hours. I repeatedly questioned the delay and was told by the pharmacist that the pharmacy had directed its pharmacists to prioritize administering COVID vaccinations rather than filling prescriptions.

On July 20, I took Kevin to Memorial Hermann Sugar Land Hospital after his condition worsened. He tested positive for COVID-19 and was admitted overnight before being discharged the following day. Within hours of returning home, he experienced severe breathing difficulties and began coughing up blood. I drove him back to the emergency department. Because I was ill, I could not accompany him into the hospital. Kevin walked into the emergency department on his own. Two hours later, I was informed that he had been placed on mechanical ventilation.

I was never able to see him while he was in this hospital.

During one of my first conversations with a nurse after Kevin was intubated, I was told he had been sedated because hospital staff were "afraid that he might run out of there." Throughout his hospitalization, I repeatedly asked his physicians to consider Ivermectin, Hydroxychloroquine, and other treatments as I understood they were being used by other physicians at that time and I was told those requests were denied because they were not part of the hospital's treatment protocol. I also requested supportive therapies, including intravenous vitamins, which were likewise declined.

After approximately three weeks, I was asked to consent to placement of a feeding tube. By then, Kevin had been on a ventilator for three weeks and had not eaten since before his admission. Around the same time, I was informed that he would need to be transferred to a long-term care facility.

While preparing for his transfer, staff at the receiving facility asked me several times whether Kevin had a Do Not Resuscitate (DNR) order. I unequivocally answered no. Staff informed me that a DNR appeared in his medical record. I did not consent to or authorize the DNR and Kevin had not authorized one to my knowledge.

Kevin was transferred while still on a ventilator. Staff at the receiving facility told me he was the sickest patient they had ever received. Kevin remained at the long-term acute care facility for four days before he passed away.

I respectfully ask Congress to ensure that no family experiences what ours did. Patients and their designated decision-makers deserve informed consent, transparency in medical decision-making, meaningful participation in care decisions, and assurance that a Do Not Resuscitate order or other limitation on life-sustaining treatment will not be entered into a patient's medical record without the knowledge and authorization of the patient or the person legally empowered to make those decisions. Thank you for allowing my family's experience to become part of the official record.