

Thank you, Senator Ron Johnson, for your continued willingness to examine the experiences of American families during the COVID-19 pandemic and for providing a forum in which these accounts can be entered into the public record.

I am writing to document the events surrounding the hospitalization and death of my father, Richard Gallivan, at Miami Valley Hospital (Premier Health) in Dayton, Ohio, in late 2021.

My father carefully researched the COVID-19 vaccines, reviewed available data on side effects, and decided that he and my mother would not receive them. He located a local physician affiliated with the FLCCC (Front Line Critical Care Alliance), obtained their protocol and kept the recommended medications on hand in case of illness.

In early November 2021, my mother became ill with the Delta variant. Using the medications prescribed by their doctor, she promptly began taking ivermectin, corticosteroids, and supportive vitamins. My father was a selfless man. He placed his hands on my mother and asked God to take her sickness and to give it to him. She made a full recovery at home with the FLCCC protocol of ivermectin, steroids and vitamins.

My father delayed starting ivermectin when he became symptomatic. I believe this was due to the difficulties obtaining a pharmacy refill and his concern that they would run out of medication. His illness progressed. He was prescribed an antibiotic for pneumonia and was going to get an X-ray in two days. On November 16, I called him and he could barely speak because of the severity of his cough. We checked his oxygen saturation with a home pulse oximeter; the readings were 92, then 75, 64, 71. I advised them to call the ambulance so that trained personnel could verify the readings with their equipment. The ambulance team recorded an oxygen saturation of 77. My father did NOT want to go to the hospital and the lead member of the ambulance team said he would be ok. An hour later, he agreed to go, hoping he would be allowed to continue the ivermectin and antibiotics for pneumonia already prescribed by his physician.

My Mom was permitted to stay with him in the Emergency Room. He was transferred to Miami Valley Hospital Main/Premier Health in Dayton Ohio. When the transport team arrived, they told my Mom to kiss him goodbye.

The next day, the physician noted in my father's medical chart "I had a long discussion with the patient regarding the purpose of Tocilizumab and why we are not giving the patient Ivermectin, which he was started on 11/11/21 by his pulmonologist. Patient had been very adamant that he wanted Ivermectin and threatened to sue the hospital if he was not given this medication."

My father refused Remdesivir upon admission because he had researched the drug, but he was persuaded to accept Tocilizumab. A nursing note that evening stated that the patient should not take these supplements because we do not know how they will interact with his meds here. Patient stated "You cannot take away my vitamins, dammit! I need to give myself a fighting chance and get out of here alive!" Pt did not allow this RN to remove meds from bedside table. 911 team notified.

From the beginning it felt like a fight. I was scared, and I know that my father was as well. He had a strong desire to live.

He gave me access to his MyChart account and I followed every note. Nearly every physician entry highlighted that he was "NOT Vaccinated against COVID." He did better on CPAP during the day, with oxygen saturations in the high 90s but at night staff insisted on BiPAP and sedation meds. His condition deteriorated each time this was forced. When I requested IV vitamins, I was told none were available in the entire hospital. I repeatedly asked that bacterial pneumonia be ruled out and antibiotics be considered, but staff insisted that the illness was viral and refused to test or advocate to the physician for antibiotics. Breathing treatments were denied on the grounds that they would aerosolize the virus. Incentive spirometry was discouraged because "he needed to rest." It was impossible to reach a physician by telephone; nurses would end conversations by stating that there was an emergency.

During a FaceTime call while my father was on CPAP with oxygen levels in the high 90s, he told my husband, "Take care of her." We assured him we were doing everything possible to fight for him and bring him home. He replied, "It's different with this-the doctor wants to put me on a ventilator."

Hospital food and drinks were not brought, even though we ordered them, so we delivered small meals and smoothies to the desk; it took hours for them to be delivered to his room.

On subsequent FaceTime calls my father appeared increasingly sedated and disoriented. One nurse told us that if he cannot tolerate the BiPAP that he would be intubated and, at his age, he would not survive. The evening before intubation, a nurse stated in an angry tone in front of him, "This is serious! Everyone in your family needs to get vaccinated EVERYONE!"

The next morning, he could barely speak, kept losing consciousness, and dropped the phone. On the FaceTime call I could see the nurse from the night before watching in the background. We told him we loved him; he placed his hands together in a gesture of prayer as the nurse took the phone and ended the call. He was intubated minutes later. During the procedure he vomited and bit his tongue. The physician told us that the intubation was to

“give his lungs rest” and would last approximately two weeks. I felt that this was the beginning of the end.

Once intubated, family members were allowed to be in the room, and we took turns staying with him. Four days after intubation, when I spoke to him, he squeezed my hand strongly. The nurse remarked, “Oh we don’t want to see that response” and administered a sedating medication through his IV.

I continued to monitor his care through MyChart and researched every development. Over the following weeks his condition declined rapidly. He was handled roughly when being moved; on one occasion his arm was left dangling on the side of the bed. He developed liver and kidney failure requiring CRRT. There was significant extremity edema, cardiac ischemia, inferolateral cardiac injury, pneumothorax, tracheostomy and PEG placement, and bilateral lower extremity DVT. He suffered a bowel perforation requiring surgery that led to bacterial sepsis. This all ended with a PEA arrest on 12/16/21.

He was isolated from his family, denied the right to try treatments like ivermectin prescribed by his own physician, overly sedated, denied high-dose vitamins and adequate nutrition, denied breathing treatments, mocked for his vaccination status, chemically paralyzed and physically restrained. The daily medications included a combination of Precedex, propofol, fentanyl, morphine, midazolam, Seroquel, Haldol, ketamine, anti schizophrenic/anti-psychotic medications and many others. My mother was pressured regarding DNR status and palliative care while we continued to request life-saving measures. We were scolded and told that the only patients on ventilators were unvaccinated.

This was a place that we trusted and went to for help. Once we were there, I felt like I was fighting a war with the medical team. I felt helpless trying to save my Dad’s life.

He suffered for 30 days. Suffering is worse than death.

On the final evening, my father attempted to communicate with me; his hazy, medicated eyes shifted toward me when I spoke. The nurse administered Dilaudid and his eyes became fixed and he stopped moving his head. His respirations became more rapid, and he was breathing over the ventilator. The nurse wanted to give him Seroquel to slow his breathing. I hesitated because I did not understand why an antipsychotic was necessary in addition to the heavy sedation that he was already receiving. She administered the Seroquel. Approximately 25-30 minutes later I heard a gurgling noise, ran into the hallway, and alerted staff. The nurse turned the monitor so I could not see the numbers dropping. When I asked whether I should call my mother, she said no. In a panic, I called my brother

and husband and told them to hurry and then called my mother. She was able to speak to him and recite the Lord's Prayer as he was dying.

A simple search that night revealed major drug interactions/contraindicated between Dilaudid and Seroquel that can cause serious side effects including respiratory distress, coma and even death. I was concerned about interactions occurring with the other medications already running through his IV.

My father is with his Savior, Jesus Christ. He was a proud American and Veteran who served this country for over 40 years. More importantly, he was a devoted husband, father, and papa that loved his family more than words can express. What happened to him has left our family permanently changed. The trauma of those weeks contributed, I believe, to my own subsequent breast cancer diagnosis. Differing opinions about what occurred have also divided our family.

We went to a place we trusted for help and instead felt we were fighting a war against the very people charged with his care. The combination of isolation, denial of the treatments my father and his own physician believed in, heavy multi-drug sedation, and the rapid multi-organ failure that followed has left me convinced that harm was done. I hope no other family has to experience the same helplessness or the inability to advocate effectively for a loved one who wants to live.

Thank you for the opportunity to submit this testimony for the record.

Respectfully submitted,

Meghan N. Fridley

