

I tested positive for COVID at Mercy Walk-In Clinic in McHenry, IL, where the doctor prescribed medication for me to take at home. Because I was dehydrated and concerned about my condition, I went to the ER at Northwestern Medicine in McHenry, Illinois. The hospital provided IV fluids. I used the crowded ER bathroom twice while waiting to see the emergency room doctor.

When the ER doctor came in, he told me there was no reason for me to remain in the ER because I had been on my phone and said they were releasing me. A few minutes later, he was informed that I was not vaccinated. His decision changed. He and the ER nurse decided I should remain in the hospital to be treated for my cough. Although my cough was not severe, I was told they would start me on steroids and send me home in three days.

That was August 23, 2021. Instead of being discharged after three days, I remained hospitalized until September 2, 2021. During my stay, I repeatedly asked to go home.

From the first day, I was active and trying to care for myself. I got out of bed, walked to the bathroom, washed my face, brushed my teeth, sat in a chair to get sunlight, and paced the hospital floor.

I was not allowed to have family members with me. Being separated from my family while being repeatedly asked whether I lived alone made me feel isolated and vulnerable. I had no family member present to observe what was happening, communicate my concerns, or advocate for me.

My experience with the COVID doctor was difficult. On the first day, she got very close to my face and repeatedly demanded that I explain why I had not been vaccinated. This became an ongoing conflict. At one point, she told me she was going to give me something “strong.” I became frightened and wondered if the hospital intended to put me on a ventilator.

On the third day, I was introduced to Remdesivir. I asked a nurse what the medication was, and she responded, “Trust it because it made my brother feel better.” That answer did not provide the information I wanted about the medication or my treatment.

I received injections in my stomach in the evenings. On one occasion, a male nurse inserted the needle so forcefully that I screamed from the pain. My morning IV treatments caused severe burning in my lower extremities, which made me cry. These experiences occurred repeatedly. I also noticed that one nurse would hit my oxygen reader repeatedly in the evenings. Radiologist reviewed my Xrays and told me I would be going home. Turned down the oxygen. Only to have the COVID Dr. turn it all the way up after he left.

I continued asking to be discharged, but my requests were not honored. On September 2, 2021, I was finally released.

I drove myself home. Once home, I could barely walk. My feet felt weak and as though they were flat. I also experienced nightmares for weeks.

I contacted the hospital and requested copies of all my records. After researching the medications I received, I discovered the records indicated that I had received four doses of Remdesivir on my first day in the ER. I was not aware this medication had been administered, and I do not recall signing consent specifically authorizing it. I also found errors and discrepancies in my medical records.

The hospitalization left me with serious questions about informed consent, communication, medical-record accuracy, and the decision-making surrounding my treatment and extended hospitalization. Being separated from my family and having no one there to advocate for me made the experience frightening and isolating. It significantly affected my trust in the healthcare system and motivated me to seek a clearer understanding of what happened and why.