

In July 2021, my husband, Bryan McKeel, became seriously ill with COVID-19. His symptoms began on July 1 and worsened rapidly. By July 10, he was admitted to the North Port Emergency for low oxygen levels. He was then transferred to a hospital in Sarasota after testing positive for COVID.

Early in his hospitalization, Bryan requested Hydroxychloroquine and Budesonide, but was told no, there was a “better option” and was instead treated with Remdesivir, oxygen support, steroids and antibiotics. Then, he was moved to the ICU on July 16.

On July 22, Bryan was placed on a ventilator despite expressing to family members that he did not want to be ventilated. They told us if he didn't immediately go on the vent, he would die. Under duress, we were forced to make a decision without facts. The doctor was standing there with the ventilator as we spoke. They said this would simply “give his lungs a break.” We were not informed of the severity of his condition or that he would be placed on complete life support.

As Bryan deteriorated, our family was told to prepare for the worst. Believing we had exhausted all options, we requested ivermectin as a compassionate treatment. Physicians initially refused, citing insufficient evidence for COVID-19 treatment. One doctor ultimately agreed to administer a compassionate-care dose on July 25, followed by a second the next day. After those doses, we were told Bryan’s fever had resolved, his white blood cell count had improved, his kidneys were stabilizing, he was tolerating food, and certain oxygen measures had improved.

Despite these improvements, physicians refused to continue treatment, stating it was outside of their protocol and would not be approved. Our family pleaded to the entire hospital care team, which included two doctors, vice president and chief medical officer of the hospital, pharmacist, patient advocate, lawyer, the risk management team, and a zoom attendant for continuation of ivermectin.

We offered to sign waivers and emphasized this was a life-or-death situation. The patient advocate said, “all they want is ivermectin.” The director asked the pharmacist about side effects, and after being told there were none, looked at the doctor and nodded, “okay.”

After those 2 doses, we were denied any additional doses of ivermectin.

Bryan may have been a candidate for ECMO, an advanced life-support treatment offered at larger hospitals. However, this possibility wasn't meaningfully discussed until his condition had severely declined and it was too late for a transfer. We were told by the doctor that none of the seven patients that went on this treatment in Sarasota survived. Why were transfer options not explored sooner?

Due to hospital restrictions, I was unable to be by his side, our request for clergy visitation was denied,

and nursing staff told us to limit calls to twice daily despite his critical condition.

We believe this deprived him of critical spiritual and family support during the most difficult time of his life.

Near the end, hospice care was discussed as a comfort measure, but we were not clearly informed that this could involve removing life-sustaining interventions. Only after further questioning did we understand those implications and Bryan's decline.

My husband passed away on August 3, 2021. My young daughters and I were forced to say goodbye **over an iPad.**

We are asking for greater oversight, transparency, informed consent protections, compassionate-treatment access, stronger patient and family advocacy, as well as a "right to try" during medical crises. We firmly believe Bryan may have survived had he not been denied medication that appeared to be helping. Life-saving options should not be withheld when families consent and no meaningful alternatives remain. We believe a homicide occurred.

We hope that justice will be served.