

In late 2021, while working in an intensive care unit at Aspirus Medical Center in Wausau, Wisconsin, I discovered what I came to understand was a widespread and serious problem in how hospitalized patients' COVID-19 vaccination status was documented and displayed.

Our hospital used the Epic electronic medical record system. On the home screen of each patient's chart appeared the patient's COVID-19 vaccination status. At that institution, I observed only two categories: "Fully Vaccinated" and "Unknown."

Because I was running ICUs, most records I opened belonged to critically ill patients. In November 2021—eleven months into the vaccine campaign—for the first time, I opened the chart of a patient who was identified as "Fully Vaccinated." I recall being shocked because I hadn't seen that before and immediately questioned why that was the first because I was well aware at that point of the gross inefficacy of the vaccines. So, I examined the record and found that the patient had been vaccinated in a physician's office within the hospital's own clinic system, allowing the vaccination to be entered into the electronic record.

I began asking nurses how COVID-19 vaccinations administered outside their hospital systems were documented once admitted. Many Americans had been vaccinated at pharmacies, public clinics, pop-up sites, or drive-through clinics. I learned that, in many hospitals, the immunization tab had disappeared from the chart's header menu in Epic. Nurses could no longer access the section for entering a patient's vaccination history. Even when patients presented signed vaccination cards containing dates and lot numbers, the cards were scanned into the chart or the information was placed in nursing admission notes, but it did not populate the vaccination-status field on the home screen. Those patients continued to appear as "Unknown" or "Unvaccinated."

Doctors and nurses from multiple institutions—including large academic medical centers and smaller independent hospitals, many using Epic—described the same problem. Some physicians discovered that their own records identified them as unvaccinated even after they sent in or uploaded proof of vaccination with signed cards. One nurse who worked in both a major academic system and a smaller hospital reported that the smaller hospital retained the vaccination tab which permitted nurses to enter card-verified vaccinations, while the larger system did not.

This was a fundamental departure from longstanding medical practice. Historically, credible vaccination documentation presented by a patient was entered into the electronic immunization record. During COVID-19, that practice was disrupted. Clinicians relying on the home screen were therefore given a false impression of who was hospitalized, while official data derived from incomplete electronic records could not accurately represent patients' vaccination status.

Then, approximately a year ago, I was informed by those same colleagues that I had discussed this issue with, that the “disappeared” immunization tab allowing them access to the official vaccination record suddenly reappeared—without notice or explanation—just as it had disappeared.

In my judgment, this was not an innocent clerical inconsistency. It was a systematic change in hospital documentation practices that made vaccinated patients appear unvaccinated or of unknown status. I believe it produced grossly inaccurate data and was used to help create the widespread public and professional perception that the overwhelming majority of hospitalized patients were unvaccinated. This practice, its origins, and its consequences demand a full investigation.

I ask the Senate to examine how hospitals and electronic-record systems recorded, displayed, exported, and reported COVID-19 vaccination status during 2021 and 2022. This review should examine who removed or restricted access to immunization fields; whether externally administered vaccinations were reconciled with state registries; how “Unknown” records were classified in hospital, state, federal, and media reporting; and when, why, and by whose authority those functions were restored.

Hospitals, electronic-record vendors, public-health agencies, and data contractors should preserve and make available the relevant configurations, policies, audit logs, data definitions, communications, and reporting specifications so these questions can be answered.