HEALTH KEEPERS: WHERE IS YOUR OATH?

Liberty's Nightmare Opens Its Eyes in Arizona
Taking How Many Lives?
How Far Behind is Your State or Country?
What Ever Happened to Informed Consent?

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You were wrong if you thought that the COVID-19 Plannedemic was nightmare enough, with its

- Unscientific and dangerously flawed testing,
- Unscientific and bizarre dust mask/bandanna/tee shirt/chiffon scarf face covering hysteria,
- Unscientific and awkward "social distancing" rules and sudden,
- Unnecessary, vast economic destruction of the lower and middle classes' economic stability.

Not nearly *nightmare* enough, as it turns out. Now, as they say in Courts of Law, Comes the next phase of terrifying medical tyranny in this horrifying and deadly game of Global Monopoly.

On July 2, 2020 I learned from *PPJ Gazette*[1] that Arizona had become the first state to implement its Crisis Standards of Care, or CSC. It is important to note that while many other states have CSCs, as of today, Arizona is the only State to have *implemented* them.[2] And they are, to me as a citizen, a physician, a Health Freedom Advocate and a person who, while in robust good health, would be classified, because of my age (76) as far less worthy than others of resources should I become ill and, God Forbid!, require hospital care.

It should be noted that while age is explicitly excluded as a category for care reduction or denial, the realities are far different, as anyone with an elderly parent, or themselves elderly, can eloquently testify when recounting the number of times they were urged to allow the termination of life because the elderly person "has lived a good life and it [is] time to let [him/her/your life] go."

Age counts. Negatively, in the mind set, the *mens reas*, of our new [would-be] medical masters.

The Arizona CSC 'legitimizes' how you and your loved ones may be terminated without the least shred of input from you or liability on the part of any of the members of the hospital staff or the hospital itself, or any pretense of actually honoring the universal right of Informed Consent.

It begins, soothingly enough by noting in *State Principles of COVID-19 Addendum* "*All lives are precious."*[3] and then goes on to specify that under certain circumstances, some are a lot more precious than others:

"***If resources are sufficient**, all patients who can potentially benefit from therapies will be offered therapies. If resources are insufficient, all patients will be individually assessed. No one will be categorically denied care based on stereotypes, assumptions about any person's quality of life, or judgement about a person's "worth" based on the presence or absence of disabilities. All patients, regardless of resource availability, will be treated with respect, care, and compassion. Triage decisions will be made without regard to basis of race, ethnicity, color, national origin, religion, sex, disability, veteran status, age, genetic information, sexual orientation, gender identity, quality of life, or any other ethically irrelevant criteria...*"[4] [Emphasis added by author.]

"*Prior to, as well as during, implementation of Crisis Standards of Care, all efforts must be made to determine a patient's goals of care and treatment preferences. It is imperative to know whether aggressive interventions such as hospitalization, ICU admission or mechanical ventilation are consistent with a patient's preferences. For a patient with decision-making capacity, the individual's informed refusals should be respected. All hospitalized patients should be asked about advance care planning documents, goals of care, and are strongly encouraged to appoint a proxy decision-maker (e.g., medical durable power of attorney (MDPOA) or health care agent) if not previously in place. Patients in nursing homes, skilled nursing facilities, other long-term care settings, and outpatient care settings should also be asked about their goals of care and advance care planning documents and encouraged to appoint a proxy who is aware of their preferences regarding hospitalization and critical care if not in place. If advance care planning documents are in place and available the healthcare provider should verify the patient's goals of care and treatment preferences remain the same.*"[5]

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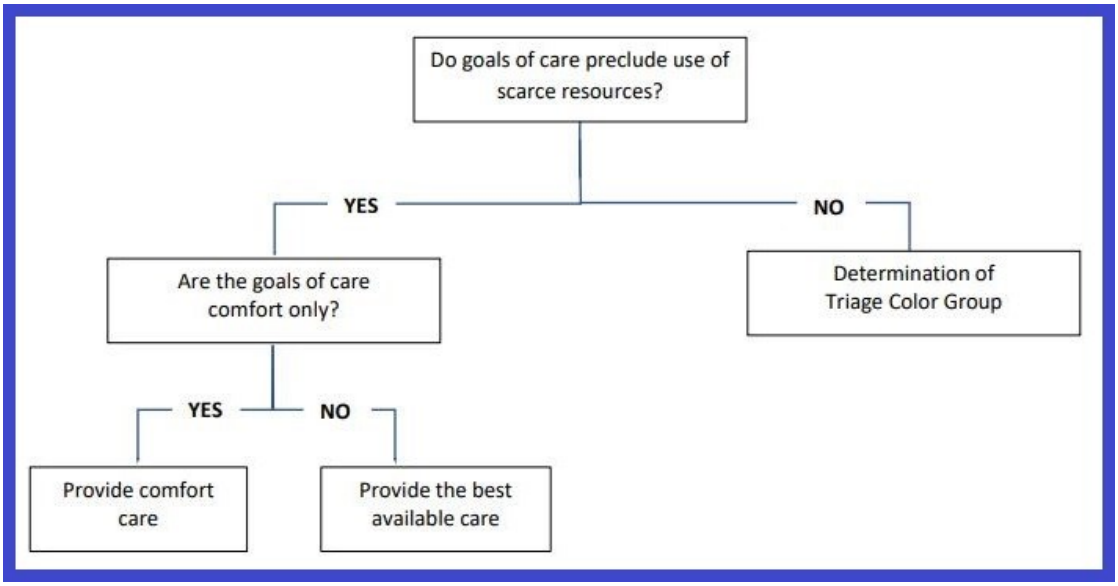
are in place and available the healthcare provider should verify the patient's goals of care and treatment preferences remain the same."[6]

And then the nightmare opens its legally protected, immune eyes:[7]



But these life and death decision makers should not be the patient's treating physician, unless that cannot be helped. Then it is fine.[8]

But the nightmare is not just a fevered COVID-19 dream. It is coming for all of us, and, like most government power grabs, it is not likely to go away: "*These triage protocols would then be applied to both COVID-19 and non-COVID-19 patients.*"[9]

A bureaucratic hierarchy will review triage score based on the following criteria and only those with the lowest scores will be deemed worthy of crisis care:[10]

STEP 1: Assign points for the triage priority score according to the ***individual patient's SOFA score*** *(range from 1-4 points), according to Reference Table 1-A / Reference Table 1-P and Summary Table 1.*

STEP 2: Assign additional points based on the individual ***evaluation of the patient and consideration of 1 year or 5 year mortality****. A maximum of 4 points (not 6 points) will added from this step.*

STEP 3: Add points from STEP 1 and STEP 2 together to produce a total triage priority score, which ranges from 1-8.

STEP 4: Triage color groupings are then assigned based on the triage priority score, according to Summary Table 2. Lower scores indicate higher likelihood of benefiting from critical care, and priority is given to those with lower scores.[11] [Emphasis added by author]

SOFA scores, upon which these decisions are to be based, are a totally inappropriate assay for decisions of this sort. SOFA is an acronym for **Sequential** Organ Failure Assessment. A single score on a given day, such as the day of admission, ("fixed day SOFA score") is NOT a reliable indicator of outcome (in this case, death) although there is evidence that the **change** in a patient's SOFA score ("delta SOFA score") is a far more accurate predictor of likely outcome.[12] [Emphasis added by author] Neither fixed day SOFA nor delta SOFA scores are accurate enough to engender

Fixed day SOFA scores predicted mortality only 3% of the time, while delta SOFA scores predicted them 32% of the time, a difference of nearly 11 times the accuracy.[13]

Note that 11 times better offers less than 1/3 accuracy. This is half of the metric upon which the decision to offer a patient treatment - or death. **That means that whether a patient is given the chance to live or die depends on a statistically meaningless score which is non-predictive 97% of the time coupled with someone's guess of whether they will live for 1 or 5 years after recovering from COVID-19, if they are given the chance to do so and manage to recover.**

And research shows that guess is not much better than the SOFA scores. Doctors and nurses, it turns out, are notoriously poor at accurately estimating the amount of time before death in patients, how much life is left to them. And senior, more experienced medical staff are as bad at it as inexperienced ones.[14]

For example, **Of 18,975 terminal patients identified as likely dying in hours or days, 10.8% either stabilized or improved** leading to a phase change. The researchers concluded that, "This highlights that even in a palliative care setting, confirming the correct diagnosis of dying with absolute certainty remains a clinically challenging exercise."[15]

Careful analysis shows that a doctor's declaration of prognosis is wrong at least 10-15% of the time.[16] In fact, in a 2012 review of autopsies, a staggering 28% had at least one misdiagnosis.[17] Such diagnoses would be an essential part of the decision-making by doctors about "how long a patient has to live".

For those cheerful enough to think that things are getting better, the nightmare has another surprise in store: diagnostic, and therefore, prognostic skills of medical personnel are getting much worse. In fact, an autopsy-confirmed study found that **false-positive diagnosis** (people incorrectly diagnosed as having a particular condition) **increased from 7% in 1989 to 15% in 1999/2000**.[18]

Twice as many medical conclusions, diagnoses, prognoses were wrong over the 11 years of comparison. How many more are wrong now? Many more, it would appear.

A study in the prestigious British Medical Journal found that the estimates of time to death in terminally ill patients found that such predictions were accurate in only 20% of the time, accuracy defined as within 33% of actual survival time.[19]

That means that 80% of the time the physician was more than 66% off in prediction of actual survival time of the terminally ill patient.

Not only that, **patients seeking help at the famed Mayo Clinic were diagnosed with something completely different 88% of the time, meaning that their original diagnosis was correct in only 12 patients out of 100.**[20]

Harried, frightened, tired, overworked doctors in a crisis situation could be expected to make even more medical mistakes and the nightmare will eat those whom they diagnose: their mistakes in diagnosis and prognosis will be denied medical care, good care or bad care, and set aside to die.

Putting the opportunity to make guesses about prognosis - about longevity - in the hands of personnel routinely wrong about these things, and coupling it with a scoring system statistically inadequate to make even an informed guess about likely longevity is a terrifying error. The final decisions, however, will not be made by treating physicians, but by Triage Officers, remote bureaucrats who are, in fact, not supposed to be treating physicians.

What the qualifications of these Triage Officers are to make these decisions are not specified in the document.

In several places, however, what is specified is that age is *not* to be factored into the triage scores received.

I find it almost impossible to believe that the bias of a harried and exhausted crisis situation doctor or nurse will not be to give preference and precedence to a younger, rather than an older, patient.

It happens now on a routine basis and, in fact, I can tell you personally that as I was taking a routine Continuing Medical Education course required by one of the States in which I hold a Medical License (New York State in this case), at the end of the topic (how to reduce opiate dependence and addition), an additional module was required (complete with required test) on how to convince people to agree to die when they were either ill or just old. The title of the module was more politically correct, something about End of Life Counseling, but, in fact, it was a script to be used to devalue and diminish *not* ending the life of the old or the ill.

This training is part of the standard curriculum of continuing and current medical education so the bias of these supposedly virtuous termination decisions is already built into the minds and score decisions of those entrusted with implementing the nightmare.

Once Triage Scores are assigned, scarce resources will be allotted based on them. If there is a tie, the tie breaker will be another Triage Officer.[21]

In a curious reversal of normal medical procedures in which clinical judgement is a primary, rather than an incidental, tool, it is to be used only if the scores are not sufficient so that "*If some*

of the information normally used to determine the severity of underlying conditions is not immediately available, clinical judgment will be required.[22]

The nightmare can draw charts to make itself look rational and even scientific:[23]

Summary Table 1: Multi-principle Strategy for Determining Triage Priority Score for an Individual Patient; Based on Pittsburgh, California and Maryland Frameworks

	0 POINTS	1 POINT	2 POINTS	3 POINTS	4 POINTS
SOFA score (Table 1-A) Or PELOD-2 score (Table 1-P)		ADULT SOFA SCORE (<6) OR PEDIATRIC PELOD-2 SCORE <12	ADULT SOFA SCORE (6-8) OR PEDIATRIC PELOD-2 SCORE 12-13	ADULT SOFA SCORE (9-11) OR PEDIATRIC PELOD-2 SCORE 14-16	ADULT SOFA SCORE (≥12) OR PEDIATRIC PELOD-2 SCORE ≥ 17
----------PLUS----------					
	ADD 0 POINTS		ADD 2 POINTS		ADD 4 POINTS
Additional considerations	Expected to live more than 5 years if patient survives the acute illness		Death expected within 5 years despite successful treatment of acute illness		Death expected within 1 year despite successful treatment of acute illness

It can even draw color coded charts to develop a lingo for nightmare death medicine: [24]

Summary Table 2: Determining Triage Color Group for an Individual Patient

Triage Color Group	Triage Priority Score from Summary Table 1
RED HIGHEST PRIORITY FOR CRITICAL CARE RESOURCES	1-3
YELLOW INTERMEDIATE PRIORITY FOR CRITICAL CARE RESOURCES	4-5
BLUE LOWEST PRIORITY FOR CRITICAL CARE RESOURCES	6-8

Charts, black and white or colored, do not, however, create science, sense or reality.

Reassuring us all that sometimes, when a patient is going to die immediately, critical care is withheld. What, exactly, does that mean?

Does it mean that a patient with a heart attack is not resuscitated since he/she will die immediately without resuscitation?

That a starved, dehydrated and head injured child is not given food, fluids and, if necessary, immediate cranial decompression since he/she will die without them?

That a poisoning victim does not have his/her stomach pumped because without that procedure, the victim will die?

That may be good news for overburdened medical budgets since a great many emergency room and EMT services can now be safely and, apparently, 'ethically' eliminated because the patient was going to die without them so we are within our medical ethics to not render them. Good to know.

In the same way, we are told, once a determination is made on the wildly inaccurate and statistically meaningless SOFA scores, equally meaningless longevity guestimate and the colorful chart rating has been determined, it is perfectly fine to behave in the same way, "*During a public health emergency, clinicians must still make those same judgments about the medical appropriateness of critical care services using the criteria they use during conventional care.*"[25]

The procedure for killing off the now officially hopeless patient is clear unless "t*wo or more patients require a single resource.*"[26]

Then the rules are clearly laid out. Priority is assigned on the basis of the following criteria:

1. *Pediatric patients < 18 years of age*
2. *First responders or frontline healthcare workers (HCWs). This prioritization reflects the instrumental value HCWs serve in the community during a pandemic, as well as an acknowledgement of the increased risk they are assuming in caring for high-risk patients. They specifically do not receive priority because of an estimation of worth.*
3. *Single caretakers for minors or dependent adults.*
4. *Pregnant patients.*
5. *Opportunity to experience life stages (childhood, young adulthood, middle years, and older years). The justification for this principle does not rely on considerations of one's intrinsic worth or social utility, but rather that younger individuals have had the least opportunity to live through life's stages. Public engagement regarding allocation of critical care resources supports the use of this principle for allocation decisions. (Neuberger 1998)*[27],[28]

"Sorry, your Aunt Elizabeth just didn't make the cut. I hear the undertaker is giving volume discounts."

But wait! What, considers the document, about those two equally-ranking patients need the resources? Not to worry. The CSC has your solution! And the framers of this document are sure you and I will agree it is completely fair: "*If patients requiring the same scarce resource cannot be effectively prioritized with any of the above, allocation should proceed randomly.*"[29]

"Oops! Yes, your son did qualify for emergency resources, also known as 'treatment', but so did another guy, so we flipped a coin and, sorry, but your child lost out. Hey, it's nothing personal! Better luck next time!"

Indeed, it is absolutely nothing personal. Or ethical. Or sane.

Can this get worse? Oh, yes! A whole lot worse.

Triage Scores will be reassessed daily. If patient's condition worsens, their score will go down. If their score goes down, the Triage Officer can assign them a worse Triage Score. If the Triage Officer wishes, s/he can assign resources to someone else.

Period.

The controlling document does admit that withdrawing life-sustaining care requires even more stringent ethical consideration than withholding it in the first place and states,

"3. *Withdrawing and withholding of life sustaining resources differ in triage whereas they are considered ethically equivalent in non-triage circumstances.* ***We therefore expect the withdrawal of a scare resource from one patient to require a more stringent justification than the withholding of a scarce resource from another.*** "[30] [Emphasis added by author]

Oh, good. Now I feel better. Don't you? Any corruption in this unscientific and terrifying process would be a deeper and more well-defended corruption.

The Triage Officer is now the *Sonderführer*, the Specialist Leader. Once he reassigns a Triage Color or rank to a patient or takes it away, the attending physician has no say. The controlling document specifically makes it clear that scarce resources can be withdrawn from one patient and given to another by the *Sonderführer*, the Triage Officer, *but the patient's physician can do nothing about it*.

Appeals are permitted. Sort of. IF there is time. IF there is another *Sonderführer* available. Either the doctor or the family can request such a review. ONLY the unscientific and rigid criteria used in the first place can be considered. No other input is permitted.

There is, it is important to note, a process for appeal that allows a *Sonderführer, and only a Sonderführer,* to make the decision on whether those resources will be taken from the patient and given to another one.

This process further confirms that, in the land of Crisis Management, the *Sonderführer* is more than king. The *Sonderführer* holds the power of life and death in his/her hands.

What could possibly go wrong?

Here are the stated terms for review and revision of a decision by the *Sonderführer* to remove essential treatment from one patient and give them to another (say, from your father to the father of the *Sonderführer*):

1. *Appeals will be allowed if there is concern regarding whether an individual patient's Triage Priority Score or Triage Color Grouping is accurate;* ***appeals based on rejection of the criteria will not be allowed.***
   a) If a clinician elects to appeal a decision, another appointed Triage Officer(s) not involved in the original decision, if available, will be asked to review the case.
   b) If the family or decision maker elects to appeal the decision, another appointed Triage Officer(s) not involved in the original triage decision, if available, will be asked to review the case.
2. ***An appeal could be denied if there is a time-critical situation and insufficient time to conduct the appeal.*** **[31]**[Emphasis added by author]

Does anyone else see an opportunity for wealth building and death dealing corruption at the cost of innocent lives? That elephant is not just in the room, the whole hospital is in its belly!

"Wait!" you may cleverly say. "I will bring my own ventilator with me if I get COVID-19 symptoms and need to go to the hospital." Well, sort of clever, anyway. You get to keep your own ventilator, which is your personal property, and it cannot be used for someone else, at least not according to what the rules say. During that time, you are exempt from the triage system. But the moment that someone decides you need a hospital's ventilator, you are now inside their triage assessment system and now they can do what they like.[32]

When you die, and 88% of COVID-19 patients on ventilators die[33], your private property, including your ventilator, would be returned to your family, according to the rules of the game.

Well! That's a relief! Wouldn't want to lose Mom's old ventilator!

Every modern tyranny has enlisted the medical community to do its filthy work. And the emerging medical tyranny we are living and dying at the hands of is no exception. There are only two things that can change that:

First, the Will of the People, of you and of yours, of me and of mine, to say, "NO! Don't You Dare!" to the white coated marauders destroying our dignity, our health and our lives with their mandates, vaccines, training for subservience and illogic.

Masking is unscientific. Testing is dangerous and either disastrously inaccurate or totally rigged. Social distancing is subservience training and, like the others, lacks any scientific underpinning whatsoever in this situation.[34]

Second, the Will of Health Care Givers, the Health Keepers, to stand up for humane ethics.

And the coldly written death protocols noted above are beyond
uhttps://medicalxpress.com/news/2020-04-meters-social-distancing-mit-

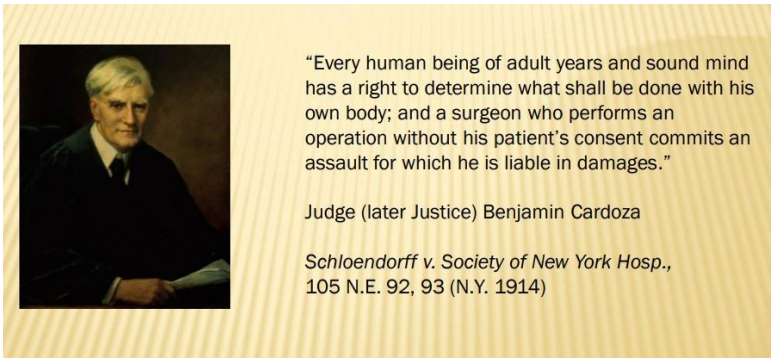
droplets.htmlnconscionable. They reek of previous "final solutions" in their legalistic, jargonistic self-justification.

Jargon justifies nothing.

Natural Solutions Foundation calls upon all health care professionals to stand together against 'politically correct' medical tyranny. ***You can refuse.***

You must refuse. **Assert your ethical standards here: www.HealthKeepersOath.org**

Medical intervention, or refusal to intervene medically, in violation of the universal right of Informed Consent is unlawful and must be refused. [35]



If we are to survive this attempt at the Great Culling [36] **and enslavement of us all, we must do it now, while we might still have a chance.**

04 July 2020

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[1] https://ppjg.me/2020/07/02/arizonas-rules-for-rationing-healthcare-in-the-covid-19-pandemic-should-terrify-you/
[2] Note: all quotes below are taken directly from Arizona's CSC which is similar to most other states' documents covering the same territory although the exact names of the documents may differ. If you have access to other, similar documents, email them to me for a comparison study at Dr.Rima@NaturalSolutionsFoundation.com.
[3] COVID-19 Addendum: Allocation of Scarce Resources in Acute Care Facilities Recommended for Approval by State Disaster Medical Advisory Committee (SDMAC) – 6/12/2020 https://azdhs.gov/documents/preparedness/epidemiology-disease-control/infectious-disease-epidemiology/novel-coronavirus/sdmac/covid-19-addendum.pdf
[4] Ibid
[5] Ibid P. 2
[6] Ibid P. 3
[7] Ibid Loc. Cit.
[8]"As per the Arizona Crisis Standards of Care Plan, 3rd edition (pages 16, 70-72) on designating a Clinical Care Committee (CCC) and Triage Officers, those serving as representatives of the CCC and Triage Staff should not be treating providers, unless that is impossible given the staffing capabilities of the facility. Triage staff will recuse themselves from triage determinations for patients they are personally treating unless no other option exists." Ibid P.4
[9] Ibid Loc Cit.
[10] Pediatric version of the SOFA score may be used for pediatric patients. Ibid P.11
[11] Ibid Loc. Cit.

[12] de Grooth, H., Geenen, I.L., Girbes, A.R. et al. SOFA and mortality endpoints in randomized controlled trials: a systematic review and meta-regression analysis. Crit Care 21, 38 (2017). https://doi.org/10.1186/s13054-017-1609-1
[13] "Fixed-day SOFA was not significantly associated with mortality (slope = 0.35 (95% CI −0.04; 0.75), p = 0.08, I 2 = 12%) and explained 3% of the overall mortality effect (R 2). Delta SOFA was significantly associated with mortality (slope = 0.70 (95% CI 0.26; 1.14), p = 0.004, I 2 = 0%) and explained 32% of the overall mortality effect (R)" Ibid.
[14] https://www.independent.co.uk/life-style/health-and-families/health-news/terminally-ill-life-expectancy-doctors-routinely-wrong-with-predictions-a7254316.html
[15] Clark, K., Connolly, A., Clapham, S., Quinsey, K., Eagar, K., and Currow, D.C. (2016). Physical symptoms at the time of dying was diagnosed: A consecutive cohort study to describe the prevalence and intensity of problems experienced by imminently dying palliative care patients by diagnosis and place of care. J Palliat Med 2016 Dec;19(12);1288-1295 doi: 10.1089/jpm.2016.0219 Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/27603007
[16] Elstein, A. Clinical reasoning in medicine. In: Higgs, J., ed. Clinical reasoning in the health professions. Oxford, England: Butterworth-Heinemann Ltd, 1995;49–59.
[17] Winters, B., Custer, J., Galvagno, S. M. Jr., Colantuoni, E., Kapoor, S.G., Lee, H. W. Diagnostic errors in the intensive care unit: a systematic review of autopsy studies. BMJ Qual Saf. 2012(21), 894-902. Retrieved from http://qualitysafety.bmj.com/content/21/11/894
[18] Kirch, W., Shapiro, F. & Fölsch, U.R. Health care quality: Misdiagnosis at a university hospital in five medical eras. J Public Health (2004) 12: 154. https://doi.org/10.1007/s10389-004-0038-1
[19] Christakis, N. A., Smith, J. L., Parkes, C. M., and Lamont, E. B. Extent and determinants of error in doctors' prognoses in terminally ill patients: prospective cohort study. BMJ 2000; 320:469. Retrieved from https://doi.org/10.1136/bmj.320.7233.469
[20] https://www.sciencedaily.com/releases/2017/04/170404084442.htm
[21]Ibid https://azdhs.gov/documents/preparedness/epidemiology-disease-control/infectious-disease-epidemiology/novel-coronavirus/sdmac/covid-19-addendum.pdf P. 5
[22] Ibid P. 5
[23] Ibid P. 6
[24] Ibid Loc. Cit.
[25] Ibid P. 7
[26] Ibid
[27] Ibid, P. 7, 8
[28] Neuberger J, Adams D, MacMaster P, Maidment A, Speed M. Assessing priorities for allocation of donor liver grafts: survey of public and clinicians. Bmj 1998;317:172-5.
[29] Ibid, P. 8
[30] Ibid
[31] Ibid
[32] When a chronically ventilated patient with their own ventilator is admitted, they will continue to be ventilated using that ventilator which is considered to be their personal property. While ventilated by their own ventilator, patients will be exempt from the triage process. Under no circumstances will a patient's home ventilator be "reallocated" to another patient. This is likewise true of other durable medical equipment that belongs to a patient. However, if a chronically ventilated patient's respiratory status changes and they need to be ventilated with a new ventilator provided by the hospital, the patient will be included for assessment and resource allocation if a triage protocol is in place for crisis standards of care. If this occurs, that patient's home ventilator remains personal property and will not be subject to involuntary reallocation. Ibid
[33] https://www.bloomberg.com/news/articles/2020-04-22/almost-9-in-10-covid-19-patients-on-ventilators-died-in-study
[34] https://medicalxpress.com/news/2020-04-meters-social-distancing-mit-droplets.html
[35] http://www.inhere.org/wp-content/uploads/2020/01/Informed-Consent.paper_.1a.pdf
[36] https://youtu.be/_gWmVtn5JsA