Covid-19 Hospital Protocols

The Perpetuation of the Virus lie via Medical Malpractice

By Jacob Diaz, U.V

Antiviral Remdesivir

HEALTHCARE & PHARMA FEBRUARY 5, 2020 / 2:21 AM / UPDATED 3 YEARS AGO

China lab seeks patent on use of Gilead's coronavirus treatment

By Zhang Yan, David Stanway 3 MIN READ

BEIJING/SHANGHAI (Reuters) - A state-run Chinese research institute has applied for a patent on the use of Gilead Sciences' experimental U.S. antiviral drug, which scientists think could provide treatment for the coronavirus that has killed hundreds and infected thousands.

Eur J Risk Regul. 2020 Apr 11 : 1–6. PMCID: PMC7156563
Published online 2020 Apr 11. doi: 10.1017/err.2020.24

COVID-19, Patents and the Never-Ending Tension between Proprietary Rights and the Protection of Public Health

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In January 2020, Chinese researchers at the Wuhan Institute of Virology filed for a patent covering the use of remdesivir, an experimental antiviral drug, to treat COVID-19. Normally, this might be

"..A study published in the New England Journal of Medicine last week reported a coronavirus patient in the United States was found to show an improvement after taking Remdesivir, which is also used to treat infectious diseases such as Ebola"..

Patent Pending and Tested?

On Thursday, the official Xinhua News Agency said clinical trials of the drug, remdesivir, were due to start.

Gilead, headquartered in Foster City, California, said it applied in 2016 for a Chinese patent on use of remdesivir against coronaviruses and is waiting for a decision. The coronavirus family includes the novel coronavirus, or 2019-nCoV, blamed for the outbreak in Wuhan.

China is forging ahead in the search for treatments for people sickened by the new coronavirus that has infected more than 28,000 people in a countrywide epidemic, killed more than 500 and seeded smaller outbreaks in 24 other nations.

The need is urgent: There are no approved treatments for illnesses caused by coronaviruses.

On Thursday, China began enrolling patients in a clinical trial of remdesivir, an antiviral medicine made by Gilead, the American pharmaceutical giant.

The drug has to be given intravenously, is experimental and not yet approved for any use, and has not been studied in patients with any coronavirus disease. But studies of infected mice and monkeys have suggested that remdesivir can fight coronaviruses.

And it appears to be safe. It was tested without ill effects in Ebola patients, although it did not work well against that virus, which is in a different family from coronaviruses.

NEJM study of Remdesivir for “Ebola”

-Study was conducted between Nov 20th-Aug 9th 2019

-Fauci cited this as proof that this non-FDA approved drug was safe and efficacious for the treatment of “Covid-19”.

- 4 different regions of the Congo were given various drug interventions

-”..On August 9, 2019, when 681 patients had been enrolled, the data and safety monitoring board conducted an interim analysis on data from 499 patients and, on the basis of two observations, recommended terminating random assignment to ZMapp and remdesivir”..

Table 2. Comparison of Death at 28 Days According to Treatment Group.

Population	ZMapp	Remdesivir	Difference, Remdesivir vs. ZMapp	MAb114	Difference, MAb114 vs. ZMapp	REGN-EB3	ZMapp Subgroup	Difference, REGN-EB3 vs. ZMapp Subgroup
	no. of deaths/ total no. (%)	*no. of deaths/ total no. (%)*	*percentage points (95% CI)*	*no. of deaths/ total no. (%)*	*percentage points (95% CI)*	*no. of deaths/ total no. (%)*	*no. of deaths/ total no. (%)*	*percentage points (95% CI)*
Overall	84/169 (49.7)	93/175 (53.1)	3.4 (–7.2 to 14.0)	61/174 (35.1)	–14.6 (–25.2 to –1.7)*	52/155 (33.5)	79/154 (51.3)	–17.8 (–28.9 to –2.9)*
Patients with high viral load†	60/71 (84.5)	64/75 (85.3)	0.8 (–15.3 to 17.2)	51/73 (69.9)	–14.6 (–33.0 to –0.5)	42/66 (63.6)	56/65 (86.2)	–22.5 (–41.8 to –5.1)
Patients with low viral load†	24/98 (24.5)	29/100 (29.0)	4.5 (–9.1 to 19.1)	10/101 (9.9)	–14.6 (–32.4 to –2.6)	10/89 (11.2)	23/89 (25.8)	–14.6 (–32.6 to –2.3)

* The result is significant according to the interim stopping boundary of P<0.035 for the MAb114 group and P<0.028 for the REGN-EB3 group.
† Patients with a high viral load had an EBOV nucleoprotein Ct value of 22.0 or less. Patients with a low viral load had an EBOV nucleoprotein Ct value of more than 22.0. The total number is the total number of patients in this category for each group.

The “Compassionate” study by Gilead themselves, cited by Fauci

-”..Of the 61 patients who received at least one dose of remdesivir, data from 8 could not be analyzed (including 7 patients with no post-treatment data and 1 with a dosing error). Of the 53 patients whose data were analyzed, 22 were in the United States, 22 in Europe or Canada, and 9 in Japan. At baseline, 30 patients (57%) were receiving mechanical ventilation and 4 (8%) were receiving extracorporeal membrane oxygenation. During a median follow-up of 18 days, 36 patients (68%) had an improvement in oxygen-support class, including 17 of 30 patients (57%) receiving mechanical ventilation who were extubated. A total of 25 patients (47%) were discharged, and 7 patients (13%) died; mortality was 18% (6 of 34) among patients receiving invasive ventilation and 5% (1 of 19) among those not receiving invasive ventilation”..

-Seven of the 53 patients (13%) died after the completion of remdesivir treatment, including 6 of 34 patients (18%) who were receiving invasive ventilation and 1 of 19 (5%) who were receiving noninvasive oxygen support

-A total of 32 patients (60%) reported adverse events during follow-up (Table 2). The most common adverse events were increased hepatic enzymes, diarrhea, rash, renal impairment, and hypotension. In general, adverse events were more common in patients receiving invasive ventilation. A total of 12 patients (23%) had serious adverse events. The most common serious adverse events — multiple-organ-dysfunction syndrome, septic shock, acute kidney injury, and hypotension — were reported in patients who were receiving invasive ventilation at baseline. Four patients (8%) discontinued remdesivir treatment prematurely: one because of worsening of preexisting renal failure, one because of multiple organ failure, and two because of elevated aminotransferases, including one patient with a maculopapular rash.

-Interesting note, the U.S Government bought all of the Remdesivir stock in 2020, only until Oct 2020 did we see other countries using it. Between then, once the U.S monopolized remdesivir around May, the “Covid Mortality” rate, became the highest in the world.

ORIGINAL ARTICLE

Remdesivir for the Treatment of Covid-19 — Final Report

This study claimed Remdesivir lessened the length of Hospitalization by 5 days, compared to placebo 15-10:

In the as-treated population, serious adverse events occurred in 131 of 532 patients (24.6%) in the remdesivir group and in 163 of 516 patients (31.6%) in the placebo group (Table S17). There were 47 serious respiratory failure adverse events in the remdesivir group (8.8% of patients), including acute respiratory failure and the need for endotracheal intubation, and 80 in the placebo group (15.5% of patients) (Table S19). No deaths were considered by the investigators to be related to treatment assignment.Grade 3 or 4 adverse events occurred on or before day 29 in 273 patients (51.3%) in the remdesivir group and in 295 (57.2%) in the placebo group (Table S18); 41 events were judged by the investigators to be related to remdesivir and 47 events to placebo (Table S17). The most common nonserious adverse events occurring in at least 5% of all patients included decreased glomerular filtration rate, decreased hemoglobin level, decreased lymphocyte count, respiratory failure, anemia, pyrexia, hyperglycemia, increased blood creatinine level, and increased blood glucose level (Table S20). The incidence of these adverse events was generally similar in the remdesivir and placebo groups.

Claimed Rem treatment had a 7% Mortality rate compared to a 12% Placebo rate. Many in the study were unblinded, shortly after. Gilead would go on to price the drug at 3,120$ for the U.S and 2,340$ for developing nations.

medRxiv
THE PREPRINT SERVER FOR HEALTH SCIENCES
CSH Cold Spring Harbor Laboratory BMJ Yale

Repurposed antiviral drugs for COVID-19 –interim WHO SOLIDARITY trial results

WHO Solidarity trial consortium, Hongchao Pan, Richard Peto, Quarraisha Abdool Karim, Marissa Alejandria, Ana Maria Henao-Restrepo, César Hernández García, Marie-Paule Kieny, Reza Malekzadeh, Srinivas Murthy, Marie-Pierre Preziosi, Srinath Reddy, Mirta Roses Periago, Vasee Sathiyamoorthy, John-Arne Røttingen, Soumya Swaminathan, as the members of the Writing Committee, assume responsibility for the content and integrity of this article

doi: https://doi.org/10.1101/2020.10.15.20209817

Now published in *New England Journal of Medicine* doi: 10.1056/NEJMoa2023184

RR for the drugs:Rem:0.95, Lopinavir: 1.00, HCQ: 1.19, Interferon: 1.16

CONCLUSIONS These Remdesivir, Hydroxychloroquine, Lopinavir and Interferon regimens appeared to have little or no effect on hospitalized COVID-19, as indicated by overall mortality, initiation of ventilation and duration of hospital stay. The mortality findings contain most of the randomized evidence on Remdesivir and Interferon, and are consistent with meta-analyses of mortality in all major trials.

Science has learned that both FDA's decision and the EU deal came about under unusual circumstances that gave the company important advantages. FDA never consulted a group of outside experts that it has at the ready to weigh in on complicated antiviral drug issues. That group, the Antimicrobial Drugs Advisory Committee (AMDAC), mixes infectious disease clinicians with biostatisticians, pharmacists, and a consumer representative to review all available data on experimental treatments and make recommendations to FDA about drug approvals—yet it has not convened once during the pandemic. The European Union, meanwhile, decided to settle on the remdesivir pricing exactly 1 week before the disappointing Solidarity trial results came out. It was unaware of those results, although Gilead, having donated remdesivir to the trial, was informed of the data on 23 September and knew the trial was a bust. "This is a very, very bad look for the FDA, and the dealings between Gilead and EU make it another layer of badness," says Eric Topol, a cardiologist at the Scripps Research Translational Institute who objected to remdesivir's FDA approval.

But both decisions baffled scientists who have closely watched the clinical trials of remdesivir unfold over the past 6 months—and who have many questions about remdesivir's worth. At best, one large, well-designed study found remdesivir modestly reduced the time to recover from COVID-19 in hospitalized patients with severe illness. A few smaller studies found no impact of treatment on the disease whatsoever. Then, on 15 October—in this month's decidedly unfavorable news for Gilead—the fourth and largest controlled study delivered what some believed was a coup de grâce: The World Health Organization's (WHO's) Solidarity trial showed that remdesivir does not reduce mortality or the time COVID-19 patients take to recover.

ivir *d by the FDA for the nt of COVID-19 in als aged ≥28 days and g ≥3 kg.*	**Dose for Adults and Children Weighing ≥40 kg** • RDV 200 mg IV on Day 1, then RDV 100 mg IV once daily from Day 2 **Dose for Children Aged ≥28 Days and Weighing 3 kg to <40 kg** • RDV 5 mg/kg IV on Day 1, then RDV 2.5 mg/kg IV once daily from Day 2 **Total Treatment Duration** *Nonhospitalized Patients* • 3 days *Hospitalized Patients* • 5 days or until hospital discharge	• Nausea • ALT and AST elevations • HSRs • Increases in prothrombin time • Drug vehicle is SBECD, which has been associated with renal and liver toxicity. SBECD may accumulate in patients with moderate or severe renal impairment. • Each 100-mg vial of RDV lyophilized powder contains 3 g of SBECD, and each 100-mg/20-mL vial of RDV solution contains 6 g of SBECD. • Consider preferentially using the lyophilized powder formulation (which contains less SBECD) in patients with renal impairment.	• Monitor patients for infusion reactions during the infusion and observe them for ≥1 hour after the infusion as clinically appropriate. • Monitor renal function, hepatic function, and prothrombin time as clinically indicated.	• Clinical drug-drug interaction studies of RDV have not been conducted. • In vitro, RDV is a minor substrate of CYP3A4; a substrate of OATP1B1 and P-gp; and an inhibitor of CYP3A4, OATP1B1, OATP1B3, and MATE1.[3]	• The FDA does not r using RDV in patien eGFR of <30 mL/mi Remdesivir for info using RDV in peopl insufficiency.

> Clin Pharmacol Ther. 2021 Apr;109(4):1021-1024. doi: 10.1002/cpt.2145. Epub 2021 Jan 16.

Remdesivir and Acute Renal Failure: A Potential Safety Signal From Disproportionality Analysis of the WHO Safety Database

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PMID: 33340409 DOI: 10.1002/cpt.2145

Remdesivir is approved for emergency use by the US Food and Drug Administration (FDA) and authorized conditionally by the European Medicines Agency (EMA) for patients with coronavirus disease 2019 (COVID-19). Its benefit-risk ratio is still being explored because data in the field are rather scant. A decrease of the creatinine clearance associated with remdesivir has been inconstantly reported in clinical trials with unclear relevance. Despite these uncertainties, we searched for a potential signal of acute renal failure (ARF) in pharmacovigilance postmarketing data. An analysis of the international pharmacovigilance postmarketing databases (VigiBase) of the World Health Organization (WHO) was performed, using two disproportionality methods. Reporting odds ratio (ROR) compared the number of ARF cases reported with remdesivir, with those reported with other drugs prescribed in comparable situations of COVID-19 (hydroxychloroquine, tocilizumab, and lopinavir/ritonavir). The combination of the terms "acute renal failure" and "remdesivir" yielded a statistically significant disproportionality signal with 138 observed cases instead of the 9 expected. ROR of ARF with remdesivir was 20-fold (20.3; confidence interval 0.95 [15.7-26.3], P < 0.0001]) that of comparative drugs. Based on ARF cases reported in VigiBase, and despite the caveats inherent to COVID-19 circumstances, we detected a statistically significant pharmacovigilance signal of nephrotoxicity associated with remdesivir, deserving a thorough qualitative assessment of all available data. Meanwhile, as recommended in its Summary of Product Characteristics, assessment of patients with COVID-19 renal function should prevail before and during treatment with remdesivir in

Inconsistent at BEST

Mortality Benefit of Remdesivir in COVID-19: A Systematic Review and Meta-Analysis

This study looked at 9 of the 680 studies of the Remdesivir/Covid relationship and found it decreased mortality.

Original Investigation | Infectious Diseases

July 15, 2021

Association of Remdesivir Treatment With Survival and Length of Hospital Stay Among US Veterans Hospitalized With COVID-19

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» Author Affiliations | Article Information

JAMA Netw Open. 2021;4(7):e2114741. doi:10.1001/jamanetworkopen.2021.14741

Yet, 6 months later…

In this cohort study of US veterans hospitalized with COVID-19, remdesivir treatment was not associated with improved survival but was associated with longer hospital stays. Routine use of remdesivir may be associated with increased use of hospital beds while not being associated with improvements in survival.

"Why would remdesivir treatment extend length of stay? Complications of treatment, such as kidney injury, could extend hospitalizations, but rates of adverse events associated with remdesivir were low in trials". As they acknowledge kidney injury while citing the very study that ignored another study published the same day that showed its ineffectiveness.

Lancet. 2020 16-22 May; 395(10236): 1569–1578.
Published online 2020 Apr 29. doi: 10.1016/S0140-6736(20)31022-9
PMCID: PMC7190303
PMID: 32423584

Remdesivir in adults with severe COVID-19: a randomised, double-blind, placebo-controlled, multicentre trial

In this study of adult patients admitted to hospital for severe COVID-19, remdesivir was not associated with statistically significant clinical benefits. However, the numerical reduction in time to clinical improvement in those treated earlier requires confirmation in larger studies. Adverse events were reported in 102 (66%) of 155 remdesivir recipients versus 50 (64%) of 78 placebo recipients. Remdesivir was stopped early because of adverse events in 18 (12%) patients versus four (5%) patients who stopped placebo early. Hypoalbuminemia, among many other AEs were linked the Remdesivir. The former being linked to Liver toxicity.

Fauci didn't mention" 04/29 (The same day at the Final Report) -NIH Study: Our trial found that intravenous remdesivir did not significantly improve the time to clinical improvement, mortality, or time to clearance of virus in patients with serious COVID-19 compared with placebo…Remdesivir did not result in significant reductions in SARS-CoV-2 RNA loads or detectability in upper respiratory tract or sputum specimens in this study despite showing strong antiviral effects in preclinical models of infection with coronaviruses.

They then try to justify it saying: Although not statistically significant, patients receiving remdesivir had a numerically faster time to clinical improvement than those receiving placebo among patients with symptom duration of 10 days or less

Multi-Drug Protocols and Midazolam

Azithromycin (AB)- Nausea, Vomiting, Headaches, Liver Damage, Change in taste etc.

Doxycycline (AB)- Nausea, Vomiting, Upset Stomach, Blood in Stool, Bloating, Rapid Heart Rate, Shortness of breath etc.

Precedex (Sed)- Slowed Breathing, Coughing, Irregular HeartBeat, Anemia, Nausea, Hypotension, Hypoxia, Cardiac arrest etc.

Lorazepam (Sed)- Drowsiness, headache, Confusion, Tiredness, Muscle Weakness, Irregular HeartBeat, Diarrhea, Cardiac Arrest etc.

Morphine (Narc PM)- Respiratory Distress, Adrenal Insufficiency, Circulatory Depression, Slow HeartBeat, Diarrhea, Nausea, Confusion, Blurred Vision, Chest Pain, Coma, Death etc.

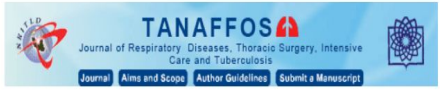
Vancomycin (AB)- Renal Failure, Nausea, Vomiting, diarrhea, Stomach pain, Epidermal Necrolysis etc

Dexamethasone (ST)- “Infections”, increased blood glucose (sugar) levels, changes in blood pressure, damage to bones, psychiatric problems, and adrenal dysfunction;

Fentanyl (PK)- Respiratory Depression, Confusion, Nausea, Vomiting, Pupillary constriction, Constipation

Midazolam (Sed)- Respiratory arrest, Respiratory Distress, Nausea, Cough, Vomiting, Thrombosis, CNS Suppression etc.

Journal List > Tanaffos > v.20(2); 2021 Feb > PMC8710217



Tanaffos. 2021 Feb; 20(2): 164–171.

PMCID: PMC8710217

PMID: 34976088

Effects of Morphine and Fentanyl on Patients with COVID-19

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Analgesia and Sedation in Patients with COVID-19

Approximately 14 percent of patients with COVID-19 infection experience a severe form of hypoxic respiratory failure, with 5 percent requiring mechanical ventilation.[1] The dyspnea, air hunger, physical discomfort of being intubated, and need to prevent self-extubation have made sedation of these patients challenging, with many requiring high doses of multiple medications to achieve comfort. Moreover, in the subset of patients with low lung compliance and acute respiratory distress syndrome, use of low tidal volumes, controlled ventilation, and prone positioning require high levels of sedation and often neuromuscular blockade to permit proper ventilation.[2,3]

Standard critical care management involves daily interruption of sedation, which reduces the number of days on the ventilator.[4] Attention to sedation is important in the COVID-19 pandemic both for optimal patient care and because sedative and analgesic medications are in high demand. In March, the demand for sedatives increased by 91 percent, for analgesics by 79 percent, and for neuromuscular blockers by 105 percent.[5]

At present, sedation/analgesia regimens are based on standard critical care guidelines, with some adaptations to the environment. For patients who are not intubated, bolus dosing of hydromorphone or fentanyl for analgesia and midazolam for sedation/anxiolysis are effective first-line agents. A dexmedetomidine infusion is another option to provide light to medium sedation while allowing intermittent patient wakefulness and is effective in patients at risk for or experiencing alcohol withdrawal.

In intubated patients, a fentanyl infusion is commonly used initially for analgesia, but because of fentanyl's lipophilic properties and tachyphylaxis with long-term use, hydromorphone is a good alternative, with the advantage of being least affected by organ dysfunction. For sedation, propofol is the usual first choice, with supplementation by intravenous boluses of a benzodiazepine. When heavy sedation is required, a midazolam or ketamine infusion may be added. For ventilator dyssynchrony despite adequate sedation, bolus doses of neuromuscular blockers are preferable to continuous infusions.

The results of this study did not show any significant change in the use of fentanyl and morphine compared to patients with COVID 19. This may be due to the use of these drugs in the viral phase of the disease. The use of morphine and fentanyl in the viral phase of COVID 19 disease do not show significant benefits. *Study claims that " Experimental data..suggest that morphine has potent immunoregulatory properties, and may attenuate inflammatory processes .."

The results in Figure 2 show that the use of morphine and fentanyl could not significantly change the inflammatory parameters of patients.

HM Government

NHS

COVID-19 Hospital Discharge Service Requirements

This document has been withdrawn because it is out of date. For the latest guidance go to:

https://www.gov.uk/government/collections/hospital-discharge-service-guidance

Published 19 March 2020

UK regulators state that you should only receive midazolam in a hospital or doctor's office that has the equipment that is needed to monitor your heart and lungs and to provide life-saving medical treatment quickly if your breathing slows or stops.

A doctor or nurse should watch you closely after you receive this medication to make sure that you are breathing properly because midazolam induces significant depression of respiration. Your doctor should also be made aware if you have a severe infection or if you have or have ever had any lung, airway, or breathing problems or heart disease.

Midazolam is also used before medical procedures and surgery to cause drowsiness, relieve anxiety, and prevent any memory of the event. It is also sometimes given as part of the anesthesia during surgery to produce a loss of consciousness.

Midazolam is also used to cause a state of decreased consciousness in seriously ill people in intensive care units who are breathing with the help of a machine.

Midazolam should be used with extreme caution in patients who have chronic renal failure, impaired hepatic function, or impaired cardiac function. It should also be used with extreme caution in obese patients, or elderly patients.

On the 19th March a directive was sent out to the NHS which required them to discharge all patients who they deemed to not require a hospital bed. They declared that transfers from the ward must happen within one hour of that decision being made to a designated discharge area, and that discharge from hospital should happen within 2 hours. NHS trusts were told that "they must adhere" to the new directive.

This was done to allegedly free up beds, of which they estimated would amount to an extra 15,000 free beds within just one week of the directive being implemented.

It freed up so many beds that bed occupancy during April – June 2020 was 30% down on the previous year. Why on earth would these people already be in a hospital bed if they did not need to be? You attend hospital because you require medical treatment, not because you want a lie down and a good nights sleep.

This directive meant that people who required medical treatment and attention were discharged into Care homes in the thousands.

But Matt Hancock's abandonment of the elderly and vulnerable didn't end there. Whilst the NHS was busy discharging patients who required medical treatment into care homes under his directive, Matt Hancock and the Department of Health were busy trying to source them all a certain drug known as **midazolam**.

*Taken from Expose Article

A closer look at Midazolam

WARNINGS

Personnel and Equipment for Monitoring and Resuscitation

Adults and Pediatrics: Intravenous midazolam hydrochloride has been associated with respiratory depression and respiratory arrest, especially when used for sedation in noncritical care settings. In some cases, where this was not recognized promptly and treated effectively, death or hypoxic encephalopathy has resulted. Intravenous midazolam hydrochloride should be used only in hospital or ambulatory care settings, including physicians' and dental offices, that provide for continuous monitoring of respiratory and cardiac function, e.g., pulse oximetry. Immediate availability of resuscitative drugs and age- and size-appropriate equipment for bag/valve/mask ventilation and intubation, and personnel trained in their use and skilled in airway management should be assured (see WARNINGS). For deeply sedated pediatric patients, a dedicated individual, other than the practitioner performing the procedure, should monitor the patient throughout the procedure.

Risks From Concomitant Use With Opioids

Concomitant use of benzodiazepines and opioids may result in profound sedation, respiratory depression, coma, and death. Monitor patients for respiratory depression and sedation (see WARNINGS and PRECAUTIONS, DRUG INTERACTIONS).

Source – US National Library of Medicine

Individualization of Dosage

Midazolam hydrochloride must never be used without individualization of dosage. The initial intravenous dose for sedation in adult patients may be as little as 1 mg, but should not exceed 2.5 mg in a normal healthy adult. Lower doses are necessary for older (over 60 years) or debilitated patients and in patients receiving concomitant narcotics or other central nervous system (CNS) depressants. The initial dose and all subsequent doses should always be titrated slowly; administer over at least 2 minutes and allow an additional 2 or more minutes to fully evaluate the sedative effect. The use of the 1 mg/mL formulation or dilution of the 1 mg/mL or 5 mg/mL formulation is recommended to facilitate slower injection. Doses of sedative medications in pediatric patients must be calculated on a mg/kg basis, and initial doses and all subsequent doses should always be titrated slowly. The initial pediatric dose of midazolam for sedation/anxiolysis/amnesia is age, procedure, and route dependent (see DOSAGE AND ADMINISTRATION for complete dosing information).

Source – US National Library of Medicine

A drug that causes respiratory failure to use against a "Respiratory disease"?

University Hospitals Birmingham NHS
NHS Foundation Trust

Drugs for comfort at the end of life include the following:

Drug Class	Examples	Uses
Benzodiazepines	Midazolam, lorazepam	• Fear, anxiety and agitation
Strong opioids	Morphine, oxycodone	• Typically used for pain • Can be used to relieve breathlessness – reduces the sensitivity and reflex response to the raised pCO2 levels seen in respiratory failure.
Antipsychotic drugs	Levomepromazine, haloperidol	• Typically used for nausea (low doses) • Agitation and delirium (higher doses)
Hyoscine butylbromide		• Reduce airway secretions and 'death rattle' – this symptom may not bother the patient necessarily but can be upsetting for relatives and staff alike.

End of Life Care for Patients with COVID-19

Version 2

Date: 30/09/2020

V2, Written 9/30/20, Approved 01/01/21, Review 01/31/23

END OF LIFE CARE FOR PATIENTS WITH CORONAVIRUS

BACKGROUND

The following advice relates to patients being managed **OUTSIDE OF CRITICAL CARE** and who are **thought likely to die in the coming hours or days** despite all previous or ongoing best efforts.

Some patients will be suffering from **multi organ failure** and/or **thrombo-embolic disorders** and some primarily from **respiratory failure**.

Some patients dying from COVID-19 suffer a significant degree of **delirium or agitation** which may be difficult to manage.

This NHS document states that midazolam should be used for sedation prior to the patient requiring mechanical ventilation, something we know has been required in hospitals for people who have developed severe pneumonia, of which we are told is due to Covid-19. However it also states that midazolam should only be used if 1st line and 2nd line drugs do not provide adequate sedation, but does include the caveat that midazolam alone can be added to 1st line drugs to reduce Propofol infusion rates. *Source*

3rd Line
Morphine 0.04-0.2 mg/kg/hour
Midazolam 0.04-0.2mg/kg/hour
This regimen may be used if 1st and 2nd line drugs fail to provide adequate sedation without unacceptable cardiovascular depression or Midazolam alone can be added to the first line drugs to reduce Propofol infusion rates.

This NHS document states that midazolam should be used for sedation prior to having a operation. *Source*

Drugs preferred for sedation

The preferred drugs to be used for sedation are midazolam and fentanyl. These are both short acting drugs with an onset of 1-2 minutes and a peak effect of 3-5 minutes. The analgesic effects of fentanyl last about 30-60 minutes therefore occasionally morphine is needed for a more prolonged analgesic effect after the procedure. Morphine has a longer onset with a peak intravenous effect of 20 minutes, therefore th patients should be observed for at least 10-15 minutes before the midazolam is administered. See appendix 2 for further information about dosing, side effects and cautions. Propofol should not be used by non-anaesthetists for sedation.

This document produced by the NHS states that Midazolam should be used for comfort at end of life care due to Covid-19 to ease fear, anxiety and agitation. *Source*

University Hospitals Birmingham NHS
NHS Foundation Trust

Benzodiazepines = FIRST LINE for anxiety, fear and agitation

Midazolam – suggest start with **low doses** for patients naïve to this drug but be prepared, if response is poor or short lived and anxiety is severe, to **escalate dosing sharply if required**.

- **Generally**: Start with 2.5 mg SC or IV
- If patient **is particularly frail**: use 1.25mg
- If **extremely distressed** or show **tolerance** to this group of drugs: may require higher doses e.g. 5 -10 mg

If ward areas **cannot access midazolam** then lorazepam can be used as a substitute – generally **2.5 mg of midazolam can be regarded as 'equivalent' to 500 mcg of injectable lorazepam**.
Seek advice.

For patients not responding to midazolam – this might be because doses have been too low or not frequent enough. Some patients might need much higher doses than normal. **Seek advice** if needed.

GUIDANCE SHEET 1

PRN DRUGS AND DOSES FOR CORONAVIRUS PATIENTS BEING CARED FOR OUTSIDE OF CRITICAL CARE AND WHO ARE AT RISK OF DYING IMMINENTLY
What drugs and doses should I use to ensure my patient is comfortable?
Please see also additional end of life care guidance notes as this advice is general and not specific.
Is your patient distressed from symptoms of respiratory / organ failure?

- If **YES** – offer reassurance and emotional support in first instance

If further support is needed offer patient medication to:

- Help relieve breathlessness / reduce anxiety and to help with sleep or rest.

If medication declined by patient continue to offer reassurance and emotional support and ask again later if they wish to reconsider having medication for comfort.

For patients who are agreeable to medication and primarily anxious, agitated or scared give:

- **Midazolam 1.25- 2.5 mg SC or IV FIRST LINE**
- **Morphine 1.25 - 2.5 mg SC or IV SECOND LINE**

Repeat after 20 minutes if not effective – consider using higher dose or both drugs in combination.

Review again after further 20 minutes. If still not comfortable ring and speak to palliative care for advice – see contact numbers below

For dying patients who are agitated but primarily suffering from delirium give:

- **Levomepromazine 6.25-12.5 mg SC or IV (consider 3.125 mg in frail elderly)**

Antipsychotic drugs – generally in conjunction with a strong opioid or benzodiazepine and best used when **DELIRIUM** is prominent

These drugs can **reduce delirium** and in higher doses can cause sedation. For some patients **sedation might be a useful side effect** when managing **terminal restlessness.**

- **Levomepromazine** = FIRST LINE in dying patients.
  1. Generally - **low doses** e.g. 6.25 mg – 12.5 mg SC/IV can be used to begin with especially if nausea is a feature. Clinical experience would suggest that for agitation and anxiety significantly higher doses may be needed (e.g. 25 mg and above). 3.125 mg might be a starting dose in the frail elderly.
  2. Can also be given as a **continuous infusion** – doses guided by previous 24 hour requirements.
  3. Can be used in **conjunction with morphine and midazolam** – in exceptional circumstances it can be used with both drugs simultaneously.

If levomepromazine is not available use haloperidol – **Seek advice from palliative care or Geriatric Medicine**

Prior to the "Pandemic", 0.5-1 MG was the recommended dose for elderly or unwell. After, we saw between 1.5-10 MGs being given

Hyoscine butylbromide

- Dose: **20 mg IV or S/C**

Sedative	Dose	Onset	Side effects	Cautions
Midazolam	Healthy adult: 1-2mg bolus. Titrate further small boluses with at least 2 minutes between doses. Usually max 5mg required. Elderly or unwell: 0.5-1mg bolus. Titrate further small boluses with at least 2 minutes between doses. Often no more than 2 mg	3-5 minutes for peak effect. Half life 1.5-3.5 hours.	CARDIORESPIRATORY DEPRESSION especially associated with opioids. Gastro-intestinal disturbances, anaphylaxis, drowsiness, confusion, ataxia, amnesia, headache, paradoxical excitement and aggression (especially in children and elderly), dysarthria; injection-site reactions. For complete list see BNF	Cardiac disease; hepatic impairment; renal impairment; (increases plasma half life x2-2.5) respiratory disease; myasthenia gravis; history of drug or alcohol abuse; risk of severe hypotension in hypovolaemia, vasoconstriction, hypothermia; pregnancy and breast-feeding

Supplies of sedative used for COVID-19 patients diverted from France to avoid potential shortages

Exclusive: Accord Healthcare has told *The Pharmaceutical Journal* that "some French label stock" of midazolam is now being sold into UK wholesalers.

2 Years worth of Midazolam purchased by the U.K

Q378 **Dr Evans:** The syringe drivers are used to deliver medications such as midazolam and morphine. Do you have any precautions in place to ensure that we have enough of those medications?

Matt Hancock: Yes. We have a big project to make sure that the global supply chains for those sorts of medications, as well as the ITU medications that I spoke about earlier, are clear. In fact, those medicines are made in a relatively small number of factories around the world, so it is a delicate supply chain and we are in contact with the whole supply chain.

04/17/20 P.M

More than 2m operations cancelled as NHS fights Covid-19

Backlog of procedures in England could cost NHS £3bn to work through after crisis

- Coronavirus - latest updates
- See all our coronavirus coverage

All Operations halted across the U.K around the same time (03/20). So, why need Midazolam?

So can Matt Hancock explain why during April 2020 out of hospital prescribing for Midazolam was twice the amount seen in 2019?

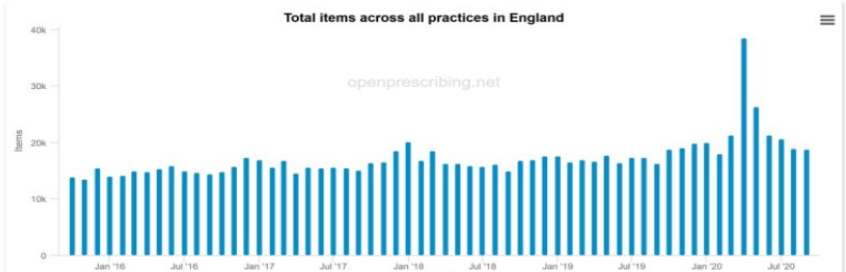
Midazolam Hydrochloride (1501041T0)

Part of chapter 15 Anaesthesia, section 15.1 General anaesthesia, paragraph 15.1.4 Sedative and analgesic peri-operative drgs

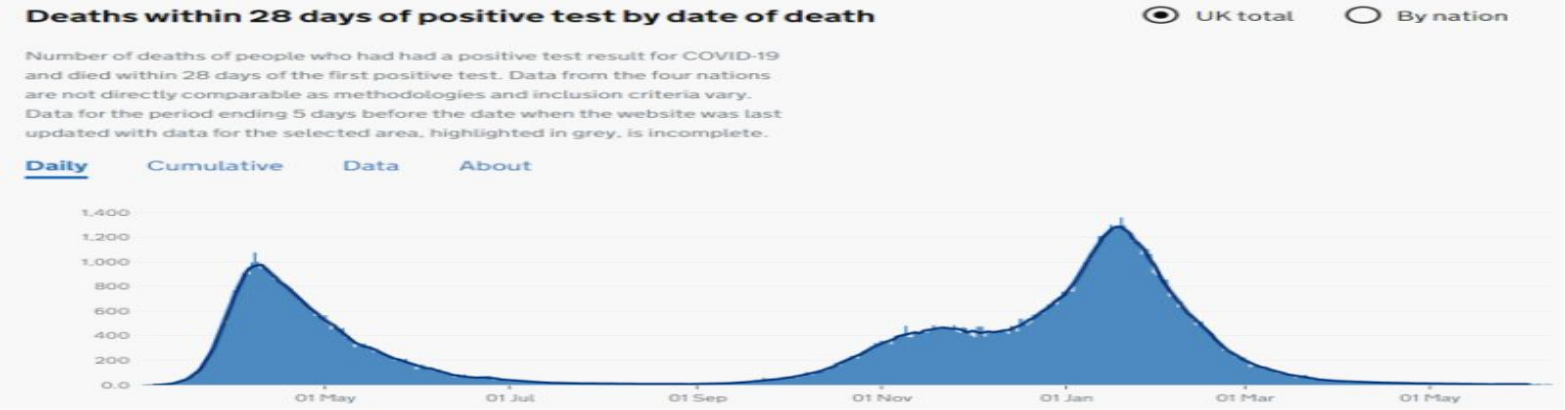
High-level prescribing trends for Midazolam Hydrochloride (BNF code 1501041T0) across all GP practices in NHS England for the last five years. You can see which CCGs prescribe most of this chemical relative to its class, or learn more about this site.

View all matching dm+d items.

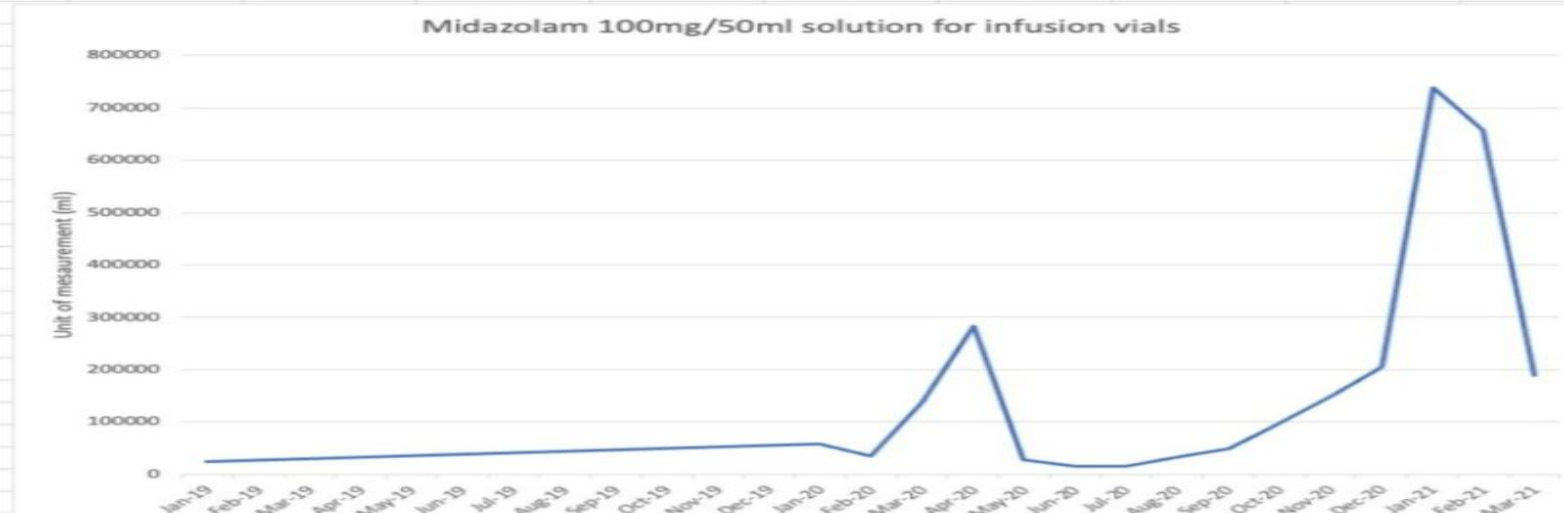
Trends Items Spending



According to official data in April 2019 up to 21,977 prescriptions for Midazolam were issued, containing 171,952 items, the vast majority being Midazolam Hydrochloride. However in April 2020 45,033 prescriptions for Midazolam were issued, containing 333,229 items, the vast majority being Midazolam Hydrochloride. That is a 104.91% increase in the number of prescriptions issued for Midazolam and a 93.85% increase in the number of items they contained. But these weren't issued in hospitals, they were issued by GP practices which can only mean one thing, they were issued for end of life care.



The above is a graph displayed on the UK Government website displaying deaths within 28 days of a positive test result for Covid-19 by date of death.
The following graph has been created using data on the amount of Midazolam solution produced each month from January 20219 through to March 2021.



Hospitals beds in April 2020 30% were down compared to the previous year. A&E attendance was 57% down in April 2020 compared to the previous year. Care home deaths were 205% up in April 2020 compared to April 2019. The vast majority of alleged Covid deaths are people over the age of 85.

“YOU get a DNR YOU get a DNR everyone gets a DNR”

The parliamentary Joint Committee on Human Rights reported that they had “received deeply troubling evidence from numerous sources that during the COVID19 pandemic DNACPR notices have been applied in a blanket fashion to some categories of person by some care providers, without any involvement of the individuals or their families…. (it is) discriminatory and contrary to both the ECHR and the Equality Act 2010 to apply DNACPR notices in a blanket manner to groups on the basis of a particular type of impairment, such as a learning disability; or on the grounds of age alone. …” Almost 10% of people using services or families who responded to their call for evidence told the British Institute of Human Rights that they had experienced pressure or use of DNACPR orders. Thirty-four per cent of people working in health and/or social care said they were under pressure to put DNACPRs in place without involving the person. In addition, 71% of advocacy organisations and campaigners said they experienced DNACPR orders put in place or pressure to make them without being involved in the decision. In their interviews with relatives, care home managers, advocacy organisations and legal representatives, Amnesty found examples of the inappropriate or unlawful use of DNACPR forms – including blanket DNACPR, their inappropriate individual use and recommendations for use – by GPs, clinical commissioning groups (CCGs), hospitals and care homes. They also found that staff incorrectly interpreting DNACPR prevented people getting access to hospital care and treatment. Amnesty also highlighted that health and social care staff reported pressure during the pandemic to put DNACPRs in place without consultation.

We know this happened because an Amnesty report and CQC report said so.

DENIAL OF ACCESS TO HOSPITALS AND OTHER MEDICAL SERVICES

Amnesty International has received multiple reports of care home residents' right to NHS services, including access to general medical services (GMS) and hospital admission, being denied during the pandemic, violating their right to health and potentially their right to life, as well as their right to non-discrimination. Care homes managers have pointed out that such reluctance or refusal to admit older care home residents to hospital could not be explained by need, as hospital bed capacity was never reached.[110]

The amnesty report states that –

‘Care home managers and staff and relatives of care home residents in different parts of the country told Amnesty International how, in their experience, sending residents to hospital was discouraged or outright refused by hospitals, ambulance teams, and GPs. A manager in Yorkshire said: “We were heavily discouraged from sending residents to hospital. We talked about it in meetings; we were all aware of this.”’

‘*Another manager in Hampshire recalled:*
There wasn’t much option to send people to hospital. We managed to send one patient to hospital because the nurse was very firm and insisted that the lady was too uncomfortable and we could not do any more to make her more comfortable but the hospital could. In hospital the lady tested COVID positive and was treated and survived and came back. She is 92 and in great shape.
She explained that:
There was a presumption that people in care homes would all die if they got COVID, which is wrong. It shows how little the government knows about the reality of care homes.’

CareQuality Commission

For example, one told us the doctor on call had advised care home staff that if the older people in their care contracted COVID-19, they would have a DNACPR put in place. Another said doctors were refusing to visit a care home because they had had two residents die from COVID-19. Care staff were asked to take observations that they were not trained for, and all residents had a DNACPR in place.

Review of Do Not Attempt Cardiopulmonary Resuscitation decisions during the COVID-19 pandemic

Interim report

November 2020

AS IF EXPENDABLE

THE UK GOVERNMENT’S FAILURE TO PROTECT OLDER PEOPLE IN CARE HOMES DURING THE COVID-19 PANDEMIC

AMNESTY INTERNATIONAL

Ventilators

> Crit Care Med. 1997 Jan;25(1):28-32. doi: 10.1097/00003246-199701000-00008.

Mortality is directly related to the duration of mechanical ventilation before the initiation of extracorporeal life support for severe respiratory failure

T Pranikoff [1], R B Hirschl, C N Steimle, H L Anderson 3rd, R H Bartlett

Affiliations + expand

PMID: 8989172 DOI: 10.1097/00003246-199701000-00008

This study found, when used for Severe Respiratory failure, Ventilators have a 50% Mortality Rate

April 22, 2020, 2:42 PM

Almost 9 in 10 Covid-19 Patients on Ventilators Died in Study

Robert Langreth
Bloomberg News

- Researchers tracked 2,634 outcomes in NY-area hospitals
- Only 3% of those over 65 on ventilators survived, report says

A giant study that examined outcomes for more than 2,600 patients found an extraordinarily high 88% death rate among Covid-19 patients in the New York City area who had to be placed on mechanical devices to help them breathe.

Topics

Coronavirus
Respiratory Devices
Physicians

Dr Tom Cowan in Contagion Myth: "..These patients don't need help breathing, they need more oxygen when they take a breath...these are not signs of a contagious disease but a disruption of our mechanisms for producing energy and getting oxygen into the red blood cells".

Dr Cameron K. Sidell, believed the ARDS being seen in “Covid” patients (NYC 2020) was in fact not being caused by “Covid”, rather was being caused by the misuse of the ventilators to treat patients who seemed to be suffering from oxygen deprivation and not Respiratory failure

Hospitals Retreat From Early Covid Treatment and Return to Basics

Changing practices, based on data and experience, appear to be improving outcomes for the sickest coronavirus patients

Last spring, doctors put patients on ventilators partly to limit contagion at a time when it was less clear how the virus spread when protective masks and gowns were in short supply. **Doctors could have employed other kinds of breathing support devices that don't require risky sedation, but early reports suggested patients using them could spray dangerous amounts of virus into the air**, said Theodore Iwashyna, a critical-care physician at University of Michigan and Department of Veterans Affairs hospitals in Ann Arbor, Mich.

Subsequent research found the alternative devices to ventilators, such as delivering oxygen through nasal tubes, weren't as risky to caretakers as believed. Doctors also gained experience with covid-19 patients, learning to spot signs of who might suddenly turn seriously ill, some said.

The WSJ article describes a study conducted that now allows doctors to predict who needs a ventilator and who does not:

It found more doctors now follow the pre-pandemic protocols, which have reduced the number of deaths and shortened the time patients spend on ventilators, HCA's chief medical officer said.

Before the pandemic, between about 30% to more than 40% of ventilator patients died, according to research. Numbers were sharply higher in the pandemic's early hot spot in Wuhan, China. **As the pandemic grew, hospitals in the US reported death rates in some cases of about 50% for ventilated covid-19 patients.**

Last spring, with less known about the disease, **doctors often pre-emptively put patients on ventilators or gave powerful sedatives largely abandoned in recent years.** The aim was to save the seriously ill and **protect hospital staff from Covid-19.**

Now hospital treatment for the most critically ill looks more like it did before the pandemic. **Doctors hold off longer before placing patients on ventilators. Patients get less powerful sedatives, with doctors checking more frequently to see if they can halt the drugs entirely and dialling back how much air ventilators push into patients' lungs with each breath.**

"We were intubating sick patients very early. Not for the patient's benefit, but to control the epidemic and to save other patients," Dr. Iwashyna said "That felt awful."

*Taken from James Lyons article from the Expose

One study of three New York City hospitals found the death rate for all covid-19 patients dropped to 7.6% from 25.6% between March and August after accounting for younger, healthier patients in the summer. Hospitals in New York were less crowded in August than during the April surge, which could increase mortality, the study's authors wrote in October in the Journal of Hospital Medicine. The

In some of the earliest reports of COVID-19 from Wuhan, mortality rates among those admitted to ICUs ranged from 52% to 62% and increased to 86–97% among those requiring invasive mechanical ventilation (5, 6, 15, 16). In more recent data from the United Kingdom, 67% of those who had received mechanical ventilation died, as compared with 22% of patients intubated with viral pneumonia in the preceding 3 years (3). Early reports of smaller cohorts from Seattle, where some of the first COVID-19 outbreaks occurred in the United States, indicated that 50–67% of patients admitted to the ICU and 71–75% of those receiving invasive mechanical ventilation died (1, 2). A recently published report from New York found 24.5% mortality among those who required mechanical ventilation, but with 72.2% of patients still admitted to the hospital (4).

ICU and Ventilator Mortality Among Critically Ill Adults With Coronavirus Disease 2019, May 2020

Ventilator-associated Pneumonia (VAP)

| Print

Ventilator-associated pneumonia is a lung infection that develops in a person who is on a ventilator. A ventilator is a machine that is used to help a patient breathe by giving oxygen through a tube placed in a patient's mouth or nose, or through a hole in the front of the neck. An infection may occur if germs enter through the tube and get into the patient's lungs. CDC provides guidelines and tools to the healthcare community to help end ventilator-associated pneumonia and resources to help the public understand these infections and take measures to safeguard their own health when possible.

Ventilator-Induced Lung Injury (VILI)

Ajith Kumar AK; Fatima Anjum.

Author Information and Affiliations

Last Update: December 11, 2022.

Continuing Education Activity

Go to:

Ventilator-induced lung injury is the acute lung injury inflicted or aggravated by mechanical ventilation during treatment and has the potential to cause significant morbidity and mortality. The potential morbidity and the mortality impact of ventilator-induced lung injury are increasingly recognized across the world. However, accurate data on the incidence and prevalence of this condition is still scanty. This activity covers the etiology, clinical evaluation, and measures to attenuate or prevent this dreaded condition highlighting the importance of an interprofessional team in the diagnosis and management.

Ventilator-induced lung injury is a clinical diagnosis made by ruling out common causes of respiratory deterioration on a ventilator and common etiologies of ARDS. New-onset pneumonia, cardiogenic pulmonary edema, endobronchial intubation, lung collapse, pneumothorax, pulmonary embolism (thrombotic a well as non-thrombotic), auto PEEPing, pleural effusion, and abdominal distension could give rise to respiratory deterioration. Sepsis, aspiration, infectious pneumonia, severe trauma and/or fractures, pulmonary contusion, burns, inhalational injuries(e.g., smoke, gases, near drowning), and transfusion-associated lung injury need to be ruled out. ARDS could also occur after post cardiopulmonary bye pass and major surgeries, pancreatitis, and in patients following haematopoetic stem cell transplant.

Outcomes for Patients Who Were Discharged or Died

Among the 2634 patients who were discharged or had died at the study end point, during hospitalization, 373 (14.2%) were treated in the ICU, 320 (12.2%) received invasive mechanical ventilation, 81 (3.2%) were treated with kidney replacement therapy, and 553 (21%) died (Table 5). As of April 4, 2020, for patients requiring mechanical ventilation (n = 1151, 20.2%), 38 (3.3%) were discharged alive, 282 (24.5%) died, and 831 (72.2%) remained in hospital. Mortality rates for those who received mechanical ventilation in the 18-to-65 and older-than-65 age groups were 76.4% and 97.2%, respectively. Mortality rates for those in the 18-to-65 and older-than-65 age groups who did not receive mechanical ventilation were 1.98% and 26.6%, respectively. There were no deaths in the younger-than-18 age group. The overall length of stay was 4.1 days (IQR, 2.3-6.8). The median post-discharge follow-up time was 4.4 days (IQR, 2.2-9.3). A total of 45 patients (2.2%) were readmitted during the study period. The median time to readmission was 3 days (IQR, 1.0-4.5). Of the patients who were discharged or had died at the study end point, 436 (16.6%) were younger than age 50 with a score of 0 on the Charlson Comorbidity Index, of whom 9 died.

Original Investigation FREE

April 22, 2020

Presenting Characteristics, Comorbidities, and Outcomes Among 5700 Patients Hospitalized With COVID-19 in the New York City Area

Safiya Richardson, MD, MPH[1,2]; Jamie S. Hirsch, MD, MA, MSB[1,2,3]; Mangala Narasimhan, DO[2]; et al

Author Affiliations | Article Information

JAMA. 2020;323(20):2052-2059. doi:10.1001/jama.2020.6775

Table 5. Clinical Measures and Outcomes for Patients Discharged Alive, Dead, and In Hospital at Study End Point by Age

Clinical measure	Total discharged alive and dead patients (N = 2634)	Discharged alive			Died			In hospital		
		<18 y (n = 32)	18-65 y (n = 1373)	>65 y (n = 676)	<18 y (n = 0)	18-65 y (n = 134)	>65 y (n = 419)	<18 (n = 14)	18-65 (n = 1565)	>65 (n = 1487)
Invasive mechanical ventilation[a]	320 (12.2)	0	33 (2.4)	5 (0.7)	NA	107 (79.9)	175 (41.8)	4 (28.6)	449 (28.7)	378 (25.4)
ICU care	373 (14.2)	2 (6.3)	62 (4.5)	18 (2.7)	NA	109 (81.3)	182 (43.4)	5 (35.7)	490 (31.3)	413 (27.8)
Absolute lymphocyte count at nadir, median (IQR), $\times 10^9$/L (reference range, 1.0-3.3)	0.8 (0.5-1.14)	2.3 (1.2-5.0)	0.9 (0.7-1.2)	0.8 (0.5-1.1)	NA	0.5 (0.3-0.8)	0.5 (0.3-0.8)	2.0 (1.0-3.5)	0.7 (0.5-1.0)	0.6 (0.4-0.9)
No.	2626	32	1371	675		134	417	3	1564	1486
Acute kidney injury[b]	523 (22.2)	1 (11.1)	93 (7.5)	82 (13.1)	NA	98 (83.8)	249 (68.4)	2 (14.3)	388 (25.5)	457 (34.5)
No.	2351	8	1237	624		117	364	8	1400	1326
Kidney replacement therapy	81 (3.2)	0	2 (0.1)	1 (0.2)	NA	43 (35.0)	35 (8.8)	0	82 (5.4)	

Follow the Money

Data that disprove the COVID-19 pandemic

By Colleen Huber "..The incentive for mis-stated US mortality data is the financial influence created by the US CARES Act, which budgeted $175 billion dollars for distribution to hospitals for treatment of COVID-19 patients, with many hospitals receiving millions of dollars in such aid.[6] Specific financial incentives that favored COVID-19 diagnosis over other similar diagnoses such as flu, pneumonia and bronchitis especially, included a Medicare incentive of only $5,000 per patient for pneumonia, but $13,000 per patient for the pathologically indistinguishable COVID-19 pneumonia.[7] [8] Further, the CARES Act incentive of $39,000 to treat such a patient with a ventilator resulted in financially lucrative outcomes for hospitals, but medically lethal outcomes for patients".[9]

Nurse Erin on WTP: 10,000$ Covid Death Incentives at Nursing Homes

CDC Director Robert Redfield states that financial policies resulted in elevated Covid hospitalization rates/death toll statistics. The CARES act directs a 20% bonus Medicaid payment to hospitals, for every Covid diagnosis.

CDC Guidelines for Certifying Covid-19 deaths: "...in cases where a definite diagnosis of Covid 19 cannot be made but it is suspected or likely(the circumstances are compelling within a reasonable amount of certainty) it is acceptable to report Covid 19 on a death certificate as 'probable' or 'presumed'.

Payouts:

Sen Scott Jensen states: Hospitals make (13K) off of Covid Diagnosis from Medicare and (39K) off of use of ventilators. Dr Judy Mikovits, on the Plandemic Documentary, stated: "..and you've killed them with the ventilator because you gave them the wrong treatment...and you call it Covid 19".

The Payout

Procedure	Hospital Payment
Admitting Cvd Patient	$13,000
Administering Remdesivir	Approx. $3,200
Remdesivir for Medicare Patient	$13,000
Patient put on ventilator	$39,000
Extended Hospital stay due to inflicted complications	+ $$$$$$$

State	Money Received for EACH Covid Case
Alabama	$158,000
Alaska	$306,000
Arizona	$23,000
Arkansas	$285,000
California	$145,000
Colorado	$58,000
Connecticut	$38,000
Delaware	$127,000
District of Columbia	$56,000
Florida	$132,000
Georgia	$73,000
Hawaii	$301,000
Idaho	$100,000
Illinois	$73,000
Indiana	$105,000
Iowa	$235,000
Kansas	$291,000
Kentucky	$297,000
Louisiana	$26,000
Maine	$260,000
Maryland	$120,000
Massachusetts	$44,000
Michigan	$44,000
Minnesota	$380,000
Mississippi	$166,000
Missouri	$175,000

State	Money Received for EACH Covid Case
Montana	$315,000
Nebraska	$379,000
Nevada	$98,000
New Hampshire	$201,000
New Jersey	$18,000
New Mexico	$171,000
New York	$12,000
North Carolina	$252,000
North Dakota	$339,000
Ohio	$180,000
Oklahoma	$291,000
Oregon	$220,000
Pennsylvania	$68,000
Rhode Island	$52,000
South Carolina	$186,000
South Dakota	$241,000
Tennessee	$166,000
Texas	$184,000
Utah	$94,000
Vermont	$87,000
Virginia	$201,000
Washington	$58,000
West Virginia	$471,000
Wisconsin	$163,000
Wyoming	$278,000

Canada Free Press article excerpt:

"Upon admission to a once-trusted hospital, American patients with COVID-19 become virtual prisoners, subjected to a rigid treatment protocol…for rationing medical care in those over age 50. They have a shockingly high mortality rate…"

"As exposed in audio recordings, hospital executives in Arizona admitted meeting several times a week to lower standards of care, with coordinated restrictions on visitation rights. Most COVID-19 patients' families are deliberately kept in the dark about what is really being done to their loved ones."

"The combination that enables this tragic and avoidable loss of hundreds of thousands of lives includes (1) The CARES Act, which provides hospitals with bonus incentive payments for all things related to COVID-19 (testing, diagnosing, admitting to hospital, use of remdesivir and ventilators, reporting COVID-19 deaths, and vaccinations) and (2) waivers of customary and long-standing patient rights by the Centers for Medicare and Medicaid Services (CMS)."

"In 2020, the Texas Hospital Association submitted requests for waivers to CMS. According to Texas attorney Jerri Ward, 'CMS has granted "waivers" of federal law regarding patient rights. Specifically, CMS purports to allow hospitals to violate the rights of patients or their surrogates with regard to medical record access, to have patient visitation, and to be free from seclusion.'…The purported waivers are meant to isolate and gain total control over the patient and to deny patient and patient's decision-maker the ability to exercise informed consent."

"Creating a 'National Pandemic Emergency' provided justification for such sweeping actions that override individual physician medical decision-making and patients' rights. The CARES Act provides incentives for hospitals to use treatments dictated solely by the federal government under the auspices of the NIH. These 'bounties' must paid back if not 'earned' by making the COVID-19 diagnosis and following the COVID-19 protocol."

Excerpt goes on…

“The hospital payments include:

* A ‘free’ required PCR test in the Emergency Room or upon admission for every patient, with government-paid fee to hospital.

* Added bonus payment for each positive COVID-19 diagnosis.

* Another bonus for a COVID-19 admission to the hospital.

* A 20 percent ‘boost’ bonus payment from Medicare on the entire hospital bill for use of remdesivir instead of medicines such as Ivermectin.

* Another and larger bonus payment to the hospital if a COVID-19 patient is mechanically ventilated.

* More money to the hospital if cause of death is listed as COVID-19, even if patient did not die directly of COVID-19.

* A COVID-19 diagnosis also provides extra payments to coroners.”

“CMS implemented ‘value-based’ payment programs that track data such as how many workers at a healthcare facility receive a COVID-19 vaccine. Now we see why many hospitals implemented COVID-19 vaccine mandates. They are paid more.”

“Outside hospitals, physician MIPS [Merit-based Incentive Payment System] quality metrics link doctors’ income to performance-based pay for treating patients with COVID-19 EUA drugs. Failure to report information to CMS can cost the physician 4% of reimbursement.”

And on..

“Because of obfuscation with medical coding and legal jargon, we cannot be certain of the actual amount each hospital receives per COVID-19 patient. But Attorney Thomas Renz and CMS whistleblowers have calculated a total payment of at least $100,000 per patient.”

“There are deaths from the government-directed COVID treatments. For remdesivir, studies show that 71–75 percent of patients suffer an adverse effect, and the drug often had to be stopped after five to ten days because of these effects, such as kidney and liver damage, and death. Remdesivir trials during the 2018 West African Ebola outbreak had to be discontinued because death rate exceeded 50%.

Yet, in 2020, Anthony Fauci directed that remdesivir was to be the drug hospitals use to treat COVID-19, even when the COVID clinical trials of remdesivir showed similar adverse effects.

In ventilated patients, the death toll is staggering. A National Library of Medicine January 2021 report of 69 studies involving more than 57,000 patients concluded that fatality rates were 45 percent in COVID-19 patients receiving invasive mechanical ventilation, increasing to 84 percent in older patients. Renz announced at a Truth for Health Foundation Press Conference that CMS data showed that in Texas hospitals, 84.9% percent of all patients died after more than 96 hours on a ventilator.”

“Then there are deaths from restrictions on effective treatments for hospitalized patients. Renz and a team of data analysts have estimated that more than 800,000 deaths in America’s hospitals, in COVID-19 and other patients, have been caused by approaches restricting fluids, nutrition, antibiotics, effective antivirals, anti-inflammatories, and therapeutic doses of anti-coagulants.”

A Story-

(Our amazing Grace): “Got covid” around the same time as her mother. Symptoms of a cold. Oxygen level below 90%, taken to urgent care. “Positive test”. She had elevated inflammation markers, physician told parents to take her to hospital. The first day she was doing fine, the second day the Dr pressured the father to put her on a ventilator. (Based on a blood draw test). A retaken test showed that she was fine. They were pressured 5x in total to put her on a vent if her oxygen went below 90%. Third day, nurse says her oxygen is at 85%, father does a test and it shows shes at 95% and nurse validated the test, no signs of decline from Grace. Nurse acknowledged the finger leads would get sweaty which led to false “low” readings. Head nurse comes with Armed Guard, states its because the father was shutting off the alarms, however that was due to permission from nurses to turn off non essential alarms, “Last 3 shift nurses don't want do in the room”. Father is cautioned by attorney friend to leave, last time he sees her. Alone in hospital for 44 hours, mother couldn't be the replacement advocate because of her positive test. Hospital denied advocacy for Grace, parents get lawyers involved, Sister (Jess) made as replacement advocate. 4 days prior to her death, doctors placed Grace on a Sedation med (Precedex), she was on the drug for four days even though the package insert says to not use for more then 1 day. IN conjunction with other drugs on the last day. Doctors did not communicate with her POA (Mother) or Jessica. CNS drugs aren't meant to be mixed, black box warning cautions this. Put in restraints for wanting to use the BR. Patient was not monitored nor given a bedside watch with the reversal drug. Jess said Grace felt Cold, Nurse denies that she's cold. Jess was the one to check for a pulse (lack) and see that her eyes had rolled back. One hour later, Jess calls parents to warn them, Nurses state over the phone that Grace is DNR. Dr ordered it, not the family. Family has continually stated they never accepted this nor were they contacted with regards to a DNR, rather a DNI. Grace dies a few minutes later and parents forced to watch through Facetime. However, that last morning, after Scott and Cindy DID NOT give the hospital permission to "use a ventilator in case it becomes necessary," [for the 5th time!] the doctor ordered Grace to be strapped to the bed, for wanting to go to the bathroom, and increased the dosage of sedation to 14X the original dosage. The hospital recorded Grace’s oxygen saturation at 44%, on their big monitor, when it was 93%! Why? He then ordered an anxiety med and morphine which should never be combined! Why? Because the hospital was only making $1,680/day on Grace’s care because she wasn’t on a ventilator? Because the hospital was at maximum capacity the day Grace died with better paying patients in the ER waiting for a room

a. At no time did we ask for Grace to be labeled DNR. We also did not agree to DNR status at any time. The hospital’s letter to us, explaining her DNR status, references the doctor note, above, as the reason Grace was labeled DNR.
b. We never signed any statement regarding Grace being DNR, as required by law.
c. On Grace’s last morning, the doctor encouraged us to approve a feeding tube because Grace was improving – why would anyone be considering DNR when she was doing so well?
d. Grace was not wearing a DNR bracelet, as required by law.