

WHAT THE NURSES SAW

An investigation into
systemic medical murders
that took place in hospitals
during the COVID Panic and
the nurses who fought back
to save their patients



Ken McCarthy

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**AN INVESTIGATION INTO SYSTEMIC MEDICAL MURDERS THAT TOOK
PLACE IN HOSPITALS DURING THE COVID PANIC AND THE NURSES WHO
FOUGHT BACK TO SAVE THEIR PATIENTS**

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INTRODUCTORY QUOTES

“Whenever we give up, leave behind, and forget too much, there is always the danger that the things we have neglected will return with added force.”

— Carl Jung, *Memories, Dreams, Reflections*

“We’re killing these patients with protocols that obviously don’t work and they’re not only not listening to the nurses, they are firing anyone who speaks out.”

— Erin Olszewski, Registered Nurse

“All men make mistakes, but a good man yields when he knows his course is wrong, and repairs the evil. The only crime is pride.”

— Sophocles, *Antigone*

DEDICATION

To *all* the nurses who honored their oath, said “no,” and worked, and continue to work, to protect their patients from a thoroughly corrupt system gone mad.

To the nurses and others who persist in advocating for their patients in the face of bullying, loss of employment, challenges to their licenses, legal harassment, slander by the so-called news media, and physical threats to themselves and their families enabled by the tech companies who control social media.

To all the nurses, and to all who support them and will come to support them in the future, who have put themselves on the front line in the struggle to create a medical system based on integrity and designed to put the interests of the patient first.

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INTRODUCTION

“The world is a dangerous place to live, not because of the people who are evil, but because of the people who don’t do anything about it.”

– Albert Einstein

Hippocrates, the father of western medicine, is reputed to have given the following advice to physicians: “First, do no harm.”

This is good advice for any profession, but it’s particularly important in medicine given that death resulting from medical treatment is the #3 leading cause of death in the United States. (Johns Hopkins). One noted researcher, whose book *Death by Medicine* appears in the resources section of this book, believes it’s *the* #1 cause, which puts it ahead of even heart disease and cancer as the leading cause of death for Americans.

Medicine is familiar with this phenomenon and even has a technical term for it: “iatrogenesis.” Like many medical terms which come from Greek (pericardium, “around the heart”; thrombosis, “disease of clotting”) the meaning of iatrogenic is a lot clearer in the original language: “iatros” (doctor) – “genesis” (origin).

No human activity can ever be free from error, but to be clear, this book is not about the kind of error all human beings are prone to.

Instead its about the systematic coercion of health care professionals (nurses, physicians, respiratory therapists, and others) by institutions (federal and state bureaucracies; hospitals and the corporations that own them; and licensing boards) into actively withholding known safe and effective treatments (ibuprofen and steroids) and deploying dangerous protocols that were in many cases completely unnecessary (intubation and venting) and known to be harmful and lacked legitimate scientific or medical justification for their use (remdesivir).

As you will learn from the eye-witness accounts and technical information presented in this book, calling the failed COVID protocols “errors” is not accurate.

These protocols were explicitly ordered by those who took dictatorial control of the medical system early in the Panic (spring of 2020). Further, when they were shown to be demonstrably failing and harming many thousands of people, experienced health care professionals who raised informed concerns were silenced through demotion, firing, and organized campaigns of harassment promoted by the news media and enabled by companies like Google, Facebook, Twitter, and TikTok, in some cases in collaboration with the White House and the Department of Justice’s FBI.

If this sounds very bad, it’s because it is.

What This Means for You

At some point in your life, you or one of your loved ones may find yourself in an intensive care unit or requiring serious medical care. If this ever happens, your survival will depend on a number of factors.

The first thing most people think about in circumstances like this is the desirability of having a skilled and experienced doctor or doctors on the case. Others will also hope to have access to the latest in medical technology. These factors can indeed make the difference between life and death and successful recovery or a life of disability, but they leave out a third essential factor: the quality of the nurses who will be treating you.

- It is the nurses who carry out the doctor's best idea of what needs to be done.

- It is the nurses and allied professionals who maintain, operate, and monitor technology and drug reactions to make sure they are doing what they are intended to do and not causing harm. Given that the #3 cause of death in the U.S. is iatrogenic (caused by medical treatment) this is not a trivial function.

- It is the nurses who care for the patient after the doctor is gone and keeps doctors informed of the details of the patient's progress or setbacks.

And it is the nurses who when witnessing mistakes are *required by the oath of their profession* to speak up and advocate for patients when patients are unable to do so and their loved ones are not immediately available to do so for them.

This trio of factors — physicians, technology, nurses — constitutes the full team and this is the full team you should be praying to have.

The Hidden Players in the Game of Saving Your Life

Unfortunately, today in what we call “modern” medicine, there are other factors besides the people in the room working to save your life and help you recover your health.

The hospital administrator, often a non-doctor who has never participated in the medical care of any human being, will determine what level of resources you will receive from the doctors and nurses who treat you—unless your doctor and/or nurse push back on your behalf.

The administrators in turn take their orders from the hospital CFO (chief financial officer), who in turn get their orders from the CFO and CEO of the hospital group that owns the hospital. The technical term for these owners is an Integrative Delivery Network (IDN) and these IDNs wield vast power. Of the over 6,000 individual hospitals, over 10% are operated by just five IDNs.

Above the IDNs are governmental organizations. In the U.S. that would be the CDC, the FDA, and the NIH. The NIH produces what it calls “research” which the FDA turns into regulations regarding drugs and procedures and which then become specific advice from the CDC. The people at this level, who may or may not have medical training, are not involved in the day-to-day bedside care of patients. Every sovereign nation has its own layers of medical bureaucracy similarly configured.

One More Player Who’d Like to Rule Them All

At the time of this writing, there is a proposal to add yet another layer on top of the current structure: the WHO, the World Health Organization, headquartered in Geneva, Switzerland, an agency of the United Nations.

WHO decisions are passed down by the decree of whoever happens to be Director-General at the time. The delegates, members of the World Health Assembly (an organization made up of unelected bureaucrats appointed by their respective national governments), cast their votes by secret ballot for Director-General. No citizen of any country plays any role in the process. The Director-General is in office for five years and can, if re-elected, serve one additional five-year term.

The current Director-General of the WHO is Tedros Adhanom Ghebreyesus. He began his political life as a member of an ethnic paramilitary group called the Tigray People’s Liberation Front of Ethiopia, which fought a 15-year armed struggle against the then-government of Ethiopia.

Not a medical doctor, Tedros earned a Ph.D. in community health. With this foundation, he was appointed Minister of Health by the leader of the Tigray People’s Liberation Front when it ultimately succeeded in taking over Ethiopia. In 2012, he was appointed Ethiopia’s Minister of Foreign Affairs and in 2019 he was elected the Director-General of the WHO.

I bring this up for two reasons:

First, Tedros' biography is representative of the career path of many of the people who become voting members of the World Health Assembly, the people who gave him his position as supreme leader of the WHO. They are, first and foremost, political operatives, and may or may not be trained or experienced in giving medical care. (The vast majority are not.)

Second, there is a very real possibility that we will all someday be living in a world in which whoever occupies the office of the Director-General of the WHO will determine: a) what level of care you will or will not receive, b) what drugs and/or procedures you will have access to or be denied access to, and c) what medical procedures will be perpetuated even if they are obviously ineffective and dangerous.

Under a "new and improved" system, which is currently being proposed, the proclamations of the Director-General of the WHO will override the health and medical policies of the bureaucrats of the 194 countries that are members of the WHO.

What this means in practice is that what your doctor and nurses can do to help you when you need help and the technology and drugs they will be permitted to use in the process of helping you will be controlled by the man or woman who occupies the post of Director-General of the WHO.

IDNs (conglomerates that operate scores of individual hospitals) which today take their orders from bureaucrats in Washington, DC, and pass them down to hospital administrators will then take their orders from Geneva and those orders will come from a man or woman who may or may not be someone with a medical education and clinical experience.

Whether this particular hyper-centralized system ever comes to pass or not, it's important for you to know that when your doctors and nurses are hard at work trying to save your life in an emergency situation in a hospital or doctor's office, other parties — parties who are not doctors and have economic and/or political considerations that have nothing to do with the saving of your life — may, in fact, be the most important factor in whether or not you avoid death or serious disability.

If you are comfortable with such an arrangement, you possess a degree of equanimity that I do not. Thus my writing of this book.

What The Nurses Saw — It was Murder

“What the Nurses Saw” is documentation of what happens in the real world when bureaucrats, in this case bureaucrats in Washington DC, take literal dictatorial control over the practice of medicine.

The book’s subtitle brings more precision to what’s in the narrative: “Systematic Medical Murder in Hospitals During the COVID Panic...”

The practice of medicine today is nothing if not a systematized, top-down operation. I don’t think any honest physician practicing in today’s environment would dispute this. Whatever happens in U.S. hospitals follows bureaucratic policy that is by definition systematic.

I use “medical murder” to mean murder by medical means, specifically death caused by the deliberate withholding of specific drugs and procedures that are known to work and/or the use of specific drugs and procedures that are known to be harmful. For the purpose of this book, I am defining such activities as medical murder.

The law defines the killing of others with a variety of technical terms — murder, homicide, manslaughter — and each U.S. state defines things differently in an attempt to differentiate circumstances. There’s homicide of varying degrees. There’s manslaughter of varying degrees. Then there is criminally negligent homicide which, despite containing the word “homicide” in it, is considered a less serious charge than manslaughter.

In New York State (every state defines things differently and I had to pick one) “criminally negligent homicide” means causing a death by an act or a failure to act. The perpetrator’s act does not need to be intentional or even reckless to qualify.

For example, if a doctor or a nurse who is employed to care for a particular patient deliberately withholds a medication that is known to be life-saving and the patient dies, a prosecutor can make the case that, beyond garden-variety malpractice, an act of criminally negligent homicide has occurred. The same principle could apply if the health care practitioner

deliberately applies a therapy that they have reason to believe not only does not work but also is known to seriously injure and kill patients.

I use the term “murder” in the title, not as a specific legal term, but in the way murder is understood in common speech. In short, if you carry out an act that is likely to injure someone and they die, it’s murder.

The COVID Panic

During the COVID Panic, the legal waters were muddied considerably because bureaucrats at the U.S. federal, state, and local levels ordered doctors and nurses to both deny traditionally accepted protocols for respiratory distress and related inflammation and use entirely new and poorly tested drugs and other protocols that gave every indication at the level of actual practice of being ineffective at best, and injurious to the point of being fatal at worst.

I use the phrase “COVID Panic” instead of “pandemic” for two specific reasons.

First, the term “pandemic” was decreed by the WHO, specifically by the non-physician Tedros Adhanom Ghebreyesus whose background I described earlier. In the case of what was and continues to be called COVID, it uses a new definition of the term “pandemic” that is legalistic, not medical, and until recent years would never have been accepted in the way it was and continues to be used today.

Second, seasonal occurrences of respiratory distress have been a fact of human life since long before the beginning of recorded history. Early false narratives to the contrary, all of which have since been thoroughly refuted, the symptoms of COVID were not entirely new and neither was the virus type, the coronavirus. Previous to COVID, science had long accepted that the coronavirus type was one of the carriers of what’s called “the common cold.”

In short, the “pandemic” was exaggerated and did not merit the label. Further, the disorder associated with it, while threatening to people in frail

or seriously compromised health, was inconsequential to the overwhelming majority of the population with near zero statistical risk to young people, children, and infants, and then only in cases with serious preconditions. For this, the world was shut down with trillions of dollars in damages to poor and working people around the world, which was only the tip of the iceberg of the grave, widespread, and lasting social harm that was done in the maniacal and unhinged crusade to “stop the spread”.

Further, I use the term “panic” with very specific and deliberate intention. “Panic” is a noun and it is both a transitive and intransitive verb. If you slept through grammar class as I did the first time, here’s what this means. In one case, a person can panic. That’s an intransitive use of the verb. A person can also panic another person. That’s the transitive use of the verb. Panic can also be used as a noun. For example the phrase “He felt panic” is an example of panic being used as a noun.

Sometimes the word “panic” is used in conjunction with the word financial, as in “financial panic.” This refers to a social condition when large numbers of people suddenly become worried about the safety of their bank accounts, pensions, financial investments, and the condition of the economy. Panics can be, and sometimes are, created with malicious intent. For example, a miscreant yelling “Fire!” in a crowded movie theater when there is no fire has created a panic. History shows that bureaucrats, politicians, and news media owners have been involved in creating panics to serve their own agendas.

It is my opinion, though I do not attempt to prove it in this particular book, that what is called the “COVID Pandemic” should more accurately be called the “COVID Panic.” (In three other books *Unraveling the COVID Con: Part One*, *Unraveling the COVID Con: Part Two*, and *Fauci’s First Fraud*, I lay out my case for this in some detail.)

In summary, the subtitle of this book “Systematic Medical Murder in Hospitals During the COVID Panic...” is not arbitrary and not intended to be sensational. On the contrary, I am attempting, in good faith, to be as accurate and descriptive of the situation as I can be.

...And the Nurses Who Fought Back

This book is specifically about what nurses saw in ICUs (intensive care units) and other components of the medical system in the U.S. and Canada during the COVID Panic. And what they saw was systematic, top-down ordered murder.

We won't know how many people died this way and, absent of any serious attempt by the government to get to the bottom of this crime against humanity, we will, in all probability, never know.

We do know how many people were reported to have “died of COVID” in the U.S.: Roughly 1,000,000. We also know what percentage of these people died in hospitals (vs. at home): roughly 90%.

This means roughly 900,000 people who reportedly died of COVID were under the care of a medical system that: a) denied patients well-established therapeutics for respiratory infections and inflammation (ibuprofen and steroids), b) used ineffective and poorly understood pharmaceutical products known to cause organ failure (ex. remdesivir), c) overused and misused ventilators including injurious and obviously incorrect settings and without even minimally acceptable levels of skilled supervision, and d) denied patients drugs like ivermectin that have a well-established high safety profile and that clinicians around the world reported were effective in treating the symptoms associated with COVID.

In short, nurses were ordered to do things they could see were injuring and killing their patients and were prohibited from doing things that they knew had a chance to save them.

A small percentage of nurses honored their professional oath to be advocates for their patients and spoke up against these practices. In retaliation, these nurses were harassed and removed from ICUs and, in many cases, fired and professionally blackballed. (Recall that a small number of corporations (IDNs) control the vast majority of the nation's hospitals.) Some had their licenses challenged and taken away from them.

In one particularly egregious anti-social operation, a group of Internet troll-thugs, who called themselves Team Halo and were literally endorsed by the U.N., targeted specific nurses like Nicole Sirotek to whom this book is dedicated. This resulted in death threats against her, threats of violence against her children, and strange men showing up on her property, aided by the fact that Team Halo members went so far as to post Sirotek's home address on the Internet. (Sirotek's book *Dark Influence: How Social Media Influencers Were Used to Manipulate the COVID Pandemic* documents this and other officially-supported and officially-tolerated abuses of the Internet.)

In addition to the nurses who spoke out and paid the price for doing so, some nurses quietly stayed on to mitigate harm, in some cases even assisting families to evacuate their at-risk family members from hospitals where they were clearly not safe.

Making Sense of the Evil

Despite the heroic actions of many nurses, only a small fraction of whom appear in this book, the vast majority of nurses went along with the top-down orders to do things that predictably and repeatedly ended in the death, often the miserable death, of the vulnerable people entrusted in their care.

To the thousands of new and inexperienced nurses, some young and some mid-life career transitioners, who were put in COVID ICUs with zero ICU training and experience (a shockingly large number): You were lied to, actively deceived, and aggressively bullied into taking the actions you took by people who fundamentally abused their authority.

The entire episode gives the appearance of being deliberately engineered in order to: a) enrich cooperating hospitals, b) raise the "COVID" death count, and c) create justification for the Emergency Use Authorization of dangerous drugs like remdesivir and d) provide the foundation for a multi-billion-dollar media program which terrorized and then coerced millions of people into accepting inadequately tested medical technology (mRNA vaccines) that has proven to be neither effective nor safe.

What's Needed, What's Next

A book like this could have appeared as early as the fall of 2020. That it is only appearing now towards the end of 2023 and had to be compiled by someone who is not a journalist, not a historian, not an attorney, not a medical ethics professional, and not a professional public health advocate is an indication of how thoroughly and completely the decent people of the world have been abandoned by the so-called establishment.

In a decent society, the moment that professional nurses with years of emergency medicine and ICU experience spoke up about the harm COVID protocols were causing, they should have been listened to by news media outlets, government officials, and the healthcare hierarchy.

Of course, this did not happen.

Instead, the nurses who honored their oath were ignored, harassed, slandered, and attacked, often viciously. The good news is that in the face of this fundamental assault on the practice of nursing, many thousands of nurses have opted out of the system and are now serving their communities directly and outside of what is giving all the appearances of a hopelessly corrupt system. The book documents some of these fledgling and promising efforts. I hope you will support them. Your life and the lives of your loved ones may well depend on it someday.

In a decent society, experienced nurses who witnessed this massive crime against humanity would have been invited to give their eyewitness testimony to investigators and would be protected from harassment by law enforcement. Additionally, hospital administrators; CEOs of hospital groups; local, state, and federal bureaucrats; ad agency and public relations operatives; politicians and their appointees; and executives of social media companies who participated and sometimes even coordinated harassment and terror campaigns against the nurses and other medical professionals who spoke out, would be subpoenaed and compelled to answer pointed questions about the details of how this system operated, how it came into being and who directed it.

We need something like the Nuremberg Doctors Trials which were held after World War II, but something far more serious and comprehensive. I am working on a book that addresses this in detail called *The Nuremberg Code and Its Modern Enemies*.

In the absence of such an initiative, which I imagine can only be undertaken adequately by Congress given the resources and legal clout required, we need to acknowledge that our healthcare system has reached the point where it's not only incompetent and corrupt, it's become a positive danger to human life. We also should have long ago stopped calling it a health care system. It cares little for health and provides very little care. It should be called the medical services industry and the octopus-like grip it has taken on our country should be acknowledged.

On a pure dollar and cents level, one of every five dollars spent in the U.S. is spent on the products of the medical services industry, as is one of every three tax dollars. The U.S., more than any country in the world, and by a large measure, has been colonized by this industry. As part of this process, the industry and its operatives have corrupted and perverted science, academia, and the news media. Now it's hard at work to weaken and degrade the last pillar that keeps the system even remotely functioning — the integrity of the nursing profession.

If we fail to support our good nurses, help them hold the line, and start aggressively turning things around, there is no practical limit to how far this totalitarian medical dictatorship which we in fact live under will go in its future abuse and exploitation of human beings.

Ken McCarthy
August 24, 2023

PART ONE: EARLY WARNINGS - FIRST IGNORED AND THEN SUPPRESSED

“The medical profession is the only one which was and is permitted by its social and legal standing to govern itself, make its own laws, and enforce its own disciplinary measures. It operates as a brotherhood of members who regulate entry, performance, and behavior, and who themselves are accountable to no one for their conduct.”

— Richard Lamm

(American politician, former Governor of Colorado, and author of *The Brave New World of Health Care*)

PROLOGUE TO PART ONE

When a person is drowning, or there is some other immediate and obvious threat to life and health like a fire or an unfolding violent act, no one in their right mind would stop and take the time to write and edit a polished memo and politic it up the chain-of-command in order to attract attention to the problem.

In the case of fires, there are fire alarms and when a fire alarm goes off action is taken immediately, even knowing that occasionally there are such things as false alarms.

Imagine the lunacy of a fire department not only ignoring but also deliberately suppressing an alarm called in by an experienced fireman.

This is exactly what Nicole Sirotek and other experienced intensive care and emergency nurses and doctors encountered during the official COVID response. They could clearly see that new and unproven techniques were failing and tried-and-true methods of caring for patients were expressly forbidden—and they spoke up.

Part One starts with her statement, dated, and a link to the original video of her speaking.

We made a few alterations to grammar and other things in the written transcript for the sake of clarity. Otherwise, these were her words just as

they were spoken.

CHAPTER 1

THE SHOT CENSORED BY THE NEWS MEDIA AROUND THE WORLD



Nurse Nicole Sirotek. A screenshot from her May 1st, 2020 Facebook live video that went viral. The complete video referred to in this chapter can be seen here: www.WhatTheNursesSaw.com

On May 4th, 2020, a YouTube channel that normally doesn't get much traffic re-posted a video that has since been seen by countless millions of viewers. I say "countless" because it has been re-posted by hundreds of individuals across all social media channels — Facebook, Twitter, YouTube, Instagram, TikTok, and others.

Many of these social media companies removed the video and excerpts of it as quickly as they were posted and, except for a minor scattering of press attention after the New York Post broke the story, this video and what it signifies has been ignored.

The original video was a Facebook Live broadcast on May 1st, and intended for a small audience of friends and colleagues.

What viewers outside the original intended audience saw was a then-unidentified woman in nursing scrubs describing in graphic detail the chaos and horror she said she was witnessing in the intensive care unit (ICU) of a New York City hospital.

The theme of her comments, which were presented extemporaneously, was unequivocal: Patients were dying not as the result of the course of a disease, but from gross incompetence and negligence. These failings appeared not only to be allowed to go unchecked but also to be the direct result of procedures and systems aggressively enforced by the hospital administration.

In short, while people were suffering and dying unnecessarily, experienced, capable people on the scene were not only being ignored when they spoke up, they were also threatened with disciplinary action, removal from the ICU, and being fired and even blackballed industry-wide if they did not remain quiet and refused to follow orders.

Very quickly, it was learned that the speaker was Nicole Sirotek. Like hundreds of nurses from all over the country who responded to the call for help, Sirotek traveled from her home (in her case Nevada) to New York City. She and the others were headed to what was described as the “epicenter of the pandemic” and were prepared to be exposed to and treat patients suffering from what was then being presented as an unprecedented virus of extreme lethality.

Nicole Sirotek was raised in California’s Central Valley by a single-mother immigrant. Spanish was her first language. Despite her family’s poverty—as a child, she spent time in homeless shelters and even briefly lived in a car—her mother encouraged her that she could better herself through education. When her family attained greater stability during her high school years, she flourished as a student, graduated from college, and entered graduate school in life sciences which involved working in East Africa where she participated in HIV research.

After moving to rural Nevada, Nicole switched careers to nursing and earned a Bachelor’s degree in nursing and an RN and EMS RN license as well as certifications in numerous nursing disciplines including critical care, legal nurse consultant, infection control, and flight nursing (air ambulance).

In addition to working in ICUs and surgical settings, she has over five years experience as a flight nurse. As a contractor for a nonprofit humanitarian agency, she worked in Syria with refugees and has first-hand experience with field hospital conditions.

At the beginning of the the COVID crisis, she went to New York City where she worked as a contract nurse at Metropolitan Hospital and Lincoln Medical Center. After leaving New York, she worked with and coordinated the efforts of fellow volunteer nurses in Central and South America and the Caribbean dealing with respiratory problems like COVID and other medical conditions in challenged communities.

I strongly recommend that any readers who have not heard Nicole's words as they were being delivered in those dark days do that now, and even those who have heard them in part or full do that too. You can see the full unedited video by going to WhatTheNursesSaw.com.

Keep in mind that this video was seen by millions, but it was ignored and sometimes aggressively censored by hospital administrators; the news media including the Big Tech companies that control the public conversation; doctors and their medical associations; local, state, and federal officials; politicians; and public health bureaucracies, local and national.

Failing to heed the very clear alarm this video raised resulted in the needless death and suffering of hundreds of thousands of people (millions worldwide) as well as the anguish of their families, friends, and communities.

Ninety-two percent (92%) of all the individuals who reported to have “died of COVID” passed away in hospitals and other similar institutions. ¹

Of the hundreds of thousands in this category, how many died under circumstances akin to those Sirotek and other nurses describe in this book? Absent a comprehensive and rigorous hospital-by-hospital investigation by government authorities on a national scale, backed by subpoena power, we may never know. Nonetheless, it seems hard to deny that a certain number of deaths resulted from unhinged, authoritarian, and self-serving orders issued by those in positions of authority.

The only aspect yet to be determined is the specific legal definition of the culpability that the authorities responsible for creating the conditions leading to these deaths bear.

What follows are key excerpts from the eyewitness account Sirotek conveyed to her audience:

“Hey everyone. Great goodness. It is 8:42 New York time. And I got to my regular unit and they took my patient away. And now I’m getting switched units. This is exactly what happened before at the other hospital. As soon as I told somebody in management (what was going on) and tried to advocate for my patient, they take the patient away from me, and then they moved me.

I legitimately don’t even know what to do anymore. Even the advocacy groups don’t give a shit about these people.

I know not everybody’s going to live. I’m not that green or ignorant or, you know, bright-eyed and bushy-tailed to think that, okay. I know we’re going to have a shit ton of people die. But these people aren’t dying from COVID.

Nobody is listening. They don’t care what is happening to these people. They don’t. I’m literally coming here every day and watching them kill them.

I don’t even know what to do anymore. I tried calling advocacy groups, I tried talking with management here, like the nursing admin. Nothing. Nobody’s doing anything. We still have a 100% mortality rate in the ICU unit I just left.

They literally don’t even know when (a patient) is dead. How many times have I told you they’ve assigned me a dead person? How long have they been dead? Nobody knows.

How is anybody assessing anything without a stethoscope? Normally we have those disposable stethoscopes, but I knew what we were coming into. So I brought my own chunky one. Nobody’s listened to anybody’s lungs as long as I’ve been here, even with disposable stethoscopes.

I’m not a doctor, but I’m pretty sure that when you defibrillate somebody with a heartbeat of 40 and a stable rhythm, and you kill them, that’s murder.

And I'm pretty sure that when you put somebody's PEEP (positive end expiratory pressure on a ventilator) up to like 25 and you blow their lungs out and they die, I'm pretty sure that's murder. I mean, I just watched a doctor drop a central line and rupture the subclavian vein, and the guy bled to death. COVID didn't place that central line. COVID didn't kill that guy.

I watched an anesthesiologist place an ET tube and rupture their esophagus and the guy choked to death on his own blood. COVID didn't place that ET tube incorrectly.

They're not dying of COVID, okay? Some people will end up with multi-organ failures and filled with clots that kill them and they'll die. People, I know this. I'm not some new grad who's gonna save everybody in the world. Okay. I am literally telling you that they're murdering these people. And nobody will listen to me.

I tried talking to hospital management. I tried calling CMS (Centers for Medicare & Medicaid Services). I tried calling the equivalent of their Division of Aging. I tried calling a couple of Black Power groups in the area. Who else? This took several hours. I tried contacting a newspaper. Nobody called me back.

The only way I can put this into context for everybody is — and this is going to be kind of an extreme example, this is like really, the only thing I can come up with — is like if we were in Nazi Germany, and they were taking the Jews to go put them in a gas chamber. I'm the one saying, "Hey, this is not good. This is bad. This is wrong. We shouldn't be doing this." And then everyone tells me, "Hang in there. You're doing a great job. You can't save everybody. You're amazing. You're a great nurse." Guys, I know I'm a good nurse. I know I go in there and I give it 500% every day. I know I'm not being negligent. Okay, I know that. What I need is someone to help me save these people from being killed from gross negligence and complete medical mismanagement. And no one is listening to me.

Like for real, nobody's listening. I even tried getting a hold of black advocacy groups here. They just put me on hold or hang up on me. I tried talking to management, and now I got moved units. I don't know what to do anymore. Can someone come up with some type of solution for me? Because I'm out of ideas."

1. This number (92%) is based off of an average over three years, 2020-2022. “In 2020 alone, the Centers for Disease Control and Prevention (CDC) reported 350,831 deaths in which COVID-19 was the underlying cause of death listed on the death certificate; of those deaths, 19,413 occurred in the decedent’s home.” In other words, 94.46% of ‘COVID deaths’ in 2020 occurred in hospitals and other institutions. (Source: <https://rockinst.org/blog/home-or-hospital-what-place-of-death-can-tell-us-about-covid-19-and-public-health/>)

CHAPTER 2

THE HEARING YOU DIDN'T HEAR

JANUARY 24, 2022

Unless you live in Wisconsin or an adjoining state, you may not recognize the name Ron Johnson.

He's one of the two elected officials who represent Wisconsin in the U.S. Senate. That alone is not enough to make his name a household word, but he should be known to every American nonetheless.

After decades in business (he was first an accountant, then a machinist, and eventually CEO of a packaging manufacturer), Johnson ran for U.S. Senate in 2010 without any previous experience in politics. He won that election and Wisconsinites liked him well enough to re-elect him twice, once in 2016 and again in 2022.

During one of the greatest social disasters the U.S. has ever faced, Johnson was one of the very few Congresspeople who asked any questions at all about the official COVID narrative and the government response. And

he did more than ask questions. As Chairman of the Senate Homeland Security Committee, he organized five public Senate Roundtables where he invited medical and health experts, many with international reputations, to give their perspectives on the catastrophe.

In all likelihood, you never heard about these Senate-hosted events. You probably also never heard about the dramatic increase in alcohol and drug-related deaths and the unprecedented rates of suicide especially among the young — including children — during the COVID Panic.¹ It's now known that during this period the White House used FBI agents and other government operatives to coordinate with the Big Tech social media companies to censor the comments of hundreds of doctors, scientists, nurses, and public health experts who questioned the official COVID narrative.

Johnson gave these silenced experts a voice and the news media, which has otherwise demonstrated a penchant for broadcasting hearings of all sorts during this period, not only did not televise the hearings but also never reported their existence except occasionally to smear Senator Johnson with charges of being a “conspiracy theorist.”

Johnson held three Roundtables which addressed, among other things, the much-censored topic of the denial of proven therapeutics to COVID patients — including Ibuprofen and steroids — and COVID vaccine injuries showing up in alarming numbers in young people, children, and young adults including servicemen and women.

Nicole Sirotek was invited to give a brief presentation at one of these Roundtables.



Nicole Sirotek testifying at the “COVID-19: A Second Opinion” roundtable discussion on January 24th, 2022.

Nicole Sirotek: *Thank you, Senator, for giving me an uninterrupted opportunity to represent the harm that is coming to the patients in American hospitals and the lack of early intervention.*

My name is Nicole Sirotek. I’m a registered nurse. I’ve been a registered nurse for over a decade. My specialty is critical care, trauma, and flight.

My story actually begins back in May of 2020. I was one of the original nurses that went to NYC to help with the COVID pandemic because, as we remember, they needed nurses – and most importantly, they needed ventilators. Well, I was the whole package, a flight nurse that can manage ventilators.

When I arrived there, the gross negligence and the medical malfeasance that happened there, and the complete medical mismanagement of these patients, is what has led us to the situation that we’re in right now: the pandemic and the hysteria that was created from poor public health measures and poor execution of appropriate early intervention strategies.

And the handicapping of medical professionals doing their job has led to where we are right now and into the crisis situation that we are in.

When I was in New York, and what continues to happen today is that many of them are not dying from COVID.

What many people don't know about me is that I'm actually a master's prepared biochemist and I have worked extensively with the HIV virus, tracking genetic mutation. So I feel very comfortable going toe-to-toe with some of these doctors here.

I am not a doctor; I'm a nurse, but what we saw on these front lines...we knew what was happening. When we asked for the ibuprofen, they said, "No," it was contraindicated. When we asked why aren't we giving them steroids? "Oh, well, it's not... we're just following orders." Following orders led to the sheer number of deaths that has occurred in these hospitals.

I didn't see a single patient die of COVID. I've seen a substantial number of patients die of negligence and medical malfeasance. I'm unfortunately known, globally viral, as the nurse who was in the break room sobbing, saying that they were murdering my patients. The pharmaceutical companies had gone into those hospitals and decided to "practice", I guess you can say, on the minorities, on the disadvantaged, on the marginalized populations that we know had no advocates because the very agencies that should have been protecting them were closed because we were "sheltering in place."

While I was there and I saw that the pharmaceutical companies were rolling out remdesivir onto the patients I tried to get a hold of the IRBs (Institutional Review Boards), I tried to get a hold of my appropriate chain of command. I tried CMS, I tried the Department of Health. And they rolled out remdesivir onto a substantial number of patients. We all saw it was killing them and now it's an FDA-approved drug that is continuing to kill patients in the United States.

As nurses, we've collected information that you may not get from the doctors because where they do quantitative data, in nursing research we do qualitative data with a humanistic phenomenological approach. We've collected the data from patients from across the country, patients we have

been trying to help. I formed the organization American Frontline Nurses as an the advocacy network so nurses could advocate for these patients. This data pool we collected shows patients who get remdesivir have a less than 25% chance of survival if they get more than two doses.

Now they're rolling it out on children as well, and into the nursing homes and skilled nursing facilities as early intervention, even though Dr. Pierre Kory and Dr. Marik have already demonstrated that there are cost-effective medications out there. As a result of this, we are going to see an increase of deaths across our country. And we haven't even touched on the vaccines. The expert panels here have already described that situation very well.

Two days ago, as an emergency flight nurse, I flew out my first 10-year-old with a heart attack. I had to fight the doctor in the ER because he said "10-year-olds don't have heart attacks." I had to argue for 30 minutes to force his hand to get an EKG to find out that he was almost a complete STEMI which is ST-Elevated Myocardial Infarction. You could see it lit up on the 12-lead EKG. He said: "That's not possible." I replied: "He was just vaccinated yesterday so it is very much possible."

All day, every day, people are asking me and the nurse advocates at American Frontline Nurses to help them in vaccine injury situations because, as you've seen, there is victim shaming. "Oh, it's anxiety. Oh, it's this." If they report a vaccine injury, the physician, the corporation, the hospital, the clinic, won't get reimbursed so instead they label it as anxiety, neuropathy, or Guillain-Barré Syndrome when in actuality it's very realistically a vaccine injury.

I've traveled extensively in South America, India, and South Africa, working in hot zones, working to stop the spread of the virus via early intervention. Nowhere in the countries I've been to, and they are all developing nations, do I see these issues that we see here in the United States. I'm a very proud American citizen. I come from a family of immigrants. And my mother told me that the United States is the best country in the world. But the reality is that our level of healthcare has deteriorated to substandard, third-world nation healthcare. I tell people that they are literally better off in a field hospital in South America than they are in level-one trauma designer hospitals in the United States.

We're getting reports from across the country relayed to us by our members at American Frontline Nurses, about patients not getting food, patients not getting water. How come a patient hasn't been fed in nine days? Why do I need to get a court order to force a hospital to feed a person who isn't intubated, and who's literally telling you they would like food? "Well, you can't take the BiPAP mask off." That's what we nurses are for! We're there to help you take that off and to help you eat, but we're not allowed to. If patients are on a ventilator in this country, they're not getting basic standards of care. I've had patients who haven't been bathed, haven't been fed, haven't been given water, haven't been turned. If you ask me, these aren't hospitals anymore. They've become extermination camps.

Under no other circumstance in the United States have we ever isolated people for hundreds of hours at a time with no human contact. It's not even allowed in the prisons. You're not allowed to isolate a prisoner for beyond a certain amount of time because it is horrible for their mental health and is considered inhumane. Everyone knows that. However, in these hospitals now, we're allowed to isolate patients from their families for days, and their only method of contact, as they are saying goodbye to their loved ones for the last time is over an iPhone as Jennifer Bridges has just demonstrated to us.

Personally, I was fired for sneaking a Hispanic family in to say the last rights with their dying family member. So thank you Senator Johnson for giving nurses the opportunity to come and represent our patients because as you can see, we're not being given this opportunity to be heard in our communities even though we are the link between the doctors and the patients, and the patient's last line of defense. Their life may depend on a nurse's advocacy.

Senator Ron Johnson: *Thank you for being a nurse.*

Note: Sirotek's original comments have been edited for clarity with her oversight and approval.

You can view the video of Nicole's testimony and the entire hearing at: www.WhatTheNursesSaw.com

Testimony from **"COVID-19: A Second Opinion"** an all-day Senate Roundtable discussion with:

Dr. Peter McCullough, Dr. Ryan Cole, Dr. Harvey Risch, Dr. Pierre Kory, Dr. Richard Urso, Dr. Christina Parks, Dr. Mary Bowden, Dr. Harpal Mangat, Dr. Paul Marik, Dr. Aaron Kheriaty, Dr. Robert Malone, Dr. David Wiseman, Dr. Jay Bhattacharya. Additional statements by Dr. Paul Alexander, Steve Kirsch, Dr. Ben Marble, Brianne Dressen, Kyle Warner, Jennifer Bridges, Thomas Renz, Leigh Dundas, and Nicole Sirotek.

1. “Researchers identified 5,568 youth who died by suicide during the first 10 months of the pandemic, which was higher than the expected number of deaths had the pandemic not occurred.” (Source: <https://www.nimh.nih.gov/news/science-news/2023/youth-suicide-rates-increased-during-the-covid-19-pandemic>)

PART TWO: EARLY WARNINGS - 2020

WHAT WAS KNOWABLE IN THE SPRING OF 2020

*“**T**he very first requirement in a hospital is that it should do the sick no harm.”*

— Florence Nightingale

PROLOGUE TO PART TWO

“What did he know and when did he know it?”

This question first became the formula for how people look at the culpability of leaders during the Watergate era.

Specifically, regarding the break-in of the Democratic National Committee headquarters at the Watergate office building, what did then-president Richard Nixon know about it, and when did he first learn about it?

Was he only made aware of it from news reports along with the rest of the population? Was he given accurate information about it then? Did he gain accurate information about it and then publicly lie about the facts afterward? Or, worst-case scenario, did he actually order the break-in and/or know that people under his command were routinely doing criminal things like this with his blanket authorization?

The answer to these questions made all the difference in the world.

After all, no one can blame a leadership (too much) if their subordinates engage in illicit behavior and take active steps to cover it up and keep it outside of the leadership's awareness.

Regarding the medical murders that took place, and continue to take place, accelerating during — but not starting with — the COVID Panic,

several groups have responsibility in the matter:

1. The doctors, nurses, and other healthcare practitioners who carried out the orders to use treatment methods that (it quickly became obvious) did not work and harmed — and withheld treatment methods that had a long well-established track record of working (ex. steroids and anti-inflammatories)

2. The unions that represent nurses and healthcare workers

3. The hospital administrators who ordered these actions with the threat of penalties, including demotion and job termination, against doctors and nurses who would not comply with their orders

4. The CEOs and other top executives of the companies that owned the hospitals that carried out these operations

5. The state and local level public health officials of jurisdictions where hospitals carried out these orders

6. The federal bureaucrats who not only made the recommendations but also financially incentivized the hospitals that carried out these orders and may have even financially threatened those that considered refusing

7. The elected officials in jurisdictions where these operations took place, specifically governors and county executives, and, in the case of large cities, the mayors

8. Universities and faculty members who conduct research and employ experts in the fields of medicine, public health, law, and medical ethics and were silent and even participated in censorship of the topic (see Stanford Internet Observatory)

9. The so-called news media which, in theory at least, exists in order to research important topics of public interest and report the facts to the public in a timely manner (thus the name of their product “the news”)

I may have left out some groups, but I think I’ve covered the most important ones.

When did these groups know that during the COVID Panic patients were routinely being killed by the deliberate withholding of time-proven therapies and the use of newly-crafted protocols which it soon became clear

not only didn't work, but also routinely caused grave harm up to and including death?

There is a principle of law called "notice." For example, if your town decides to suspend the right to park your car on your street because street repairs need to be made, they can't just start ticketing and towing away cars without first going through the procedure of giving you notice, in this case probably by posting signs throughout the neighborhood in advance stating the day parking rights will be suspended.

When did the nine groups listed above get "notice" that the methods being used to treat COVID were not only not working, but also harming?

Amazingly, all these years later, many still claim they know nothing of what happened and how it came to be. This would fall under the category of aggressively willful ignorance.

Unfortunately, ignorance of a condition is an "excuse" for not taking remedial action. If a governor, or a news director, or a university professor, or the CEO of a hospital chain somehow managed to remain unaware of the mayhem being committed in U.S. hospitals, they can, somewhat reasonably, claim "I did not receive notice and I did not know" and thus evade responsibility.

This section is made up of two extended interviews I conducted early in the summer of 2020 based on reports that first appeared in the spring of 2020.

The first was with an experienced intensive care nurse who was one of the contractors who worked in a New York City public hospital during the COVID Panic. The second was with a veteran nurse of over forty years of experience who was also a Ph.D.-level educator of nurses in the UK.

The former appeared on numerous mainstream news programs including at least one segment which aired on a U.S. news network with global reach on June 11th, 2020 (Tucker Carlson Tonight on Fox News).

One would think that this report would have constituted notice to Fox News, at a minimum, and by extension other news outlets in the U.S. and around the world. Presumably, the legal departments of corporations that own large hospital chains could have been aware of, and may have even

issued legal opinions to their employers about, the explosive charge that their hospitals were killing patients.

Do public health officials, federal health bureaucrats, hospital administrators, and elected officials monitor major news outlets? It seems that they do and that they especially did during the COVID Panic because many of them made public statements that indicated they were getting their information and even procedural guidance about COVID from the news media.

The question “What did they know and when did they know it?” remains an open one, but it is something, for somebody, to sort out.

Meanwhile, these two interviews constitute what was knowable in the summer of 2020 to anyone who had a reasonable level of interest in the question: “Why are so many people dying of COVID in U.S. hospitals and other care facilities?”

CHAPTER 3

HORROR ON THE FRONT LINES

ERIN MARIE OLSZEWSKI INTERVIEW - JUNE 11, 2020

“I attribute my success to this; I never gave nor took any excuse.”
— Florence Nightingale

Ken McCarthy: Erin is both an Army veteran and a nurse. Normally, our society likes to honor veterans and nurses as heroes, except when they have something to say that authorities don't want to hear. Today, we have someone I consider a hero. Some of you may already know her from some of the videos that she's appeared in. In this conversation, we will get into some technical details that will help illuminate some of the vital information she's been sharing. Before we go any further, for people who don't know you, you are an Army veteran, correct?

Erin Marie Olszewski: Yes.

Ken McCarthy: You started when you were 17?

Erin Marie Olszewski: Yes, I signed when I was 17. I guess I've always been kind of a rebel. It was before the September 11th attack, so I was in basic training when that tragedy occurred. You know how everybody remembers where they were? That's where I was, and I realized, "All right, I guess this is my path."

I was deployed to Iraq, which was my first real experience away from home as a young 18-year-old. I got back a couple of years later.

Ken McCarthy: Were you part of the original waves over there?

Erin Marie Olszewski: Yes, I was part of the first wave. We went to Iraq, and my team was one of the teams that took down the Saddam statue. We were the first ones in the country with the Marines and the 82nd Airborne.



Erin, age 18. The first wave of the invasion of Iraq. "We were the first ones in the country with the Marines and the 82nd Airborne."

Ken McCarthy: That's quite a life already by 18. Did you get your nursing training in the army or afterward?

Erin Marie Olszewski: I served my years, did my time, got out, and went to nursing school. I no longer felt like the army was the life for me. I always wanted to be a nurse. That's what I always wanted to do, so I went to school for it. Even when I was back in high school, I was a CNA

(Certified Nursing Assistant), and I always loved that area and always knew that's what I wanted to do. I started out with my LPN (Licensed Practical Nurse). Then I went on to get my associate's RN (Registered Nurse) degree, and then my bachelor's degree in nursing. I went through all the steps and worked my way up to where I am now.

Ken McCarthy: And now you live in Florida?

Erin Marie Olszewski: Yes. I'm actually from Wisconsin, so I'm a transplant. But I do live in Florida now, and I've lived here for a while, but I am a Midwesterner at heart.



Nurse Erin Marie Olszewski

Ken McCarthy: Let's address a big issue right away, and then we're going to get some details. You have the unique experience of having been a nurse during COVID in a Florida hospital and later working with COVID

patients as a nurse in a New York City hospital. For people who don't know your story, would you tell us the difference in broad strokes? We'll get into the technical details later, like the number of people that died, percentages, survival rates, and those kinds of things.

Erin Marie Olszewski: When this pandemic hit, of course, everybody was preparing, including hospitals and staff. Nobody knew what to expect. All our eyes were on New York because it was called the epicenter. Where I am located, the staff at my hospital was being furloughed. We didn't have anything to do. There were very few patients. It was not busy, and nobody could figure out what was going on.

We ended up cross-training around the hospital. I was cross-training on different floors so that when the anticipated wave hit, we could do any jobs needed. When I got an offer to go to New York to help, I asked my employer if that would be okay because there wasn't really anything to do locally. I didn't think the wave would hit us, and it never did. So my manager ok'd it. I hopped on a plane and headed out to the pandemic epicenter, ready to help. I was also hoping to get some insight into what was going on with the pandemic.

Ken McCarthy: And again, you're somebody who lived in an active combat zone. You're not somebody who's never seen difficulties. You know how hairy things can get, so you were mentally prepared.

Erin Marie Olszewski: Yes, getting off that plane was eerily similar to going into a war zone. It was interesting because, in a warzone, you immediately get to work when you get off the plane. When we landed in Kuwait, we were ready to go. When I landed in New York, we taxied over to a four-star hotel in Times Square, and we sat around waiting for an assignment for three days.

That was one of the first red flags. "Why am I not in a hospital if this is a pandemic and you need nurses so badly? We're just sitting here." The traveling nurse agency I went through was funded through FEMA, which was paying quite a bit of money.

We were making \$10,000 a week while we were there, which is unheard of. That's a lot of money to pay a nurse who isn't even being utilized. I felt like it was such a waste. A lot of people don't know that part of the story.

Some nurses were there before me and sat for 18 days. Why were these people not being used?

Ken McCarthy: FEMA handled this? They were the ones writing the paychecks?

Erin Marie Olszewski: FEMA was funding it, but the hospitals were supposed to be putting the nurses into the hospitals.

I don't know who was responsible for that. All I know is that it sent off a huge red flag for me before I even stepped foot into a hospital.

Ken McCarthy: You mentioned in a previous interview that in Florida there were some COVID cases. Some people came in the door with the problem and they had a good survival rate. Do I have that correct?

Erin Marie Olszewski: Yes, absolutely. I was working in the emergency room while we were waiting for the wave. There would be people who'd come to the emergency room with a positive COVID test. The difference between how we treated them and how they treated them in New York was profound. We used the hydroxychloroquine and zinc protocol. That's what people were prescribed in Florida.

If they were asymptomatic, they were sent home and quarantined. If they were admitted, the very, very last treatment was a ventilator. Venting a COVID patient was unheard of. At the time I left, we hadn't vented a single patient though I understand later that one patient was vented after I left and he survived and went home.

When I got to New York, it was a very different situation. Hydroxychloroquine was banned for off-label use. If doctors did try to prescribe it, they would likely lose their licenses and their jobs. In New York, the first line of defense was the ventilators. Very different from how we treated COVID patients in Florida. Two different places with very different outcomes.

Ken McCarthy: Let's talk about some of the nuts and bolts information that people need to know to visualize how hospitals work.

In any hospital, there are many different players. There are the doctors, the nurses, the techs. There are the orderlies and people who do the cleaning

and handle all those essential tasks, and every person is vital to the team. For example, without orderlies, you can't have a hospital, right? Things would fall into chaos within a few hours, right?

Erin Marie Olszewski: Right.

Ken McCarthy: There are a lot of people doing a lot of important work, but the pecking order, understandably so, is doctors on top, issuing the orders and nurses supporting the doctors' efforts. Of course, orderlies and techs are doing their thing, but there is one wrinkle to this. As a licensed nurse, you are sworn to specific ethical standards. Can you talk about the ethical training and the ethical responsibilities that nurses have that people may not be aware of?

Erin Marie Olszewski: Our professional oath states that we're the patient's advocate. If we see something unethical, without integrity, or something that will harm a patient, it's our duty to report it. We are considered mandatory reporters. The problem with what happened in New York is that it was turned into a liability-free environment by the order of the governor, Andrew Cuomo.

When that occurred, all normal standards went out the window, and people were doing whatever they wanted to do. You mentioned the pecking order. Above the doctors, and I think this is where the problem started, you have the governor and hospital administrators making medical decisions for how patients would be treated that they were not even remotely qualified to make.

People without boots on the ground in these hospitals were giving orders on how to treat patients. Why was this happening? How did these people who had never been inside these facilities end up making decisions for treatment, putting themselves in-between the doctor-patient relationship?

This put everybody in a terrible position, especially the doctors because now they couldn't even prescribe hydroxychloroquine if they wanted to. They were laughed at if they asked for anything, like the high-dose IV vitamin C that Dr. Chang was using in Asia successfully.

They had to follow the orders that came from above, whatever those orders were whether they made sense or not. I tried to go up the chain of

command when I was there, but I was shut down over and over and over again. Eventually, I was kicked out for speaking out and asking too many questions, something that should never happen to a nurse in a medical setting.

Ken McCarthy: I want to stress that it is a nurse's job to speak up because mistakes get made. Sometimes, you have to tell the doctor, "This patient already got his insulin shot," for example, "Don't give him another one or you'll kill him." And the doctor should listen and say, "Oh goodness. Thank you for catching that."

It sounds like the governor of New York became the medical dictator of New York City hospitals. He decreed what was permissible and what was not permissible. We all know he screamed for ventilators, right? He wanted 30,000 ventilators for New York, and if he didn't get them, he said there would be a catastrophe, and the administrators of the hospitals just fell into line.

I'm also wondering, do hospital administrators ever take an oath to protect patients? I have a gut feeling that, as administrators, they don't take such an oath. But I could be wrong.

Erin Marie Olszewski: I don't think there's an oath. They probably sign some code of conduct with the hospital when they take that position to protect and serve their patients. That's an interesting point that nobody has brought up yet. But it would be good to find that out.

Ken McCarthy: The hospital administrator is a kind of "god." Am I stretching things a bit there when talking about how things actually run?

Erin Marie Olszewski: No, not a bit.

Ken McCarthy: In a sense, if the hospital administrator says, "Stand on your head," you better stand on your head, or you'll lose your job, or you'll get written up, or something terrible might happen to your career. The hospital administrators are a very, very powerful bunch.

Within the hospitals, the care orders for COVID patients were clearly coming from the hospital administrators, who were getting them from the governor's office, who was getting them from where? Who was advising him?

I did a little bit of research and it didn't require me to be Sherlock Holmes. The guy who was New York's head of Public Health and advising Cuomo doesn't have a public health degree. He's not even an infectious disease guy. He's an anaesthesiologist who specializes in pediatric cardiology, which is great, but it didn't really prepare him for the job at hand. Also, he appears to have spent more time in government and quasi-government jobs than practicing medicine.

There's another important point I'd like to raise about all this. Nurses and doctors are not interchangeable. For example, just because somebody has an MD doesn't mean they're prepared to handle every medical situation. If anybody doubts this, the next time you need open heart surgery, call your podiatrist and see if he can give you a deal on it. So we know there are specialties within the medical world, right?

In an emergency with a pandemic and people coming in with an infectious disease, you're going to want a staff of doctors, nurses, and techs who have the correct skills for the specific problems they're going to face. Even if this was an emergency and a surprise, and we didn't know a whole lot about it, we did know it was a respiratory disease, and we knew it was infectious.

Many things were known, which should have informed the people doing the planning. "What kind of doctors do we need? What kind of nurses do we need? What kind of techs do we need?" Tell me about your experience with the personnel you encountered while working in the New York City hospital. Their backgrounds and skill sets.

Erin Marie Olszewski: That's a good point. I'm going to circle back, and then I'll get to that question. You brought up how Cuomo ordered the 30,000 vents back in March. How did he know we would need 30,000 vents? When he ordered those, why didn't he think to order people to run them, too? That was another part of the wheel that was broken. He didn't think, and nobody who advised him was thinking, "Oh, we're going to need respiratory therapists to run those vents."

Most ICU nurses don't even touch vents ever. It's a doctor's role and it's the respiratory therapists who handle the equipment. As nurses, we manage the patient, monitor the patient, and keep an eye on their well-being, but it's

the respiratory therapists who are specifically trained for this role who operate the equipment.

With the money they were spending, they could have easily brought in top respiratory therapists from all around the world, but they didn't. We had one, maybe two, respiratory therapists per shift for all these floors of vented patients, running around frantically. The respiratory therapists couldn't even chart anything, which is a big part of their jobs, because they were stretched so ridiculously thin.

Ken McCarthy: So, there was a shortage of respiratory therapists, and these people are highly trained, right? This is not a weekend seminar that they go to. This is a serious profession. Even though you're not a respiratory therapist, you've worked with them and probably chatted with them. Do you know, offhand, what's involved in their education? I imagine they receive years of serious training and then they get better and better at it as time goes on.

Erin Marie Olszewski: Yes, this is what they do. They work with ventilators, they work with patients' breathing, and they understand all the lab work and everything that goes into monitoring these patients on a vent. It's not a simple profession. It takes a lot of study. It's right up there with getting an advanced nursing degree. They're very highly trained.

That was another reason why New York patients died. The staffing. The staffing agency that I went with pretty much took every single nurse who applied. If you had a nursing degree, you were in. They literally put newly graduated nurses with no experience onto ICU floors.

You don't know how to do everything in nursing just by getting a degree. Sure, we're generally trained in every area, but after you graduate, you go into a specialty, and you get to really know that area. They should have brought in ICU nurses, respiratory therapists, and emergency room nurses.

Another problem is that even though the staffing agency asked what our specialties were that didn't mean you would be put in that area. So there were floor nurses who had never worked in an ICU or emergency room, being put into an ICU, given three or four patients, and told to figure it out.

And mind you, when I was there, it wasn't crazy frantic. Things were running like a normal hospital. We were only as busy as a normal hospital on a normal day, but it was a liability-free environment. The unqualified nurses who were put with these patients could have been switched out, and it could have been made right, but nobody in the administration cared. These poor nurses were put in a terrible situation. They tried their best, but they were given technical tasks they had no training or experience for.

Ken McCarthy: So, there was a shortage of respiratory therapists, and there were nurses who didn't have the proper training, with no fault of their own. If you're a student and somebody throws you into an intense ICU environment, that's unfair to the nurse. It's unfair to everybody. But you made a really interesting point, and I want to make sure everybody got it. The volume of patients was not the problem, it was the configuration of the personnel. Are you saying the volume was like a typical, busy ICU environment, but not more than that?

Erin Marie Olszewski: Yes.

Ken McCarthy: The franticness came from the fact that there was a shortage of trained respiratory therapists which proved to be disastrous.

Now we're going to get into the details of what it means to be on a mechanical ventilator because I think most people don't understand. They hear the word vent and think, "Okay, I guess it's a medical thing, whatever." It's not exactly rocket science, but it's pretty darn close. And talk about an intrusive medical practice. It's an intense thing.

With Cuomo screaming, "I need vents, I need vents." Did anyone even know what a vent is? Did they know what it means to intubate somebody? We're going to get into that. When you have a shortage of respiratory therapists, that's like not having a guy to drive the bus. It's like, "Hey, we're going to put a bunch of people on a bus and we don't have a driver. Just put a brick on the accelerator and we'll hope for the best." It's not going to work out. People are going to die, right? Or am I exaggerating?

Erin Marie Olszewski: No, I used a similar analogy when I was talking to somebody else about this. "Here's a car, and I realize you're only 12 years old, but you're going to just have to figure that out." It doesn't make sense. And you don't have to be a rocket scientist to know that if you order

30,000 ventilators, you should probably also make sure that you have people to run them. People lost their lives who didn't need to because of this.

Now the whole scenario of "COVID deaths" is terrifying people around the world who are looking at New York as the epicenter. They're locked in their homes, watching TV and scared thinking that COVID is so absolutely deadly that everybody's dying from it, but people were not being told the truth. That's what I'm trying to do, tell people what really happened.

Ken McCarthy: Let's take a step back for everybody. Erin worked in two hospitals, one in Florida and one in New York City. In Florida, people didn't die. In New York, the vast majority died. We're beginning to understand why: a shortage of respiratory therapists and not the right mix of personnel. Nursing, like everything else in this world, is a specialty, and if somebody doesn't have ICU experience, putting them in an ICU is not a good thing.

I think all of the nurses, even the techs, and probably some of the doctors must have been traumatized by the situation. You're in a no-win situation where people are unnecessarily dying, and you're there trying to hold things together. There's no real way to hold it together because the whole thing's configured incorrectly. Let's talk about some of the specifics of how things actually worked in the hospital.

Let's talk about patient intake. You talked in another interview about the strange methodology by which patients were admitted and identified as being 'COVID' or 'non-COVID' and how they were treated and moved around. From the point of view of a patient coming in off the street with symptoms, what did they experience? How were they moved around? And what happened to them in the New York City hospital?

Erin Marie Olszewski: This is another spot where things went wrong. I'm going to compare my hospital in Florida to how these people were admitted in New York. We worked with the individual in Florida so that we could look at the big picture. Could this be COVID? Possibly. Could this be anxiety because you're terrified because you've been told everybody's dying, and you're scared now that you might have it? Most likely. We

would test them for the flu first and get that result back. If they were negative, we would test them for COVID. We didn't jump right to COVID.

In contrast, in New York, everybody was automatically a potential COVID case. Everybody. They didn't look for anything else.

You could come in with stroke-like symptoms. We knew COVID may have caused stroke symptoms, but you don't treat it like COVID until we've ruled out stroke. Right? In New York, they were treating everybody as a COVID patient. Everybody was another dollar sign, essentially.

A person could come in having a panic attack and "That's probably COVID" in the New York mindset so they would be admitted as a COVID rule out. They would take a test, which had a five to 10-day turnaround, even though there was a rapid result test available that they didn't use, which is another reason things went wrong. And then they'd be admitted to a floor, and on that floor were other COVID-positive patients. So, if they didn't have COVID, the likelihood of them getting it after being admitted to a COVID floor was very high, and they usually did.

Ken McCarthy: If this was as infectious as they said it was, and you put a non-infected person in a ward with a bunch of infected people, you're inviting that person to get infected, right? That's just common sense. But that's how they did it. So, in Florida, when somebody came in, you would say, "Let's find out what this isn't. It's not the flu because we just gave a flu test. It's not this. It's not that." That's standard medical practice. You don't just blindly diagnose everybody who walks in with the disease of the day. That's not the way medicine works. But, in New York City, that's how it worked. They went straight to the COVID suspicion.

Erin Marie Olszewski: Yes. It was the way of life there, and everybody accepted it as normal because that was the order from above and nobody wanted to hear anything else.

Ken McCarthy: So, the laws of standard medicine and ordinary common sense were thrown out the window. If you walked in the door of a hospital with virtually any complaint, you were automatically a COVID suspect.

Erin Marie Olszewski: Yes.

Ken McCarthy: You point out that instead of doing the rapid tests, they did the multi-day test, and that if they decided to keep the person, they put them in a ward with people they knew were active COVID patients, whether they knew the person had COVID or not.

Erin Marie Olszewski: Yes.

Ken McCarthy: What determined whether a person stayed in the hospital? Because I know a lot of places would treat people, send them home, and ask them to self-quarantine. Were they basically taking everybody that walked in off the street and putting them in a hospital bed?

Erin Marie Olszewski: I wasn't in the emergency room there. So, I don't know exactly how the admitting process worked. I was on the floors, and I can tell you that the minute an ICU bed was available, there was already a patient in there, on the vent, on the same vent the previous patient had just gotten off. It was essentially an assembly line to a body bag. It just worked that way. I can't tell you, from my perspective, how people were admitted, but I do know that many people were admitted to these floors that didn't need to be admitted at all.

Ken McCarthy: I know you won't have a hard number here. I'm just asking for an impression. What percentage of the people who ended up in a ward ended up on a vent?

Erin Marie Olszewski: I only worked in the ICU where everybody was on a vent. My friends who worked there, my fellow travel nurses who were on a non-ICU unit, would be transferring many of their patients to the ICU unit. So it's hard to pinpoint a percentage. Most people I saw would either be on a ventilator soon or already on a ventilator.

Ken McCarthy: As soon as a ventilator opened up, they had another person on it right away?

Erin Marie Olszewski: Yes. A vent never rested.

Ken McCarthy: When people were put on the wards in a holding pattern, were they made to wear masks? Do you know?

Erin Marie Olszewski: I think in their rooms, no. I would see some people, not everybody. It wasn't consistent.

Ken McCarthy: I bring it up because it's becoming clear that mask-wearing alone can create hypoxia. I'm wondering how many people went to the hospital with some other type of problem and had a mask put on them, and after several hours, when they did an oxygen saturation test, discovered, "Oh, this person's got a bad number. Let's vent them." This is just speculation on my part.

You talked about a guy who appeared to have nothing more than an anxiety attack, and this is a really hard story to hear, but people need to hear it to understand the kinds of things that happened. Can you tell me a little bit about that story?

Erin Marie Olszewski: Yes. A younger man presented to the emergency room with difficulty breathing and other symptoms. I wasn't in the emergency room, but that's what his chart stated. He was admitted and put on a BiPAP, which is a less invasive breathing machine that's pretty commonly used. It's safe and effective, and a lot of people use them, even at home. They'll use them overnight if they have sleep apnea or other breathing disorders.

Think of it from the patient's perspective. You're terrified. You're going into this hospital that has been all over the national news, with freezer trucks of bodies in the back. You're going in with symptoms of difficulty breathing, etc. It's terrifying. Remember, these patients are being admitted without family members with them, so they are completely alone. They get admitted to these rooms. Everybody they see is dressed in head-to-toe PPE, so you can't tell who anybody is and everybody they see looks scary.

Ken McCarthy: Yes.

Erin Marie Olszewski: As a patient, all you can see is people's eyes, and that's it. The nurses can't hear them. The nurses look terrifying. The patients are terrified. These machines are very uncomfortable on people's faces, so it causes even more anxiety and now they can't even talk because they have a breathing machine on their faces.

Their anxiety is going up. They're getting really uncomfortable. In my hospital, in that type of scenario, we would have gotten a staff member to sit with this patient in their room and comfort them, be by their side, hold their hand, and walk them through what to expect and take the time to work

with them and take care of them. That would have saved the young man's life right there.

I wasn't with him during this time. A friend of mine that I worked with on this unit was and he said what happened was the patient finally said, "I just can't keep it on. I just can't." He was getting really restless, and he was worried and scared.

The doctor residents ruled the roost there. Residents are doctors who have finished medical school but don't have any hands-on clinical experience, so normally they shouldn't work alone.

The resident told the patient, "Well if you can't handle this, you're probably going to die if you don't get on a ventilator." That's how they coerced patients into signing consent forms to be vented. The patient didn't want to sign it. This is what my friend told me, and from looking into the background, it made sense to me that he didn't want to do it.

But after a while, finally, he said, "If this is going to save my life, I guess this is what I have to do." He didn't know any better and didn't have any family or anybody there to advocate for him. The nurses didn't have much say. If you started questioning what the residents were doing, you were moved or kicked out of the hospital.

Ken McCarthy: It's fundamental to medical ethics that a patient needs to know the risk of any procedure that's proposed for them. We're going to talk about what it means to intubate and ventilate somebody in a second because I bet 99% of people who've heard all about ventilators for the last four months have no idea what it means to be intubated and put on a ventilator.

I had personal experience of being in a New York hospital, where a physician, very likely a resident because they were a very young person, tried to talk me into an invasive, and what turned out to be unnecessary, procedure, an expensive procedure, by the way.

The reason I went to the emergency room is that I went from being 100% to not even being able to hold my head up in the space of a half hour. And I thought, "Maybe I'm having a heart attack." I didn't know, I'm not a doctor. So I went to an emergency room.

I was in the waiting room for three hours. Then they put me on a gurney with a drip. I was in the hallway lying there alone for another three hours. No one talked to me. No one looked at me for six hours, and I was too weak to move. This was a normal day, not in the COVID-era. Just “another day in the office” in a New York City hospital, and a private one to boot.

Erin Marie Olszewski: They wanted to give you contrast dye and probably put you in a CT scan.

Ken McCarthy: Yes. At that point, I was starting to feel a little bit better, and I figured, “Look, if I’ve been here six hours and nobody’s looked at me, there must not be anything that bad going on with me. I’m going home.” So I went home. But this doctor was pushing me hard to get this procedure done. She used a lot of pressure.

Let’s talk about the doctors. What does it mean to be a resident?

Erin Marie Olszewski: Being a resident means that you’ve completed the book portion of medical school but haven’t completed the clinical hands-on portion.

Ken McCarthy: Do they have a medical degree?

Erin Marie Olszewski: They do, but they’re not able to work on their own until they complete their residency. It’s like nurses. Nurses go through the same process. We must have a certain amount of clinical hours before we can practice independently.

Ken McCarthy: You say that residents have to be supervised, but were they? It sounds like they were ignoring nurses like yourself who had years of practical experience and making all kinds of life-and-death calls without any apparent supervision.

The resident has book knowledge. The experienced nurse has been working with human beings for years. Lacking clinical experience, residents could easily make mistakes. They could make judgment errors, they could have gaps in their education, and not understand what they’re doing. Is that fair to say?

Erin Marie Olszewski: Yes, absolutely. If you’ve ever been to a hospital or had a family member in a hospital, you see the nurse 99% of your stay.

And for the other 1%, you'll see the doctor making rounds. They look you up and down and maybe write an order. The nurses have hands-on patient care. That's what we do, and we're good at it. That is our entire passion and our career.

That's why I don't want to be a doctor because I love the close patient interaction. So yes, these residents haven't had that hands-on. They've been in the books, but they haven't been in front of a patient, which makes a big difference in patient care. You have to look at the emotions of your patients, too, not just their symptoms. They are not just the lab numbers on the computer screen. A lot goes into taking care of a patient outside of just the symptoms they're showing.

Ken McCarthy: Another nurse came forward and said that sometimes the residents made big mistakes based on their lack of experience. Some of them wouldn't listen and just went ahead with things that were injurious to the patients.

Erin Marie Olszewski: Yes, ego got in the way for some doctors because it's hard for some doctors to admit they're wrong. A nurse, who has, in their mind, less training than a doctor, is trying to correct them. It was a huge power struggle, and it's like that on a good day in the hospital.

Most nurses would attest to this. Most of them are terrified to even speak to a doctor. It's that type of environment: a hierarchy. This is costing patients their lives and their health, and this is taking place outside of the pandemic, too. That's why as a society we need to look at our health care and how it's set up and reform it so it's working for the people instead of working against them.

Ken McCarthy: As you pointed out earlier in the call, New York hospitals were decreed a liability-free zone, so there was even less supervision than usual. Were these residents supervised? Was anybody watching or directing them or giving advice from a higher level, saying, "Hey, you have to be careful with that." Or were they just cut loose?

Erin Marie Olszewski: It depended on the attending MD. The attending doctor is in charge of the residents and the fellows, so it depends on who the attending is. I had a couple of attendings I never even saw. I had no idea

who they were because they never came into the unit. So yes, the residents ruled the roost in some ICU units I worked in.

Some attendings were good. The good ones were rounding with the residents, teaching them, and training them. I can't make a blanket statement that every resident, attending, fellow, or nurse was bad. But essentially, the good ones were outnumbered.

Let's say you have a really good resident and a really good attending doctor on the day shift, and then they go home. Then, a new round of residents and attendings take over and ruin things. You get back in the morning, and now your patient who'd been showing signs of improvement is probably not going to make it because they were given such poor care overnight.

Also, there was no consistency. The residents and attendings went around in groups, and the group would stay for a week and then they'd go to a new unit. Every week we'd get a brand-new set of residents and attendings taking care of the patients. There was no consistency in care.

Continuity of care is a big deal. I would stay with most of my patients every single day. I knew them inside and out. I knew everything about them. I knew where they were from. When you're taking care of patients, you get to know them. Even if they were on a ventilator, I would talk to their families on FaceTime. I would do my best to get to know the person I was caring for. But the residents didn't have that same experience. They were moved around and switched around so often that there was no way to keep up with the progress these patients were making along the way.

Ken McCarthy: That's incredible. How long would a resident stay in a given scenario? A week? Two weeks?

Erin Marie Olszewski: Usually, a week, and then they would go to a different floor. They were rounding all over the hospital. As I said in my video, in my opinion, the residents were essentially just practicing their skills. It was the mindset of the majority that, "Well, they're not going to make it anyway. So it is what it is."

That was hard for me to swallow, "You're not even going to try? You guys aren't even going to try, you're just going to give up?" Some of these

patients had a fighting chance.

The young man I mentioned earlier with the BiPAP. They actually extubated him, put him on a BiPAP, and then re-intubated him. He died. He was only 35 years old. He didn't have to die, and I knew that, everybody knew that. I have a recording of a doctor saying that he didn't have to die. He said that a sitter would have been a good idea and would have probably saved his life. "But, oh well." That was the mindset.

These people died because nobody cared. They were seen as disposable. The majority of patients admitted to the ICU were very low-income. They were viewed as disposable human beings, and that, in itself, should make anybody sick to their stomach.

Ken McCarthy: This was a public hospital?

Erin Marie Olszewski: Yes.

Ken McCarthy: I don't know the details, and you may not know them, either, but there's information that people can look up themselves, that there was some special payout from Medicare or Medicaid. If you diagnosed somebody with COVID, the hospital automatically got a big check, and if you put somebody on a vent, the hospital got an even bigger check. Does that ring true to you?

Erin Marie Olszewski: Yes, and that's another thing that I question. I don't understand why the government would incentivize \$11,000 for every single patient admitted for a COVID positive or a COVID rule out.

Ken McCarthy: What does it mean to rule out? COVID rule out?

Erin Marie Olszewski: Those are those patients that were tested in the emergency room and were awaiting their results. They still got paid to admit them to the hospital.

Ken McCarthy: They call it a 'rule out,' but in normal English, we would think, "Oh, we've ruled it out. He doesn't have COVID." But it meant something else in this world.

Erin Marie Olszewski: Yes, "awaiting results," essentially.

Ken McCarthy: And they still get paid as if it were a COVID patient?

Erin Marie Olszewski: Yes, as far as I know. I am 99.9% sure. That entire hospital turned into a COVID hospital, which meant patients were either COVID-positive or COVID rule-outs. Pretty much everybody was a COVID rule out. And the hospital got another \$39,000 if they intubated and ventilated the patient. These patients are from a low-income population, and there was no family in these rooms. The likelihood of patients going on a vent was pretty high.

A lot of money was involved, and like I said, the vents never rested. Once one patient died, they would put a new patient on that same ventilator within minutes.

Ken McCarthy: Let's talk about what it means to intubate somebody and what it means to be on a ventilator. I have a feeling 99.9% of our listeners who've heard this term – vents, vents, vents – have no idea what that means. Would you mind talking about that?

Erin Marie Olszewski: When you're put on a ventilator, the machine is essentially breathing for you. For that to work, you have to be paralyzed. You can't move, and you have to be sedated so you don't wake up. It's essentially a medically induced coma. You can compare it to being under general anesthesia while in surgery.

Ken McCarthy: Okay.

Erin Marie Olszewski: To do that, you need to be given a lot of different paralytics and sedatives, and at that point, you're entirely reliant on your caregiver, your nurse, your doctors, and your residents, especially when you don't have any family in the room. You're just on a bed, on a ventilator that's breathing for you, with a whole lot of IV medication going into you.



“The average is usually about five or six different drips, and some people had as many as 12, 13, or 14 drips.”

Ken McCarthy: This is a critical point. It’s not like they give you a pill, and you fall asleep. How many intravenous drips are continuously hooked up to a single person on a vent? It’s a lot, correct?

Erin Marie Olszewski: The average is usually about five or six different drips, and some people had as many as 12, 13, or 14 drips. As you’re on the ventilator longer and longer, you progressively get worse. Every single day that you’re on a ventilator is one more day that you probably won’t get off of it.

The ventilator is meant to be the last resort and should never be a first line of defense. If you absolutely need it and cannot breathe on your own, it has to be done very, very carefully. In a normal situation, we would never do something like that to a patient, putting them on a ventilator without them truly needing it.

Ken McCarthy: A last resort, “We’ve exhausted every conceivable option. We know it may kill this guy putting him on a vent but we’ve exhausted every conceivable option.” That’s normally how someone goes on a vent.

It sounds like what they did in New York City, and other parts of the world, is if you had a breathing problem the response would be, “We think you have COVID, so we’re going to put you on a ventilator right away.” And, as you point out, five to six intravenous tubes are going into you, maybe as many as 12, 13, or 14. Another obvious thing that people aren’t aware of is how do patients drink or eat when they’re in that state?

Erin Marie Olszewski: They don’t. They would do tube feedings, put another little tube down your throat into your stomach, and drip in tube feeding. Half the time, they wouldn’t even do that. They wouldn’t normally run any fluids because the patients were getting so many fluids from the IV medications alone. Your food consists of something like Ensure being dripped into your stomach, and that’s it. That’s what you got for food, and the only fluids came from what was in the medication.

Ken McCarthy: To put this in context, you already have seriously compromised health and now you’re on half a dozen or more powerful, non-trivial drugs whose only purpose is to keep you on the vent. They don’t contribute to your health or recovery in any way and your liver and kidneys have to process them all. By the way, isn’t fentanyl one of the drugs that they sometimes use as a painkiller?

Erin Marie Olszewski: Yes, and that was pretty consistent. We used that with pretty much every single patient. And they used a lot of propofol. These are all drugs that normally you’d not see used as much as they were being used.

Ken McCarthy: So the person already has a serious health condition, They’re being given six to 14 different powerful drugs. Their only source of nutrition is a tube into their stomach and other than what’s in the drip, they’re not getting any fluid. And this is going on day after day, week after week, into months for some patients. Then people say, “He died of COVID.” They could have died just from going through this procedure alone because it could kill a healthy person. Right?

Erin Marie Olszewski: Yes.

Ken McCarthy: And then, not to get gross, but we've got to understand the totality of the situation. How does somebody take care of their elimination when they're in a coma? I mean, this is also a problematic, unhealthy circumstance, right?

Erin Marie Olszewski: Yes, many of them had the indwelling Foley catheter for urine collection, and for stool, we would have to clean them daily, but half the time, they weren't being cleaned properly. There was a patient I took over the care of who had dried feces all the way up his back that had probably been there for weeks.

Unfortunately, this was the dominant mindset of this entire hospital: "Well, they're going to die and they're not awake anyway." But I could not look at this and not say something. These patients and their families deserve that. They deserve to have somebody to speak out for them because obviously, they weren't able to speak for themselves.

Ken McCarthy: There was another nurse, I think, one of your colleagues or someone you know. She said that when she'd start a new shift and was sent to care for patients, when she went to their rooms, very often they'd been dead for hours and no one on the previous shift had even noticed.

Erin Marie Olszewski: Yes, Nicole Sirotek. She lives in Nevada. We connected after my video went out. I ended up calling her. I had seen her video while I was still in New York, and I was so thankful. I thought, "Oh, my gosh, I'm not the only one." At that time, I was already recording, and I knew that I would be coming out with this, but I needed to stay in that hospital because I needed to give the patients I was taking care of a fighting chance. I wouldn't even leave their room because I wanted to protect them.

But when I got kicked out, I thought, "Alright, this is it." I reached out to Nicole. There are a lot of us. There are quite a few nurses and respiratory therapists who have contacted me, but they're not ready to speak out publicly. But wait. There will be a lot of us coming forward. Hopefully, with the video I put out, I opened the gates so people don't have to be afraid. I don't want anybody to be afraid to tell the truth. Just get it off your chest because many people live with what they saw, and they saw some awful things. To keep that inside and not say anything is traumatic.

Ken McCarthy: Absolutely. There's a phrase that's used all the time: "Thank you for your service." And it's just a throwaway thing people say, but one of the hardest things is to speak out in an environment like this. We know it's hard because not many people have done it. You and Nicole are among the very, very few, and it's so essential. You know it, and I hope our listeners get this. Thousands of nurses, respiratory therapists, and physicians have witnessed the things you described, but only a tiny handful have had the courage to step up and put it on the line the way you have.

This puts you, Nicole, and others at risk. It's just a fact. You're going to get backlash from people. It's just part of the deal and I want to thank you for doing it. There was talk about the possibility of some attorney getting involved in this. Is anything developing along those lines that you're aware of? Sometimes, I think, at this point, the court system is our only salvation right now. All kinds of stuff can go down in a declared emergency, but once it's over, it's a matter of the laws of evidence, and you can't just tell people to shut up. People can present evidence and talk about what actually happened. Do you know any legal actions being taken on behalf of the people who died in these hospitals and their families?

Erin Marie Olszewski: I will say that I am represented by multiple attorneys from multiple different specialties. And I can't touch on that right now. But I will when I can.

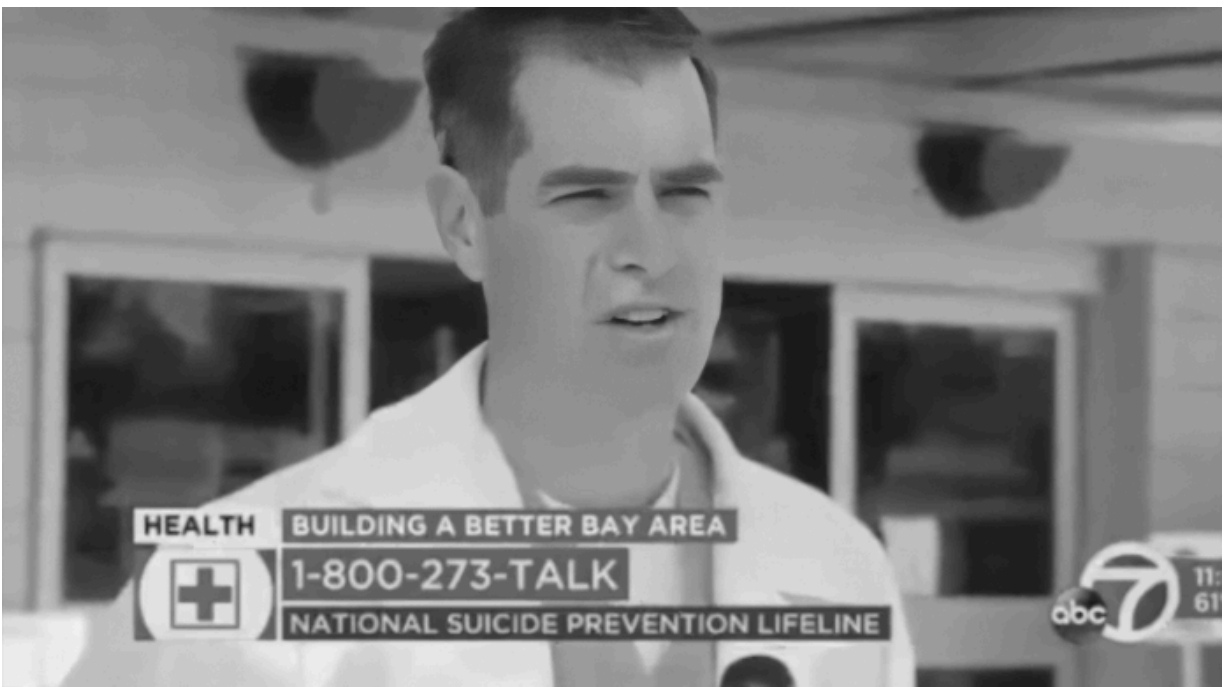
Ken McCarthy: To bring this full circle, something that you said that is so important, and maybe we'll end on this: the rest of the country was looking at the New York experience and thinking that it was the indicator of what they could expect in terms of illness and death rates and number of people dying from COVID. It's so important that we heard Erin's story because we now know what was going on in some of these hospitals. To put it mildly, it wasn't the best of care. People were put on vents too quickly. Patients didn't receive anything approximating decent care in many cases.

These are some things for everybody to chew on. People shouldn't look at New York City and say, "Well, that's what's coming to my town or our city. That's how it's going to be in my community." I live in the countryside and I looked it up: we have a population density of 99 people per square mile. Yet, I see people walking down country roads with no other human being around for miles, wearing masks, and I want to cry "How can these

people be so terrorized? Didn't anybody ever educate them about basic common-sense health?"

Erin Marie Olszewski: They deserve to know the truth so they don't have to live in fear. There are mottos, "We're in this together," and "We can do it, we can get through it together." But why isn't anybody talking about this? A few people are, but I can't get a lot of news stations to even discuss this, and I think it's because they don't want to be wrong, and this reality doesn't fit the narrative.

Not only did this affect the patients who died needlessly, but it's also affecting everybody at home, too. There's been a huge increase in anxiety and suicides. People have been locked in their homes for months. It's not a way to live and it's changing everything. Are our kids going to be forced to wear masks at school next based on New York death numbers that aren't what they seem?



A doctor being interviewed outside a Bay Area hospital early in the pandemic. "The numbers that we've seen are sort of unprecedented. We've never seen numbers like this in such a short period of time. I mean, we've seen a year's worth of suicide attempts in the last four weeks."

Ken McCarthy: Thank you so much for what you've done to step forward.

Folks, if you've never been a whistleblower, it's one of the hardest things on Earth. It's almost easier to be in combat because everybody's patting you on the back, and nobody questions what you're doing. "You had to do what you had to do, and you did it."

To stand up and say, "I was in this situation..." wherever it is, whether it's in a hospital or any place, and say, "Things went wrong" with everybody around you telling you, "Shut up. Don't talk about it. We don't want to hear about it." It's a very hard psychological position to be in. Our society, our country, our communities, our children, our future. We can't keep these things safe without people who are willing to call things as they are. So Erin, thank you for all you've done.

Erin Marie Olszewski: I appreciate your listening, your time, and everything you're doing to get the truth out to people so that can make up their own minds about what they think about it.

Erin Marie Olszewski, BSN, RN, has spent her life fighting for the freedom of everyday Americans. As a young woman, she joined the US Army to fight overseas in Operation Iraqi Freedom. Returning home, she turned her focus, drive, and dedication to defending our most deeply held values on American soil. Erin has spent years fighting for medical freedom. As a registered nurse and a mom of a vaccine-injured child, she has seen firsthand the effects of forced treatment on infants, young children, and adults.

*In 2020, Erin volunteered for the front lines yet again as a traveling nurse assigned to New York's Elmhurst Hospital during the COVID-19 pandemic. What she found there horrified her and inspired a new focus to her advocacy. Erin's book, **The Undercover Epicenter Nurse**, reveals how gross negligence, insurance fraud, medical malpractice, and good old-fashioned greed killed everyday Americans at Elmhurst and beyond. Her new fight is a fight for a return to ethics, transparency, and respect for the*

truth—values sorely needed in the medical field today, and in our country at large. Everyday Americans are needed in that battle as well.

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CHAPTER 4

THE CONTROLLED DEMOLITION OF THE UK'S NATIONAL HEALTH SERVICE

KEVIN CORBETT PH.D. INTERVIEW - JULY 13, 2020

“How very little can be done under the spirit of fear.”
— Florence Nightingale

Ken McCarthy: Today we have a special guest from the UK, Dr. Kevin Corbett, Ph.D. Kevin has a unique background for addressing the matter at hand. Of course, the matter at hand today is COVID and most importantly how various governments are responding to it. Kevin's an expert on what's going on in the UK and we're going to get into that because it's a predictor of what might happen in other countries. Kevin, thank you for joining us.

Kevin, your professional background is as a nurse?

Dr. Kevin Corbett PhD: Yes, I qualified in the mid-1980s as a registered nurse.

I went to work initially in surgery and had some experience in intensive care and high dependency, as well as coronary care. I then went to work in one of the first HIV/AIDS wards in the United Kingdom, which was opened by Princess Diana in 1987. I had a clinical career in HIV and AIDS. I was a staff nurse, a charge nurse, and ended up becoming a clinical nurse specialist and a lecturer in HIV/AIDS nursing and infectious diseases. I then had the usual senior lecturer experience in higher education universities within the United Kingdom and as a senior lecturer in what we call adult nursing, or general nursing. I also gained experience in research, training, education, and public health.

My background is very broad, as well as specific. My Ph.D. was in medical sociology. I looked at people's experiences of testing for HIV and AIDS. I looked at people's experiences with the ELISA (enzyme-linked immunoassay), the Western Blot tests, the PCR (polymerase chain reaction) tests, and the CD4 cell count tests. When the COVID issue emerged quite recently, it was like my Ph.D. had come into a new era as it were, because I could interpret what we were being told in relation to the RT-PCR (Reverse transcription PCR) tests, as being false and inaccurate information from the government. And then, of course, I had links with the HIV/AIDS dissidents from the 1990s and 2000s, such as David Crowe, Peter Duesberg, Celia Farber, and all the people who have been involved in the critique of that science who seem to me to be very well versed to help lead some sort of critique of the COVID science.

Ken McCarthy: Absolutely. We've been making an effort to educate our viewers about AIDS. I call it the AIDS scam.

(Editor's note: See the book *Fauci's First Fraud: The Foundation of Medical Totalitarianism in America*.)

I often say that, if the AIDS scam, for lack of a better word, had been exposed thoroughly, we probably wouldn't have the COVID scam that we have today. The patterns of abuse that were used during the AIDS scam are almost identical to the patterns of abuse we see with the COVID scam. It's a different disease but an absolutely similar playbook.

Dr. Kevin Corbett PhD: Yes, the metaphor I use is a cinematic one. The HIV/AIDS experience was like the trailer for the main feature, the main

feature film being COVID-19 and SARS-COV2, which we have here now. HIV/AIDS affected very different population groups, very specific groups. Those were the at-risk groups, and now everybody is, with COVID and SARS-COV2, deemed an at-risk group. We're all told we're at risk from this.

The general public is in the situation now that HIV/AIDS patients were in during the 1980s and 1990s, except now it's a much more widespread experience; all people are being targeted. We've also got specific targets now in this country where the government is focusing on specific communities to lock down. We've got lockdowns happening now in Leicester City, in the middle of England. We're possibly going to have lockdowns in other cities like Bradford, Kirklees, and Sheffield. It's a bit like Victoria in Australia, where they're focusing on specific communities to target for testing and lockdown.

Ken McCarthy: By the way, when we refer to the AIDS scam, we're not denying that some people were gravely ill.

There's no question about that. The question is, what was the cause? And what was the proper treatment?

Dr. Kevin Corbett PhD: And with HIV/AIDS, you had the different generations of technology for testing people. You also had different waves and different generations of people affected. The first groups of people affected had multiple health challenges. This denialist discourse is a very dangerous one because you can't deny statistics and figures. We have to look at and analyze what the statistics and figures tell us.

Ken McCarthy: One of the confusions around AIDS was that they kept expanding the number of diseases that would be considered AIDS. It originally started as two somewhat different diseases, and I think by the time they were done, any one of 29 or more diseases suddenly became AIDS.

Dr. Kevin Corbett PhD: You're seeing a similar thing with COVID because of the ever-expanding list of symptoms they attribute to it. We have the olfactory symptoms; people talking about losing their sense of smell along with other sensory disturbances. There are similar drives to expand the COVID symptoms further, but overall the COVID symptoms are

incredibly generic and quite expansive already. Today a practitioner can code anything as COVID, such as a headache, sore throat, cough, a temperature, or feeling hot. They all trigger a presumptive COVID diagnosis.

If you present at primary care, or, as you call it, emergency room facilities, you'll be coded as a presumptive COVID case if you present with any of those symptoms, irrespective of any laboratory work. That's the major issue. One of the big issues I saw at the British National Health Service since Christmas, certainly in London where I live was this almost total closure of primary care and general practice in London. You could not get in to see a GP (general practitioner). And the only way that you could get access to any medical advice through the National Health Service was through a telephone system called 111. Which is different to the 999 service.

Ken McCarthy: It's 911 here in America.

Dr. Kevin Corbett PhD: 911, we call it 999. But the 111 service is basically a telephone triage. They re-organized the service in February and March, along the lines of respiratory or non-respiratory symptoms. They were interviewing you on the telephone or online for any suspicion of respiratory symptoms. You were immediately fast-tracked as a COVID case or a presumptive COVID case if you told them that you had a temperature or a cough. All these generic symptoms which could be hundreds of different things were presumed to indicate COVID.

Part of my experience was as a nurse practitioner, and as you know, nurse practitioners are involved in diagnosing patients. The differential diagnosis since Christmas in this country (England) has been skewed towards a COVID presumptive diagnosis, which is non-scientific. It's a pernicious deviation from medical practice. Pernicious and evil. It's an awful word to use, but I can't use another word to describe it because it's so unscientific. It's a form of viral hygiene that's very reminiscent of the racial hygiene that was prevalent in 1930s, Germany. That was part of the reason why I wrote this article called "The 'COVID Nazification' of the National Health Service" because of the direct parallels to the abuses of medical power and practice that we saw in Germany in the 1930s, which are in the history

books. There are very few people around, if any, now, that can remember those days, so it deserves some analysis.

Lots of my colleagues were contacting me very unhappy. They were telling me what was happening within the service was a bastardization of medical practice, a skewed version, based on this notion of COVID, SARS-COV2, this total push towards viral hygiene that we're seeing now. It's become quite embedded.

Anybody presenting at an emergency room was being coded as COVID, based on no scientific evidence, just presumption, and of course, that went down the line. Consequently, these very perfunctory studies that were done about aerosol transmission were used to push the doctors and nurses towards closed circuit management of these patients, and by that, I mean, intubation, tracheal intubation, and mechanical ventilation.

Of course, what you're so good about in North America is people standing up and saying, "This is wrong." You've got a much better history of this than we have. Very few people here have been able to stand out in the same way as the doctors in New York, such as that very young doctor called Kyle and those wonderful nurses who have made those videos in the United States. You can see the protocol-driven care based on these notions of viral hygiene and fear. Contagion fear. Fear of transmission.

This is what reminded me of 1930s Germany because Hitler's Nazi Germany promoted this contagion fear within society. The Jews were the target initially. Not just the Jews, but other individuals, people with learning disabilities, people who are incapacitated, gypsies, homosexuals, whole sets of groups in society that this was trained on initially, this contagion fear. In Germany then, it was about the gene pools and contamination of the gene pool. These groups were seen to be contaminating the national gene pool whereas now the parallel is this new viral hygiene mania.

We've got this notion of a contagion that's "out there," to use that X-Files term. It's out there in society. The government of this country has told the whole of the nation "Any of you can have it, and any of you can transmit it." That's the parrot propaganda message that was put on every poster on every street in this country. Anyone can have it. Anybody can transmit it. It

made everybody a risk to everybody else, overnight. Very similar to the power that the Nazis had in Nazi Germany.



An example of the posters the NHS distributed in the UK during COVID, with the tag line “Stay home. Protect the NHS. Save lives.”

Unfortunately, that viral hygiene contagion fear went straight through the population, irrespective of training. You have doctors, nurses, and healthcare facilities guided by this propaganda. They get somebody coming into an ER department in London who’s got a temperature, that may have a cough, and instead of thinking, “Oh, this could be flu, this could be a cold, or this could be something else to do with the condition you already have...”

Immediately it’s a COVID case, which requires intubation and elective ventilation. I had colleagues phoning me, in March and April. I was doing a little bit of what we call clinical supervision in a way, that all healthcare professionals do. We guide and help each other arrive at some sort of order to the symptoms.

A colleague of mine, a senior ER physician, called me one night and he said, “I’m really worried about the false positive rate here. I’ve intubated four people tonight, and I’m not sure why I’ve done that, except the protocol. I’m driven by the protocol. I’m driven by colleagues who are frightened and guided by this protocol. If I didn’t intubate and ventilate them, they wouldn’t be happy.”

This whole scenario has been set up where people’s behavior is being guided by the protocol, but also the fear that’s been released amongst your colleagues. I said to my colleague; let’s call him John, for the sake of confidentiality, “What are the X-rays like? Why did you go quickly to ventilation, to intubation?” “Well, bilateral whiteout on the X-rays.” I had a look at these, and very often there were pre-existing conditions. “And what was their oxygen saturation?” They weren’t that bad, but because they had a cough and a temperature and some of these COVID symptoms, they were being driven toward ventilation.

He said, “Yes, it could be flu, it could have been flu that I’ve intubated.” On one end of the differential, it could have been flu. So, I said, “Well, you need to get right up there to the ICU, and check it out.” But it’s too late because the patient’s already in the system. They’re transferred over to another intensive care unit and it’s for them to manage. This was the pathway, as we call it. I don’t know what you call them in America but we have these patient pathways that are protocol-driven.

Now, the interesting thing about those protocols, which I probably shouldn’t have gotten a hold of but acquired surreptitiously from several hospitals, was that a lot of these were developed by the agency we have here in this country called the National Institute for Health and Care Excellence (NICE). I suppose it’s something like the FDA. You have these overarching agencies as well, but NICE has this image in this country of a rationing agency because it was created by the Blair government to rationalize the pharmaceutical industry to produce evidence.

NICE would produce evidence of what’s most effective for the NHS to invest in. This is about the use of public resources. The National Health Service – and people may disagree with me – is a socialist-driven health service. It’s come out of Social Welfare principles after the Second World War. A socialist government set up the NHS in 1945. It does have a socialist

mantle to it. It's a sacred cow within British culture. I'm trying to think of American sacred cows.

Ken McCarthy: It'd be Social Security.

Dr. Kevin Corbett PhD: Yes, something that's incontestable, within the country, incontestably good. It's like saying, "Jesus Christ was a good guy." Very few people are going to say, "The National Health Service is an evil thing." But, in the last 20 years, in this country, if you look at the evidence, the National Health Service has been implicated in massive inquiries.

We had a GP in Manchester in the early 2000s, who killed well over 500 patients. We had a Mid Staffordshire Hospital about 10-12 years ago that killed hundreds of patients through neglect. We have a continuing inquiry now into the Gosport Hospital in Hampshire, which over 20 years has killed hundreds and hundreds of patients through malpractice. When you look at the evidence, this mantle of the NHS has become a little bit tarnished. But still, the majority of people would say, hand on their heart, they'd rather have that than an American-style system where you pay at the point of delivery.

So, coming back to my colleague who phoned me that night in an ER department in London, thinking he was intubating flu. This deviation of differential diagnosis; I've experienced this with lots of colleagues and lots of ER departments in London. It's been pretty standard since the end of February and the beginning of March. COVID has been the presumptive diagnosis all the time.

You go in now and all the staff are wearing masks and PPE. Physical examination is becoming a thing of the past. Physical examination, where you are examined, your chest examined with a stethoscope, is going to become a thing of the past, I feel, and people are going to be scanned. They are being scanned and having CT scans and X-rays. Everything's going to be at a distance.

I was looking at the nursing literature the other day from the Hong Kong universities, and the big push is for tele-nursing, like telemedicine. Low-touch or non-touch is the guiding paradigm now because of this contagion fear that's been released. This is happening widespread throughout society. The issue in the NHS is that since February, or earlier, you've had this

tiering of the service into respiratory symptoms, one side, and non-respiratory, the other. It is a command and control that's gone right through the ether of the NHS. It has gone right through the substance of the National Health Service and the 111 telephone service. The general practitioner service won't see you if you've got any respiratory symptoms at all and everything's being done at a distance.

In January and February, they cleared hospital wards in the United Kingdom. They cleared psychiatric units. They cleared general medical wards to prepare for the cases and the hospitals went into shutdown. The public was disbarred. You couldn't visit people in the hospital. You weren't allowed. Therefore, the level of scrutiny within the hospital service, as well as public scrutiny, has gone down. We had a new statute and the British law was changed.

There was a new act of Parliament that came in March, called the Coronavirus Act. It wasn't voted on by any of the parties. It was waved through by an all-party agreement on a Friday afternoon. This is like the Enablement Act in Germany that gave Hitler's regime huge power over the country. The Coronavirus Act allows all sorts of things now. You should read it. It's an incredible act of Parliament.



Rishi Sunak, Boris Johnson, and Jenny Harries. The UK government announces its COVID plan, the 339-page Coronavirus Act 2020, March 20, 2020.

At the moment, if a public health official feels that you are, or suspects you to be, at risk of exposure, you can be asked to give a sample. You can be asked to be tested. If you refuse, you can be taken, and it can be done by force. We have this situation now in the United Kingdom where it's basically, and I don't like to say this, but it is a form of martial law.

The viral hygiene concept, the contagion fear, has infected the legislation with the Coronavirus Act, which is being extended every week. There are new clauses added to it and there are new powers given to the police. For example, as of right now, we cannot gather in groups of six or more. It's illegal.

Ken McCarthy: In the whole country?

Dr. Kevin Corbett PhD: In the whole country. Only two households can gather together, as long as they're not six or more. They're getting away with the Coronavirus Act because people don't understand the implications of it. People believe in the virus and people are going along with the

Nazification through the culture. You've got to walk into the supermarket in a certain way. When I go to church on Sunday, I've got to go down the aisle in a certain order and come out of the church in a certain order. I've got to wash my hands three times. This command and control that's gone through the whole of the culture so quickly, is that word, I can never pronounce the German word...

Ken McCarthy: Gleichschaltung.

Dr. Kevin Corbett PhD: Gleichschaltung, which means command and control. It was used in this book by, Robert Brady from 1937, and it's also used in books by Paul Julian Weindling, who's an expert on Nazi Germany and Nazification. *Nazi Medicine and the Nuremberg Trials and Health, Race and German Politics between National Unification and Nazism 1870-1945*.

This command and control, we're seeing it operationalized now. It's bureaucratized and institutionalized through the law, and it's being operationalized everywhere, right through the National Health Service, but also in the wider culture. They are widening streets in London and the signs on the streets, "Pavement being altered for social distancing." They're altering the physical infrastructure in London to accommodate social distancing. So don't tell me this is going to go in a few weeks. The sidewalks on the London Bridge have been widened and changed for social distancing. This is happening now, right throughout the culture.

Now we're waiting this week for Boris Johnson to announce that mask-wearing is going to be mandatory in shops. You're not going to be able to go shopping unless you have a mask on. You're not able to go on public transport now unless you wear a mask, or you're exempt. You can say you're exempt, but you know what will happen, and what's happened. I've gone on public transport without a mask, and you get shouted at and you get shamed. You get people looking at you. You get people photographing you and putting your photograph on Twitter. It's not happened to me yet, but I understand it's happened to a lot of people.

Like Nazi Germany, they use fear. The fear infects the population. You don't need the Gestapo to be on your street corner because the public will do it for you. People are being made to conform by a whip that's gone right

through society. The contagion fear is the whip, and that will make people think, “You can’t do this, and why are you not wearing a mask? You’re putting me at risk.” You can see how the mechanism works.

Ken McCarthy: We have a similar thing in the United States. The governor of each state has assumed dictatorial powers. Here in New York State, you’re not allowed to go to any shop without a mask. It’s extraordinary. Everything that you’re describing is happening here. I live in a little village with very few people. I think there are about 90 people per square mile in the county, and I see people walking down country roads with no one around them and they’re wearing a mask.

There are a few things I want to double back on just to make sure everybody understands. When a patient comes in, let’s say they’re presenting respiratory problems which could be the flu or asthma. It could be a reaction to air pollution or a reaction to toxic aerosols. We have people spraying Lysol. Those products are highly toxic, and if you’re using them in a closed space, that could create respiratory problems. It could be garden variety pneumonia. It could be emphysema. There are dozens of syndromes, and what you’re saying is happening here in the United States. No matter what you’ve got, the system assumes it’s COVID.

The second thing that you said, and we did an entire show on this, and we cannot repeat this too often, is intubation is a very invasive, very serious, and, frankly, dangerous therapy. It’s a therapy of the last resort when there are no other options. You know that you’re possibly killing the person by putting them on a ventilator. At least that’s how it’s been explained to me.

Dr. Kevin Corbett PhD: You’re absolutely right in everything you said. And to support that, what I would say that intubation and mechanical ventilation are life-saving interventions for somebody who’s had a heart attack and is unconscious, or for somebody whose respiratory system needs to be maintained. People who’ve had a heart bypass and major surgery, or people who have a major road traffic accident and come in in a real mess will benefit from intubation. This is one of the first things you do because in those situations the risks of the intervention are outweighed by the benefits, in the sense that they’re lifesaving. If you don’t do it, the person will die.

That's a different situation than when somebody comes in short of breath, with oxygen levels around 89-90%, which is just below the normal border, and they don't seem to be that short of breath. But in these situations, you can't use a mask, or non-invasive ventilator support in this setting, because of the COVID fear. They've gone towards intubation and ventilation as a first line of intervention.

The problem with that is it's not like a heart attack victim or road traffic accident with a head injury, or somebody who's comatose and can't maintain their airway and can't breathe properly. When you electively ventilate somebody, you've got to sedate them and make them unconscious. Then you and the machine are responsible for ventilating and keeping the heart going. Then you've got to monitor all the organ systems to maintain that person.

It's a whole new ballgame now. I had a situation relayed to me where this woman was in her late 40s and was told by the doctor that she probably got COVID and needed to be ventilated to save her life. My colleagues said to me, "What do you think?" And I said, "Well, what did you do with her clinically?" "Well, she had to go into the other room with her mobile phone to phone her husband to tell him this information." And I immediately said, "Well, if she's able to walk from one end of the department to another with a mobile telephone, she doesn't need to be ventilated." And he said, "Absolutely. That's what I told the doctors." Do you see what I'm saying?

Ken McCarthy: Absolutely.

Dr. Kevin Corbett PhD: The contagion fear and the protocol drive the patient down the pathway. I wrote a whole book on this called the Anti-Coronavirus Toolkit, and I Americanized it because I thought, "The Americans can understand this better than the British." I described the situation as the "COVID-19 freeway." When you get on a freeway (I've driven a lot in the States), you come down a ramp onto the freeway, and you get sucked along in all these lanes, like the 405 in LA where there are six lanes or ten lanes. They're fantastic freeways compared to the things we have here in the United Kingdom. To drive, they're very exciting, but once you're on one you get sucked along and it's not easy to get off. And these pathways we have for COVID are very much like that. Once the patient gets into it, they're processed through it.

What sort of consent can a patient give in a situation like this? Likewise, with all these tests, RT-PCR, the throat swab, and antibody tests, if people knew the science of it, if they read the data sheets from the manufacturers, they'd know these were fast-tracked through on EUA (emergency use authorization). They're not products that have come from randomized controlled trials for years. There's no validity to them. Knowing all that, would anybody say, "I want that"?

People are, I have to say, subject to the expertise that they're given. And the British have got this conformism. Unlike the Americans, we're very loath to stand up and shout and demonstrate. We're not like the French. We don't go on the streets every week. You've seen this in British society, this absolute conformity. Lots of people I know have been surprised about how the British have just buckled under and accepted all this bad science from Imperial College. They've just buckled under the stuff that Birx and Fauci have been pushing out in the States, and I'm wondering, will there come a level with this? Will there be a critical point at which people will wake up and say, "This is too much"?

Ken McCarthy: Would you give me your reaction to this analogy? Somebody comes into the ER with chest pain. You don't immediately take out a saw and open up their chest. That seems to be what they're doing with COVID. Is that a fair analogy?

Dr. Kevin Corbett PhD: A very good analogy indeed. The algorithm to diagnose chest pain is guided by the principles of doing several things. The first thing would be, is it cardiac in origin? Is the chest pain classically cardiac? Does the pain radiate down the left arm? Does it go up into the neck or the jaw? Where is the pain? Does it move? Is it static? What does it feel like on a scale of one to ten? Is it mild? Is it severe? Is it crushing? Is the person breathless at the same time? What's the color of their skin like? Are they blue? Are they white? Is the circulation affected?

All these things, a nurse practitioner or physician would do automatically as they're interviewing somebody. How would you do that over the telephone? How would you do that when you've got somebody who's two meters distant from you, and you can't put your hands on them? You can do it to some extent, but you're going to have a lot of false positives doing that. You also need to do lab work on somebody. Just watch any episode of

American TV hospital series, like ER. You do a full blood count, you do your electrolytes, you do cardiac enzymes, you do a whole workup. You can do some of it standing in any ER department these days, and you can get results very quickly.

Now, why is that not being done when somebody presents with a sore throat, pyrexia (a raised body temperature), and a cough? Why isn't that similar workup being done with them? Why are they automatically being processed as COVID or presumed COVID until the PCR test comes back? It's quite bizarre really. The reason for that, I would say, is because the propaganda – "the science" propaganda – that has been put out since day one by the WHO and is being bought up by all the local and national health authorities. It's been pushed down the line and thrown down our throats as clinicians.

That's what you saw with the videos very clearly in America. The Bakersfield doctors, Dr. Kyle in New York, the nurses, those wonderful nurses, were able to confound this propaganda by their own clinical experience and immediately challenged it and said, "This is incorrect." And look what happened. Some of these doctors suffered as a result. We have one consultant in this country who has said, "COVID is a hoax," and he's been suspended by the General Medical Council, and his registration has been suspended.

Ken McCarthy: We have a state legislator in Minnesota, who is also a general practitioner with 35 years of experience. He didn't call anything a hoax. He just questioned a few things and his license is now up for review in retaliation.

Dr. Kevin Corbett PhD: Ken, can I divulge something personal? I was a lecturer for a long time, and then I retired from the university four years ago, when I was 61. I worked as a consultant, doing bits of research. Then, a couple of years ago, I decided at the end of my nursing career that I wanted to do something clinical hands-on again before I finished because I've been in the university for so long doing research, teaching, and publishing.

Since universities are not very good in this country at allowing nurse academics to be clinicians, I thought I'd go and work as a nurse practitioner.

I got a very nice job with the Metropolitan Police working in custody with people who are arrested. It's like an ER where you're the only nurse and there are no doctors on site. You're diagnosing, and doing the differential diagnosis every day, every minute. You're looking at the risk and assessing whether somebody should go to the hospital, etc.

When I came out of that job, just coming up to my 65th birthday last December, just before the COVID stuff broke in February, I was contacted by a few colleagues in one of the well-known London hospitals, "We need somebody like you. We need a Ph.D. nurse to come in. We're doing all these tests."

I got offered this very good job, and what they wanted me to do was to force people to have tests. They wanted me to coerce people into having tests. They didn't use those words. But when I said, "Where are the consents for this? People need to consent." And they said, "Of course, they'll consent. Just tell them it's an emergency and they've got to have it." I said, "Well, I'm not so sure about that." I've taught medical ethics for 20 years, on and off, and you can call the subject different things in different curricula, but I've taught around those subjects for a long time. I said, "Well, what happens if people say, no, they don't want the throat swabbed? They don't want the antibody tests?" They said to me at the interview, "It's your job to make them agree." I said, "Well, I don't agree with that."

So, I got a really bad feeling about the way the NHS was going, and I came out of that interview and turned the job down. I reached a point where I couldn't work in this, so I took myself out. What I wanted to do was fight it. I thought, "I cannot fight this while I'm on the nursing registry because I'll be reported." That article that you just mentioned, *The COVID Nazification of National Health Service*. I know several people in the nursing profession in this country have already contacted the nurse regulator about me because of it. They wanted to file a complaint, saying it was unprofessional. But because I'm no longer on the register, I'm immune to complaints about my clinical practice.

(Editor's note: The complete text of Kevin's article *The COVID Nazification of National Health Service* is in Appendix 6 of this book.)

What happened in February and March propelled me into this situation where I can use my background and clinical experience to try and alert people and try and encourage some sort of criticality about this. I hesitate to use the word fight. I'm not sure it is a fight. It's more of an education to think critically about what they're doing and what's actually happening in society based on my 30 years as an educator and a clinician.

Every nurse and every doctor is an educator. You don't have to be in a university; they're teaching people all the time. They're teaching colleagues or teaching the public. Look at those Bakersfield doctors, Dr. Kyle in New York, and those nurses. I could sense the validity of what they were saying by listening to them. The internal validity of what they were saying, to me as a trained healthcare professional, spoke within the first few minutes of their videos. I automatically knew these were credible stories.

It matched everything I've heard here in London, and I'm constantly now, every week, getting contacted by, generally, retired doctors who agree with me 100%. They've read my papers, they've seen what's happened to Dr. Adil, the doctor who's been suspended. Other cases are coming up as well, so there is a groundswell of opinion emerging now that is critical of what's happening and I'm hoping that this will gain momentum like a snowball because we need a bit of American spirit here. America has a written Constitution and was founded outside Europe by people who fled, were thrown out, or didn't agree. The United States has a different psyche. It's always one of contest, trial, and public discussion of things.

There's transparency about your society. You may not appreciate it, but I appreciate it. We appreciate it over here in the United Kingdom because we've tried to emulate it in many ways, but we're still a very conformist society, in many respects. I'm sure that America is in its way, as well. But what I've seen in terms of doctors making videos and nurses making videos, I haven't seen that here in this country. I've been able to do one interview with a nurse, off-camera. She's very good. It's three and a half minutes and it doesn't go into all these issues. It just mentions a couple of contradictory issues.

It's very difficult to get doctors and nurses here to stand up. I think the other thing that's very important to mention is what's happened since Christmas. It's a trend that's been in place for a long time, maybe the last 20

years. The medical healthcare professionals' allegiances have been shifted toward the state and the government and away from the patients that they're dealing with.

That's another similarity to Nazi Germany where the Volk, the nation, became the patient. People have to sacrifice for the nation. And we've seen that in the last few months with the National Health Service: "Stay at home, don't bother National Health Service, don't even call us because we're protecting the National Health Service." Well, what about the individual who needs medical attention now?

The government takes the tax for the National Health Service and now it tells us to stay at home. "We don't want to see you if you've got symptoms. Just hang on. Hang on." And of course, that's what happened since Christmas.

People with COPD, asthma, diabetes, type 1 and type 2, people having strokes, people having heart attacks—all happened in their homes because they were told to stay at home. People with cancer were left untreated. Everybody's got an anecdote about that. I've got a friend who's 62 and was diagnosed with lung cancer at the end of February, and the consultant said, "At the moment, with the COVID thing coming up, we can't treat you. We'll send you home and we'll contact you." She was finally contacted in April. Her cancer had gone untreated for at least two months. That's quite a significant anecdote, isn't it?

I wrote that anecdote in a polite email to my member of parliament, who is a very famous man called Sir Keir Starmer, who happens to be the leader of the Labour Party, taking over from Jeremy Corbyn. I got no answer to that email. I suppose I did write it in a heartstring way, saying that this person was left in the lurch. We have been abandoned by our elected representatives, and that's not unusual. It's happened in the States.

Ken McCarthy: Sure. We have the same thing here. Pregnant women, people needing physical therapy, disabled children needing special care, people needing dental services. Basically, every normal medical procedure has been in suspension for months with no apparent end in sight.

Dr. Kevin Corbett PhD: Exactly. We had cases like that because the General Dental Council in this country in March suspended all dentistry,

completely, and the only way you could see a dental surgeon was through the 111-telephone service. You're put into the National Health Service through an A&E (accident and emergency) department, and it took weeks.

There were cases of people, here in the United Kingdom in the 21st century, who were taking their own teeth out. They had abscesses, and dentists weren't treating people and they couldn't get into the service. Every specialty's been the same. The contagion fear is dictating the whole strata of the National Health Service.

Ken McCarthy: Talking about the contagion fear, this might be a good point to do a review of the specific parallels between what's going on and the Nazi era. There's an excellent book on the subject by Robert Jay Lifton called *The Nazi Doctors*.

The whole contagion fear in Nazi Germany was based on garbage science. It was ludicrous and we're finding the same thing with COVID. The idea that you have to be six feet, or two meters, away from somebody, or that just simply by breathing an asymptomatic person could walk down the street and leave a stream of a deadly virus that hangs in the air. It's pure insanity.

Dr. Kevin Corbett PhD: In Lifton's book (*The Nazi Doctors*), he addresses a seminal study from the 1980s. He was brilliant in the way that he was able to capture firsthand accounts before people died. What he found was that many of these people were ordinary doctors and that the contagion fear infected the whole of society. People were being propagandized around racial hygiene. It was these concepts that impacted and skewed medical practice in a very pernicious way and viral hygiene is the parallel today.

The issues in Roberts's book are described in great depth, and people reading that should be able to make the links to what's happening today. In the 1920s and 30s eugenics was the key thing. It was everywhere, including America. The Nazis borrowed a lot of the American theory and what happened was the Nazification of racial hygiene is like the "COVIDification" of viral hygiene now.

They're saying to us that "genetic sequencing" of something equals "isolation of the virus." A genetic sequence is equivalent to morphology,

and this is a sort of modern-day version of the Nazification of virology. What will happen? I don't know where this is going to end up, but you've got these incredible statements now being made by scientists around the transmission concerns of this so-called agent which has never been purified. It's never been isolated in a traditional biological sense.

That's something that I'll be criticized for saying, because, now the notion is you can't criticize science as a citizen, you've got to be a scientist to say something. I don't know what you feel about that. But do citizens not have a right to criticize science?

Ken McCarthy: Well, facts are facts and if bureaucrats decide they are now going to change science and medicine by decree, there better be a discussion of that by people who have relevant training and experience in the subject.

The technical term that's used is "purified", but the layman might more easily think of it as "isolating" the virus. Nobody has ever isolated this virus adequately. The only pictures I've seen, besides the science fiction 3D graphics that the news people show us night and day, are very sketchy, fuzzy, black-and-white photos that could be almost anything.

Dr. Kevin Corbett PhD: Exactly. When this all broke in February, I worked up a set of questions that I wanted to ask the public health authorities. I managed to identify a professor at Imperial College, Maria Zambon, who is in charge of the reference laboratories for COVID testing. The reference laboratories, I'm sure, are the ones that do the confirmation testing. They're in charge of all the methodology that's used across the health service.

I asked her, "Why do you not isolate the virus? Purify it in relation to developing a gold standard for the test?" And the response was just one sentence: "WHO advised us not to isolate." This is an example of how our national science is now being superseded by a supranational organization called the WHO. I know that a lot has been talked about this in the United States. I know that Trump's coming out of the WHO, is that right?

Ken McCarthy: It's astonishing. Yes, he says he intends to remove the United States from the WHO.

Dr. Kevin Corbett PhD: I think he's absolutely right. He's right because, let's face it, the WHO has a vested interest. They've said so many contradictory things since Christmas. They said it wasn't infectious. They said don't shut borders, it'd be racist. They've said the complete opposite now. We've got to wear masks. All this contagion fear. Discredited organizations should not be guiding our laboratory testing in this country.

I put all that stuff on my website, Public Health England, and Professor Zambon answered all the questions. People can have a look at it, but it's quite technical. That's the problem with all this. It's arcane and technical, and the experts rely on that and are in effect telling the public, "Don't bother your little heads over this. We know all about this. We've isolated the virus and we've got accurate tests. Just get on and walk down the sidewalk in a certain way, go into the supermarket in a certain way, do what we tell you, wear masks, just be compliant, and everything will be fine." And it won't be because now they're saying to us, this week in the United Kingdom, the antibodies are not going to last.

Ken McCarthy: They're saying that here, too.

Dr. Kevin Corbett PhD: They're preparing the public for vaccination with the claim that herd immunity won't work. That's what they're saying. And when you look at the papers that are pushing this, and you look at who's funding it, you're led to the usual suspects: Wellcome, GSK, Bill and Melinda Gates.

Ken McCarthy: What's interesting is that Bill and Melinda Gates declared 2010, "The Decade of the Vaccination." On their board was Fauci. Also on the project's board was the then-head of the WHO, Margaret Chan, who just recently left that position. She now works directly for Communist Chinese. She spent 10 years as head of the World Health Organization, and without putting too fine a point on it, she was incompetent. An absolute bumbling incompetent, and yet one who wielded tremendous power. I've seen the numbers on the hundreds of millions of dollars that Bill Gates, who desperately wants to be a major player in the vaccine industry, has given to the World Health Organization, the CDC, the NIH, and universities like Oxford and Johns Hopkins. It's extraordinary.

There's one other thing about Nazification so that people realize that we're not using that word lightly. What I'm going to describe next came from a book called *Doctors From Hell*, by a woman named Vivien Spitz. There was a most illuminating introduction to that book, a foreword by an MD named Fredrick Abrams. In addition to the garbage science they used to make the German people fear contagion, the other thing that's very similar is the fact that the Nazis removed all Jewish doctors and nurses from academic posts, from managing hospitals, from government agencies and replaced them with card-carrying Nazi Party members who also happened to be MDs and nurses. According to Abrams, the medical profession in Germany during the Nazi time had a higher percentage of active Nazi Party members than any other profession. This is a very important thing for people to understand.

The other thing is the issue of informed consent. We have testimony and actual video of doctors lying to patients to get them to agree to be intubated saying, "Well, we'll be able to get you out of here faster if you consent to being intubated." That's not accurate. Once you put somebody on a ventilator, now it's become, as you pointed out, a very heavy management situation. And it's a very involved technical process to get somebody off a ventilator safely. There's nothing quick or easy about it. People are agreeing to a serious invasive medical procedure without being properly informed and as the result of deceit and coercion.

There's one last piece, and I'm sure you're aware of this. The linchpin that kept the Nazi slave camps operating, which doubled as extermination camps, was the medical personnel and one of the linchpins of their mass murder operations was the falsification of death certificates which were signed off on by doctors.

Dr. Kevin Corbett PhD: Yes, exactly.

Ken McCarthy: We're seeing it here in the US. I don't know about it in the UK, but we're seeing that in the United States. A guy comes in with stage four cancer, advanced diabetes, and stroke, and he dies, and they declare it a death from COVID and that becomes the public record of his cause of death. That is a fraud so serious that during the Nuremberg Doctors' Trial after WWII, falsification of death certificates was one of the charges brought against Nazi doctors.

Dr. Kevin Corbett PhD: Yes, exactly. And I can talk a bit about that because we have a similar situation. The Coronavirus Act that was passed in the UK removes the need for a coroner's jury.

Ken McCarthy: What?!

Dr. Kevin Corbett PhD: It states that explicitly. Therefore, the coroner can decide the cause of death. We've had situations where coroners decided "This is a COVID case," when the clinical evidence said the opposite. As we discussed earlier, you've got this skewing of the differential diagnosis, and you've got these presumptive COVID diagnoses being made. That carries forward through the whole system. When somebody dies, they're presumed COVID already, so the coroner will just rubber stamp that, and there won't be a need for an inquiry.

I think you've had more transparency over that in the United States, because of your system, and the willingness of people to speak out. Here, in the UK, you've heard of this happening behind closed doors. You've heard of this, by and by, second hand or third hand, but people haven't written about it. In that article that I wrote, people found it horrific that I even thought about such things, let alone had evidence of it.

This is very powerful in this country. There was a case that hit the media and *Spiked* online. There was a 19-year-old COVID death, and the media went wild over this because it shows anybody can get it. There were photos of her. The reality was that this woman had a congenital heart problem and died at the end stage of a long line of illness. I think the doctors looking after her put it down as ventricular failure but a coroner overturned it. The notes said she had a cough when she was dying.

Somebody with a complex cardiac condition who died after a long illness was rebranded as COVID. It's quite hard for the public in this country to get their hands on that data. We have a Freedom of Information Act of Parliament, but we're not very good in this country, unlike the Americans, at getting our hands on the experts and calling them to account. We tend to put our experts on a pedestal and do what they say to a greater degree than the Americans do. This is a way of covering up the deaths.

Ken McCarthy: This is exactly what happened in the camps.

Dr. Kevin Corbett PhD: Yes, it was.

Ken McCarthy: This is very important for people to understand. Many camps were primarily slave labor. And when somebody was no longer fit for labor, they would simply murder them by lethal injection, which of course would be administered by a doctor or a nurse.

A key point, and one that many people don't realize, is that the Nazis were very law-abiding. They had orders and regulations, and they followed them. They produced death certificates as required by law. It wasn't legal to do the things they were doing, and they knew it, so when they murdered somebody through medical experimentation for example, they "handled" it by attributing it to a natural cause. Problem solved. This monkeying with the integrity of the death certificate process is not trivial. It's not a small thing. It was a very serious offense then and it is a very serious offense today.

Dr. Kevin Corbett PhD: Medical practice, and by that, I mean healthcare practice, is always double-edged. I used to teach this to medical students. Whoever wrote the Hippocratic Oath knew this because they warned in the Hippocratic Oath about the iatrogenic effects. Medicine can be killing, or it can be curing. It's double-edged. It's two sides of the coin. And the thing is, the Nazis were very clever at covering this up covertly. They had all sorts of experimental programs operating across the country, involving the camps and outside of the camps.

They killed people with learning disabilities. They killed people who were mentally ill with schizophrenia and other mental diagnoses. And it was all done covertly. When some of it hit public awareness, there were complaints and they rolled it back.

What you've got in this country now, undoubtedly, is a lack of informed consent in the National Health Service. How can there be? They are no doubt trialing all these antivirals on people along with other drugs. It must be a heyday for what's called unchecked medicine. By the way, you can look at the medical journals on any website today, and there's a fast track for COVID papers. "Do you want your COVID paper published quickly? Click here." You can see that. It's a feeding frenzy right now.

Ken McCarthy: Our vaccination program goes by the codename Operation Warp Speed. It's being co-managed by a US Army General and Moncef Slaoui. Throughout his career, Slaoui has been on the news media promoting whatever vaccine they come up with. He always thinks it's the greatest thing. But even Slaoui is horrified and was on the news the other day saying he's horrified at the speed with which the Coronavirus vaccine is being pushed. I'm sure he'll never be allowed to speak about this topic in public this way again. He points out that we've been trying to develop vaccines for Coronaviruses for decades and that this is not a new virus type. It may be a new variety, but the class of virus is not new at all and is the basis of the common cold. We've been trying to develop vaccines for Coronavirus forever, and it's always ended in disaster. It doesn't seem feasible.

I don't know if this is well-known, but are you familiar with the book *The Search for an AIDS Vaccine: Ethical Issues in the Development and Testing of a Preventive HIV Vaccine*?

Dr. Kevin Corbett PhD: Yes.

Ken McCarthy: It was written by a woman named Christine Grady. And in my reading of it, it's an argument for justifying a substantial altering of the current ethical standards around human medical experimentation. And there's a punch line to this story: the author is the wife of Tony Fauci.

Dr. Kevin Corbett PhD: Yes, I've seen her.

Ken McCarthy: She's the head of bioethics and human experimentation standards for our National Institutes of Health. Can you imagine? And this fact is not even known to the public.

Dr. Kevin Corbett PhD: That's a very interesting title for that book, about the AIDS vaccine. Go back to 1994 and a very famous virologist named Bernard Fields, who wrote several textbooks, authored a very famous paper called *AIDS: A Time to Turn to Basic Science*. The paper was very coded. It said, if you take the polio situation, it was the isolation of the polio virus that allowed us to develop a vaccine. In the next sentence, he said, "HIV has been identified." Identified, not isolated.

Ken McCarthy: Right.

Dr. Kevin Corbett PhD: He didn't use the word "isolated". He was certainly well aware of the difference between "identified" which is a bureaucratic term and "isolated" or "purified" which is how we discuss these things in science. He wrote that paper shortly before he died, and I firmly believe what he was saying to the virologists is, we've got PCR, we've got all this high-tech geneticization, but unless you get the basics right, you're not going to get a vaccine. He's saying to them, you haven't got the basics right. It's very easy for these genetic virologists to turn around and laugh at the Perth Group (a group of doctors and scientists who question the role of HIV in AIDS). They like to laugh at Peter Duesberg, the distinguished virologist from Berkeley whom Fauci and friends drove out of academic science for questioning them. They like to laugh at anybody who pokes their finger at the Achilles heel of AIDS science.

Just the fact that all these years later there's no vaccine for AIDS proves their case. The science around AIDS is fundamentally wrong. When I went to work in HIV in 1987, Professor Semple at the Middlesex Hospital unit, the one Princess Diana opened, went on the front of the Daily Express saying, "We'll have a vaccine in two years." Now it's 2020, and that was 1987. I was in my 30s then. I'm in my 60s now. No vaccine. Let's remember the history. After all the money pumped into it, COVID is going to be the same thing but on a bigger scale. A bigger waste of money, a bigger hoax, destructive to culture, and destructive to medical practice.

I didn't like using the word 'Nazification', but with the command and control throughout the whole of the medical and healthcare practice in this country, that is what has happened. It's like somebody's got the reins, and they're pulling the horses together, and corralling them in one direction only, irrespective of the truth. Unless something happens, and there's a sort of grand wake-up, we're heading for a viral hygiene dystopia.

The book that I read when this all started was Isaac Asimov's *The Naked Sun*, published in 1956, which told of another world far across the universe but inhabited by humans, where people lived virtual lives on screens. They were frightened of infections, so they never met, and when they did, they had masks, and nasal filters, and they wore gloves.

Ken McCarthy: My goodness. What's the name of that book?

Dr. Kevin Corbett PhD: *The Naked Sun*. Isaac Asimov. 1956.

When I read it, I thought, “This guy Asimov is interesting,” like Philip K, Dick. These people had an idea of where society was headed. They were living in the 40s and 50s, but they could see it coming. They could see the dystopian elements already. George Orwell was the same here in this country. It’s Orwellian, what we’re living through now.

Last week, our Minister of Health in the United Kingdom said it’s mandatory for people to wear masks on public transport in the United Kingdom. There’s a 100-pound fine if they are not exempt, and for the people that are exempt, maybe we should give them badges that they can wear. My tweet that day was, to the world, “Badges for exemptions? How about a pink triangle? Or yellow star?” You get the message.

Ken McCarthy: Absolutely. Which, for people that don’t know that historical reference, that’s how the Nazis coded people, by making them wear colored patches that identified their particular “contagion”.

Dr. Kevin Corbett PhD: I went to a public seminar in Oxford on the weekend and we discussed contradictions to the science with members of the public. It was very civilized. We had a couple of very angry epidemiologists from the University, but generally, it was a very civilized discussion. It wasn’t a demonstration in any way. I didn’t wear a mask on the train and people were looking at me as though I was a risk. Nobody said anything, although people do now in London. Apparently, there have been instances in the last few weeks in London, where buses have been stopped by members of the public because people got on without masks, and other people wanted them removed, so the police were called.

You don’t have to read Isaac Asimov and you don’t have to know much about Nazi Germany, but I do think it helps to have a bit of a background here because of the history and the fiction. It’s been done before, but we haven’t learned from it.

Why are people being pushed drugs and interventions in hospitals and ER departments in our countries without informed consent, when we had Nuremberg trials? Anybody being asked to have a test should say, “Can I see the datasheet from the manufacturer for that test? I’d like to know what they say about the test.” If you read it, you wouldn’t have it, wouldn’t touch

it, as the British say, with a barge pole. I don't know if you have a similar saying.

Ken McCarthy: We say, "With a 10-foot pole," which is probably how long a barge pole is. And maybe this is a good issue to end on. There's so much to discuss regarding the issue of the testing. David Crowe brought attention to a case where a man in China was tested and found positive. He was put in the hospital and then they found him negative and released him. Then they found him positive again and brought him back to the hospital, by force. He was in this endless loop, all based on an unreliable test. And there's something similar coming down the road, here.

I'm in a county where the county executive, who has no background in science or medicine, is telling everybody we should all get tested and tested constantly, which was the same nonsense during the AIDS era. "Everybody should get tested for AIDS." The tests were unreliable. And the frightening thing is, these unreliable results can be used against you. In the AIDS era, they were used to force pregnant women to take AZT and feed AZT to their newborn babies.

AZT, by the way, for people that don't know, is a serious carcinogen and mutagen that killed hundreds of thousands of people, and its use was justified by the same kind of garbage science that is being used to justify the COVID measures.

Dr. Kevin Corbett PhD: Absolutely. I'd encourage everybody to read David Crowe's work on antibody testing and the RT-PCR tests. We have a situation in this country where healthcare providers are forcibly coercing their employees to test, and one of them in London has made their employees test every weekend. Every week, they've got to line up at the hospital with a card and they've got to have it stamped before they can go back to work the following day. Then the manager has to read that stamp and sign a form.

This is like a prison. It's like Nazi Germany. It's like Stalin's Russia. It's like a communist system. And there's no informed consent there because the contracts have been changed. I've read their contracts. They're told, "Refusal will be disciplinary and dismissal." That is not informed consent. That is coercion. That is Nazism, or whatever you want to call it.

Ken McCarthy: It's not based on any medicine that we've ever seen in the history of humanity. Except maybe Nazi medicine, or Maoist medicine, or Soviet medicine.

Dr. Kevin Corbett PhD: Lysenko science. It's a sort of bastardization of science for ideological purposes or a belief system. They cream off the bits of the science they want you to believe that fit their agenda. I don't like using "they," but the authorities; it's the people coordinating this that's the problem.

(Editor's note: Trofim Lysenko was a political favorite of the Soviet director Josef Stalin. Scientists who refused to go along with his idiosyncratic and fundamentally flawed opinions on genetics were jailed by the hundreds for disagreeing with him. Nikolai Vavilov, one the greatest agronomist/geneticists who ever lived, was sentenced to death for questioning Lysenko's declarations. His sentence was commuted to 20 years in prison, where he died two years later, some authors believe from the effects of starvation.)

Ken McCarthy: For people who want to follow your work, and I strongly encourage everybody to do this, Kevin has a website.

Dr. Kevin Corbett PhD: It's <https://www.kevincorbett.com/coronahysteria>. I think the term "Corona Hysteria" is self-explanatory, don't you? We're living in a Corona Hysteria era. All my papers and links to other websites, including David Crowe's, are on the website.

Ken McCarthy: David, of course, is an excellent source for all of this. And we've listed a lot of his material on our site as well. Kevin, thank you so much for sharing your experiences.

We've been talking with Kevin Corbett, who started out as a hands-on nurse and became an educator, and Ph.D. He is somebody who has spent a lot of time studying the history and ethics of medical practice, which by the way, is part of the curriculum for all doctors and nurses.

We had medicine pre-COVID. It had a set of ethics and a set of guiding principles. As Kevin pointed out, in the UK, and in the US as well, these long-established working principles have been thrown out, and are being

replaced by, what I think Kevin fairly calls, the COVID Nazification of medicine. And it's happening in the United States, too. Kevin, thank you very much.

Dr. Kevin Corbett PhD: Thank you very much, Ken.

Kevin P. Corbett completed both undergraduate and postgraduate training in Art at the University of Reading (1979) and The Slade School of Fine Art, University College London (1981). Kevin qualified as a Registered Nurse in 1986 becoming part of the commissioned staff for Broderip Ward at The Middlesex Hospital, London, Britain's first purpose-built HIV/ AIDS unit, opened by Princess Diana in 1987.

Postgraduate nursing research followed at King's College London (1987-1989) into improving metered dose inhalation through patient training in the physiology of the inhaled route. This won support from the Stimulating Progress fund of London's North East Thames Regional Health Authority and Vitalograph Ltd (UK). Doctoral research (1995-2001) focused on patients' indeterminate experiences of the tests used in HIV/AIDS, the ELISA, Western blot, and PCR tests. Kevin has more than thirty years of experience in gaining 150k+ in research funds for leading and participating as principal and co-instigator.

He is a qualified nurse educator who has worked in university education, research, and public health at Kingston/St. George's University of London, University of York, Liverpool John Moores, Canterbury Christ Church University, and Middlesex University. Kevin also has experience in acute clinical, forensic, and community nursing with over one hundred research outputs in peer-reviewed, patient-reviewed, and citizen science publications. Current research and consultancy are focused on human physiology, visual art, and citizen participation in science and technology

<https://www.kevinpcorbett.com/coronahysteria/>

PART THREE: ATROCITIES, RESISTANCE, AND THE ATTACK ON FREE SPEECH

*“Unlimited power in the hands of limited people always leads to
cruelty.”*

— Aleksandr I. Solzhenitsyn,
The Gulag Archipelago 1918–1956

PROLOGUE TO PART THREE

I interviewed Erin Marie Olszewski and Kevin Corbett, the subjects of Part Two of this book, in the summer of 2020 because I was dissatisfied with the news media's sound-byte approach to their eyewitness testimonies.

I assumed that as the year progressed one of the news networks or big-name podcasters would find the time for an extended interview with one or both of them and that other experienced nurses would be invited to share their eyewitness accounts in depth too. After all, COVID and the response to COVID was the #1 story of 2020 and countless thousands of hours were devoted to reporting on it.

What could be more important than examining the plausible charge that COVID patients were dying not of COVID but as the result of top-down orders that demanded the withholding of time-proven therapeutics like ibuprofen and steroids and the exclusive use of experimental drugs with terrible safety records, like remdesivir and that extreme and unprecedented measures like intubation and venting?

After all, the stated goal of the official lockstep response to the COVID threat was to "save lives".

Based on this goal, for the first time in human history, businesses, schools, and churches were shut down for months on end causing serious

financial and mental health injuries worldwide. Later, mask-wearing became mandatory in many places, and still later, compulsory injections of the products of poorly rested mRNA technology became a condition for employment and receiving an education.

If credible witnesses were coming forward and reporting that withholding some treatments while advancing others was causing death, shouldn't that story have risen to the top of the pile for a serious examination?

Apparently not.

I waited for press coverage on this topic during the remainder of 2020 assuming it would eventually happen. It did not.

I waited for press coverage on this topic in 2021 assuming it would eventually happen. It did not.

I waited for press coverage on this topic in 2022 assuming it would eventually happen. It did not.

I waited for press coverage on this topic in 2023 assuming it would eventually happen. It did not.

By the summer of 2023, three full years after my original interviews with Erin and Kevin, I realized that I better start interviewing nurses and putting their eyewitness accounts in a book, because it appeared that no one else was going to.

In Part Three we have interviews with three American nurses, including Nicole Sirotek.

Four things stood out from these interviews conducted three years after the first set of interviews:

1. For many nurses, nursing is a calling

For them, it's not simply one of many job options with fixed hours and a steady paycheck. It's what they most want to do in the world. Many who enter nursing get the calling early in life after seeing loved ones suffer through ill health and this experience imbues them with the desire to relieve the suffering of others and help people regain their health and function after a blow.

2. The reign of terror was not limited geographically or temporally

The program to ban safe and effective early treatment options and promote extreme and dangerous ones was not limited to the early chaotic months in New York City public hospitals. It was nationwide and persisted for years and apparently still persists in many places to this day.

3. The enforcement of the program was thorough, uniform, and brutal

Nurses and doctors who pointed out the abject failure of the CHC-NIH-FDA protocols were removed from intensive care units. Some were fired outright and some found they were blacklisted and could not get employment elsewhere regardless of their years of experience and stellar career track records. Some had their licenses challenged by a well-funded army of Internet troll vigilantes and also received death threats and personal visits to their homes by these same people.

Therefore, not only was a protocol created and promulgated that did not work and caused observable harm, a nationwide system was put in place to enforce its exclusive use, which included the systematic targeting of professionals who questioned it. Hospitals, news media organizations, licensing boards, and the tech companies that have a government-enabled monopoly on digital public discourse worked together, apparently with the direct support of the White House and the FBI, to enforce it.

4. Nurses continue to fight back despite everything that has been thrown at them to date.

CHAPTER 5

FREEING NURSES, FREEING PATIENTS

KIMBERLY OVERTON INTERVIEW - JUNE 12, 2023

“Let us never consider ourselves finished, nurses. We must be learning all of our lives.”

— Florence Nightingale

Ken McCarthy: Where are you based, Kim?

Kimberly Overton: I’m in Hendersonville, Tennessee, just outside of Nashville.

Ken McCarthy: How long have you been a nurse?

Kimberly Overton: I’ve been in healthcare for 26 years, and I’ve been a registered nurse for seven.

Ken McCarthy: You made the transition from another part of healthcare to nursing?

Kimberly Overton: I've always wanted to be a nurse. I wanted to be a nurse since I was two. That's all I've ever wanted to do. But it was really—I was very young when I had my son. I was 17, and I just wasn't able to go to school at that time. But I always wanted to go back. Finally, I decided to go back when I was about 35. It took me forever, but I did it.

Ken McCarthy: I have a friend who went back at 50 and finally got her nursing degree.

Kimberly Overton: It's never too late.

Ken McCarthy: It's true. You know what I learned from watching her go through it? It is serious training. There's nothing lightweight or casual about it.

Kimberly Overton: No. That's why I took it very seriously. I walked away from this career that I loved and that I worked really, really hard at. I tell people, "You know how long I wanted to be a nurse. You know how hard I worked to get there. So to see me walk away from that should tell you something."

Ken McCarthy: Absolutely. What kind of nursing did you specialize in?

Kimberly Overton: Critical Care. I worked in an intensive care unit throughout the pandemic, caring for COVID patients.

Ken McCarthy: You saw what was called the frontline.

Kimberly Overton: Yes. Nurses saw a lot. Unfortunately, not all of us are speaking up and speaking out. In my opinion, the nurses could have stopped so much of this early on if we just all collectively stood up and said, "No." The moment that they told us our patient couldn't have an advocate at their side, we should have stood up and said, "Absolutely not." We really could have stopped this.

Ken McCarthy: That raises an important point. I'm grateful to the authentic heroes and heroines, and I also understand the pressure people were under.

Kimberly Overton: I try to be sympathetic to people's circumstances, but the hardest thing for me is when people tell me "Thank you so much. I

wish I could have done that. But I have a mortgage to pay.” Or, “I have bills to pay.” Well, I have a mortgage to pay and bills to pay, too.

Ken McCarthy: Yes. I do some work with Vera Sharav. So we’re often talking about the Holocaust. A whole lot of people had to go along with that for it to have happened.

Kimberly Overton: Right. Exactly.

Ken McCarthy: Let’s talk about something you referred to a few minutes ago, which is the idea of nurses as advocates for patients. Tell us about what that means, for those that aren’t familiar with that.

Kimberly Overton: That’s generally the foundation of nursing, that we are the patients’ advocates. We are their last line of defense in many cases, especially in the case of an ICU nurse. We have had to step in and question orders. I can’t tell you how many times nurses have had to step in and call a physician out, and say, “Are you sure you want to prescribe this medication for that patient at that dose? Because you might kill them.” That has happened more times than you would even want to imagine.

Nurses are truly a patient’s last line of defense, so it frightens me when we get to a point where nurses are afraid to question authority. That’s a problem. I can’t begin to tell you how at-risk that is going to leave our patient population when we have these nurses who are too afraid, or they don’t feel educated enough, to question a doctor’s order. Because the third leading cause of death in the United States is preventable medical error.

(Editor’s note: By some measurements, preventable medical error is the #1 cause of death in the United States.)

Ken McCarthy: I’ve been on this since February 1st, 2020 I couldn’t understand how one random guy dying of a respiratory problem in the most polluted city in the world became an international medical and scientific panic overnight. I’m old enough to remember Jim Henson, the guy who created the Muppets.

He walked into a hospital relatively healthy at the age of 55, having just signed a \$200 million contract with Disney, and they took him out the back door in a body bag. They said he had pneumonia with “unusual symptoms.”

Which to me means he caught a hospital infection and they didn't want to admit it.

Kimberly Overton: Exactly.

Ken McCarthy: But that's the exact same set of facts in Wuhan. A guy came in with pneumonia and "unusual symptoms." I hate to be crass, but... so what?

Kimberly Overton: We don't shut down the world for it.

Ken McCarthy: Also, how did it come to pass that the whole scientific community stopped everything they were doing, and hundreds of them started looking for the virus that killed this random guy who was a smoker and already in poor health? That's when I said, "Wait a minute. This doesn't sound right." I thought it was just going to be a "Get your flu shot" vaccine promotion scam. I had no idea how far it was going to go.

Kimberly Overton: Yes. From the beginning, nothing made any sense to me. I've been questioning it since March of 2020. I said, "Something's not right here."

Ken McCarthy: When you say you were pointing out potential doctors' errors, this was going on long before COVID?

Kimberly Overton: Yes. Long before COVID. This is just everyday run-of-the-mill stuff. Again, we are the last line of defense to these patients. The doctors aren't there. It's the nurse who's with the patient, it is the nurse who notices the trends and what's happening with their condition. When we have a doctor there, it's because a nurse has called them to the bedside. They're recognizing that the patient is declining very rapidly, or they're looking at trends in their labs, or imaging, and then they're calling physicians. Nurses don't get credit for their role of advocating, standing in the gap, and protecting their patients.

Ken McCarthy: I think everybody's aware that when you see a doctor, it's often for 30 seconds or less. And I may be exaggerating, but I don't think I'm exaggerating too much.

Kimberly Overton: Not really.

Ken McCarthy: I guess that's just the way the system works. However, nurses have much more prolonged regular contact, daily, or hourly, depending on the case.

Kimberly Overton: During COVID we could not get the physicians onto the floor. They would not even come on the floor. If they did come on the floor, they would come in and they would assess the patient literally from the door. They wouldn't go in the room near the patient. They said they were trying to preserve PPE (personal protective equipment) for the nurses, which was ridiculous. They were afraid to come onto the floor during COVID.

Ken McCarthy: Erin Marie was telling me that the residents, the newly graduated doctors, residents, were given control of the ICU. Sometimes the supervising physician showed up, and sometimes they didn't. So you had a bunch of guys and gals who only really knew what was in their medical textbooks. Suddenly, they're confronting something that looks catastrophic with no experience. The only experienced people in a situation like that would be nurses who have been trained for and spent time in ICUs.

Kimberly Overton: Exactly. And that's part of standing in the gap, being that last line of defense for the patient. Many times, unfortunately, it is standing and protecting from a physician, or their lack of knowledge. They're human, right? They get burnt out just like anybody else, and they can make errors and mistakes as well. It may not always be a lack of knowledge, but burnout or human error. As nurses, we need to focus and be mindful of that.

Ken McCarthy: To be charitable, maybe they just aren't as familiar with the patient and the patient's condition. They may be in a time vise where they have no time and they have to make a quick decision. That's where having a trained and experienced person who has spent prolonged time with the patient comes in handy. Now, what about the politics? Every workplace has politics.

It seems to me that at the top of the pyramid is the hospital administrator, and it appears that they can order anything and it gets done no matter how lunatic. Next below them in the pecking order is the physician. Next below that are the nurses. I imagine physicians are all different. Some are probably very easy to work with and very respectful. I'm sure there's the other

extreme as well. How do you manage that? If you're dealing with a reasonable doctor, then there's no issue. But you must sometimes have to deal with unreasonable doctors. What do you do then?

Kimberly Overton: A good ICU nurse is just going to tell it to them like it is. They're going to advocate for their patients. They're not going to cower from a physician. There are plenty of physicians who will try to intimidate nurses, and a good nurse will take it over their head, if necessary, to protect their patient. That's why I get nervous with these younger nurses, or these new nurses that are coming in. They're just too afraid.

They're all protocol, protocol, protocol. They're not asking questions. It's very dangerous for these patients. If you're not going to question a physician, or if you're not willing to go over their head if necessary to protect your patients. Our main objective should be patient safety and providing compassionate care while they're at the hospital.

Ken McCarthy: That's actually part of your profession. This is not something you cooked up or a few nurses got together and said, "Hey, this would be a good idea." This is right at the core of your profession.

Kimberly Overton: This is the foundation, the guiding principles of ethical nursing. We advocate for our patient's bodily autonomy. Giving them all of the information, all of the education, and letting them come to their own decision. And we support that decision, whatever that may be, whether we agree with it personally or not. We support them. That's autonomy. One of the guiding principles of ethical nursing.

Ken McCarthy: During the COVID era, you were mentioning inexperienced nurses. Erin told me that when she showed up at the hospital In New York City, most of the nurses were in their first year, their second year, or just got out of school. All of those ICUs where all those people died were full of inexperienced nurses. How young can a nurse be?

Kimberly Overton: Around 19 or 20.

Ken McCarthy: That's young. Normally, they're going to be intimidated by authority. It's not unusual. Because the ICUs were devoid of experienced nurses, but for one or two, that was a recipe for disaster. Now let's get down to the particulars of COVID. We've heard from Erin, first of all, that there

were not enough experienced nurses. The residents were put in charge. They didn't know what they were doing. The supervising physicians either showed up or didn't. What was it like in your particular hospital?

Kimberly Overton: It was pretty much the same. During the height of COVID, the physicians were not coming on the floor, they were assessing, based on the nurses' assessments. We would tell them how the patient was doing. But they weren't coming in, they weren't putting their hands on the patients. They weren't even putting stethoscopes on these patients and listening to their lungs. That's a problem.

They would talk about how they were trying to preserve PPE for the nurses, but I don't buy that. Let me tell you, there was never a shortage of PPE. They had it locked in the basement, under lock and key with a hospital administrator who would babysit it. It was the most absurd thing I've ever seen.

These policies didn't make any sense to me. They would give us our N95 masks, they gave us three masks and we'd have to wear them one mask per shift. We would typically work three 12-hour shifts a week. They would give us enough for the week. We would wear that same N95 mask from our COVID patient rooms to our non-COVID patient rooms. Pre-COVID, infection control policy does not allow for anything like that to happen. We always don and doff our PPE in that particular room. We don't take it out because then it would spread all over the hospital.

Ken McCarthy: So given how COVID was described as a highly contagious disease, there was an existing protocol, maybe 100-plus years old, that says you don't do that.

Kimberly Overton: Right. If it's an infectious process like that, we don and doff PPE inside the room. Everything is kept in the room. But they were having us wear the same mask throughout the hospital, not just where our patient was, but everywhere we went in this hospital we would have the same N95 mask on which, by the way, we could not breathe in those damn things. There wasn't enough staff to just have COVID-only nurses. The nurse would have an assignment of a COVID patient, and then maybe a COVID-negative patient that was there for another reason. We're kind of

giving everybody COVID at this point because we're going into their room with that same mask on.

Ken McCarthy: Based on the protocols and procedures that had been put in place.

Kimberly Overton: Right. And early on, I said, "This makes absolutely no sense. Why would we do this?" And the only answer that we would ever get was, "It's protocol."

Ken McCarthy: I assume the protocol came from the hospital administrator?

Kimberly Overton: Yes, it's all top-down. The orders would come from our hospital administrator, but they're getting their marching orders from the government. It's all the NIH and CDC protocols. They would just deploy them without question.

Ken McCarthy: The NIH tells the hospital administrators what to do, and they tell the physicians, and they tell the senior nurses, and then they pass it on to the rest of the staff. There was a lot of fear, obviously, especially in the early weeks and months, when this was presented as the "deadliest never-before-seen disease ever to hit humanity." Whether that was true or not, people didn't know, because they weren't getting the straight information. A lot of people believed the virus was universally deadly and yet went to work anyway. In their minds, they were risking their lives.

Kimberly Overton: They were telling us this was the deadliest virus known to man, but as nurses, as physicians, when we go to work at the hospital, we never know what we're coming into contact with, tuberculosis, all the infectious diseases, we don't know. That's why we use universal precautions. When we suspect a respiratory virus, we wear the appropriate PPE, or put the patient in a negative pressure room, that sort of thing. But we never stopped life as we know it. And we never locked down and told visitors that they couldn't come in and see their family members.

All of these policies, to me, never made sense. Taking away the advocate from the patient was a huge one for me. We were isolating these people. Clustering their care and not even getting in the room with them. As ICU nurses, we typically have two patients apiece, and they wanted us to be in

that room as little as possible. At this point, we've already been exposed, right? So it doesn't matter. It doesn't matter how many times we go in and out of this patient's room, we've already been exposed. We should be in there providing care – and regular care – not isolating, locking them away, and maybe going in every couple of hours to check on them. That's not care.

Ken McCarthy: What was recommended was “Don't spend time with these patients.”

Kimberly Overton: Yes, basically get in and get out. They even got to a point where they were starting to put the IV pumps into the hallway so that we didn't even have to go into the room to change or adjust medications. That's very dangerous because when you're adjusting medications, you should be assessing your patient's condition, you should be assessing your patient in bed. Yet they're having you make adjustments in a hallway without an assessment.

Ken McCarthy: This raises a point that I talked about with Erin that most people still are not aware of. You don't just hand somebody over who is about to be intubated and vented and hope for the best. You attach them to all kinds of drips. Did you work exclusively with people that were on ventilators?

Kimberly Overton: It was a mix, but yes, many of our patients during that time were on ventilators. We had patients who were on vents, patients who were not, and some cardiac.

Ken McCarthy: Under normal conditions, you would have respiratory therapists in ample supply to make sure that the people on the ventilators were being carefully monitored because it's a very delicate thing when you put somebody on a ventilator. It's not, as some people still think, just a face mask. They don't realize it's a tube down your throat. They also don't realize it's paralytics, which prevent you from moving. It's a powerful analgesic. It's like being under anesthesia.

Kimberly Overton: It is. They're using things like propofol, which is used as anesthesia for some conscious sedation procedures. They were using that. They were using paralytics. And, of course, really high doses of fentanyl to keep these patients knocked out.

When you put a patient on a ventilator, the following day, typically, you do a breathing trial. You turn off the ventilator settings and you see how they're able to breathe on their own. Are they able to follow commands? If they're able to breathe and follow commands, all of these things, and they score appropriately, then they will attempt extubation of the patient. But they had them on so much medication that it was nearly impossible to get them to pass that breathing trial.

This becomes interesting when you look at the CARES Act or the PREP Act, I can't remember which one it was, that will pay out, I can't remember what it pays out, but if they are on the ventilator for 96 hours or longer, there's a larger payout.

(Editor's note: From the AJ DePriest interview: Respiratory System diagnosis with ventilator support for more than 96 hours was \$39,896.58, in addition to the per-COVID admission payout.)

Ken McCarthy: I knew that just putting people on a ventilator was a payday.

Kimberly Overton: And if you stayed on it for 96 hours or longer, I think \$39,000. Don't quote me, but I think it's around \$39,000 if you're on for 96 hours or longer. The protocol had them on so much medication that they would never be able to pass that type of awakening trial. They have to be alert and awake and follow commands and all of that. And that just wasn't happening.

Ken McCarthy: Because the drug dose they used knocks you out.

Kimberly Overton: Yes.

Ken McCarthy: You're going to be groggy at best. Do those drugs suppress your breathing?

Kimberly Overton: They do, they absolutely do.

Ken McCarthy: The diaphragm is a muscle. If all the muscles of the body are relaxed by the high dose of the drugs they're on, then the thing that's keeping the person alive is that vent, the machine that takes over the work of the diaphragm to keep the lungs working.

Kimberly Overton: Exactly.

Ken McCarthy: There was a lot of comment early on, which “disappeared” from the Internet within weeks, that the vent settings people were ordered to use were wrong and causing injuries.

Kimberly Overton: In all my career, I had never seen the PEEP (positive end-expiratory pressure) settings set so high. Typically we see it at about five, and we were seeing that pressure at fifteen. We were blowing people’s lungs out. It was just so much pressure on their lungs. Then we had them on this medication, they were putting them on remdesivir, which was absurd to begin with.

By the time these patients were getting to us in the hospital, they were typically well past the viral replication phase, and already several days into the symptomatic phase. Remdesivir is an antiviral. If there’s no viral replication occurring, there is no reason to use it, especially given its known risks.

What we see happening as soon as the remdesivir arrives is organ failure, kidneys shutting down. Remdesivir is nephrotoxic, meaning it’s damaging to the kidneys. I started asking the question, “Why do we continue to use this medication? By the time they get to us, it’s too late for the remdesivir to be effective. So why do we continue to use this medication? It’s clearly doing more harm than good.” The bigger question is, why is the government financially incentivizing its use? Hospitals would get, I think, \$3,000, or more, and a 20% bonus for using remdesivir per patient. Alarming because if you look back to the Ebola trials of 2018, 54% of those study participants died.

Ken McCarthy: There’s so much to unpack there. I want to make sure that everybody catches this because it’s so mind-boggling. The theory is that there’s a virus, and the person gets the virus, and the virus replicates in their body. It’s the symptoms of your body reacting to the virus load that’s the actual danger. What you’re saying is that at a certain point, the virus stops replicating and the thing you’re dealing with is the symptoms, the things the body does to fight the virus which can be harmful to the body itself.



April 29, 2020. Anthony Fauci, announcing remdesivir will be the drug of choice for treating COVID. “We would normally have waited several days until the data gets further, to dot the I and cross the T, but the data are not going to change. Some of the numbers may change a little, but the conclusion will not change.”

Remdesivir is meant to suppress the replication of viruses. The virus has already stopped replicating, and yet you were ordered to give them remdesivir. You might say, “Well, okay, what’s so bad about that?” Remdesivir is not aspirin. Its side effects are kidney failure and liver failure. Who knows how many were killed or seriously injured by it? Remember they kept saying, “This virus behaves so unusually. It damages kidneys, it damages the liver.” I’m no rocket scientist, but I don’t see how a respiratory problem is going to damage your liver and kidneys that fast. The only thing that works that fast is something toxic.

Kimberly Overton: I say this all the time, Ken. They kept telling us, “Listen, COVID is killing all of these patients.” But that was not the case at all. It was the complete and total medical mismanagement of COVID that was killing all of our patients. It wasn’t the virus at all. Because if it was the virus itself, then why were we not pulling bodies out of homes, or off of the

streets? Think about our homeless population. Why weren't they dying? And why did so few people die of this disease at home? The only place anybody was dying in large numbers was in the hospital. We should be asking why.

Ken McCarthy: We now have a clue, which is the remdesivir. People deemed COVID patients were given a very potent, toxic drug. It was a failed drug. They stopped using it for Ebola, but inexplicably fast-tracked it for use on COVID patients and then the very same adverse reactions listed on the box, including kidney damage, happened.

Kimberly Overton: Exactly, because it was killing everybody. The other thing, when we talk about giving them remdesivir, which does not work, we were not giving medications that did prove to work, therapeutics like ivermectin, hydroxychloroquine, or vitamin C. We couldn't even give IV vitamin C. They weren't doing things like giving steroids. They weren't mitigating the damage. We've been treating viral infections forever, and the antiviral medication may not have been able to work at that point, but we always mitigate damage.

(Editor's note: The history of remdesivir along with the complete list of its known adverse reactions appears in Appendix 5 of this book.)

We know what happens. Blood clots. We should have been using anticoagulant therapy for that. We should have been using anti-inflammatories or steroids to treat these infections and the inflammation because the virus triggers inflammation. And we were doing nothing. We were just leaving them there, putting them on a ventilator, putting them on remdesivir, not doing anything to mitigate that damage or the inflammation. Basically, just leaving them there to die.

If they did give steroids, and this was my personal experience, they would order them in such a sub-therapeutic dose that it didn't matter. They were giving such low doses of it that it wouldn't have done anything. I kept asking, "Why are we giving them such low doses of steroids? Why aren't we giving them ibuprofen to deal with the inflammation?" They would say things like, "Ibuprofen is contraindicated in COVID patients." I'd never heard anything so absurd.

Ken McCarthy: Again, these were all top-down protocols. No ibuprofen, which is Advil. No Advil. Now, you don't want to be taking handfuls of Advil consistently for many years, but if you're dying, you want to take some, right?

Kimberly Overton: They weren't using ibuprofen at all

Ken McCarthy: Let's not forget, there was a medical world pre-COVID. Would you ever have been ordered to give that low level of steroids?

Kimberly Overton: Never. It would have been much, much higher.

Ken McCarthy: All of this was top-down from the hospital administrator, who got it from the NIH.

Kimberly Overton: As nurses, we're questioning. I said, "Why are we giving such a low dose of these steroids? It's not going to do anything." The physicians, all they would ever say was, "That's the protocol." They knew it wouldn't work, but they wouldn't question it.

"I will prevent disease whenever I can, for prevention is preferable to cure."

– Lawrence Lasagna,
Dean of the School of Medicine at Tufts University (1964), from his
modernization of the Hippocratic Oath, still in use and sworn to by
graduates of many medical schools in the U.S.

What people forget about physicians is that, like everyone else in corporate America, they are employees, nothing more. Everybody reveres them, "Oh, the physician knows, the doctor knows", but they're paycheck employees, just like the rest of us. Unfortunately, they get a larger paycheck and I guess a lot of them are afraid to lose it. I can't imagine putting a paycheck ahead of human life. I just can't understand that mindset.

Ken McCarthy: The protocol for COVID was no ivermectin or any of these other things that might hold down the viral load. No ibuprofen, which is known to handle inflammation. Sub-therapeutic doses of steroids, much less than had ever been given.

Kimberly Overton: No vitamins at all.

Ken McCarthy: Right, no vitamin C. No vitamin D. But they did have plenty of remdesivir, which is a drug that they withdrew from use because it didn't work for Ebola. It was killing people in the Ebola clinics as well. It was killing people. It sounds to me, I don't want to be a "conspiracy theorist," but it sounds to me like the NIH either deliberately or through gross incompetence, and it hardly matters which because the people are dead, was dictating the exact wrong course of action every step of the way. How does that happen with a hospital full of medical school-trained and state-licensed physicians?

Kimberly Overton: I ask all the time, "Are these physicians complicit in this lie? Or did they not know any better, when they should have?" I leave it to you to decide which of those scenarios is more frightening: that they don't know any better, or that they're complicit in letting so many people die knowing that these protocols weren't going to work and then obviously didn't.

That's why I thank God for these brave physicians like Dr. Richard Urso, and Dr. Peter McCullough, who spoke up early on saying, "This is not what we do." Richard Urso will tell you he figured out how to treat this disease process early on. He's an eye doctor for God's sake, and he's taking all these COVID patients, and having great success. He had it figured out probably in March of 2020. He couldn't believe his fellow docs were just letting people die.



Kimberly Overton with Dr. Richard Urso, a big supporter of Nurse Freedom Network and Remnant Nursing

The reason that they were intubating a lot of these patients was not because they were in distress. They were doing it in an attempt to contain the virus. Because once a patient is placed on the ventilator, they're then on a closed-circuit system, so they are supposedly no longer disseminating the virus into the air. That was a protocol, too. They kept pushing for early intubation to protect hospital staff. That is ludicrous to me. That is so egregious because that is no longer about the patient in the bed. It was about theoretically protecting the staff. Bottom line: You don't do high-risk medical interventions on patients to protect somebody else. Period.

Ken McCarthy: Let's talk about how high-risk intubation is. We touched on it. I'm going to tell you what I understand about it, and then please fill in the blanks or correct me if I'm wrong. Number one, you've got to get a pipe down somebody's throat, which nobody wants. So you have to be knocked out for it to happen.

Kimberly Overton: You have to sedate them. You've got to use a paralytic. A lot of times, you can't even get that tube in, so it can cause trauma to the vocal cords.

Ken McCarthy: Even getting that pipe down your throat is not without risk. Then to do that, they use all these drugs. We're not talking about one dose of drugs. You're hooking somebody to an IV, and there might be four or five, ten, or more different IVs that that person is on, steadily.

As you pointed out, one of the other brilliant protocols they had was not to let nurses be in the room to look at the patient and see how they were faring with all these different IVs. You couldn't have created a better system if your goal was to use the doctors and nurses in hospitals to kill as many people as possible. They were telling nurses, "Oh, well, we're going to leave the monitor out in the hallway, you don't even have to look at the patient. Just change the bag." Right?

Kimberly Overton: Exactly. Right. To me, that was an issue early on. I said, "We're supposed to be assessing the patient every time we make a change on their IV medications, especially with the drips. We need to be assessing the patient, we need to be looking at the patient, we need to be touching the patient." There are so many things in assessing you cannot do from behind a glass window.

Ken McCarthy: People don't think about this, but of course, nobody on a ventilator is eating.

Kimberly Overton: No.

Ken McCarthy: I asked Erin about hydration and she said they considered the fluid from the IV sufficient hydration. If you want to kill somebody, deprive them of fresh water for long enough and that alone takes them out, especially if they have a fever, inflammation, and a lot of waste to flush out.

Kimberly Overton: Even the patients that weren't ventilated, like the ones that were on a BiPAP. They didn't get food or water either. I don't know if you're familiar with the case of Grace Schara. She was 19 years old.

(Editor's note: Grace's full story can be found at: OurAmazingGrace.net/Tragedy-hospital)

Ken McCarthy: I know Scott, her father.

Kimberly Overton: I know Scott well. It's such a heartbreaking case. In her case, she had on the BiPAP and they were telling her that she could not eat and she could not drink. She couldn't take off her mask. There were so many different alternatives in that situation. They could have put her on high-flow so that she could eat something. They didn't give her any nutrition. I've heard horror stories like this from family members who lost loved ones to these protocols, that they were not fed.

Ken McCarthy: As we mentioned before, there was a big financial incentive to put people on ventilators.

In addition to the financial incentive, they also terrorized the staff, including physicians, with the idea that this virus was so deadly that the only way to keep the staff safe was to intubate the patients, which, as you point out, is crazy.

Kimberly Overton: That's not something that we should ever, ever do. From a practical point of view, at that point, we've all already been exposed. Plus we're all using PPE to protect ourselves, but we are putting these patients on a vent knowing there's about an 80% chance that once they're on the vent they're not ever coming off of it. That was a real problem for me. They kept on pushing the early intubation. I said, "No. Early treatment. Because it works."

Ken McCarthy: Under the best of circumstances, a lot of people never make it off a vent.

Kimberly Overton: Exactly.

Ken McCarthy: We should make sure everybody understands that putting someone on a ventilator is an extreme last-ditch effort to keep

somebody alive. It's not something you do casually. It's not a band-aid. It's not aspirin. It's not a glass of water. It's, "We've done every other thing that we can do. We are out of all other options. Let's vent them and see if we can keep them alive long enough until they can recover."

Kimberly Overton: Right. And what's interesting about that is if you remember when these patients were coming to the emergency room, at least in my hospital, they had criteria that they had to meet to get admitted. They had to have an oxygen level – it didn't matter how sick they were – if their oxygen level was not at 88 or below, then they would not admit them into the hospital, would not admit them into the ICU. They were telling these patients, that no matter how sick, they were to go home and just come back when they couldn't breathe. Come back when you are a prime candidate for us to put you on a ventilator.

Ken McCarthy: To speak of the non-vented people. I know that in Scott and Grace's case, he did a home test, and I think Grace's blood oxygen was around 92. Which isn't bad. I've tested mine. I've been 92 at times. I wasn't dying. He was concerned because he like so many people had been terrorized. That's what a lot of people forget, all these years later, the intensity and relentlessness of terror campaign. And it was a terror campaign. It was science-free from the beginning and flew in the face of everything we know about medicine and taking care of people.

Kimberly Overton: The death ticker at the bottom of the TV screen...

Ken McCarthy: Exactly. Thank you for reminding me. The daily tickers which were burned into every news program screen quite deviously showed how many people reportedly died of COVID cumulatively. It gave the appearance that many people were dying every day. If you did that with car accidents, it would also be horrifying. You'd see the numbers just get bigger and bigger and bigger and bigger without any perspective.



CNN and other news outlets promoted hysteria by keeping cumulative “case” and death count graphics on their news screens.

So Scott brought Grace to the hospital, this is my understanding of the story, and they took complete control over her at that point. They did not vent her, but as you said they did other things to her in the hospital which killed her.

Kimberly Overton: They put her on a BiPAP, which is the mask.

Ken McCarthy: It sounded like they were setting up to vent her. I know that they kept asking permission to.

Kimberly Overton: Yes, that was my understanding that they wanted to and her father did not want her to be vented and it didn't sound like it was necessary. From everything I knew of the case, it didn't sound like she was a candidate for that. That wouldn't be remotely necessary with her oxygen levels. They said that she was tolerating the BiPAP just fine. And then they gave her that combination of medications that were lethal, the propofol, I believe it was lorazepam, and something else. I can't remember what the third one was, but they were medications that you should not have given in

combination and in such a short time. I think it was in under 29 minutes that she was given these three central nervous system depressants that would depress her respiration. Plus an illegal DNR (do not resuscitate) order.

Ken McCarthy: Yes. Pre-COVID, it was well known that you did not give these drugs all at once in rapid succession because of the danger. If people aren't aware, your diaphragm, which controls your lungs, is essentially a muscle. It's more complex than that, but it's essentially a muscle. If you're using drugs to profoundly relax all the muscles in the body, you might relax the diaphragm too much and that's going to be a pretty quick death.

Kimberly Overton: Considering that this is a patient who's already in respiratory distress, why would you do that?

Ken McCarthy: Meanwhile, as you were saying, when we were first talking about this, no water, no food.

Kimberly Overton: Not to mention they don't have any loved ones there. The patient is afraid. They don't have anyone, no family members at their side, no advocates at their side, and the nurses are barely in the room with them. So they're afraid.

Ken McCarthy: The non-vented patients received the same level of non-care as the vented patients. I know that for some reason Scott was able to be in the hospital until they threw him out.

Kimberly Overton: Yes, because of the ADA (Americans with Disabilities Act) rules, because of Grace's underlying disability (Down's Syndrome), she was allowed to have an advocate. Which if you think about it makes no sense. Either it's the deadliest virus known to man or it's not. As far as I'm concerned, you can have family members sign a liability waiver. After all, these are the people who just literally drove in the same car with the patient, they were living in the same house, so they've already been exposed. My thinking was just have them sign a liability waiver and let them stay with their family member.

Ken McCarthy: Hospitals certainly know how to produce forms. They have people fill them out all day long. Right? You kept asking questions, kept asking questions, and you were getting ridiculous answers. It seemed

that every protocol they had put in place, these aggressive and unprecedented protocols, none of them made sense. None of them worked, all of them seem to be contra-indicated. You were doing everything you could. What happened?

Kimberly Overton: I ended up leaving, I ended up leaving bedside because I just couldn't watch one more of my patients needlessly die when I knew that there was safe and effective treatment available. But the hospitals were denying this treatment to my patients. I just couldn't do it. It just became too much of a burden for me to bear anymore.

Then by the time I left, I was also starting to see the vaccine injuries that were coming in. I was starting to see that very early in 2021. We started seeing those injuries early on, and I just couldn't do it anymore.

I ended up leaving the bedside. I started working from home doing telephone triage nursing. I thought that would be a good alternative for a while, and it was. But then they wanted me to start recommending the vaccine for everyone, including children. They wanted me to not only recommend it, they wanted me to use the words "safe and effective." Period. Which we would have no way of knowing because we had no long-term safety data. And the short-term data, as I mentioned, I was already showing these injuries at the bedside. The short-term data was alarming.

There was no way I was going to be complicit in this and I resigned from my position. I said, "There's no way that I'm going to advise these parents to vaccinate their children against this virus," which, by the way, has a 99.9815% survival rate for children.

Ken McCarthy: Those who didn't survive had a serious pre-existing medical condition and could have been killed by a garden-variety flu or even a bad cold.

Kimberly Overton: Exactly.

Ken McCarthy: All kinds of things could have killed them. A bad infection.

Kimberly Overton: Even those people did great if they stayed out of the hospital. If they just stayed at home.

Ken McCarthy: You make a really important point. If this virus was as they described it, there should have been dead homeless people lining the streets. Elderly people and others who lived alone and without support networks should have died at home in large numbers. too. After all, they didn't have the benefit of "modern" medical care," but overwhelmingly it was people who went to the hospital who died.

By the way, Before SARS-2 there was a SARS-1, also seemingly originating in China and Canada lost its mind over it, not as crazy as it got with COVID, but it also went nuts for a while.

Here's the takeaway. The death rate for people with SARS-1 in Canada was twice as high as in China. David Crowe is the one who pointed out that when SARS-1 came around, it was the modern Canadian "ultra-scientific" approach to SARS-1 that killed more people than the more modest approach that was taking place in China. What happened with COVID looks like a similar thing but on a much, much larger scale.

(Editor's note: Crowe passed away in the summer of 2020 from a fast-moving cancer. A copy of his paper on SARS-1 appears on the website: www.WhatTheNursesSaw.com)

You were a triage nurse, tele-triage. Were you working for the hospital or working for a company?

Kimberly Overton: It was HCA, which is the Hospital Corporation of America, the largest hospital corporation in the United States. We would take calls from around the country. I can tell you about the number of cardiac symptoms, and things that were very likely related to vaccine injury, about 18 to 40 years of age. We were seeing a ton of chest pain and cardiac symptoms, and they were all post-vaccine.

I started seeing these things that were making me question. I didn't come into this as an "anti-vaxxer" by any means. I have received flu shots, I have received other vaccines, and my child received his childhood vaccines. I wasn't anti-vax. COVID was very eye-opening to me, I'll say that.

The vaccine was produced so quickly and it used a brand new untested technology. I wasn't comfortable getting it for myself. I thought "Well, risk mitigation, I think I if I got the virus..." By the way, it took me three years

to get COVID. Even after directly caring for these patients for that amount of time. I never got COVID until much later. That's a whole other story. You can read about that. Peter McCullough ended up treating my COVID in his home. Because I was in Dallas, and he said, "Come to my house and I'll take care of you." He gave me chicken soup and everything. Very kind.

Ken McCarthy: You were operating like an emergency room nurse, except you were on the telephone.

Kimberly Overton: Correct. We would tell them, "Based on your symptoms, you should hang up and call 911," or "You should go into the emergency room," or "Maybe you can go in to see your doctor tomorrow." We would give them a disposition of what they should do based on the symptoms that they were reporting. We were seeing so many cardiac symptoms that were very likely related to vaccine injury.

Ken McCarthy: You weren't specifically set up to be a COVID tele-nurse, you were just a tele-nurse in general. And in the process, you get these calls from 30-year-old guys who are having heart attacks, and you're asking "Have you done anything different lately?" And the answer was, "Yes, I just got a vaccine."

Kimberly Overton: Which is not one of the questions that we were ordered to ask. But I started asking it. I started keeping my own data. I thought, "Okay, we have this new vaccine that's just come out. I'm starting to see the trend." So I started keeping a notebook right here at my desk that I would make checkmarks in every time I would get something that was, to me, suspicious for vaccine injury.

Ken McCarthy: Meanwhile, they were telling you, "Anybody that you talk to, make sure they're vaccinated. And if they're not, urge them to."

Kimberly Overton: Yes. We literally had a script. The screens that we used, say the question was, "Should I get this vaccine?" Or "Is it safe?" Our answer to that in the script said: "Yes." Period. "It is safe and effective." Period. That's where I refused.

Ken McCarthy: This wasn't an ideological or philosophical thing for you. You had been talking to all these people, and seeing young people with heart problems who shouldn't be having them, and in numbers that you've

never seen before. How many times in your career has a 30-year-old come in with a heart attack to the ICU?

Kimberly Overton: Not very often. This is something we were seeing in people even younger than that, like 20-22 years old. They were having these awful chest pains, and all of these things that were very, very odd. It was typically within two weeks of vaccination.

By the way, this is very important. Remember, back when they started the initial rollout, they didn't consider you fully vaccinated unless you had two doses. There was no "partially vaccinated" category, nothing like that. If you hadn't received two doses yet, you were recorded as unvaccinated. Therefore, injuries after the first vaccination were not attributed to the vaccine at all.

Ken McCarthy: What a fraud. So somebody goes in and they get the vaccination. The first shot. Then they have a heart attack or some other kind of heart problem, and the question is, "Well, did you get the second one?" And if the answer is "Not yet." "Oh, well, then you're unvaccinated."

Kimberly Overton: Right. You had to be two weeks post your second vaccination to be considered vaccinated.

Ken McCarthy: So if you got the first vaccine, and then got the second dose, but it was one week and six days later, you'd still be considered "unvaccinated." So when all these criminals in the government — and that's what they are, criminals — were talking about COVID as a "disease of the unvaccinated"...

Kimberly Overton: Sure, exactly. Because there's no "disease of the partially vaccinated." All of those people who died or had serious adverse effects from the vaccine were considered unvaccinated.

Ken McCarthy: You had the script that they wanted you to read, that you did not read. Were they also encouraging families to have their children down to infants get the injections?

Kimberly Overton: Yes. That was so disturbing to me. Children have virtually zero risk of death from COVID. There is no way that we should ever be introducing an experimental product like this to children when they are at virtually zero risk of death.

Ken McCarthy: Tell me about your organization, your role in it, and how people can help.

Kimberly Overton: I have two organizations. The first one is Nurse Freedom Network.

I started that back in July of 2021. I did just to take a stand against the unconstitutional mandates. I started doing it more of an advocacy route. I started going to local hospitals that were firing their nurses for not being vaccinated. We started protesting at those hospitals. Then we started building advocacy teams in different states around the country.

Beyond that, my larger vision was really to be able to create opportunities for nurses who were either displaced due to the mandates or just did not want to be a part of this sick-care system. Even pre-COVID, the most depressing thing about being an ICU nurse was watching so many of these patients come in with things that are, 85-90% of the time, completely preventable with lifestyle changes. Think about your type 2 diabetes, or your congestive heart failure. All of those things would be preventable if we would just stop giving people the band-aid of a prescription, and teach them instead how to live better, healthier lives.

Then I started Remnant Nursing, which is a private membership association. Nurse Freedom Network is a nonprofit, 501(c)(3). Remnant Nursing is a 508(c)(1)(a), which is a private membership association. We are, through that, providing concierge nursing services to people. We are doing that virtually. And we are also starting to place nurses in homes with people. People are starting to realize that they are safer at home with an experienced nurse than they are going to the hospital. If they need to be escalated to a hospital, our nurse goes with them, so they have a built-in advocate at their side.

Ken McCarthy: That's great. What's the website for Remnant Nursing?

Kimberly Overton: RemnantNursing.org.

Ken McCarthy: It's private, so you join, and you're a member of an organization?

Kimberly Overton: Yes, our plans start at \$30 a month, or there's a \$300 rate for the year. You can save money that way.

We're also partnering with Pure Blood Registry, which is doing directed donations. We provide advocacy services for people who do not want vaccinated blood. That's another thing that we provide. Our nurses will advocate and procure directed donations, procure unvaccinated blood, and then facilitate that process with a blood bank for you.

Ken McCarthy: What a great service.

Kimberly Overton: Yes, I'm excited that we've been able to do this.

We have created opportunities for nurses too. We match them with clients and they can earn up to 90% of everything that they do on our platform. The percentage of revenue is based on the education that they get and we also provide education for them. Myself, I was very allopathically trained, and based on the experiences I've had have ended up questioning everything. All of the nurses that we have now are trained in functional medicine. They are learning how to nurse from a more holistic perspective.

Any nurse can join. It's a \$1,000 one-time payment to join the referral system. They can come in at that level, and they get 50%. Let's just say for simplicity purposes, if our consults with a new patient were \$150, then that nurse would get \$75, and the organization would get \$75. If they tier up and take that functional medicine course, they are then able to earn 60% of the fees of any package or consult service. They can earn up to 90% based on the type of education that they get.

We have courses on homeopathy, functional medicine, and all sorts of things. The more they learn about holistic modalities the more that they're able to earn. They can set their own schedule, they can see patients as much or as little as they want. We're making sure that people are keeping the tenets of medical freedom, autonomy, and informed consent foremost in their practice. If they're not, then we don't want them.

Ken McCarthy: That's a great screening device. Essentially you provide them with marketing. In other words, you let the world know that this service exists. Then the nurses get the patients through your system?

Kimberly Overton: Right, and it works two ways. When people reach out to us, we can direct the patients to our nurses. We also have the nurses who are marketing themselves: "Hey folks, I'm seeing clients now, I'm in

this organization.” We get the patient to join the organization, and the referring nurse gets to keep any clients that they find themselves. Otherwise, we direct patients to nurses who are in their local area and have the training their condition requires.

It’s a self-sustaining model. We don’t have any financial backing. Nurse Freedom Network has no financial backing, and Remnant Nursing has no financial backing either. It’s self-sustainable. It’s a way for us to be able to create an alternative system and a different way of nursing. We can provide true patient-centered care, and as our patients thrive, our nurses will thrive too.

Ken McCarthy: I love how the nurses are incentivized to become more educated, more autonomous, and more informed and that you provide all kinds of meaningful training for them.

Kimberly Overton: We do. We have training, and we’re also very team-oriented. If you don’t know something, or maybe you want to bounce something off one of the other nurses, we have an entire team of nurses that work together, so the nurses need not ever feel like they’re entirely on their own, or that they won’t be able to figure something out. We want our nurses to be autonomous, but we’re here to help them.

Ken McCarthy: How does the law look at what you’re doing? I’m sure somebody’s trying to interfere with it.

Kimberly Overton: It’s a private membership association (PMA). That removes the state, local, and federal authorities. They have no jurisdiction.

Ken McCarthy: That’s great.

Kimberly Overton: This is the way everybody needs to go at this point.

Ken McCarthy: Those are the worst devils there are, those licensing boards.

Kimberly Overton: The PMA is set up to protect us because we know they’re coming for our licenses. We know that. And this is a way for us to be able to practice if that were to happen. If we didn’t have a license, we’d still be able to practice because it is our constitutionally guaranteed right to a private contract. If you’re a member, you know that I am a nurse. I may

not be licensed anymore, because they may have taken my license, but you know that and trust in the care we provide. The government has no say in that. You're agreeing to accept this advice from the nurse. It protects us legally as well. Apart from anything really egregious, we cannot be sued.

Ken McCarthy: Part of this, as you mentioned, is you give full disclosure. Maybe I'm a nurse with a license, maybe I'm an experienced nurse who no longer has a license. That's how medical freedom was explained to me long ago. It's all about disclosure and informed consent.

The thing I tell people is everybody in this business, in this world, is a human being including the doctors. Everyone's fallible, nobody's perfect. What you want is somebody who's doing their very best with the very best that's known. If you're getting that, that's the best any human being can hope for. I think we've come up with this bizarre belief that, somehow, doctors are automatically geniuses, they automatically know everything, and they never make a mistake.

Kimberly Overton: The implicit trust in the white coat is something to get away from because it's a big part of the reason that we're in the mess we're in with our health care system. As I alluded to earlier, if doctors are under a corporate structure, and most of them are these days, they are paycheck employees. And that paycheck is what matters most to many of them, unfortunately.

Ken McCarthy: Some of them are doing their best and are well-educated. But that doesn't mean they all are. I mean, you know this, but a lot of people need to get this lesson.

Let's say you have a car and it needs a mechanic to work on it. Some guys know everything. They're going to fix that car, they're not going to rip you off, and your car is going to be fine. Other guys will never be able to fix your car, they'll charge you all kinds of money, and it will be a disaster. Just because someone is a mechanic, a doctor, or even a nurse, we can't just assume that they're necessarily competent. You're providing quality control, training, and all that. What a great thing. The last thing is the Nurse Freedom Network. Who does that serve? How can people help you with that project?

Kimberly Overton: That's NurseFreedomNetwork.org. We are a 501(c)(3) non-profit organization. We advocate for nurses, we advocate for the vaccine-injured, and also for victims of the deadly hospital protocols. We are starting to hold events around the country where we educate and reach out to nurses because we want to show them that there's another way, a better way. Right now we're looking for sponsors to help us do this. We want to do a six-month tour. We're trying to get around the country. We keep it very low budget. It's about the messaging and reaching out, but it's expensive to get these nurses who, a lot of them, are financially devastated after losing their jobs. We want to be able to help cover their travel expenses and that sort of thing, so we are always looking for donations and sponsors to help.

Ken McCarthy: You're talking about the nurses who travel to train and educate other nurses?

Kimberly Overton: Yes, we educate nurses, and we educate the public. We've done several events under the title American Freedom Nurses Summit. We've done about four of those. We have one coming up in Scottsdale, Arizona, November 3rd-5th.

We have four of these big ones a year. But a lot of people can't travel. Not all nurses can travel to all these different places. We want to get everywhere. We want to get right to the nurses and have them do smaller events, even if it's just in a church basement or community center somewhere, where we're getting 50 to 100 nurses in that room and showing them that there's a better way and that they're not alone in this fight.

They don't have to be a part of a system that no longer serves its nurses or its patients. As nurses, we've been begging for change. It's never coming. It's not. We say let the system burn to the ground, and we'll walk away and start something on our own. That's why we call it "nursing reinvented" and are forging our own path. Because we're not begging for change anymore.

Ken McCarthy: That's great. And I'm sure you've done virtual events.

Kimberly Overton: Yes. We do a lot of webinars and things of that nature.

Ken McCarthy: But, of course, nothing beats face-to-face.

Kimberly Overton: Yes, I've gotten so much positive feedback from people that have come. I had one entire practice that shut down so that their whole staff could come to my events. That meant so much to me, that they would shut everything down just to make sure that they were there to hear these nurses, these brave nurses that we've got coming in from around the country. We bring people like Jodi O'Malley. Nurse Erin has spoken at my events before. Ashley Grogg, who does the VAERS Project, which provides education for nurses on VAERS (Vaccine Adverse Event Reporting System) and how to make VAERS reports.

Ken McCarthy: If somebody wants to give money, they should give it to NurseFreedomNetwork.org?

Kimberly Overton: Yes, there's a donation button there. You can also donate on RemnantNursing.org. Both sites let you donate.

Kimberly Overton is a Registered Nurse in Hendersonville, TN with a background in Critical Care. In July of 2021, she founded Nurse Freedom Network to stand against the medical tyranny we are now facing. She is a graduate of Western Kentucky University and has worked in the healthcare industry for over 25 years, serving in both clinical and administrative roles.

Kimberly has a true passion for providing patient-centered care that focuses on empowering individuals through information and education. She has been a strong advocate for autonomy and informed consent throughout her career.

Beyond the advocacy, her larger vision for Nurse Freedom Network is to create opportunities for nurses to break away from this broken and oppressive "sickcare" system, and empower them to cultivate their own environment; one in which both nurses and patients alike will thrive.

In 2022, she founded Remnant Nursing Services, a PMA specializing in the consultation & care of the vaccine injured.

Nurse Freedom Network - <https://nursefreedomnetwork.org/>

Remnant Nursing - <https://www.remnantnursing.org/>

CHAPTER 6

NURSING IN THE HEARTLAND

ASHLEY GROGG INTERVIEW - JUNE 28TH, 2023

“The best nurses have the essential qualifications before they go to school.”

— Florence Nightingale

Ken McCarthy: Ashley is a nurse who has become a political organizer by necessity, and a very good one, as well as a researcher and educator. She grew up on a farm in Indiana.

Great background to have. We were talking before the recording started. Farming is one of the professions where you actually have to work for a living. You cannot pretend. You can't write a good report or a good memo or master the intricacies of office politics and somehow succeed. You have to get up and do whatever it is you have to do. Whether it's milking the cows, or making sure that the fields are plowed and planted at the right time of the year, two things you better do on time or it's going to be a disaster. I love farmers for that reason. I also like eating every day, so I'm appreciative

of the farm families of America that make that happen. Ashley, how did you become a nurse?

Ashley Grogg: Originally, I wanted to be a veterinarian, but I couldn't stomach the thought of putting animals down. Luckily, we don't do that with people. My family had a lot of health issues. My grandparents lived with us in a duplex and we cared for them in their last years.

I knew in those moments, as my grandparents were passing away, that taking care of people was I wanted to do. I wanted to love people like that. We're not going to be able to fix everybody's problems, but we can at least make the final journey a little bit more comfortable. That's where I started.

Ken McCarthy: This may seem like a strange diversion, but I think we need to mention this fact that our culture does its best to ignore, which nurses are very aware of: We're all going to die.

Ashley Grogg: Yes.

Ken McCarthy: The question is, what will the quality of the experience be like? Will we be cared for? Will we get the best, reasonable, rational efforts to help us? Or will we be put in the jaws of a machine that's designed to extract huge amounts of money from us and our loved ones at maximum discomfort with ridiculous promises and claims that can never be true? We are going to die. We all need to think about that every day to give value to the life that we have. That's my view on this. So you said, "I'm going to be a nurse and do this all the time. This is what I'm going to do."

Ashley Grogg: All the time. Yes, I just wanted to help people. My mom was diagnosed with cancer in between my grandparents' passing away. All of these things stacked up. My mom had thyroid cancer, which they say is the most treatable kind of cancer, but by the time she was diagnosed, they told her that she likely had had it for years already.

I was only 12 or 13 when I fired her doctor because he told her that she was a bored housewife and needed to get a hobby. That did not make me very happy. I was quite a sassy preteen and told him to take a hike. My mom was so embarrassed, but we kept on searching. We finally found a nurse practitioner that I liked. I liked her because she was thorough, she asked questions, and she cared about my mom and what was going on. That

appointment resulted in her diagnosis of thyroid cancer. Unfortunately, my mom didn't beat it and she never recovered.

We were on a constant quest for a cure. We never lost sight of the idea that we were going to be able to beat this. We kids were young. When our mother was diagnosed, I think I was a freshman in high school and my youngest sister is six years younger than me. My mom wanted to be able to see my sister graduate. The illness and deaths of my grandparents and my mother coming so close together impressed me with how health and quality of life impact every aspect of life.

I can't stand unnecessary suffering. I know that we're all going to suffer at some point in our lives. We're all going to have some element of that, but we can support our patients, and people and humanity at large, and give them the tools that they need to have the best quality of life and help them meet the goals that they choose. My mom chose to take all the radiation, not necessarily chemo, but radioactive iodine. I don't think I would ever go down that road, but it was her choice.

Her goal was to see my sister graduate from high school. You have to respect that. Everybody's entitled to make their own health choices. Nobody else but that person has to live with the consequences of those choices — whether that's lengthening the life in misery, or choosing to let nature take its course without aggressive interventions.

That's what I've always tried to do, sit down with my patients and have those hard discussions. I went into cardiac care because as I moved through my career, I saw patients become sicker and sicker at younger ages. Heart failure ended up being my specialty during my time in the hospital. It was crazy to see 30-year-olds come in with advanced heart failure and have a very poor quality of life. I would lay it all out for them. They would often give me the most difficult patients because I'm a very straightforward person.

“Mr. Smith, let's sit down and talk about your options. This is what's going on with your body. This is how it's going to impact your life and this is what your future is probably going to look like. However, if you do this...” and then I'd go through the different options. “This is what it might

look like. There are no guarantees, but these are the different options. Let's talk about what works for you."

Ken McCarthy: This is the role many people think that a doctor would play and yet, as a nurse, you were taking on this very important role, which is to educate. I think the original meaning of the word doctor derives from teaching. You were taking a teaching role. You weren't diagnosing. You weren't prescribing, because you're not 'authorized' to do that, but you were educating people honestly and frankly about what their potential destiny was going to be if they didn't make some changes.

You weren't promising the moon. You weren't saying "If you do this, this, and this, there will be rainbows and unicorns, and everything will be wonderful." You said, "This will improve your chances." I always say, "Give people a fighting chance." I think that all any of us can ever ask for in life is a fighting chance. And you were doing that for your patients as a nurse.

Ashley Grogg: All you can do is just say, "Look, this is what we typically see. There are rare cases where things happen..." It's having constant conversations and education interplay between the medical professionals and the patients. As you said, we can talk a little bit more about this, but doctors have a tough job. They're very limited in their time. It's the nurse's role to fill that gap. I always tried to be with my patients when the doctors would come in so I could interpret and answer any questions that they might have because a lot of times doctors speak at a very high level and a very fast pace because they're trying to get through rounds.

You paint the picture: "This is what I've seen. This is what I've seen that has helped." It's not my place to choose for them. I don't have any skin in the game. I am just here to help guide you and give you information. I think that's one thing in the medical profession that we've lost. We just assume everybody should follow so-called best practices. They might not fit their cultural beliefs. They might not fit their personal experiences. We have to adapt to that.

I think the difference between myself and some of my colleagues is I understand death very well. Not only from farming, because it's the circle

of life, right? Today, it's Freddy the Pig, and tomorrow, it's bacon. Life works that way. People are going to die and watching so many of my family members pass away gave me a different perspective. People deserve the right to decide for themselves. It's their life and they are the only people who can decide how they want to live, in sickness and in health.

I started nursing in 2006 and when I first started things were vastly different. I was able to spend time with my patients. I worked the second shift and third shifts, and I would give my patients nightly back rubs. A simple thing that makes a big difference because sleep is important, right? I had great mentors who taught me to do that. It wasn't my invention, so don't give me credit. Those nurses have since passed away, but they were amazing mentors who taught the art of compassion and love. As time went on, I saw that attitude start to drift away, and nurses weren't made the same way that they had been.

When the automotive industry crashed, we had a massive influx of new nurses who were middle-aged people looking for a steady paycheck and nursing looked like a good option for them because there has always been a nursing shortage. As a result, we have an influx into the profession locally of people who don't have that drive to serve that you truly need to become a nurse.

When you become a nurse, you know that you're going to be cleaning people's backsides, you're going to be with people during the most vulnerable times of their lives. Sometimes it's not going to be pretty. Now you have people from, literally, "industry," coming in and being dumped into this work of heart. What should be work of heart, highly compassionate, very humble. This has changed the dynamic, and I've watched things shift over the years.

Best practices are fantastic. We should be using evidence, and science, to determine the course of treatment. But that's not an excuse to say, "This works for 80% of patients so we're going to apply it across the board." When you lose personalized care, outcomes decline across the board. I think that's what we're seeing in the United States. We've been seeing it for 20 years. "This is what's best for most, so we're going to apply it to everybody, whether it's good for everybody or not."

Ken McCarthy: You raise the really important point that the profession of nursing is (hopefully, we won't ever have to say "was") a *calling*. It's not a job. It's not "Well, I could do this. I could do that. Or I could be a nurse. Whatever." It's not that kind of a profession. You had life experiences that revealed to you that this is what you wanted to do. Not to take anything away from industrial workers, but they have a different mindset.

The other phenomenon that's interesting for me to hear about is the people who taught you and the spirit of nursing that predominated before our current era. It's very eye-opening to me. The doctor comes in and does what he or she can do in the two minutes they get, then has to run to the next person and the next person. You're the people who are with this patient over time. If a doctor sees them 1% of the time you see them 99% of the time, right?

Ashley Grogg: Yes. It's an interdisciplinary effort though. Important conversations can happen in the hospital in very short amounts of time when you earn the trust of the patients and then ask the right questions.

One of the problems is that things have become so clinical and procedural that basic human exchanges don't take place. Our patients are not machines on an assembly line. There are lots of intricacies and subtleties, and there are many variables involved. When you take away that human element, that necessary conversation, that trust gets lost.

Sometimes it's the physical therapist who pulls an important bit of information and relays it back to the nurse. Sometimes it's the phlebotomist, the person who draws blood. Sometimes it's the CNA (Certified Nursing Assistant) who's doing vitals, or helping the patient to and from the bathroom. If you allow for it, you get little bits and pieces of information from all over. Having interest and compassion. Your job is not just to be there to chart and pass medications. Your goal, as a nurse who has been called into this profession, is to help that individual heal. This transcends what the clinical paper picture is.

There's another big issue we need to address. During COVID, they took all the family members out of the picture. Who's going to advocate the best? Their family members and their friends who are close to them. They often share things that are the last piece of the puzzle to help make sure you

get the right diagnosis, the right treatments, and make sure that things aren't being missed. Taking this personalized heart out of the process is one of the major downfalls of the system and it's been going on for a long time. The groundwork for the crumbling of the medical system has been laid for a long time. COVID just exposed it.

Ken McCarthy: You brought up a really important word: advocate. As you mentioned, sometimes you get insights in odd moments, in the middle of the night, from a few phrases. The other thing that struck me, you're also helping the patient's frame of mind. The patient who finds themselves in a hospital has to be in fear. I don't know anybody who goes to the hospital who doesn't get scared to a degree. Right? Therefore, to have a human being by the bedside who is caring, answering questions, comforting, and acting like a human being is an important support to the patient.

Ashley Grogg: It's fundamental. It's one of the key parts of being a nurse.



Ashley Grogg

Ken McCarthy: You are the moral advocate. Within the context of a hospital or medical practice, you are morally deputized by the profession to be that person's advocate.

Ashley Grogg: Absolutely. I'm so thankful for all of the mentors who went before me and helped shape me and my career. It probably hit a little bit harder than for others, because, at that time, my mother was going through terrible, terrible treatment. When I was in nursing school, the professor looked each of us in the eye, and she said, "When that patient

walks in, you have to treat them like they were your favorite relative.” It’s true.

I can’t tell you how many times I would have patients that would come in, and you could see their eyes were huge. They were terrified, trembling, and the family members were freaking out, “Is mom going to die? What’s going on?” I would just say, “I promise while you are here, you are my priority, and I’m going to take care of you just like I would any member of my family.” And I did. I fought for them ferociously.

I was in often charge on the unit. There were several times I would go to bat for my patients. I can remember going toe to toe with a radiologist who wanted to do a procedure on my unit. We were short-staffed and if something had gone wrong we didn’t have the capacity to deal with it. They went to the ICU for those procedures. I was arguing to the hilt. The supervisor came up and looked around the corner, and she asked, “Ashley, are you okay?” I said, “Yes.” She just kind of went on about her business. She said, “Look, doc, she’s running this unit. She’s speaking up for her patients. She’s got valid points.” But if I hadn’t had the courage to do that, what would have happened to that patient? It takes a lot of courage to stand up to some of those physicians, but you have to. It’s not about being disrespectful. It’s not about being right. It’s about supporting the patient and doing the right thing for them.

Ken McCarthy: Something I’ve discussed with other nurses, and I’d like your feedback, is that in every group of people, there’s going to be a hierarchy and different power centers, and unfortunately, the rulers of the hospital are the accountants and the CFOs. Followed by the hospital administrators, who may have never treated a patient in their lives. Then they tell the doctors how things are going to be. Then the doctors attempt to tell the nurses how things are going to be.

Unfortunately, some of the most important people in the hospital for the patient have the lowest level of power. When you’re pushing back, you’re not only pushing back against an individual physician, you’re pushing back against the hospital administrator, and you’re pushing back against the CFO, and you’re probably pushing back against some guy on Wall Street that’s run the numbers and said, “Make money, period.”

Ashley Grogg: Yes. The nurses run the hospital. Finances, rules, and regulations - that's administration. This is why I love the fact that you're doing this book because nurses have been beaten down for so long and made to feel insignificant. There's been a lot of undermining of their intelligence, as a profession. If nurses would just stand up and say "Enough is enough" and be advocates for themselves, things would change drastically.

I've been on 12, 16, 18-hour shifts where I might have gone to the bathroom once, didn't eat anything, and maybe had a couple of sips of water as I was running through picking up meds for a patient. Nurses just take working conditions like this on the chin and roll with them. We can't keep doing that.

As I progressed in my career, I ended up in a quasi-management-type position. I was helping develop the heart failure program at a regional hospital. Part of that role involved serving on some of the different committees within the hospital.

One of my favorite committees was the quality improvement committee. Many of the nurses on the committee had moved away from the bedside and now they're in authority positions. When they get into these management roles, they forget what it's like at the bedside. That's not to say that they don't care, but now they have administrative goals that may not work with patient needs.

I can remember very clearly at one of my first times at this meeting, there were issues with lab draws going bad. The drawn blood was hemolyzing coming out of the ICU, so the patient would have to be stuck again and there were delays in results. That is not a good thing for the patient or the hospital. The solution that the committee came up with was terrible. At the time our ICUs were so poorly staffed, that they had three patients when there should have been only one, and these were critical patients.

Ken McCarthy: This was pre-COVID?

Ashley Grogg: This was pre-COVID. This was somewhere between 2012 and 2015.

Ken McCarthy: I don't want to take you off track, so please hold your thoughts, but this is important for people to know and I have yet to see any press accounts of COVID and New York. I live in New York state. New York State has cut one out of four hospital beds over the last 20 years. Our population hasn't decreased that much. They just eliminated the hospital beds. Then they acted surprised when there was not enough capacity. So you were saying that things were already strained in normal circumstances.

Ashley Grogg: Yes, it was terrible. The staffing was terrible. These nurses are routinely being put in impossible situations. Nurses need to push back and start advocating for themselves. It's past time. We can't continue on the course we're on. It's putting patients at risk.

The other side of that coin is the abuse that we allow to happen to ourselves feeds into this kind of captive mindset. I went through this myself. I would cry on my way to work, all the time. It was so horrible.

I would wake up in the middle of the night, freaking out because I thought that maybe I had missed something. It's interrupting your personal life, and you begin to feel like you are a horrible person. "I'm bad." Not that I did something wrong or made a mistake. It's this constant sense of failure and inability to do your job correctly.

Nurses have faced this for a long time, where we're constantly feeling inadequate because of time constraints and whatever else. Then you add on the fact that they know, whether they admit it or not, they know that they were causing harm to patients. They know the protocols made no sense and were bad and that is eating them alive, whether they recognize it or not.

This is that moral injury that they're going to have to come to terms with. Some, nurses, doctors, or any medical professional, will cling to the idea that the protocols they were ordered to follow and carried during COVID were right, and this further increases their cognitive dissonance. There are a lot of steps that you have to work through to start healing from something like that, and they're very painful.

Ken McCarthy: We need a reconciliation process. We're so far from it. You have the facts, I have the facts, but the average person and even the average medical health professional do not have the facts of what happened during COVID. That's the first step. The second step is for those

responsible to say, “We did this to you.” Someone has to admit it. “We put you in an impossible situation. We enforced protocols that didn’t work, couldn’t work, where it was known they could never possibly work, and we made you follow them. As a result, your patients died and were injured.” That’s the reality of the situation.

Ashley Grogg: It’s important for medical professionals to understand that you may never get that apology. You can’t hold your breath and hold up your healing based on what other people are doing.

Ken McCarthy: Agreed, thank you for making that point. But in an ideal world.

Ashley Grogg: In an ivory tower.

Ken McCarthy: In an ivory tower, in the world of perfection, unicorns, and rainbows, the very top people of our country would get on TV and say, “Terrible errors were made. We enforced deadly protocols, untested protocols that were never before used in the history of medicine, that we could have known weren’t going to work. We enforced them brutally and coerced and bullied our doctors and nurses into following them. As a result, we ended up killing hundreds of thousands of people, and we’re now going to try to make amends.” I know that’s never going to happen, but that’s the real case of what actually happened.

Maybe we can switch gears if you don’t mind. Were you a practicing nurse during the COVID era?

Ashley Grogg: Not within the hospital. I do private consulting and education outside of the hospital systems. Thankfully, I didn’t have to experience that.

Ken McCarthy: Firsthand, you didn’t experience it. But I’m sure you experienced it secondhand from many, many people.

Ashley Grogg: Yes, that is very true. I tried to stay abreast of what was happening. I knew very early on that things were not right. I was pretty sure that we had had COVID in October of 2019. My youngest daughter was a micro-preemie. She was born at 24 weeks; she was one pound, 10 ounces, and then had open heart surgery at nine months. So she’s extremely

susceptible. She and both of my in-laws came down with this crazy respiratory thing, and it had a lot of complications afterward.

I was talking with my co-workers who were still in the hospital. We were trying to figure out what was going on. Everybody was scared, but there were quite a few who recognized that something was going on. It was very interesting to see the differences in the psychological impact on those who were able to see something funny going on versus those who just fell into fear.

Ken McCarthy: This is true for all human beings. Once fear overtakes you, and you're not getting any help to get out of it, it's a pretty tight vise you're in, and I think that happened to a lot of people. They clicked into the fear mode and some never got out of it. There were also people who knew what was being pushed was wrong, but went along with it to avoid personal hassles. One example I have personal knowledge of this, but I'll protect the person's privacy. The head of infectious disease for a major, big-name hospital told me very early on, he said, "I'm wearing the mask, but this is total BS."

Ashley Grogg: Yes, they all knew that masks weren't working. And the bandanas. Oh, my goodness! I try to have compassion because it's necessary, but the mental shackles that these people allow to be placed on them are unfathomable. I can't help but relate it to the Nazi concentration camps. That's what happened in these hospitals. But I cannot imagine allowing fear to take so much hold on me that my ability to critically think is completely shut off and I now think that it's acceptable to use a bandana to protect myself. That fear completely bypassed any thinking. The level of fear just snowballed. We're probably lucky that the suicide rate was not higher.

Ken McCarthy: I agree. For people who don't know, because the news media barely if at all reported it, the suicide rate hit the highest levels we've ever seen, including among children. Why the whole world didn't stop right then and there with everybody saying, "Whoa, we have to look at this", I don't know, but the world didn't do that. And that lunatic bandana thing. And you'd see people with surgical masks hanging off their ears while they're eating lunch, and then they put it back on. Just for the record, this never occurred in medicine before, in the entire history of medicine. If

somebody had seen you with a surgical mask hanging from your ears while you were eating lunch, you would have been called into the office and given an education. Right? This wouldn't have been tolerated.

Ashley Grogg: Yes, you're contaminating that mask and it is now ineffective.

Ken McCarthy: We could go on and on about that, but I always tell people, there was medicine, pre-COVID. Then there's medical practice after COVID. Pre-COVID, you might put a mask on, but you would not wear it all day. You would take it off and dispose of it with great care. You wouldn't take it off and put it on the cafeteria table while you're eating and then put it back on. It's lunacy. Yet we have a lot of uninformed people outside the world of medicine who thought that made sense. They still don't know that that didn't make sense. That's just one example of many of how insane things became.

One thing I'd like to talk about and I realize you weren't in the hospital setting then, but I'm sure you heard a lot of stories and knew what the "protocols" were. The protocols almost ensured that people would develop raging cases of this thing and die. That's my take. Am I wrong? Am I missing something?

Ashley Grogg: No, you're right. One of the greatest puzzles for me, I remember very early on they were talking about how steroids would cause problems. I said, "Stop. Stop this. This is nuts." When that was announced an old friend and a hospital veteran, told me that her jaw dropped when she heard that. It was such an extreme reversal of normal practice.

The banning of steroids, the intubation, and the high-pressure setting on the vents...they saw that these things weren't working. They knew it. Nurses were too afraid to go into the rooms to check alarms. Everything set these patients up for failure.

There were strict orders and if you asked anything that went even slightly against the grain, you were blacklisted as "anti-science". The propaganda and the Gestapo within the hospital systems were tough. People who I previously thought were brave, bold, and "I'm going to stand up for my patients" types took a step back. On the other hand, I think that it's really

difficult to judge. We can sit here on the outside all day long and say, “Why didn’t you do something?”

Ken McCarthy: I agree. We can only talk about what we personally did or didn’t do. That’s the only thing that we can talk about fairly as far as the nurses are concerned. We need to have compassion and insight into the extreme psychological pressures that people were put under. However, we do have to acknowledge that some nurses became enforcers in this setting. That’s just a fact.

The thing about medicine, or engineering, or being involved on the bottom line side of business, is you’ve got to look at what is in front of you. You can’t wish that the symptoms aren’t there, or that the symptoms are different. “Gee, it’s unpleasant to look at so I’m going to develop a theory completely divorced from reality that makes the bad things I’m seeing go away.” You can’t do that. You have to look at it. A lot of this history is not pleasant, but back to steroids for civilians. Please explain why it was so insane to deny these patients steroids, and how completely against all previous medical practice that was.

Ashley Grogg: We give steroids for all kinds of inflammation. It’s a very basic thing. Especially with issues within the lungs, you want to reduce that inflammation so that scarring doesn’t occur and block oxygen transfer. It’s one of those basic fundamental things. Ibuprofen works on inflammation.

Ken McCarthy: Even New York Times readers knew that the problem with COVID was not COVID itself. It was the out-of-control inflammation that took place from the body reacting to it. I also heard from one nurse that even ibuprofen was not allowed in the protocols.

Ashley Grogg: They did everything they could to remove any known protocol that would help. That is what makes me so angry. We’re allowed to have those feelings. I think we should feel that anger a little bit more, but the important part is not just feeling that anger, but channeling it productively. That’s what drives me, all that anger for that completely unnecessary suffering, death, and the trauma that’s going to ensue for years. That’s what drives me to do everything I do.

I’m going to take what they meant for evil and use it for good and I’m going to bring as many people along with me as I can. Because we have to.

I am very angry that they banned those basic treatments.

We use more natural health measures in our home. I was using elderberry syrup. There was this huge outcry about how elderberry would cause more inflammation. Complete nonsense. They went down the line and crossed off all the things that would be beneficial to help patients overcome some of the inflammation and reduce the stress on the body. They just checked them all off the list and said, “Absolutely not. Don’t touch it. Don’t do it.” Basic things have been used traditionally and we know are safe and work.

Ken McCarthy: Ibuprofen, steroids, and gentle non-chemical treatments like elderberry. What other common-sense things did they make forbidden?

Ashley Grogg: I have a history of blood clots. Aspirin is widely used to help thin the blood. I remember calling my primary care physician. I asked her “Hey, should I be on aspirin?” This is something hospitals normally did in the past. When you are discharged from the ICU, they start you on aspirin, but my doctor said, “Oh, there’s not enough evidence for that.” And I said, “Okay, can we not worry about ‘the evidence’ and critically think through this?”

Is aspirin going to cause me any harm? No. Could it potentially reduce my risk of developing a blood clot and ending up in the hospital while I have COVID? Yet she’s telling me not to take it because there’s no evidence. It’s just the complete opposite of normal. There was so much fear and the focus was on, “We can only do this limited range of things to treat these patients. And we’re going to shut off our critical thinking. We’re just going to shut that off.”

Ken McCarthy: The thing they did allow, and I don’t know where they got their evidence for it, was remdesivir. They presented it as a magic elixir without risk. I believe their study of it for COVID was about six weeks and then they gave it emergency use authorization.

(Editor’s note: The story of remdesivir, its short clinical trial, and its long list of toxic side effects appears in Appendix 5 of this book.)

The other thing that they loved was intubation. We’ve talked about this in great detail, especially with Erin Marie, because she was working in an ICU. That’s something you do when you’ve tried everything else because

it's such an invasive thing. Many people don't survive venting. Not that they don't survive what happened to them, they don't survive venting. Yet people were being thrown on ventilators at the drop of a hat.

Ashley Grogg: You mentioned remdesivir. I was doing a lot of consulting from the outside and talking to patients on the inside. They were friends and family members. I wasn't getting paid. It was just something I was doing because I knew that there was a problem. People were scared to death to be in the hospital. We watched as the wave of kidney failures hit.

We heard that some staff members were telling patients, "Oh, don't worry. This isn't remdesivir," and they'd call it by the brand name instead. This was a terrifying situation, especially for elderly people. They're not going to know to look it up. They don't have a smartphone to check it out. A lot of deception was used and justified because it was "the protocol" At this point, the nurses were scared for their own lives. They're scared for their jobs. They're scared of being blacklisted for being 'anti-science.' Everybody's breathing down their necks. What are they going to do? They're going to shut up and comply.

You also had some practitioners who were adamant, ferocious, and nasty. They thought they were protecting people, but I think some of that was also protecting themselves. At some point, they're going to have to come to grips with the fact that they did some pretty serious harm.

Ken McCarthy: I was talking with someone who's a veteran EMT, and his daughter is a respiratory therapist. They were the ones operating the vents. He says she's destroyed with guilt over the realization of how many people she killed.

Ashley Grogg: I would love to talk with her. I think it's important for people to realize all the cycles of grief people who were part of this are going to have to go through.

Ken McCarthy: This is a dimension that we haven't gotten into with any other nurses so far, the psychological toll. This was one anecdotal story, but it makes sense that this would be multiplied by tens of thousands, hundreds of thousands of practitioners.

Ashley Grogg: This makes me very emotional because I can see and feel the pain in every area of society. It's not just the medical professionals. You had people who were scared and they were trying to protect their loved ones. They were trying to protect their elderly parents, so they were pushing other people to get these vaccines, and now they're having to watch as some of them have myocarditis, pericarditis, and maybe they died suddenly. This emotional toll of the things done during COVID is an invisible scar on the whole nation, but no one is addressing it.

I was watching a documentary and there was a woman who survived a Nazi concentration camp. She said, "We killed our own people." Violence broke out. In her case, it was physical violence within the concentration camps. The Nazis were able to turn people against each other through fear, through hunger. People were manipulated into killing their own because if you can get people to do that you've really broken them.

I think that's what we're seeing with COVID. We've seen all these people who are broken as a result of the things they were manipulated into doing. It cut me deeply when you said that he said, "She's destroyed." I'd like to see her rise like a phoenix. That's why I'm working to help these people. There's an opportunity for healing here, but first we have to believe that there is an opportunity for healing because if you can't believe that there's an opportunity, you're going to be lost for a while.

Ken McCarthy: We have to start by acknowledging these injuries. These psychological and moral injuries as they relate to what happened during COVID aren't even being acknowledged.

Ashley Grogg: I don't know anyone else who is talking about this. I'm working on a book on the subject.

Ken McCarthy: That's the first step. To acknowledge the injury. The second step is to believe that it can be healed. Of course, we're self-healing creatures.

Ashley Grogg: God gave you everything you need.

Ken McCarthy: It's an amazing feature of humanity. Certain people in the medical industry would like us to believe otherwise, that we are entirely dependent on their ministrations. Sometimes we do need a helping hand,

but self-healing is built into everyone. There's that old saying, "God does the cure, and the physician takes the fee." That's fair. Someone's got to show up and do the work, but make no mistake about what's healing us. It's how we were built. We were built to heal.

On February 1, 2020, I wrote, "These stories out of China are lunacy." First of all, no offense to Chinese people, but the Chinese government lies like it breathes. The news media in this country lies like it breathes too. If I'm seeing news media reports from China, I'm already doubly skeptical. I said in my tweet that day, "This looks like a vaccine marketing publicity campaign." I had no idea how far they were going to take it. "They're going to try to roll out a coronavirus vaccine, which they've been trying to do for the last 40 years unsuccessfully and they're going to put more emphasis on speed than science." That's what I said on February 1st, 2020. Something happened in your life too on February 1st, 2020?

Ashley Grogg: Yes. I have no political experience. I never wanted to be involved in politics, but I saw what happened with the measles hysteria in 2018/2019 and I knew something like COVID was coming. I didn't know when. I didn't think it would be this soon, but I went to a political leadership school on February 1st, 2020, and it set my political activism on fire. On February 8th, I filed paperwork for the nonprofit.

Ken McCarthy: How did you hear about this political leadership school?

Ashley Grogg: I was in some groups before. In Indiana, we never really had a solid medical freedom or medical liberty group. There was a small group of people who would go advocate during the legislative season, and then they would go away. There were several of us that were trying to figure out how to do this. I said, "I hate politics. I don't like lying. I have a very short temper. I'm very compassionate, but you make me mad and it's like a light switch." So there was chatter in this group, and they said, "Hey, you should take this class. It teaches you how to be effective in politics." I rolled my eyes, but I thought I'd give it a try with the idea that I could bail out after the first hour. It was a full-day class. At 10 AM I realized the class was great and I stayed for the whole thing and it was a life changer for me.

They taught me that 3% plus one is all you need to win. In the American Revolution, only 3% of the population was involved. If we can pull that 3%

plus one, activate them, and get the grassroots moving, we can be successful. February 8th is when I filed the paperwork for my nonprofit. For the past three years, each year, we've had legislative success. It's been a wild ride. I've had to be very humble and learn as I go. I'm used to being the most informed person in the room, but in the beginning, I knew absolutely nothing and had to rely on a lot of other people. Luckily, I have a great mentor.

Ken McCarthy: What's the name of the group that you started?

Ashley Grogg: Hoosiers for Medical Liberty.

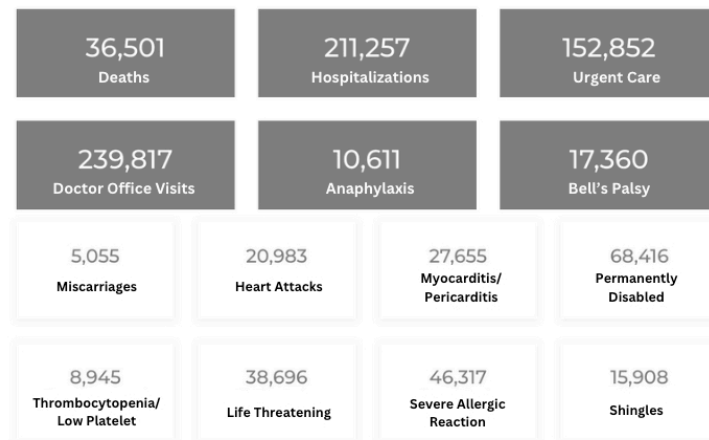
Ken McCarthy: Indiana is such a distinct state. When you drive from Ohio to Illinois, and you go through Indiana, you know you're somewhere different. You know you're not in Ohio anymore, and you know you're not in Illinois. I can't put my finger on why that is. It's a beautiful place. Very American.

Let's talk about your work with VAERS. This is so important. Tell us what VAERS is, what the problem with VAERS is, and what you're doing to remedy it.

Ashley Grogg: VAERS is the Vaccine Adverse Event Reporting System. It's a national program put together and administered by HHS through the CDC and FDA. It's a federal program. It was instituted as part of the National Childhood Vaccine Injury Act of 1986 when the government removed financial liability from the pharmaceutical companies for injuries from vaccines and placed it on taxpayers.

1,605,764 Reports Through October 27, 2023

Source: OpenVAERS.com



Adverse reactions to COVID vaccinations reported as of October 27th, 2023. Source: OpenVAERS.com

In the past, if a child received a vaccination and was injured, the parents could sue the company that made it. When that right was taken away, the incentive for manufacturers to improve their products and maintain safety disappeared. VAERS was supposed to monitor for safety signals. A safety signal is an indication that there might be a problem with a specific vaccine. Once you receive the safety signal, you drill down and investigate what might be causing the problem. Unfortunately, the system is very broken.

There are two studies that I like to quote. The first one is the Harvard VAERS study. The CDC paid them a million dollars to figure out what percentage of people who were vaccine-injured reported it to VAERS, and they came back and the results of their survey say less than 1%.

Ken McCarthy: Let's stop there to make sure everybody understands the significance of this. There is this VAERS system and, theoretically, all doctors and nurses, if there is a suspected vaccine-induced injury suspected, are required to report it. It's not an option. It's a requirement, but the Harvard study found that only 1 out of 100 suspected vaccine injuries are reported.

Ashley Grogg: It's supposed to be any health condition that happens after vaccination. Anything.

Ken McCarthy: Anything?

Ashley Grogg: Anything.

Ken McCarthy: I don't mean to be facetious, but let's say an otherwise healthy person suddenly gets a raging cold right after getting a vaccine. That needs to be reported because it might be a safety signal?

Ashley Grogg: Technically, that's what the system calls for. Yes.

Ken McCarthy: The post-vaccine signal could be a stroke. It could be convulsions. It could be passing out. It could be death.

Ashley Grogg: It could be an upper respiratory infection. It could be cellulitis. It could be neurological disorders, seizures, or encephalitis, which is swelling of the brain. There's a wide variety. The problem is there are so many myths and misconceptions that even the physicians and nurses who think they know what VAERS is, don't. In May and June of 2022, I did a survey through social media, and I asked Indiana nurses if they knew what VAERS was and if they knew where to file a report, and a series of other questions. To the question "Would you know where to go to file a VAERS report?" 76% said no.

Ken McCarthy: 76% wouldn't even know where to file an adverse reaction report. If someone dropped dead after a vaccine right in front of them, they wouldn't even know where to report that.

Ashley Grogg: Yes. So another question I asked is, "Have you ever been discouraged from investigating or making a report?" 14% said yes. That's pretty significant. 14%.

Ken McCarthy: About one out of seven reported being actively discouraged from reporting the truth of a post-vaccine event. I know of one nurse in upstate New York who was fired for offering to assist fellow hospital staff members to report vaccine injuries they suspected. In other words, she was fired for doing her job.

Ashley Grogg: Most people think that you have to prove that the vaccine caused the adverse event to report it. That's not the case. Their only job is to report suspected adverse events. Then the research into the case becomes the job of specialized staff at the FDA and CDC. The other thing that bothered me was I asked, "Have you ever encountered a patient who experienced a vaccine adverse reaction?" Then I included a variety of

answers: “Yes, and I reported it.” “No, I didn’t report it.” All the possibilities. 35% said that they had a patient who potentially had a reaction, and it never got reported.

Ken McCarthy: 35%. Wow. Over one out of three.

Ashley Grogg: When the pharmaceutical industry was made immune to product liability claims, the federal government became the defendant in vaccine injury cases. The government then created the Vaccine Injury Table and the Table of Reportable Events. This determined what injuries the government would and would not hear claims for.

On this list, the reactions go from immediate reactions – whether it’s anaphylaxis or syncope, passing out – to about six weeks, I think it’s 42 or 46 days for some reactions. Most of the medical professionals out there don’t even realize that the timelines go that far out. They think the reaction has to be immediate to be reportable.

But there’s more to this. Some of the timetables the government imposes are unrealistically short. They don’t consider the fact that many of these adverse reactions are inflammatory processes and it can take significant time for observable symptoms to develop because the body compensates and tries to work through the injury. In some cases, later down the line, a body is overwhelmed and a disease process takes root because the inflammation created by the vaccine could not be resolved.

If you go to the CDC website, the VAERS website, or the FDA website, you get spun through these complicated tables and they are very difficult to understand. Also despite billions of dollars spent sowing terror about COVID, doctors and nurses have not received even basic education about the VAERS system, how it works, and the fact they have a professional responsibility to make sure all adverse reactions are reported.

Ken McCarthy: Not only are practitioners not educated about what VAERS is and their obligation to use it, but there’s another piece to this. Apparently, the interface is horrible. For instance, if you start a session and you get interrupted, when you come back, your session is gone. You don’t get to save it, you have to go back and redo it. From a software designer’s point of view, you would only do that if you wanted to dissuade people from actually submitting the form.

Ashley Grogg: The stated intention there is privacy. If you think about it, most software used in hospital systems does have a timeout feature, because you don't want people coming in and looking at that patient's personal information there. You've got to protect it.

Ken McCarthy: OK, but there is such a thing as "save".

Ashley Grogg: Yes. You would think that they would do that. We make free information about VAERS available at VAERSProject.com that anybody can read. It's cited and sourced from the FDA and CDC websites.

I also created three practical courses on the subject which you can find more about on my website, WTAJourney.com. There's a button on the site that says VAERS. There are three course choices. One for patients and caregivers, one for providers, and one for nurses seeking education credits. The program has been approved for three credit hours for nurses that they can use towards the renewal of their license and it's nationally recognized. Of course, they have to confirm that their particular state accepts the credits, but we work with one of the largest accrediting bodies out there.

Ken McCarthy: This goes beyond Indiana.

Ashley Grogg: Yes, this is the entire country.

Ken McCarthy: Fantastic. I love this. I think everybody needs to go there and take a look. How can people support your work? Because it's very important. Is anybody else doing this as far as you know?

Ashley Grogg: Other people are bringing awareness about VAERS.

The basic VAERS Project is offered through Hoosiers for Medical Liberty, the nonprofit. I wanted a way to get the information out to people for free because there is such a need for it. I created a booklet you can download as a PDF and, if you're inspired, there's a place to donate and those donations go to Hoosiers for Medical Liberty.

The best way to support the effort is by taking the course yourself and then sharing it with others, telling others to get out there and become knowledgeable. It is going to take grassroots. That's one thing I've learned. It has to be the power of the people raising these issues and pushing them forward. Because there's so much opposition, right?

Ken McCarthy: Absolutely. So the quick and easy thing would be to go to WTAJourney.com. Pay for the course, whichever course makes sense for you, whether you're a practitioner or a nurse looking for credits or a patient, or an advocate for a patient. Thank you, by the way, for creating it. And then if listeners want to give additional money to support this good work, go to VAERSProject.com, and you'll be supporting the work of Hoosiers for Medical Liberty.

I think every living human being should be taking this course. We need to all raise our level of education. I think one thing COVID has shown is that we cannot leave it up to the system to help us, because the system is probably going to do the opposite, so we need to be as educated as we can. This is the kind of help the world needs right now. This is a worthy effort. Ashley, I just want to tell you, that talking with you today has been an honor, pleasure, and privilege.

Ashley Grogg: We're going to get them, Ken. We're going to be successful.

Ashley Grogg is a Master's prepared Registered Nurse from Indiana. She began her nursing career in 2006, specializing in cardiac care and advanced heart failure. She assisted in developing the heart failure program at a regional tertiary care hospital as the Heart Failure Coordinator Data Specialist. She also developed education programs for patients and staff. One of her favorite roles was that of educator. She firmly believes that the key to Wellness is through Awareness, inspiring her coaching and consulting business Wellness Through Awareness.

*Ashley founded Hoosiers for Medical Liberty, Indiana's most trusted medical liberty activism group, in 2020, just before COVID hit. Most recently, she has initiated the VAERS Project in order to educate healthcare personnel about VAERS. Her hope is improved risk-benefit analysis, adverse event identification, and, most importantly, decreased human suffering and improved patient outcomes through appropriate & accurate VAERS reporting. She is currently working on a book titled **Moral Injury**, more information is available on her Wellness Through Awareness website.*

The VAERS Project - <https://vaersproject.com/index.html>

Wellness Through Awareness - <https://www.wtajourney.com/>

Hoosiers for Medical Liberty - <https://H4ml.org>

CHAPTER 7

THE VIEW THREE YEARS LATER

NICOLE SIROTEK INTERVIEW - AUGUST 11, 2023

“Nursing is not a career... it’s a post-apocalyptic survival skill.”
— Unknown

Ken McCarthy: Today, we’re talking with someone that I’ve been wanting to talk to for a very long time. I’d like to introduce Nicole Sirotek. We’ve talked with a lot of nurses, starting in 2020. In talking with them, I realized there are three parts to this. One is, “What the heck happened?” Two, the fact that nurses were suppressed and kept from talking about what was going on and were retaliated against for telling the truth. Three, all the positive things nurses have done and the new organizations they’ve created, what those organizations are, and how we need to support them. That’s what I’d like to talk about today.

Nicole, your background. Obviously, you’re a nurse. I like to know how people were drawn to nursing in the first place, your early experiences, and how you got started in that profession.



Nicole Sirotek

Nicole Sirotek: I originally worked for a government lab as a bio-information processor. When I moved to Nevada, there were no jobs in genetics, so when I moved here, I found myself having to make a career change. Being a nurse was something that I had always wanted to do, but back in California, where I was originally from, the programs were so crowded—they'd have thousands of applicants for 30 seats. Nevada wasn't so affected. So, I pivoted, started with an associate's degree, got a bachelor's degree, moved on to start working on a doctorate, and then COVID hit. That's how it went.

Ken McCarthy: That's really interesting. We've always had a nursing shortage. Now we have an extreme nursing shortage! In addition to all the other things the government's screwing up, are they also making it hard for people to become nurses in California?

Nicole Sirotek: That was 10 years ago when there weren't enough programs and seats for applicants. The way the accreditation works, you can only have so many students per clinical instructor. These regulations created a bottleneck. The situation now with the nursing shortage, why it's so extreme, is that so many people exit the profession. One reason is retirement. The boomers are leaving. That was the original red flag that everyone was going to worry about. The second reason was the vaccine mandate. Many of us lost our jobs. I was one of them because I wouldn't get the vaccine. That left a huge number of people gone.

From every single state, we receive hundreds of emails every month from nursing students who have been kicked out of their programs because they won't get the COVID vaccine, or they can't be accepted to nursing school because they won't get the COVID vaccine.

Many people will have had all the other shots. Because they had childhood vaccines, like polio, but they don't feel comfortable with the COVID vaccine although many of them get flu shots every year. So, they get kicked out of programs, or they do not get accepted to programs.

Your vaccination record, upon your grade acceptance into the program, is a requirement. That's another whole can of worms, because we discovered that any university, school, or program that takes Federal Student Aid is required to accept a religious exemption. What the students are being told by their schools is that clinical site placement will not take them without the COVID vaccine. We find that 75% of the time, that's false. The nursing schools are deliberately creating a bottleneck instead of trying to work to find clinical placements for candidates.

We call those programs out. I'll say, "Where are your clinical sites? I want to see your hospital affiliation agreements and I will fight the hospital on behalf of these students." We call the hospital and say, "Hey! Are you not taking nursing students because you won't accept religious exemptions for vaccines?" We have students who have medical exemptions because they're allergic to some additives in many drugs. Often, it's very dangerous for some of them to even take antibiotics. They'll say, "No, who's saying that?" I'll say, "Apparently, this nursing school. Because we have three students that can't come to nursing school because you are a clinical site placement for—whatever specialty, OB, surgical, or whichever—and

they're saying that you won't provide clinical placement." They'll claim they never said that.

Ken McCarthy: Wow. This is cataclysmic. How are we going to have nurses if we're going to keep the best ones from getting educated?

Nicole Sirotek: Exactly. In the next five years, you're going to see critical issues in care from the clinic level to the critical care level, especially long-term care, with the boomers retiring and some of them having to go into skilled nursing facilities. I suspect that our healthcare system will become a humanitarian crisis. The quick and easy solution is to import foreign nurses, but having worked in medical settings in other countries, I know they are not trained to the same level as American nurses are.

We'll get a lot of them from China or the Philippines. Often, they're skill-based, meaning that they were taught a lot of skills, but didn't learn the knowledge base behind those skills, to troubleshoot. Because that's mostly what we do and many foreign-trained nurses can't. They're just trained to follow orders. We troubleshoot to prevent errors and deal with scarce resources. That's where the value of a nurse is, her ability to critically think through these dangerous situations instead of just following orders blindly and checking off her tasks for the shift.

Ken McCarthy: Whether it's intentional, planned, or just a mess, the quality of nursing in America is degrading at a rapid rate. We're losing, as you pointed out, the big boomer cohort. They're retiring. That body of experience is gone. Now young, aspiring nurses are being blocked, which will open the door to nurses with a different outlook. In other words, as you point out, ones that only know how to follow orders.

Nicole Sirotek: They're not going to question anything. As an example, I was in a hospital in Texas during the height of the COVID pandemic and there was a new nurse who had been a nurse for about six months. She's running down all these labs and everything that was going on with a COVID patient, a 40-something Hispanic male, undocumented. I said, "Has anyone done X, Y, and Z? Because this doesn't sound like COVID, this sounds like he's in a diabetic crisis."

For his demographic, being in his 40s, and being Hispanic, it's very plausible that he is an undiagnosed diabetic. I say, "Have you talked to the doctors about that?" She says, "This is the COVID unit. That's beyond my pay grade." I say, "No, girl, that is your job." At the end of the 12-hour shift, I had him on insulin, and we balanced out his labs. The next day, he was extubated. He didn't have COVID. He had diabetes. He needed insulin.

Ken McCarthy: How many people have died or been seriously injured because there wasn't a nurse who had the background and the integrity to intervene? Can we calculate how many? It's certainly tens of thousands. It might be hundreds of thousands.

Nicole Sirotek: I would say definitely tens of thousands. Here's one of the issues. I was one of the first waves of nurses that went to New York at the height of the pandemic, right when it started in April and May of 2020. Remember in the news, when they were asking for nurses? Did they specify what nurses they wanted? Did they say, "I want this particular type of nurse with this particular skill set"? No, they didn't. They just thought nurses could be plugged and played, like Lego bricks, into any situation. That's not the case.

You have people who are not trained on ventilators, not trained on test tubes, not trained on intubation, and all the critical care meds. It's a lot to manage and it takes special training and experience. It's not something you can learn on the fly. The problem is compounded because they're taking orders from doctors who are residents of a foreign country and are not trained to the standard of American care.

I'll be quite honest because I've been to other countries. When we're running a code, and I'm arguing with a doctor to stop doing compressions on someone because they have an end-tidal 45, in EMS, ground transport and flight (air ambulance), we always use CO₂, which is called end-tidal, to let you know that you've received resuscitation or ROSC (return of spontaneous circulation). I said, "His heart is beating, he's creating CO₂ because his cells are being oxygenated and creating this byproduct waste. Stop doing chest compressions."

Beyond basic ignorance, then you find out one doctor in the ICU was a gynecologist, another was an ophthalmologist, and another was a podiatrist. I asked, "What are you guys doing here?"

Ken McCarthy: What are they doing in an intensive care unit, which is a highly specialized area? Let's say you needed heart surgery. You would not go to a podiatrist. Yet they were putting podiatrists and people like that—ophthalmologists, gynecologists—into an intensive care unit, which is a very highly specialized practice both for nurses and doctors.

Nicole Sirotek: We had a pediatrician...he was a pediatric intensivist, but everything is so different in children, absolutely different. We have a whole set of training in flight medicine for children because the medications are different. The drug calculations are different. Everything is different in children versus adults, so the only thing we could task this pediatric intensivist to do was to be on the rounds to turn people into the prone position. We put him on the positioning team, and he went around with the team putting people in the prone position and rotating them. It was the worst allocation of staff and resources I had ever seen. I've worked in field hospitals in Syria that were better managed than those in New York City hospitals.

Ken McCarthy: These were publicly funded hospitals?

Nicole Sirotek: Yes. They were inner-city hospitals with New York Health and Safety. It was predominantly Medicare and Medicaid patients. Low income, lots of minorities. Lots of Jewish people.

Everybody's ego was so inflated when you tried to correct a practitioner, they were offended. When somebody corrects me, I listen because the outcome is that if you do not correct me if I'm about to make a mistake, or if it isn't the best option for the patient, the patient dies. This work can't be about ego.

I've been corrected multiple times in my career. In flight medicine (air ambulances) it's not just you working autonomously and independently. You're working as a unit and a team, bouncing ideas off each other: "Hey, this is what's going on." "I think this." You have to work as a team. In the ICU, they weren't working as a team. Everyone's ego took precedence because "We're in a pandemic" and blah, blah, blah.

Let me give you an example. It was the first hospital I was in, with the little Hispanic lady that I mentioned in my video. She lived the longest at two weeks. Everyone had died in that unit. Every single room, every single

bed had turned over, except for that little Hispanic lady. I think the reason was that I had a trauma nurse from Tennessee for the day shift and she had me on nights, and they kept us as a team with that one patient for some reason.

I was telling the doctors, “You don’t think that’s weird? This one patient has survived for two weeks, and we’re going to extubate her and everyone else is dead. Nobody thinks this is weird? How come she lived and nobody else did?” Nobody questioned it: “Oh, I don’t know.”

You don’t think it had anything to do with the skill set? We made sure nobody killed her. We knew what we were doing with the drugs and vent settings. We had her down to 21% oxygen, which is room air on that ventilator. She was ready to get off the vent. We pushed to get her extubated. When we did that, they took us off the case. She died that night, the little Hispanic lady.

Ken McCarthy: How did she die?

Nicole Sirotek: I don’t know the details, but they gave her two nurses who didn’t know what they were doing. Something went wrong. Her labs were pristine. She was completely healthy. There was no reason for her to die.

Ken McCarthy: As long as she was receiving competent care, she was alive. The minute she lost that, it was the end of her life. Everybody in that ward had the same outcome. They all died.

Nicole Sirotek: “Oh, it’s COVID. It’s COVID. This is a novel thing. It’s a pandemic, they’re going to die.” I said, “Not when your labs are 100% normal.” You’ve fought off the infection, you’ve been on the vent for two weeks, and we have you down to 21% oxygen, which is the lowest the ventilator will go, that is like just breathing air. Look, I am not the best nurse in the world. If anything, I’m average. There are people superior to me in their knowledge and skill base. Here was my question: If two average nurses could keep this patient alive, then why can’t we replicate these results everywhere?

There were no quality control measures for improvement. You can empirically, on the fly, improve things. If you see something working,

replicate it. We did that in field hospitals I worked in all the time. The doctors in NYC were not interested in any of that. They were interested in following the protocols that came from the news. No ibuprofen. Steroids are bad. “Just give them antibiotics and keep them on the vent.” I’d say, “What are we doing?” None of it made any sense.

Ken McCarthy: Right. For people that may not know, antibiotics don’t do anything against viruses. They work for bacteria, not viruses.

Nicole Sirotek: For example, when you’re on a ventilator and you can’t eat, your body is going to digest its proteins. You’ll go into a fasting state. Your electrolytes will go off if you don’t supplement them. This is why people who do extended fasts have to manage their electrolytes. The stuff that you’re being given, the antibiotics, the fluids, the pressors, none of that has electrolytes in it, except maybe in minuscule amounts. You put people on ventilators. And remember on the news, they wanted 30,000 ventilators? Did anybody ask for 30,000 feeding pumps to feed these people?

Now you have people who are in a catabolic state. They are cannibalizing their body, their body is breaking down, they’re wasting away, you’re filling them with fluid, and then you put them on fentanyl to sedate them, which is a narcotic that slows down your GI tract. They end up with a paralyzed GI tract or a paralytic ileus, where they’re not moving stool through their body. Then they end up with perforated bowels.

I’d ask, “Did we forget how to manage this?” When you’re on a ventilator, or if you’re bedridden, you have to be on a bowel protocol. Also, did we forget to put these people on an anti-clot protocol? Typically, we prescribe Lovenox twice a day to prevent clots for anyone who’s on a ventilator. It doesn’t matter if it’s COVID, doesn’t matter if you came from trauma, if you’re going to be on a vent, we give you some type of clotting protocol. Whether that’s putting those squeeze things on your legs or your feet, or giving you Lovenox, a mild blood thinner, none of that was being done. And they were surprised when these people threw clots that went to their hearts, brains, and lungs?

We find out that COVID has a clotting-like component to it. Then we see they’re throwing clots, or they come in and they have AFib (atrial fibrillation). Most people with AFib take Coumadin. Or they come in with

diabetes, or they come in with high blood pressure or something like that. Nobody treated the AFib. Nobody treated the diabetes. Nobody treated the blood pressure. And you're surprised when somebody has all these issues and goes into a diabetic crisis, or their heart goes crazy because you don't have their antiarrhythmics, or they start throwing clots because you didn't give them their Coumadin? It says on the record that they have AFib, and they take Coumadin at this dosage, and they're part of the Coumadin clinic. They literally just stopped giving care to these patients.

Ken McCarthy: It sounds like there was an expectation that since it was COVID everyone was going to die. New York Governor Cuomo was screaming for ventilators, but as you point out, there's a lot of other equipment that's needed to operate a ventilator safely. Nobody did anything to get that equipment. Erin mentioned to me a long time ago that you also need respiratory therapists to both operate those machines and supervise the patient. They don't operate themselves. It's a very technical process, a very specific process.

Nicole Sirotek: Under normal circumstances in the hospital setting, RT, respiratory therapy, would manage the ventilators. I, being a flight nurse, managed my own ventilators.

In flight medicine we don't have a respiratory therapist. It's typically you and another nurse or a paramedic and a pilot. You need to make things happen. We're trained for immediate trauma and life-saving interventions. That's why I know how to intubate and how to manage a ventilator because it was part of my job description. There is no respiratory therapist with you on the scene or in the helicopter or the plane. You have to manage it.

In the hospital setting, normally, the nurses would call respiratory therapy. I said I would help people with their ventilators because there was only one respiratory therapist on shift for the night for over 300 patients in that hospital.

Ken McCarthy: Tell us exactly how crazy that is. How many should there have been for 300 patients?

Nicole Sirotek: I don't know what the staffing ratio is for respiratory therapy. However, one respiratory therapist to roughly 300 patients is insane.

(Editor's Note: The interview with respiratory therapist Mark Bishofky later in this book goes into the details of the work of respiratory therapists.)

Ken McCarthy The way Erin Marie explained it to me, a lot of these nurses were new. They were new grads, or they were highly inexperienced. As you pointed out earlier, they were just asking for “nurses,” they weren’t looking for experienced nurses or nurses with a particular specialty. Anybody that had that nursing degree was in. It seems like that’s how they were running it.

Nicole Sirotek: It was worse than that. They were taking people who didn’t even have their nursing degree yet. Remember when Cuomo signed an order that allowed medical students and nursing students to work as full-fledged nurses and doctors?

Ken McCarthy: I had forgotten that.

Nicole Sirotek: I saw first-year nursing school students being tasked with managing patients on vents. That is beyond crazy.

Ken McCarthy: All they had was some academic book stuff.

Nicole Sirotek: Academic. She maybe did some bed baths. Maybe she started an IV. They gave her a critical patient on a ventilator with sedation, paralysis medication, and a pressor, which is to keep their blood pressure up.

Ken McCarthy: You wouldn’t even see this in a war zone, right?

Nicole Sirotek: No, because medics are better trained. There were so many breakdowns.

Ken McCarthy: One of the things we need to pay attention to is that some of the worst places were the public hospitals, where the patients were low-income, often without resources, and without family connections. Meanwhile, those with families were denied access to them so had no advocates.

I want to talk about the issue of advocacy. It’s come up in a lot of the interviews, and I think it’s important. When you’re getting your nursing education, you’re learning a lot of technical things, a lot of book things, a lot of practical things. But you’re also taught an ethic, which is that you are

the advocate for the patient. Can you talk about why it's essential that nurses be active and even aggressive advocates for their patients, especially in a hospital or emergency situation? What can go wrong if the nurses are not advocates?

Nicole Sirotek: Our primary job is troubleshooting. We need to bring it to people's attention if things are going wrong or if things look questionable. We are taught to question orders. If a doctor tells me to give 10 grams of morphine, that's enough to put a horse down. I'm supposed to question that. I'd say, "Hey, Doc, you wrote 10 grams of morphine. Did you mean something different?" You know, it's late at night, maybe it was a slip?

Ken McCarthy: You're the backup. You're the second pair of eyes.

Nicole Sirotek: Yes. They'll say, "Yes, it was supposed to be one milligram." I'll say, right, that's a big difference. No big deal. No shame in it. That's what we're here for. We're trained on all these processes for all these diseases, what to do to prevent certain things from happening, and what to do when things go wrong.

That's 50% of our job. It's not giving meds, it's not giving bed baths, bedside commodes, and so on. 50% of our job is surveillance of the situation to make sure nothing goes wrong and we catch mistakes before they happen. If we are prevented from doing that, the death rate will go up.

Thousands of studies have been done on this. If nurses don't feel safe speaking up, the injury and mortality rate will be higher in those units or those facilities. Those are typically hostile facilities or organizations with large levels of lateral violence, where there is no circle of safety for speaking up.

I remember one really big case that they always use in textbooks, about a nurse who tried to correct a doctor about an elderly patient who had a bleeding hematoma in his brain. She said, "It's the left side." He told her to shut up, and he operated on the right side. He cracks open the right side of the skull, but it's not there, and now everyone's frantic in the OR trying to flip this patient to crack open the left side. All because somebody wouldn't listen.

You are supposed to correct each other and it's nothing personal. It's nothing personal. I have been corrected hundreds of times, and it's all for the betterment of the patients.

That's what happens. There was one situation where I told a doctor, "Hey, this urine smells like it's got *Pseudomonas* in it." I said, "It's not showing the color of *Pseudomonas*," which is typically an aqua blue, "but I think it's there." And the doctor said to send the culture and start whatever antibiotics.

Sure enough, we got the results back the next day, and it was positive. "We're already hanging the meds, they already got it." And we stayed on top of it before the patient went septic. That's what we're supposed to do.

We're trained on escalating a situation, moving it up to the charge nurse, moving it up to the unit manager, moving it up to the house supervisor, and so on. But what we see in the time of COVID is that if you try to escalate something, especially if it's a COVID patient, you get a lot—more than normal—of hostile pushback to the point where your job and your license are endangered.

If you ask "Why aren't we giving everybody Lovenox to prevent blood clots? We do this for everybody." "Oh, it's a COVID patient. We'll report you to the board for spreading misinformation."

I was reported to the board for telling people that they can take ibuprofen when they have COVID. Do you remember on the news when they said ibuprofen was contraindicated in COVID patients? Do you know that three years later, we're still telling patients it's not okay to take ibuprofen if you have COVID symptoms? Nobody went back and told the public, "Oops, we were wrong. Go ahead and take your ibuprofen and/or Tylenol to manage your fever." Instead, they reported me and said I was outside the scope of my practice. I said, "No, I'm not. It's right there on the NIH website. You can take ibuprofen."

Ken McCarthy: People need to remember that when you're in the hospital you might see your doctor for two minutes a day if you're lucky. They come in, they take some notes. It's the nurses who see you all day and night.

The nurses are the first line of defense. They're also a second pair of eyes in case the doctor makes a human error, which we all occasionally do. In the hospital setting, an error can be fatal, so it's baked into the cake that nurses are supposed to observe, note, and ask questions.

But in the COVID environment, number one, it was assumed everyone was going to die anyway. Number two, all kinds of normal protocols, like, "You've got inflammation? How about some ibuprofen?" That's in every case, right? Maybe if somebody had an allergy you wouldn't give it to them, but normally, if somebody's inflammation is out of control, that's the norm.

My understanding is everything normal that you would do with a person with a certain set of symptoms was rejected. If you questioned anything about this irrationality, rather than getting the normal response, which is "Let's look at that. You may have a good point there," you were automatically shut down.

Nicole Sirotek: Yes. Did you know that in my entire time in New York, I never used Tylenol once to manage a fever because we weren't allowed to? They took it off the units. I was reduced to using ice packs and opening up the windows in New York in May to try to thermoregulate the patients who had fevers. That's what we were reduced to.

Ken McCarthy: This was imposed by the hospital administrators? Where did these dictates come from mechanically?

Nicole Sirotek: They came from the hospital administration

Ken McCarthy: Clearly, the effectiveness of a lot of the people in these hospitals was terrible. But let's talk about the nurse administrators because this is a new concept to me, though it makes sense. You have nurses that are working with patients, and then there are nurses that are helping on the administration side.

That's an important function too. They're getting their directives from the hospital administrator. I'm trying to figure out the chain of command. The hospital administrator declares, "We're not going to worry about people with diabetes if they have COVID. We're going to ignore their diabetes, and we're just going to treat them for COVID. No one can have anti-

inflammatories even though in every other medical case in all of human history, we would give them anti-inflammatories.”

All these insane dictates are coming down from the hospital administrators. They would be passed down to the nurse administrators, and then the nurses would be told. Now, you’d have the inexperienced nurse who hadn’t even finished her second year. You’d have a nurse that had never been in an ICU in her life. They’re hearing all this delusional, crazy information and going along with it.

Nicole Sirotek: They’re going to follow it, because, “It’s a pandemic and this is what we’re supposed to do. We’ve got our orders. Let’s go.”

When I got moved to the second hospital, it was the same thing. I’d ask, “Why are we doing this? Why aren’t we doing that?” That was the hospital with the drug trials and remdesivir.

The hospital threatened me, saying if I didn’t hang the drug, they would send me back to the hotel. At this point, I’d say, “I don’t fucking care.” I had another patient, had him for about two weeks, and he was completely resolved.

The only thing I have to worry about with him is he’s probably going to go septic from all of these drains and lines and so on. We’re going to have a problem with his white blood cell count, but everything else is good. Nothing is indicative of viral. They say, “You have to hang the remdesivir” I stood there and said, “The fuck I do,” and crossed my arms. I said, “I don’t have to do anything.” I have five reasons, legally, why I can refuse to do an intervention or hang a medication, and one of them is imminent harm to the patient.

Ken McCarthy: When you say “hang,” you’re talking about putting a bag of remdesivir into this patient who had no more symptoms of COVID?

Nicole Sirotek: Yes.

Ken McCarthy: It was your assessment based on what you’d seen and what you knew that this was going to be very detrimental to the patient. Who was pushing it? Who specifically was doing the pushing? Nurse administrators?

Nicole Sirotek: If you didn't want to do what a doctor said, they would argue with you, and then they'd get the charge nurse because there's always one nurse in charge of all the nurses on the unit.

Ken McCarthy: A doctor would give an order, and based on your experience and observing the patient, you assessed that this was going to injure the patient. You would tell the doctor, "No, I don't think it's the right thing to do." Maybe he'd not even respond to you. He'd go to the nurse administrator or the boss of the nurses and say, "Go straighten her out." That nurse would come to you. Then what would happen? What would that interaction be like?

Nicole Sirotek: In this situation with the man I referred to earlier that I was taking care of. He was COVID-negative. He had two or three swabs, COVID-negative. The only concern we had was that he could go septic from all these lines. The clinical drug coordinator came down and talked with the doctor and said he qualified for the remdesivir study.

Ken McCarthy: I'm so sorry to interrupt. What is a clinical drug coordinator?

Nicole Sirotek: It's a nurse, doctor, or a pharmacist. I've seen all three. They're in charge of the actual physical distribution of a new drug. They'll go through the charts and talk with the doctor about the clinical drug trial. There's someone above them that's looking through the records, but they're the ones that are going to come down and talk with you and get everything organized for this person to enter into the drug trial.

Ken McCarthy: There were staff people floating around who were part of this clinical drug trial, and they were somehow deputized to enforce the administration of drugs like remdesivir to patients.

Nicole Sirotek: If they qualified for the study.

Ken McCarthy: Yes, but they would just wave a magic wand regardless of the patient's condition and declare, "This guy qualifies, so you must hang a bag of remdesivir." You're saying, "No, he's ready to go. He doesn't need it. This is a dangerous drug, and I'm not going to kill him or injure him." Now you're in a battle.

Nicole Sirotek: Yes, because there's a process breakdown. Remember, this person is on a ventilator, unable to give consent. You have to go through the next of kin, which is either their spouse, their adult parent, an adult living child, or something along those lines. If they have none of that, it goes to an ethics board, which did not exist in this situation.

Somebody decided that this person qualified based on whatever the parameters were. I'd say, "This remdesivir trial is experimental for COVID. He's COVID-negative. I've already seen that of everyone who has had the COVID 'remdesivir trial' paper plastered to their door, not a single one of these people has survived."

We were in a unit that had actual critical care nurses, so everyone was living longer. The remdesivir patients were dropping off dramatically within 72 hours of receiving the drug. At that point, nobody knew about this drug. Nobody knew that it had been used originally for Ebola. We thought they just brought whatever they could to help save these people. Many people hadn't caught on. Then you look at their labs, and their white blood cell count is tanking and their electrolytes go crazy in almost a step-by-step process.

I'd say, "Nope." The number one thing that I stood firm on, because I noticed that these other people died, and he was COVID-negative, was to question why he needed this drug. Why does he need it? I said no. The clinical drug coordinator went to the doctor.

The doctor was a resident and a GI (gastrointestinal) doctor who was somehow placed in the critical care, ICU, and respiratory COVID unit. She comes over to me and says, "You have to hang that drug." I said, "I'm going to tell you what I just told her. I have five legal reasons I do not have to hang that drug. One of them is imminent harm to the patient. It will imminently harm this patient and threaten life and limb."

You can look this up. In every state, you have five basic reasons to refuse: It's fraud; It's not a legitimate order; It's a dangerous order; It's beyond your skill set to do something. For example, if the doctor wants you to amputate an arm, I'd say, "Dude, I can't amputate an arm."

I said, "I'm not hanging this drug." That doctor gets the charge nurse, who is the one overseeing the unit right now, making sure everything's

flowing the way it's supposed to. She says, "You have to do that. You have to hang this drug. He's part of the drug trial."

I say, "No, I don't." At this point, I'm just getting sassy. I'd say, "No, I don't. I do not have to. For the third time, I reiterate, COVID-negative, not applicable, no consent. Did you call his family? Because as far as I can tell, looking at his record, he has no family." He's an undocumented black man in this country with no family. It says he's a cab driver. There's some type of address, but there's no next of kin. There's nothing.

"Who decided this?" They say, "He qualifies. It's the physician's right to try." I'd say, "Sure, it's their right to try to save his life if he has COVID. He doesn't have COVID." She gets tired of arguing with me, and now I've got the doctor, I've got the clinical drug coordinator, and I've got her, and they're trying to tag team me. I said, "I don't think you understand. I'm not easily bullied." They get the nurse administrator, who is like the desk-jockey nurse.

Ken McCarthy: The boss of the boss of the nurses.

Nicole Sirotek: Yes, that was on the night shift. She comes down and says, "If you don't hang this drug, we'll send you home," meaning the hotel, "and we'll tell the staffing agency." I say, "Do it." I said, "Do it. I'll leave right now. Take my assignment. It won't be abandonment. Take my patients and send me back right now. I'll go back to Nevada. I have no problem. I came here to help people. I don't need the money. I came here because you need a nurse who can manage ventilators, and I was the perfect fit. I came here to help the country." She let me finish out the shift.

I came back the next day, and they had taken that patient away from me and given him to another nurse who hung the drug.

Two hours into the shift, I got moved up to another unit. They took one nurse off that unit and moved her down, and she was an OR nurse who couldn't manage ventilators. They moved me to a non-COVID unit that was a post-surgical unit, where we had a little old lady who had a really bad pressure ulcer on her bottom that they tried to graft together. We had one guy who was beaten with a two-by-four, so he had brain injuries. None of them were COVID, because crime was still going on, and things were still going on in the world that needed help and healthcare besides COVID.

I get there and there are seven nurses for four patients.

I sat there. I organized the supplies. I wiped blood splatter off the walls, I cleaned the windows, and I was just getting madder and madder because I knew they did not want patients off ventilators and they did not want anyone to call them on it.

They were following the orders they saw on TV, that were coming down from Cuomo and Fauci, and all this nonsense that got disseminated to the administrators, disseminated down to the staff, and everyone was blindly following along, even though what we were doing made absolutely no sense. What they were asking us to do was contradictory to what we were seeing.

I said, “There is nothing wrong with this person. There’s no negative anything in the labs that would stop the patient from taking ibuprofen. Let’s use it.” They said, “Oh, no, we can’t.” I said, “You’re not even believing your own eyes.” If we see that something works, we may not know why it works. When you’re empirically in the heat of it, you just do it. Because what you’re seeing is an immediate outcome of the intervention you do. It’s called empirical evidence.

Ken McCarthy: Let’s face it, a lot of medicine works that way, even in non-emergency situations. There are a lot of things that work, and we don’t know why they work. But they work, and they’re safe, so we do them. That’s medicine. Medicine is an art. It’s not physics or computer programming. It’s got a lot of art to it.

Part of that art is the empiricism: “He seems to be getting better when we do this. Let’s keep doing it.” Or, “Gee, this medication we just gave him, he’s going into a convulsion. Let’s not give him that medication again.” Common sense.

Nicole Sirotek: Exactly.

Ken McCarthy: But all the common sense was thrown out of the window. It’s almost hard to believe, but I guess this is how it happened. The hospital administrators were watching TV, and getting emails from the CDC, and they were ruthlessly, mindlessly enforcing things that made no sense.

Is it the case that hospital administrators just don't know anything about medicine and they couldn't use their judgment and say, "Gee, we're hearing things from the nurses and these things don't seem to make sense, maybe we should be listening to the nurses?"

I guess in the normal course of events, they're pushing paper, and you're more or less allowed to do what you need to do to keep people alive and healthy. Tell me how it works under normal circumstances because I'm trying to understand how it broke so badly.

Nicole Sirotek: Normally, we follow what are called basic standards of care. If you have a broken leg, the basic standard of care is an x-ray. If you say, "A big rock fell on my leg, and now I can't walk," we assume it's a broken leg, and we're going to follow the basic broken leg protocol: some labs, potassium to make sure you don't have a crush injury, and an x-ray.

From there, it's like an algorithm, and you follow it through. But you can order additional things "a la carte." You've got a guy with a broken leg: "The x-ray shows it's a broken leg, but the bone is protruding out of it, and you've lost a lot of blood, and your labs say that you need blood. So, a la carte, we're going to order some blood and give you that, too." That's not traditionally given with a broken leg, but because we have the assessment from the labs that shows this, we can order it a-la-carte and add it to the order set.

That's typically how it works. As you get more information, you do more interventions or other interventions. Say the patient needs an antibiotic because the bone is protruding and he could get an infection. He's allergic to this antibiotic, so that excludes that intervention. We choose a different antibiotic and a-la-carte and add it to the order set for a broken leg. We do that all the time. It was very confusing why the hospitals weren't doing that.

Once I returned from New York, people started reaching out to me. I had started American Frontline Nurses. We had hundreds of nurses who were fighting these hospitals, fighting these doctors. We'd be on a care conference, with the doctor and case manager and maybe a nurse and the family, and we're talking with these people.

I'd say, "Look, this person has COVID. It's saying that vitamin D and vitamin C are very beneficial. It's very cheap. And I know for a fact you

guys have it on your formulary.”

I’d say, “I know for a fact that you guys have vitamin C,” because I had already checked with pharmacists that it was on the formulary. “It’s not IV, it’s a pill that can be crushed and put into the feeding tube. It can be done.” I said, “Why can’t we do that? It’s very low risk.” You’d have to give them thousands of grams to harm them. We were only asking for one gram three times a day, and the nurse has to be in there three times a day for all these other medications, so we can consolidate care.

There’s a growing body of evidence, and I emailed them all the evidence, that this is all very low risk, very low liability. “Let us please have vitamin C for this patient.” The doctor says, “It’s not part of the order set.” So, the physician is talking with his attending, saying, “It’s not part of the order set. If we add it to the order set” [meaning a la carte], “it’ll get flagged.” They’re just talking amongst themselves, and we can hear it on the conference call. The attending says, “No, we can’t do that.”

Ken McCarthy: And the attending is the boss of the doctor?

Nicole Sirotek: Yes. There’s one main doctor on the floor, just like the charge nurse, there’s a charge doctor.

Ken McCarthy: Who’s giving that guy directions? Do you know who is directing the attending physician?

Nicole Sirotek: For COVID, it was the Chief of Medicine. They created the order sets. And in the order sets that come down from the administration, it gets programmed in by the pharmacy, or the informatics nurse, or whoever’s managing it. You can click those things, and you can create alarms that will go back to the pharmacist or get flagged by the informatics nurse, because there are also nurses who are managing the medical records, looking for inconsistencies, and looking to make sure that policies and procedures are followed. Once again, basic standards of care, because your reimbursement will get deducted, you’ll get penalized on your reimbursement if you don’t meet certain order sets.

Ken McCarthy: All this makes sense. You want to take the best possible treatment protocol, you want to disseminate it, and you want to make sure

everybody knows it. But what happened in this case was they had a series of protocols that didn't work and caused harm.

The CDC was telling the hospitals, "This is how we're going to handle COVID," then the chief physician said, "I don't know, it's a brand-new disease, the likes of which never before seen in the history of mankind" which was nonsense, but in any event, they said, "We've never seen this disease before. Therefore, we will accept the CDC's word that this is the way to do it."

What I still don't quite fully understand—and maybe you have some insight into this—is why they enforced it so brutally. Why they didn't say, "Wow, our experienced nurses are coming back to us and saying, 'Hey, this isn't working. This is hurting. Let's adapt.'" Have you ever seen such extreme rigidity in a medical system whereby nurses were ignored, told to shut up, and told to just do what they were told because a set of protocols was enforced from the top? Have you ever seen that?

Nicole Sirotek: I've seen it on a case-by-case basis. Internal politics. But to see it on a mass scale, I'd never seen it like that, how they were able to force the go-through with all of this. If you go to the NIH website, and the CDC website, it tells you what drugs are OK to use, and what ones aren't. That information comes down from them, from the health department, down to the hospitals, because everyone was working in that chain of command. If you deviated from those protocols, you were fired.

Everything's locked down, everyone's losing their income, people are falling behind on their mortgages, and people are defaulting on loans.

Ask yourself: If you were to lose your job, how long do you think you can financially stay afloat? Not long. Many people were drowning in debt already even before all of this happened.

The administrators had everybody in a chokehold. If you didn't do what they told you to do, if you did not blindly follow these order sets, they would fire you. Not only would they fire you, but they would report you to your state board for endangering patients, going outside your scope of practice, fraud, and misinformation. It would say right there on your record that you're under investigation, and no one would hire you.

Ken McCarthy: Who specifically would initiate that? In other words, the doctor gets the order from above, “Give him remdesivir,” and you say, “You know what? I’ve got five reasons not to, and I’m not going to give it to him.” Who is the actual person who pulls the trigger and files a report or a grievance against you? Who in the mechanism does that?

Nicole Sirotek: It’s everyone from the charge nurse to the administrative nurse, the head of the unit, or the chief nursing officer.

Ken McCarthy: Somehow, in the midst of this chaos, these people had the time to write people up and file these malicious complaints. It’s work. It’s time. They say they don’t have time to submit reports to VAERS, but they had time for this? Do you think that someone was pressuring them from above? Any insight into that?

Nicole Sirotek: Sometimes I think it was intentional. We saw emails go out to hospitals, stating that if you do not follow the protocols, you will be reported. It became an executive decision to not only terminate but also go after your license. We’re taught in nursing school to protect your license at all costs, CYA (cover your ass), document all the reasons why you refuse, and quit the job if it’s an unsafe situation. You can always get another job, but you can’t get another license.

Sometimes it came down to executive orders. When we saw those emails come out, the nurses would say, “If we don’t do this, they’re going to not only fire us...” That was another exodus from the profession. People left. They’re not going to jeopardize their license. It also became a power play: “If you don’t do what I tell you to do, I’m going to make you suffer.”

I went on a podcast, and I explained my situation, the same stories that I just told you. The CNO at my local hospital reported me to the Nevada State Board of Nursing. I haven’t worked at that hospital in a decade, but she reported to the Nevada State Board of Nursing that I was spreading misinformation, that I was defrauding the public, I was operating outside my scope of practice. That was in October 2021, and I’m still fighting these charges two years later. I’ve spent thousands of dollars fighting this complaint.

Mind you, I didn’t work in that hospital. I have no privileges at that hospital. I’m not on the payroll, I have no access to their information or

anything like that.

Ken McCarthy: It sounds like there are some vicious people in the system who have the time and the resources to attack people who don't deserve it. In other words, it's viciousness on her part. It's not like she's protecting the public.

Nicole Sirotek: That's the lateral violence we're talking about. We have a saying that "Nurses eat their young, but they also eat each other." Some people can be incredibly hostile, just for the sake of being spiteful. It's something I've noticed, and you avoid those people. Work is a power play for these people: "I have this control over you, and I'm going to use it."

This is what undermines camaraderie and the team dynamic. This is very bad because dysfunctional team dynamics endanger patients' lives.

Another issue is that if you have a license in more than one state, they can file that complaint in more than one state. I also had a complaint filed in Utah, and recently, I had all of that cleared. They said, "You're good to go. There was no harm to any patient. You didn't violate anything." Now I have to go back to Nevada, and I have to fight it there. They try to bury you in legal fees.

We haven't even talked about the misinformation that appeared once the vaccine came out, either. That was another mess of hostility, where strangers on the Internet and in foreign countries could go after your license if you said or did anything that they disagreed with.

Ken McCarthy: What? Somebody in another country could file a grievance or complaint on anyone?

Nicole Sirotek: Anyone, in any country, in any state, in any city can file an anonymous complaint.

Ken McCarthy: Here's something you might find interesting. Pre-COVID, I was working with some clinicians who were helping families that had children with extreme autism. They had developed some clinical protocols that were working. In many cases, there was a supervising physician, an MD, who was signing off on the protocols, saying, "This looks good. The kid's better. We don't know why it works, but keep doing it until we have any reason to stop."

A well-organized group of people in the UK would go to the Facebook groups of families with autism, find out who was using this protocol, look up the names and addresses of these families, and file Child Protective Services complaints against them. They'd never met the family and they never saw the children.

This was a team of people, I don't know who was employing them, but it was like a full-time job. In one group, one two-woman team who were recruited and received training from the people in the UK—one was in North Carolina, one was in Florida—filed over 300 Child Protective Services complaints this way against American families they didn't know and had never met.

Talk about sinister, sick, and twisted. But you don't need a million sick and twisted people. You only need a handful of them with a lot of time on their hands, possibly being subsidized financially by forces we don't know about. I do know that one of the ringleaders of this, who recruits and trains other women to do this, lives in England, and she has been featured in The Times of London, which is owned by Rupert Murdoch, as if she were the second coming of Jesus in female form.

Nicole Sirotek: I'll have to send you some articles by Katie Spence. You probably saw my video with Senator Ron Johnson at the Senate hearing.

(Editor's note: The transcript of Nicole's remarks appears on pages 29-37 of this book.)

After that video, an organization called Team Halo, which is a UN and World Economic Forum-created group, got some nurses and doctors together and gave them verified TikTok accounts and preferential algorithm treatment to debunk "COVID vaccine myths." They started to target people like me and hundreds of other nurses. I had a complaint come in from Australia. They had hundreds of thousands of followers on TikTok, and they would say, "Go report this nurse."

They would swarm the State Board of Nursing and shut down everything. I had to surrender my nursing license until everything calmed down. Team Halo has been disbanded, but we found another group called Shots Heard 'Round the World. I would recommend you Google them. They encourage people to report anti-vaxxers, and they will attack them.

I'm writing a book about it. I got death threats, people broke into my house, vandalized my car, and threatened to rape and murder my children. They poisoned my dog. We had bomb threats called in a site where we were working with the community.

Ken McCarthy: We saw the same thing in autism treatment.

Nicole Sirotek: They use Facebook groups to show how to find people to target and how to go after them.

Ken McCarthy: It is not an accident. It's not something happening spontaneously. These groups are recruiting, training, and directing mobs to attack people.

Nicole Sirotek: We got into the Shots Heard 'Round the World group. If you go onto their page, they tell their members, "File complaints against their license. Here's their license. Here's where you email the complaint to." Then members would write in and say, "I did it. I filed the complaint. I filed the CPS (child protective services) complaint. I'm in this mom's group and they're saying to use cold packs or hot packs instead of Tylenol for pain, so I reported them to CPS. We got this person fired from their job. We got this business shut down because they weren't using masks." It became the new Salem witch trials.

They go into the autism groups, too. They go into the special needs groups, and they will call CPS on those families as well. That had nothing to do with COVID. If you don't vaccinate your kid because your kid is extremely medically compromised, and you say, "We're not doing vaccines because quite honestly, my kid's going to die of something else before they die of tetanus."

When you've got a kid that's so bedridden, nonverbal, not there, and the parents are doing the best that they can, and they say, "We opted not to vaccinate because my child is not going to die of tetanus in this situation, and we have other things to worry about," they will go and call CPS on them. Then they'll find the doctors, and they'll file complaints against the doctors, who were treating that patient, for negligence. These people are deranged and out of their fucking minds. We have children that have been taken away that we still can't get back to the parents, and it's been several years.

Ken McCarthy: They're being supported by people at a higher level. They're being enabled, supported, and protected because what they're doing is criminal behavior. If you file a false CPS report, that's a crime. That's a criminal offense, but nobody prosecutes these people for doing that. They'll file a CPS report against somebody when they've never seen the family, they've never seen the child, and they have no basis to file the report. They're filing it anyway, and they have no legal liability. Wow.

You're working on a book. Tell us, if you'd like, do you have a title? Do you have a publisher?

Nicole Sirotek: I'm self-publishing because it was cheaper and easier, and all the profits from the book go to American Frontline Nurses. It's called *Dark Influence: How Social Media and Influencers Were Used to Manipulate the COVID Pandemic*. It all goes back to a crazy nurse practitioner from Canada, who works in Washington State, who went after me after the Ron Johnson hearing and started attacking me and calling me transphobic, accusing me of misinformation, and reporting me to the board.

Then all of his little goons and Team Halo followers attacked me for a year, to the point that we had to move and switch jobs. I will send you the paperwork. My name isn't even Nicole Sirotek anymore. It's a completely different name, which got changed under an ex parte motion to protect me, because somebody tried to kill me and Julia, another nurse, when we were in Puerto Rico, trying to help.

I said, "Y'all know I'm just a nurse, right? I'm not CIA. I'm just here in the middle of the ghetto in the slums with this medical team, giving people a steroid, an antibiotic, ivermectin, budesonide." We'd go door to door, we'd go into the churches and we would teach people. I'm Hispanic, I speak Spanish. We'd go in there and say, "This is what you need to do." We'd give out free pulse oximeters and thermometers. Told them what they needed to do if they got sick. And we saw all these high survival rates when we used ivermectin and budesonide.

We did prophylactic treatment. Part of our work is done in El Salvador. They had high survival rates when the United States was getting decimated. That's what we would do. They went after us for that.

We worked with My Free Doctor, and we treated over 300,000 people with no fatalities. Nobody died from COVID. That should be an unheard-of number. Why aren't we replicating that? They didn't like that. They didn't like the fact that I was telling people, "Ivermectin works. You can go to this organization and they'll prescribe it to you. You can go to this pharmacy, and they will fill it for you. You can order it from this company overseas, and they will ship it to you."

They went after me. When people make TikTok videos, you don't know who they are on the Internet, and you don't know who these deranged individuals are. I live in the middle of nowhere, Nevada. It takes four hours to get to my middle-of-nowhere town. I'm seven hours from Vegas and four hours from Salt Lake. I'm out there.

These people stalked my home. I have security camera footage. They're standing out in front of my home, watching my home. My husband would be at work. It's me, and at that time my two- and three-year-old, and we'd have to evacuate the house. I threw them over a fence, and we ran down the road to get away from these people, because I didn't know why they were at my door.

The police were at my home every week. When we were in Puerto Rico, somebody called in a bomb threat. It was well known where we were because we have lots of Hispanic followers, "We'll be in Puerto Rico. We'll be doing outreach; we'll be teaching all this stuff."

They've attacked all of our nurses, attacked all of our licenses. A couple of months ago, somebody poisoned my dog with rat poison. And they sent me pictures.

They took the pictures of my children they found online and put them on sexually abused children's photos that you can find on the internet. They took my children's faces and put them on those, and they mailed them to me. They mailed me letters. I can send you all this stuff, I have copies of everything saying they were going to rape me and kill my husband and rape my children and make me watch. The sick shit that these people did, all because we helped poor people.

We went into inner cities. We went to New York and for safety reasons, I'd always tell the local NYPD, "Hey, we're nurses, and we're going into

the projects here. We're bringing medicine. If any shit goes down, these are our names, and this is who you call." There would never be any crime—no crime reported—when we were in certain blocks. Because even the gang lords and the druggies would let us come through to help the people in the projects. We were giving out pulse oximeters and thermometers, and Tylenol, and that sort of thing. We would go in, and we would help these people, and nobody would bother us except the people who were organized online to attack us.

They tried to threaten us. We discovered that this Tyler guy led to an organization called Team Halo, which the UN created. Melissa Fleming (Under-Secretary-General of the United Nations of the United Nations Department of Public Information) talks about it; that they own the science, and they would make sure that there would be no spreading of misinformation. The UN sent Team Halo, and we saw emails that named their targets.

I was a target. Mary Bowden was a target. Peter McCullough was a target. They were to go after us. That led to another group called Shots Heard 'Round the World. That led to other groups that we found on Facebook, that were coordinating all of this.

Ken McCarthy: Unbelievable. I had no idea it was that bad.

Nicole Sirotek: We uncovered a nest of sinister people. You go to their TikTok accounts, and in them, they're making fun of vaccine-injured people. They're telling other people who are ill with ailments COVID and others who chose not to get the injection, "You should just die. You didn't get the vaccine, that's your fault. You should have gotten the vaccine."



Melissa Fleming, United Nations Under-Secretary-General for Global Communication. “We had another trusted messenger project which was called Team Halo and we had TikTok working with us. (Influencers) who had virtually no following to start with, got verified tiks. And many of them became kind of like national media go-to advisors...” - The World Economic Forum Sustainable Development Impact Meetings 2022 – Session: Tackling Disinformation. September 20, 2022. New York City.

“Do you have the COVID vaccine?” is now one of the screening questions of every medical interaction. Am I going to get safe care from health care practitioners like this? Are they going to deny people care because of their prejudices? We saw that happen to thousands of people when the vaccine rolled out who didn’t get the vaccine. They weren’t even given oxygen if they wanted it. Practitioners like this are a danger to public health.

I don’t know if you know the website, SorryAntiVaxxer.com. It’s run by a pediatrician. He’s part of Team Halo, and he’s part of Shots Heard ‘Round the World. They have all their followers go through social media, and if you

didn't have the COVID vaccine, and you died of COVID, they'll put up everything about you and your family on there as well.

Ken McCarthy: It's allowed to run and nobody's saying anything about it. Somehow it's okay for people on social media to threaten people with murder and assault in the name of "fighting disinformation". Meanwhile, if a licensed physician or nurse with years of experience questions a protocol, they have their licenses challenged, and they're dragged through the mud in the news media. Quite a system they've got.

Nicole Sirotek: Now Team Halo has been disbanded. Katie Spence from the Epoch Times followed the entire story when we told her about it, so she's run three or four articles about it. I can send them to you. She wrote about how Team Halo has disbanded and all the Team Halo members that have been attacking us took down the #TeamHalo and #ImATeamHaloMember hashtags. The website is down; the emails are no longer active.

I said, "Yes, because they can be sued now." I told her, "Just because Team Halo is gone, every one of these influencers has been taught how to do this and has been sanctioned, and they taught their followers and they're going to continue to do this."

Even if you want to fight back, you financially can't do it. Do I choose the financial stability of my family over going after these people? Or do I take the abuse and continue to move forward? The book I'm working on covers all of these things. We also found out that there were fake doctors on Twitter.

Ken McCarthy: I knew about that nonsense. Make-believe doctors. As well as doctors who claimed to be treating COVID patients but were not, like the New York-based pediatrician with over 100,000 Twitter followers who was hectoring parents to get their children injected.

On a positive note, tell me the name of your organization.

Nicole Sirotek: It's called American Frontline Nurses. Our focus is patient and nurse advocacy, but we also work in the policy arena.

We have no employees. It's 100% volunteer-based, 100% of all money received goes back to programs and services. It pays for us to keep up the

website which has all the free classes that we offer.

We pay for medications. We pay for patient transport. We pay for hotels for families, like when a patient has to go for treatment in a completely different state. Other practical things too. Let's say you're in a hospital, and you've been there for several weeks, and when you come home, there's no food. I saw this as a home health nurse. We get somebody back from surgery, they've been in the hospital or a long-term care facility for over a month, and none of the food was edible. It's all expired. I had a patient once eating a jar of jelly because that was the only thing that was left.

We will use the Walmart app, a grocery store app, and have food delivered to their homes anywhere in the country. We had a wheelchair ramp Amazon Primed to someone's house and had a church set up for them.

That's where all of our money goes. I have a regular job that isn't even healthcare and that's how I pay my bills.

Ken McCarthy: Are you services for COVID patients in particular?

Nicole Sirotek: Any patient. We help people where there have been medical kidnappings. We advocate for people who are receiving poor and substandard care. For example, if they're not feeding you in the nursing home, or if you're not getting the appropriate standard of care if you broke your leg. We started with COVID, but in fact, medical negligence is one of the leading causes of death in America, some say the #1 cause.

We have nurses who specialize in foster care issues, too. We had to protect them because Team Halo was going after them and their licenses. But regardless of the situation, if somebody comes to us, we work to get them connected to the right type of nurse in the right location.

We had a family that was fighting to get their children back from CPS custody, and when they got them back, they didn't have a Christmas tree, they didn't have Christmas presents. We provided all of that so they could have a normal Christmas. We do all sorts of things.

Our slogan is "Educate, Equip, and Empower". We either educate you by providing free classes—you can see a lot of the training we've done. You have to go to AmericanFrontlineNurses.org, not "America," because that goes to a scam site. There, you can see all the programs that we offer.

We have the Smile Makers Program, where if you have a medically needy child or something's going on with your child and they're in the hospital—because sometimes that can be weeks and months in the hospital—we'll send them sensory activities so they don't fall behind. Play-dough, little toys that they can manipulate, open-ended playthings based on their physical condition and developmental needs.

When the earthquakes hit Turkey, there was a lot of post-traumatic stress disorder among the EMS rescue workers who went there. We set up group therapy sessions for that.

When the monkeypox outbreak happened, we educated LGBTQ people and sex workers around the world, especially in the Philippines. We have a large Filipino following.

We educated them on monkeypox, how to prevent it, and so on. Sex workers are not going to stop being sex workers because there's an outbreak. Many of them are one trick away from starvation, especially in the Philippines, so we taught them how to be safe. I think their maximum number of monkeypox cases was four when it was blowing up here in the United States.

Ken McCarthy: How many nurses are in the organization? I think you gave the number earlier.

Nicole Sirotek: 26,000 American nurses, but if you factor in allied health and foreign nurses and doctors in our network, it's probably 30,000-plus.

Ken McCarthy: They're members of your organization, and they are on the lookout for help where it's needed?

Nicole Sirotek: We train these nurses in all of these evolving situations. We taught them COVID management. Many of them didn't know how to manage ventilators appropriately, so we said, "We're going to teach you how to manage ventilators. We're going to teach you the appropriate lab work. We're going to teach you interventions. We're going to teach you how to protect your license when they go after you for refusing to do things that kill patients."

We protect the nurses and we teach them, too. A new example, with all of the gender nonsense that's going on, gender-affirming care, ER nurses and

ICU nurses are getting slammed with complications related to these surgeries and related to these drugs. We launched an entire course teaching nurses what happens, what to do, what to look for, potential standards of care that need to be done, and resources for the patient and the family.

Ken McCarthy: You need to be doing this because the medical system is not.

Nicole Sirotek: No, it's not.

We have a 12-year-old boy who wanted to be a girl and they put him on hormone therapy, and he now has osteoporosis. When the family went back to the doctor who wrote the prescription his answer was, "Oh, well, there's nothing I can do for you for this complication." They put the child on Boniva. Boniva is a once-a-week pill for osteoporosis. I asked, "What about stopping the hormone therapy? It's injuring him."

Ken McCarthy: The fashion now is to call the "treatment" of these children gender-affirming. I call it sexual mutilation by chemical or surgical means. I think we have to be very careful with our language and call these things what they are. Nothing is gender-affirming about these surgeries or drug regimens for children. They're a jackpot for the hospitals and the surgeons who perform these mutilating procedures and Big Pharma which turns these children and young people into drug customers for life which is why they can afford to pay the activists who push these things.

Nicole Sirotek: It's mutilation. They can report me for saying so, but I don't care what they say. Nurses didn't know what to do when these situations came up. Even the doctors in the ER and the ICU, they'd say, "We are not trained for this." You'll go to one facility and get the care, maybe in a different state or a different part of the state, then come back to your local hospital and nobody knows how to deal with the ramifications. These aren't simple, low-level interventions. They are very serious operations.

We've run thousands of nurses through this training, which I don't feel is biased. I'd say, "We're training you on complications, what to look for with these drugs and these surgeries, and how to manage based on what hundreds of nurses are telling us from the front lines." This is what we do. We warned everybody about remdesivir and pregnancy and the birth defects

that were happening as well. Doctors still haven't picked up on that. The nurses saw it long before, and we warned everybody about it.

Ken McCarthy: So you have this membership and your members provide you with information and intelligence: "Hey, this is what we're seeing." You convert that into programs. Nobody's helping these kids after they've been sexually mutilated by surgeons, who leave it up to the local doctors and nurses to clean up the disasters they're creating.

Nicole Sirotek: They weren't trained for that, so we trained them.

Ken McCarthy: You get the intelligence on what these problems are and then you create the programs to help solve the problem. Then you disseminate the programs. It sounds like you're also providing a social work function. How does that work? You mentioned that somebody might have been in the hospital for a prolonged period, but now they're coming home and all the food in the house is spoiled, so they have nothing to eat. That's a social work function. How does that get taken up by your organization?

Nicole Sirotek: Either a patient, a family member, or a nurse contacts us. They'll tell us about the situation. When I was a home health nurse, we had programs in place that would have brought Meals on Wheels to these patients, but of course, if it's 5 p.m. on a Friday, and everything is closed, there's nobody available to do the intake form. As a home health nurse, I would go to the grocery store and I would spend \$100 on food, and I would bring it to them easy-to-microwave meals. Then on Monday, we'd work to get social services involved. That's the beauty of our organization. If somebody comes to us, the nurse or family, and says, "This is what's going on." We have free rein to use the donation money that is being entrusted to us to help these people in any way they need. We're not working with or waiting for a government bureaucracy.

We had a vaccine-injured person who was wheelchair-confined, and they lived in a modular trailer, and there were only steps going up there. They said, "We can't get him in and out of the house." I said, "I got you." We work with the nurse or the person that's there. In this case, it was a nurse. She was part of our network. She said, "Can you guys get him a wheelchair

ramp?" I said, "I don't know, we've never done this before. Let me check Amazon."

She said, "My church will put it together if you can send the ramp." That's how we managed it. Somebody contacted us and said, "Hey, my next-door neighbor has no food because they just came back from the hospital. We're bringing over leftovers, but we need more." I went to the WalMart.com app and got everything that they wanted.

We'll talk with them, and ask if they're allergic to anything because we don't want to give them food that they're not going to eat. "What do you want? What's your regular stuff?" They'll say, "This would be easy for me right now." We send them everything.

We have people with medically complex children who've fallen into a financial hole. They can't get Depends, they can't get briefs, or they can't get barrier cream. We will pay for that and we'll have Amazon deliver it to their house.

We had parents who had a medically complex child who was in the pediatric hospital, and the parents needed a hotel because only one could be in the hospital at a time. They needed a hotel room so they could go back and forth between themselves. We paid for the hotel. We have free rein to help in those ways.

We don't have a standard protocol, but typically, when our following, our people, and our nurses come to us we try to help solve their problem if it's within our means. Granted, the funding has substantially dried up because of inflation and recession and everyone financially struggling right now, so we have less to work with.

We're focusing on educating and allocating our financial resources the best that we can. We don't go around to the churches in different states and teach people anymore because that just eats up funds, but we recently paid for mental health consultations for a mother whose baby just died because of negligence in a hospital.

We use Maslow's hierarchy of needs to ration our resources. Do they have food, electricity, water, sanitation? We work our way up Maslow's hierarchy of needs for our financials. We've also partnered with other

groups. If we don't have it, maybe another group does. Our case manager nurses are good at finding resources in their local areas. There might be a lag, but we can usually figure out a way to get the resources there.

Ken McCarthy: By working with social services agencies, private and public.

Nicole Sirotek: Yes, because the nurses know their local agencies and systems. They know their community and what's available. It's a lot of connecting people—people, patients, families, local resources, and nurses.

Ken McCarthy: This is taking place nationally and internationally. To summarize, you've got all these nurse members, and one thing they're doing is providing you with intelligence about what the problems are out there. Sometimes that calls for an education program, and you step up and do the education program. Sometimes nurses will be working a particular case where they know of a specific human problem—no food, no ramp to the trailer—and they'll apply to you and ask if you can help. If you have the resources or can find them by working with a local group, you help. If you don't, you can't, but you do what you can.

I knew some of this, but I didn't know all the details, but I'm glad we were able to get into them. Nicole Sirotek, who's now using a different name because she has to protect herself from the maniacs out there enabled by our great leaders, thank you for your service.

Nicole Sirotek is an American nurse (RN and EMS) with experience in critical care and flight nursing.

She has a Bachelor's degree in nursing and an RN and EMS RN license as well as certifications in numerous nursing disciplines including critical care, legal nurse consultant, infection control, and flight nursing (air ambulance). In addition to working in ICUs and surgical settings, she has over five years experience as a flight nurse. As a contractor for a nonprofit

humanitarian agency, she worked in Syria with refugees and has first-hand experience with field hospital conditions.

At the beginning of the the COVID crisis, she went to New York City where she worked as a contract nurse at Metropolitan Hospital and Lincoln Medical Center. After leaving New York, she worked with and coordinated the efforts of fellow volunteer nurses in Central and South America and the Caribbean dealing with respiratory problems like COVID and other medical conditions in challenged communities.

*At the time of this writing Nicole is working on a forthcoming book, **Dark Influence**, her personal account of how social media and influencers were used to control the direction of the COVID-19 pandemic.*

PART FOUR: WHAT THE NURSES SAW IN CANADA

“You treat a disease: you win, you lose. You treat a person, I guarantee you win—no matter the outcome.”

— Robin Williams in *Patch Adams*

PROLOGUE TO PART FOUR

The United States medical system was not the only one that promoted the brutal treatment and medical murder of its most vulnerable patients.

And the U.S. was not the only country where nurses fought back.

In each country, execution of the details varied, but the overall theme, especially in the countries of the European Union, the British Commonwealth, and the countries they and the U.S. have influence over, was the same: Top-down directives promoted unproven and untested methods, threw all previous experience with respiratory distress and infectious disease out the window, and systematically attacked experienced professionals who asked questions and refused to comply or remain silent about the crimes they witnessed.

If an honest and comprehensive history of the global phenomenon of the COVID Panic is ever written, there will have to be a long chapter on the extraordinary success of the enormous, spontaneous, and peaceful nationwide protest in Canada triggered by what was intended to be a modest convoy of independent Canadian truckers to the country's capital, Ottawa.

The multi-week demonstration, which started in the depth of the Canadian winter (January 2022), was ultimately shut down using organized

police violence against demonstrators; vandalism and seizing of their property; and the theft of money from the bank accounts of supporters, all under the cover of the country's War Measure Act which was invoked only long enough to complete the removal of citizens from the front of the Canadian Parliament and then withdrawn.

In Part Four, we meet two leaders of the Canadian resistance. Conveniently, one is an expert dealing in birth, the other an expert in end-of-life care. Not only do they help us form a picture of how things were handled in Canada, they also help us understand the severe and deadly impact the protocols and other directives had on newborns and their families and on the elderly living in institutions.

We also learn that months before the heroic Canadian trucker's convoy, the first group to organize a nationwide demonstration against unhinged COVID "countermeasures" were Canada's nurses who started their nationwide action in September of 2021.

CHAPTER 8

THE ABANDONMENT OF THE ELDERLY AND INFIRM

SARAH CHOUJOUNIAN INTERVIEW - JUNE 13, 2023

“Apprehension, uncertainty, waiting, expectation, fear of surprise, do a patient more harm than any exertion. Remember he is face to face with his enemy all the time.”

— Florence Nightingale

Ken McCarthy: We are here with Sarah Choujounian, one of the leaders of Canadian Frontline Nurses.

Sarah, can you tell us what your specialty is as a nurse? And when did you start?

Sarah Choujounian: Yes. Well, first, thank you so much for having me. I have been a nurse since 2004 and have worked in a nursing home for the greater part of my career. I also had a second job in the community,

working with kids with disabilities. I worked through an agency that sent me to people's homes.

Ken McCarthy: We can say you're a veteran nurse for sure. You witnessed two things during COVID: what went on in the nursing homes and the impact of the lockdowns on mental health.

Sarah Choujounian: I facilitated mental health in the community using support groups. I was really big on that because I have experienced a lot of trauma in my own life, and I did a lot of work on myself before the pandemic.

I saw a lot of people in the mental health communities deteriorate.

It was painful to see. I think there was a 40% increase in anxiety medications, which were already overused.

Ken McCarthy: It was fostered by a tidal wave of misinformation and disinformation from the so-called authorities. I liken it to saturation bombing and used the Vietnam War as a model. We were like peasants with our water buffalo, minding our own businesses, plowing our fields, planting our rice, and taking care of our kids, and suddenly there were planes overhead dropping bombs on us. We don't know who they are or why they came. We just knew we were being bombed with terrorizing media messages every day.

Let's talk about the area where you were on the front line. How long had you been working in nursing homes?

Sarah Choujounian: I've worked in a nursing home since 2007. I was also the chief steward of the union where I worked. I was already very boisterous about the things I didn't find right in the workplace.

As far as COVID was concerned I knew immediately from working in a nursing home that the government does not care about these people. They get only a fraction of the money daily for food compared to what prisoners get. They're fed foods that I wouldn't eat. Now they're going to shut down the entire economy for my residents who the government has never shown any care for? I didn't buy it.

I knew right away we were being lied to and I thought my co-workers would know too, but nobody wanted to talk about it, even the nurses who weren't buying it. Everybody was really scared. As chief steward of the union, I called the union leadership and said, "Listen, what are we going to do about this? They're taking away all our rights. They're taking away my residents' rights." The union turned around and said, "Sarah, don't you care about your residents?" And that's when I knew they wouldn't be on our side. As a single mom of three with a lot of debt who now couldn't go to my other job, I stayed quiet for a bit.

I was really scared. I watched my residents deteriorate under the lockdowns. I had a resident who died of a heart attack within one week of them starting. The nursing home was locked down and her family couldn't come in to see her. She was the type of person who, every time I arrived in the morning, I had to call her family to find out exactly what time they were going to come in because my resident was going to ask me every five minutes, "When are they coming?" And if they were a few minutes late, she'd have an anxiety attack, and she thought they were dead. So, can you imagine what a week would do to this lady who had heart problems?

Nursing homes are the last stop for these people. They have nothing left but their loved ones, and when their loved ones come in, you can see them come to life. What happened when they didn't come in? Some of these residents would stop eating. It's called failure to thrive, and they died alone.

We could only let families come in if death was imminent within hours or so. Families could come in, one by one. They could have five minutes, all gowned up with masks and shields. Residents couldn't recognize them, and the resident was probably unconscious from being on morphine and almost dead.

It was unacceptable to witness residents see their families through the windows and be unable to talk to them and not understand. Some residents were getting agitated because they had dementia and they didn't understand why their families were on the other side of the glass. This led to decisions being made, such as, "This family shouldn't come to the care home anymore." It was just terrible.



Family members were not allowed to visit their relatives in Canadian care homes during the COVID pandemic unless death of the patient was imminent.

Then it got even worse when we started getting tested. At the nursing home where I worked, three housekeeping staff tested positive with no symptoms. Because they were housekeeping, they worked around the whole facility so they locked down the entire facility internally. Residents had to stay in their rooms for 14 days. Then the staff gets re-tested, and if one person tests positive, the lockdown starts all over again. Since I do the social media for Canadian Frontline Nurses, I received dozens and dozens of stories like these.

Ken McCarthy: So, if anyone in the whole facility tested positive, they would lock down everyone in the facility in their rooms?

Sarah Choujounian: Yes, if those same housekeepers tested positive again or if a resident in a specific unit was positive, they would lock down everyone in that unit.

The people in the other units could go outside rooms and eat in the dining room, but once you have someone on your floor test positive, you're in your room for 14 days until everybody on that floor tests negative.

Ken McCarthy: Restricted alone to a single room for 14 days?

Sarah Choujounian: Yes, restricted to your room and without showers. I've heard stories of people not having showers for two months. That's depressing for them in itself, not being able to get clean. But then it got worse. Some people didn't want to stay in their rooms and were fighting back. And then they were said to have bad behavior, so a call was made and then the doctor would sedate them. Then, they would stay in their room. Some people just wanted to walk in the hall with their walkers, and if they didn't listen, they'd take their walkers away. How dangerous is that? They risked falling. People are not in their rooms with them; they're alone. And if they have a hip fracture, it's downhill from there.

Then, their family couldn't come in, and it was just a mess. It became so bad that my mental health deteriorated. In the past, the one way that I was able to overcome all my addictions, trauma, and everything was by standing in my truth and going back and looking at the things that bothered me, taking care of them, and finding new solutions.

I notice that anytime I deviate from my truth, I start not being well. The situation was dangerous for me because I cannot live with myself when I'm not in my truth. I hate labels, but I used to drink and I'm an alcoholic. I'm five years sober.

Ken McCarthy: You have a big vulnerability to alcohol.

Sarah Choujounian: Yes, exactly and all the liquor stores were open. They closed everything, but they left the liquor and weed stores open. I stopped my drinking and smoking by trading it off for going to the gym. You can imagine what it felt like when I couldn't go to the gym. The liquor stores were open and people were isolated. It was just a mess.

So, I decided that I was going to speak out, but before I did, I found a group of people on Facebook who were thinking like me, which helped. So now I was telling all my nursing stories there, and I was able to let things out. People were loving it. I thought, "This is great. I need to keep doing this."

Then a troll went to my Facebook profile, took a picture of my post, researched who my employer was, and called them, and I was put under investigation right away. They didn't want me to come in anymore and wouldn't tell me why. I was in the union, and I demanded, "You have to tell me why." I had been fighting them on everything.

The long-term care facility was making us wear one mask for eight hours, and they were making us reuse gowns. Then they were telling us to take it off, hang it up, and put it on again. I thought, "But there's a pandemic, isn't there?" Everything was a fight, and I couldn't wear the mask. It was giving me anxiety. I didn't want them to take my temperature on my forehead with that gun-like thermometer. I was causing a lot of trouble.

I knew they couldn't wait to get rid of me because I had been causing trouble for the administration for years because I was protecting people's rights. But I was very confident. I thought, "I'm chief steward. You can't fire me." Around the same time someone asked me, "Do you want to come and speak at a rally?" and I said yes. So, in October 2020, I was the first nurse to speak up at a rally in Canada. I founded Nurses Against Lockdowns, spoke out, and was fired three days later. The rally was on a Saturday, and on Monday, I was fired.

Ken McCarthy: Wow. So as of October 2020, you were out of the nursing home. You witnessed what was happening from the time it started in March until October, but then you were out. What you did see before you were removed was the complete abandonment of all normal sanitation procedures, like the idea of reusing personal protective equipment. As you point out, they were doing crazy things like telling you to reuse a protective gown, which you would normally throw out very carefully. And they're saying, "Oh, hang it up and wear it again." Just pure craziness. It's not medical, not scientific, and it's completely out of the norm. The other thing you witnessed was the denial of the very basic human right of the residents to see their loved ones and the forcing residents to stay in their rooms alone for weeks, if not months, on end. Very cruel.

Sarah Choujounian: Many facilities throughout Canada had people locked in their rooms alone for months because they kept testing positive. We know that the PCR test is not a diagnostic test. At some point, they were cycling so high that some nursing homes were constantly locked down.

Ken McCarthy: You can find any genetic material in any human being if you cycle the PRC high enough. You could find plague. I'm sure you could find viruses from Mars in people. You just have to cycle it enough. The man who invented the PCR technology, Nobel Prize winner Kary Mullis, invented it as a tool to allow researchers to generate genetic material from a small sample rapidly. He said, "PCR should never be used as a diagnostic tool. It has nothing to do with diagnosis. It's an amplifier of genetic material." A lot of people are aware of this little detail, but most people aren't and thus they don't know that the COVID tests were entirely fraudulent and entirely unscientific.

And then you make the point, which is so important, that somebody might be utterly healthy, clear-eyed, with no runny nose, they haven't coughed once, but if they test positive, suddenly, they're a "COVID case". They're contaminated. They're infected with the virus and are now a danger to humanity, and everything around them has to be shut down. There was a news story about the Canadian military that had to get into some of these nursing homes because they had spiraled so completely out of control. Do you know anything about these stories?

Sarah Choujounian: It was a staffing problem. If everyone's testing positive and can't be at work, and you have other people who have two jobs and can't come to this job anymore, it becomes a horror story with whole floors of residents having only one PSW (personal support worker). No one can handle a situation like that by themselves.



Kary Mullis, Nobel Prize winner (Chemistry, 1993). Inventor of PCR, a laboratory technique for rapidly amplifying a specific segment of DNA, which can then be studied in greater detail. “Anyone can test positive for practically anything with a PCR test, if you run it long enough. With PCR if you do it well, you can find almost anything in anybody. It doesn’t tell you that you’re sick.” - Kary Mullis

Ken McCarthy: We’re talking about elderly, frail people. They’re not only older, they’re also frail. They wouldn’t be in a nursing home if they weren’t frail. Tell us about the spectrum of daily assistance that people in nursing homes need. Once we know what kind of help they need, then we’ll better understand the enormity of the impact on them when they stopped getting that help.

Sarah Choujounian: Well, there’s a range. The worst-case scenario is that they can’t move. They’re in bed and need complete care. They need to

be turned every two hours because when you can't move, it creates a lot of pressure sores. So those people are at risk for huge wounds. We have to turn them all the time, change them, constantly feed them, or maybe they have a gastric tube they are fed from, so we have to take care of that.

Some are almost independent. Some are physically independent but not mentally. They can't get dressed. Then, there are typical activities of daily living that we help people with, like eating, getting dressed, and showering. Toileting is important, as is skincare and whatever treatments they need and their medications.

So, what happens is, if there are not enough people to take care of them, and they're in diapers too long, they get a wound that can get worse fast. People die from wounds like that. You become septic at some point. Many can't swallow well and have trouble eating and I've heard stories of people who choked in their room by themselves. The risk of choking was listed in their charts, but they were forced to eat alone. There was not enough staff, and they were in their rooms because they couldn't eat in the dining room. It was just a disaster. Everything was upside down.

But I think the biggest thing people don't realize is that if you have one personal support worker for many people—and keep in mind, even before the pandemic, we didn't have enough staffing—what happens is that the residents don't get any human contact. We didn't have physio coming in, we didn't have activities anymore; all these things stopped. They're in their rooms alone, in isolation, and we know isolation kills. People give up. If they have nothing else, they may give up and want to die. It's called failure to thrive. They have nothing to look forward to. So, when those soldiers went in, it was neglect that made their intervention necessary. It wasn't COVID.

Ken McCarthy: This was a predictable situation. People who work in this kind of environment, the administrators and government officials who oversee nursing homes would have had to know that if you isolate residents and don't give them the support and human contact they need, they would suffer terribly and fail to thrive.

So, the reason the military had to go in was because the residents were being neglected?

Sarah Choujounian: Yes, it was neglect.

Ken McCarthy: There was some original reporting for a second about the horror that they encountered when they went into these places.

Sarah Choujounian: Yes, I saw that.

Ken McCarthy: But then it disappeared from the news cycle fast.

Were you the only person in your facility who was willing to say anything?

Sarah Choujounian: Yes.

For a while, Kristen Nagle and I were alone as the only two speaking out in all of Canada. Now we have a few more with us, but many nurses are still very scared to speak about the situation.

Ken McCarthy: Nurses are still scared to speak about it?

Sarah Choujounian: Oh, yes, it's a big problem.

Ken McCarthy: It sounds like what happened to you is very simple. You went to a rally and three days later they fired you.

Sarah Choujounian: After I was fired, I founded Nurses Against Lockdown to unite nurses. I naively thought that if I spoke out, all the nurses in the crowd would come, and we would be together, but that didn't happen. They all supported me online, behind the scenes, but nobody wanted to come forward.

Then Kristen Nagel saw me, and she reached out to me, and she reached out to the nurses in the United States who spoke out before us: Nicole Sirotek and Erin Marie. And we decided that we were going to come together. We were invited by Del Bigtree to speak at a health and freedom Summit in Washington, DC, on January 6, 2021.

Kristen and I said, "This is awesome." We just wanted a big crowd, having no idea how political it was or anything like that. We headed there, and we were a block from the Capitol and the so-called insurrection. When we came home from there, I returned to my other job and I got fired from it, and then we were both put under investigation, which, for me, has turned into a disciplinary procedure that I'm going through right now.

We were defamed internationally by the news media and called domestic terrorists by some. We got hundreds of death threats. I do the social media; it was intense. And the RCMP even knocked on my door. That's like the equivalent of the FBI for Canada. They wanted to know if I was a domestic terrorist. Crazy.

But we just kept going. We got a lot of hate, but then people who were on our side saw us on TV and in the Washington Post and National Post. We were all over the place. We got a wave of supporters after that and figured, "Oh, when the media does this, we get a lot of threats, but then we get more people behind the movement. It's actually a good thing." So, we kept going.

For two years, we kept advocating and went across the country twice, educating people. We organized the National Hospital Protest, which was huge here. This all happened before the trucker's convoy. It was so successful that the media defamed us once again, saying that we were harming people and that because of our demonstrations people couldn't get into the hospitals, that people were missing their cancer appointments, and that we were violent. And so, again, the death threats came rolling in, but this time someone published our home addresses. There was a bounty put on our heads, so it was serious. None of this helped my trauma.

Ken McCarthy: Tell me about that hospital action. I believe I saw a video of nurses and their supporters on that big boardwalk in Quebec City overlooking the St. Lawrence. Was that part of your operation?

Sarah Choujounian: I think that was one of ours. We did it on September 1st and then again on September 13th, and we planned on doing it until the mandates stopped to bring awareness to the hospitals. They tried to make it look like we were against the nurses and the people inside. It made us look like, "Oh my God, these crazy Washington DC nurses again!" The attacks came because it was so successful. Vancouver had 10,000 people around the hospital, which was their biggest event yet. Winnipeg was huge. It was everywhere. It was the whole country at the same time, and it was making an impact.

Now we know that every time we make an impact, the media will come and run stories to smear us. Otherwise, they entirely ignore us and our message. We understand how they work.

The Prime Minister called us extremists. Canada created a new law where you can't protest in front of hospitals, which was a big thing. We had to stop our public demonstrations because the situation became so bad, the defamation, and the online threats. We had to stop.

Ken McCarthy: All this came before the trucker strike?

Sarah Choujounian: Yes, this was September 2021.

Ken McCarthy: And the trucker strike started in January of 2022.



*From the film What Happened in Ottawa? | Freedom Convoy 2022
Documentary (March 2022) by Ken McCarthy*

Sarah Choujounian: Out of all that, we have three legal cases going on. We hired lawyers because you only have a limited time to sue the media for defamation. We sued them for a million dollars. We sued the Canadian Nurses Association and another outlet in Vancouver that wrote this ridiculous article about us. We just lost that case. We were so confident going in. There was no way for us to lose. It was straightforward.

What happened is we were counter-sued under something called the SLAPP law (Strategic Lawsuits Against Public Participation).

The SLAPP law is supposed to protect grassroots organizations like us from big corporations for defamation when we're trying to serve and inform the public. The Canadian Nurses Association turned it around and decided to SLAPP us and the court let them do it. The next thing we know there's a judgment against us for half a million dollars. We found out this week they're asking for \$315,000 in the next 30 days. We're appealing it, but we were told we have only a very slight chance of prevailing in the case. This is just some of the corruption we're dealing with.

Ken McCarthy: So, their legal position was that by challenging their defamation of you, and they clearly defamed you, you defamed them? You were the bad guys because they were a little grassroots, defenseless group. Wow. Every time I think I've heard it all, I hear another crazy story like this.

Sarah Choujounian: These are big cases. We have an immediate \$75,000 legal bill pending to pay on this case. We need a quarter million. It's just crazy. I've adjusted to the idea, and I think, "That's fine. We'll get that. We'll figure it out. One step at a time."

Ken McCarthy: It's good to have that attitude when you're in a situation like this. What other legal and news media atrocities have they committed? You've listed a lot of them already. Are there any more?

Sarah Choujounian: I have a really big case going on right now and another case I'll talk about. Kristen and I were part of the trucker's convoy, too. Kristen was there for three weeks, boots on the ground, live, and I went on the weekends.

We were the first to legally go after the Canadian federal government and the Attorney General for using the Emergencies Act to attack the truckers and their supporters.



Justin Trudeau invokes the Emergencies Act to authorize the use of government violence against peaceful demonstrators in Ottawa and suspend the civil rights of all Canadians.

Ken McCarthy: Canadian Frontline Nurses was the first?

Sarah Choujounian: Yes.

Ken McCarthy: Wow. That's great.

Sarah Choujounian: Yes. People don't understand the importance of this case. If we lose and Canadians are not allowed to have political opinions, then there's no democracy. This is a big case that is going to cost us quite a bit.

Another critical case is my disciplinary hearing with the College of Nurses of Ontario. Remember, I was the first to speak out, and I created Nurses Against Lockdowns, so they're going after me first. They're making an example out of me and have twelve allegations against me. Allegations regarding me speaking out about the cycles on the PCR tests, things I posted on social media, and videos I posted of other people talking. They're trying to say that I wasn't allowed to do that. Twelve allegations! It was supposed to be a seven-day court case, our experts against theirs.

We're 14 days into the case and counting. They're going so slow because they know we have no money and it costs us a lot to be in court. It's a public hearing so the public should have access to it, but they're making it practically impossible for people to access the hearings. People have to email them to get the links.

People have told me, "Sarah, I can't get the links. I'm being blocked." Our lawyer reached out to them, and they said, "Oh, a lot of people were asking for the link and our system crashed." It's been a few months and a lot of people are still not getting links. Some people called and were told that they reserve the right to decide if they want to give out the links or not, so in effect they've censored what is supposed to be a public hearing.

Ken McCarthy: Can you publish those links yourself to your followers?

Sarah Choujounian: No.

Ken McCarthy: What?

Sarah Choujounian: That's the thing. I can't. It would create problems for my case. I have two expert witnesses. Two doctors here who spoke out. The College of Nurses of Ontario cross-examined my expert for 10 hours trying to disprove that he was qualified to testify. They spent 10 hours on that, and then they decided that he was only partially qualified for one and a half of the four issues he was supposed to cover.

It's very, very corrupt, and we want people to see the case. We don't necessarily expect to win at this level. This is the College Nurse's own court, so we expect to lose and are prepared to appeal it. More expenses. It's \$100,000 just for this part, and then, it's going to be another \$100,000 for the appeals. I would like to take it to the Superior Court.

People ask me, "Why are you doing this when you don't even want your license." And it's true. They're coming after me to revoke my license, and I don't even want it.

I've created mental health programs to help people go to the root cause of their problems instead of taking medications because I believe this is real nursing. We're creating a new healthcare paradigm. So, I want nothing to do with them, but I still believe they need to be held accountable.

The College of Nurses of Ontario's responsibility is to make sure that they protect the public. In nursing school, the first thing we learn in ethics class is that when the medical industry turns against the people, it's our duty—and I'm quoting our books—to advocate for what is best for our community. I'm doing my job, and you want to punish me and take my license? I'm very stubborn. That's not going to happen. I will stand and lose everything but my soul and my integrity.

I'm not doing the case for me. I'm doing this to set a precedent. It's very important because if they can censor me, then that's it. I don't know of anyone else who will have lawyers and will spend hundreds of thousands on a case like this. Nobody's speaking. People are scared. This is our chance. If we lose, nurses will just be censored forever. They won't be able to be patient advocates and advocate for what's best for their patients. Patients won't be able to give informed consent.

Nurses are the last line of defense between the medical industry and the patient, and that will be gone. We can't do this anymore and speaking up is a core responsibility of nurses. I don't think people understand how important this is. We saw that during COVID there was no free speech and we saw how much harm was done. So this case is very important. If we win, it'll empower nurses throughout Canada. We'll have our voices. We won't have to follow these regulatory bodies when they're corrupt. I didn't sign up to be a tool in their big monster machine. Do you know what I mean?

So that's what we're doing. We're trying to collect a quarter of a million dollars right now. I'm very happy and thankful for people. I think it's been a month since I did my SOS, and we've reached \$80,000, so we're really happy about that, and we're going to keep fighting. I always tell people, "It's not a donation. Look at it as an investment in the future of health care for your kids and the next generations." We have to fight back against this agenda.

Ken McCarthy: Unbelievable. Again, no matter how many stories like this I hear, I always think I've heard the worst. And then I hear more stories. I think it's pretty clear how people can help and why people should help. They can help by sending money for this case. What else does Canadian Frontline Nurses do? What other projects are you involved in?

Sarah Choujounian: Because of all the attacks and the court cases, we'd been limited but have been speaking out and advocating for health freedom, but we realized it wasn't enough and it was time for us to start creating the world we wanted to see.

Sarah Choujounian: Canadian Frontline Nurses is creating a new healthcare paradigm. Bringing care back into the community and getting people out of the hospitals and nursing homes and back into the community from birth to death. Why die in an institution surrounded by four white walls and staff when you can die at home, surrounded by your loved ones and belongings? And why not celebrate life while the person is transitioning?

We don't believe in the 'patient' mentality that the medical industry has. When you're a patient, you're a victim. "You need something from the outside to come and heal you. You're flawed. Your body doesn't know how to heal itself." We don't believe in that at all. And that's a critical point. What you believe creates your world, your life. We believe that people are active participants in their care, and when they're ready to heal, we're here to educate, empower, and guide them to do that.

Our bodies are divinely created and they know how to heal themselves. We just have to let them. So how do we do this? We have two types of memberships in Canada. We have our nurse's membership. That's \$100 a year and it includes being listed in our directory of service providers.

We have all kinds of nurses in our network. There are nurses who still have their licenses with the College but don't want to be a part of the system right now. They can give conventional care to people in the community. Then we have nurses like me who want to get out of the system who don't want their licenses anymore and who want to give a different type of care. I empower people to heal and rise above their mental health challenges by giving them the tools and knowledge they need to start healing themselves.

Ken McCarthy: They can do that on their own, but with support.

Sarah Choujounian: Absolutely. I run support groups that teach these things.

Ken McCarthy: It's not the current model. The current model, as you pointed out earlier, says "People are broken, and it's all hopeless, and their only salvation is for the drug company to put them on a series of drugs for the rest of their lives."

Sarah Choujounian: That's the current model. It keeps people in victim mode. In the case of psychological and emotional problems, if people understand how trauma works and how it shows up in their bodies and learn some tools to help themselves, they can recover and thrive. People can go to the root cause when they have the right information. I've seen it with the programs I'm running now.

As an organization, we're working to empower nurses to come out and find their true purpose and passion.

We have nurses like Kristen Nagle doing the birth companion course. I think we have six nurses doing that. Giving birth in a community, some of these people get no ultrasound and have nothing to do with the medical industry. Babies are being born straight in the community. I don't know if you know, but it's more dangerous to give birth in a hospital these days than in the community. Another example, we have nurses who are now holistic nutritionists. There's a lot of variety, although a lot of our nurses still carry out the roles of traditional nurses.

Nurses are creating hubs. They team up with others of like mind, maybe with a doctor, a holistic nutritionist, different types of nurses, and personal support workers.

We've partnered with CHA which is the Canadian Health Alliance. They're the umbrella and we're the nurse's organization under them. They're creating a lot of hubs.

And then we have public memberships, which cost \$50 a year. Our goal is to make our public members mentally and emotionally independent so we provide lots of education. Members also have access to all the nurses in our directory.

Every two weeks, we have a live guest who comes on to answer questions. For instance, we might have someone talking about how to cure cancer or how to correct your eyesight. Medically, we've been lied to about just about everything. We've had classes on how to cure your diabetes. How

to balance your hormones. All kinds of things. These live webinars are recorded and uploaded to the website and are accessible at any time. For example, my workshop on how to recover from fibromyalgia is three hours and it's free for anyone who is a member.

Ken McCarthy: It's great. So, a non-nurse becomes a member, giving them access to the services. We have a population of people who have very good educations in health and medical issues. Many of them have years, if not decades of experience. Rather than working in this crazy top-down system, where some bureaucrat in Ottawa follows the orders from the CDC or the World Health Organization and imposes protocols on people that don't work and can even harm and kill, you're creating a network of trained, experienced nurses with real practical knowledge to work with clients directly

Look, everybody's human. Our doctors are human. Our nurses are human. All that we can reasonably hope for is that they're as educated as they can be, that they care as much as they can, and that they respond to the person in front of them, not dictates from Ottawa or DC or Geneva, and that they give it their best shot. You made a very important point, and I love that this is baked into the cake: your health is ultimately your responsibility. You can get help, you can consult, but you cannot and should not outsource your thinking about your own health.

There may be things that undermine our health that aren't our fault, but they are our responsibility. For example, how many people blithely and unknowingly eat whatever the supermarket sells because they assume that food manufacturers and governments care about our health?

Sarah Choujounian: Yes.

Ken McCarthy: At least half the products in supermarkets are pure poison. You wouldn't feed them to a dog you cared about. How many people are unknowingly eating food that is literally poison?

Speaking of that, I spoke with one intensive care nurse who told me "90% of the people who end up in the ICU could have avoided it by getting educated and changing their behavior." We all need a boost. We all need a coach. Big athletic stars have coaches to keep them going. To me, the proper role of a nurse or a doctor is to educate, encourage, answer

questions, and give someone a push in the right direction. Use your technical knowledge where it's needed, but a lot of it's just, "Here's what you need to do and you can do it." That's part of being a clinician, right?

Sarah Choujounian: Exactly.

Ken McCarthy: To circle back here, your responsibility as a nurse is to the patients in front of you. That's your first responsibility. If some bureaucrat in Ottawa or Toronto is telling you to do something patently crazy and unscientific that there's no medical precedence for, and you know it's going to injure your patients, it's your job to speak up and say, "No."

Sarah Choujounian: Exactly.

Ken McCarthy: And the system's response to your advocacy on behalf of your patients is to try to take away your license. And then the media, of course, gets involved on the system's side and devotes its resources to vilifying and demonizing you.

To take this full circle, every nurse is taught that they're supposed to be on the front line in terms of ethical issues. They're supposed to advocate for their patients and residents against the hospital administration, against the pharmaceutical industry, and the bureaucrats they own. Your nurse is the person that is working with you. So you want them to be able to fulfill that role on your behalf unimpeded. However, throughout COVID, it appears the Canadian government used the pandemic hysteria as a means to try to strip this role from nursing. Things weren't this bad pre-COVID, is that right?

Sarah Choujounian: I didn't recognize it then, but in retrospect, I now realize it was a problem before. Clinicians were not looking at instructions before giving vaccines or flu shots. They didn't inform the residents, "Hey, there's an alternative to this." Informed consent requires telling people about the health risks of a medical intervention, the benefits, how it works in the body, and its function. There was none of that. I think informed consent also includes informing people about alternatives. The alternative: "Your immune system knows how to do this without this vaccine." Patients must feel they have the right to ask any questions they want about a procedure being proposed. Now I realize that we didn't have that in our medical industry. Drugs and vaccinations were the only options offered.

Ken McCarthy: Yes. Is it rational to believe that pharmaceutical products are some kind of magic that overcomes every issue? Is it rational to discount the restorative power of nature of which we are a part? I always tell people, “Look, we’re here.” Our ancestors didn’t have antibiotics, MRIs, or hospitals. Yet we’re here and every single one of us is descended from a long line of people who had none of this.

Of course, some of what we have today is a net benefit and sometimes people need extraordinary interventions. There are car accidents and other emergencies. Things come up and it’s good to have modern interventions available, but in general, we’re self-healing beings. If we weren’t self-healing beings, we wouldn’t be here.

A lot of people overcomplicate the roots of the medical crisis. They think there’s a grand conspiracy, and in a way, there is, but it’s a very simple conspiracy to break. The day you say, “I’m a self-healing being, and realize the answer is in what I eat, how I think, how I behave, how I sleep, how I interact with others, and how I exercise or don’t exercise.” The day you do all that, and accept the reality of the nature of your existence, you’re free.

Sarah Choujounian: Exactly.

Ken McCarthy: But we have a whole bunch of people, rich and poor, educated and uneducated, who don’t want to take responsibility. They cultivate a sense of powerlessness and they are looking for someone to rescue them. The guys in white coats have managed to persuade us that they are our rescuers and all we have to do in return is do everything they say without question. It’s quite a trick.

For thousands of years, one of the most powerful weapons conquerors could have had was the ability to convince the other side that the conqueror’s magic, including healing magic, was superior. At the end of the day, people are only truly concerned about a handful of things: money, love, and their health, and many people at one time or another get positively scared about their health. If you can pretend, through great manipulation, that you are the ultimate source of health information and healing, you’ve just captured the population. You’ve got them. And that’s what these folks have been doing for years. Before COVID, I said that we were living in a medical dictatorship.

Sarah Choujounian: We were.

I had fibromyalgia. It took them two years to diagnose me. I thought I was going to die and everything was falling apart. I couldn't work. I'm a single mom of three. And they said, "Maybe it's in your head." And I thought, "Oh, my God, these doctors have been with me for 20 years. They know I'm not like this."

I couldn't work, so I decided to do my own research and found out about fibromyalgia. I discovered that it was all about toxicity. Here in Canada, the medical system claims that they don't know what causes it and write it off as a long-term disability. The main symptoms of fibromyalgia are extreme fatigue and lots of nerve pain, so they put you on painkillers, sleeping pills, and other really bad stuff. They'll put you on hormones and other medications that make things worse in the long run.

You take the medications, and at first, you might feel better, but it's creating more toxicity. Then you need higher and higher doses and at some point, you can't go to an even higher dose, but you still haven't gotten to the root cause of the problem. It becomes a long-term disability.

Instead of going that route, I researched and found the tools and knowledge I needed to get better. I got sober, started going to the gym, and lost 60 pounds. I started eating organic foods, taking the necessary supplements, and massaging. A lot of self-care. The next thing you know, I didn't have fibromyalgia. Nothing. I was in the best shape of my life. That's when I started thinking "What are my residents eating?" In retrospect, I was blessed to have fibromyalgia. It was the biggest blessing in disguise of my life.

Ken McCarthy: It's not only what they eat, but also the drugs they are taking. And then, as you point out, the effect of the drugs wears off, and you need higher and higher doses. Then, the drugs create other symptoms. So what do they do? They give you a whole new round of drugs.

Sarah Choujounian: It's a great business.

Ken McCarthy: Oh, it's the best business in the world and the government pays for all of it via the taxes they extract from people's paychecks. I have a book here and the appendix lists all the drugs that older

people should be very careful about. It's seven pages long and small type. The average doctor will give a frail elderly person the same dose of a drug that you'd give a big six-foot guy who's 220 pounds. You can't give that to a five-foot elderly person who's 90 pounds, but they do it anyway. The book lists drugs commonly given to elderly patients along with their adverse reactions: confusion, drowsiness, insomnia, agitation, delirium, falls, heart problems, kidney problems, and death.

I doubt 1 out of 1,000 doctors could pass a simple test on the adverse reactions and contraindications of the drugs they prescribe daily to older people, or anyone else for that matter. How much misery in old age is caused by this carelessness?

(Editor's note: The book referenced is *The Gift of Caring: Saving Our Parents from the Perils of Modern Healthcare* by Marcy Cottrell Houle, MS, and Elizabeth Eckstrom, MD, MPH.)

Sarah Choujounian: I know! Now that I'm out of nursing, I'm thinking, "Were any of my residents as sick as they appeared or were they simply poisoned?" Do you know the story of Amanda Forbes? Doctors told her that her father was as good as dead and the only option was palliative care and they were going to let him die.

She took him out of there, and now he's thriving. He wasn't dying. He had diabetes and he had diabetes because they were feeding him with a G tube (gastrostomy tube). The first ingredient is sugar. Anybody fed this way will end up needing insulin. Once I got away from the system I realized, "Oh, my God, I was making people sick. And then I was giving them their doctor's prescription to try to stabilize what I'd done."

Ken McCarthy: If there's anything good that comes out of this COVID catastrophe, it's that all of us who cared to were forced to stop and say "Wait a minute. What the heck is going on here? What are we doing? Let's go back to basics and re-evaluate everything because we are way off course."

It's human nature to fall into a routine and, of course, if you're trained a certain way and supervised a certain way and everyone around you is doing things in a certain way, at first, you're going to proceed the same way. It's

just normal, but clearly, the system is on a very dark path and a major change of course is needed and needed fast.

For people who want to help the work of Canadian Frontline Nurses, where do they go?

Sarah Choujounian: It's CanadianFrontlineNurses.ca

Ken McCarthy: The last thing I want to say is we all admire the Canadian trucker movement, which became a national movement and inspired actions all over the world, but we need to recognize that the nurses went first. The nurses came out first. I didn't know that before you and I spoke today, and it's a very important thing to acknowledge. I'm a big believer that whoever goes first should get the credit for that.

The group is CanadianFrontlineNurses.ca. Support them. I think this is one of the best things you can do with your money right now if you want a health care system for yourselves, your loved ones, your children, and your descendants into the future because the medical system is out of control. Sarah, you and the US nurses are the single most promising development I have seen come of this catastrophe. God bless you.

Sarah Choujounian *was one of the first nurses to speak up against the lockdowns in Canada in October 2020. She was fired, put under five investigations by the College of Nurses, defamed internationally by the media, received countless death threats, and even had the RCMP show up at her door. She is the co-founder of Canadian Frontline Nurses, proud advocates for medical freedom.*

Sarah is also the founder of Lighting Up Dark Corners, an organization aiming at empowering people to heal and rise above their mental health issues by going to the root cause of the problem instead of numbing them with drugs and/or prescription medications.

Canadian Frontline Nurses -
<https://www.canadianfrontlinenurses.ca/>

Lighting Up Dark Corners -
<https://www.lightingupdarkcorners.com/>

CHAPTER 9

DENYING PREGNANT WOMEN, NEWBORNS, AND THEIR FAMILIES HUMANE CARE

KRISTEN NAGLE INTERVIEW - JUNE 9, 2023

“Constant attention by a good nurse may be just as important as a major operation by a surgeon.”

— Dag Hammarskjöld

Swedish economist and diplomat
former Secretary-General of the United Nations

Ken McCarthy: You're in London, Ontario and you're a nurse. How long have you been a nurse and what's your specialty?

Kristen Nagle: I'm a former nurse now. I resigned my license this year. I graduated from nursing school in 2006 and worked in a neonatal intensive care unit for 12 years working with premature babies.

Ken McCarthy: Tell me, what attracted you to neonatal nursing? What it's like? What are the joys of it?

Kristen Nagle: I always loved working with kids. Even through nursing school, when I would work with adults, I thought, “No, this is just not my area.” Throughout my whole life, I was a camp counselor and swim instructor. I’ve always worked with kids. When I went into nursing, I started in pediatrics, which was great. You have one-year-olds up to almost 18-year-olds, so sometimes you’re working with adult-sized patients too. It was great. I liked the relationships I had with the kids and with the parents.

I did that for two years, but I was moving to Toronto, and someone presented a job opportunity to me in the NICU (Neonatal Intensive Care Unit). “Oh, that seems scary. That’s a whole new specialty. That’s a whole different level of expertise”, but in the end, I decided, “Okay, I’ll try it.” Thankfully, I accepted the job, and they had an incredible mentorship program of 18 months. I got classroom training and training alongside another nurse, and I just loved it.

I wasn’t expecting to love it as much as I did, but I loved working with the babies. I loved the relationships with the parents. I loved watching them have their first moments with their babies, even just holding up a little feeding tube for the first time and watching mom’s milk nourish the baby, the first time they got to hold their baby skin to skin.

I worked with micro preemies (prematurely born babies), and they would fit in the palm of your hand. Twenty-three weeks and up. You go in, you do your care, you love these babies, and you get to watch them grow. They’re in our care for 100 days or more sometimes and you create this beautiful relationship with the babies and the families. I loved that.

Ken McCarthy: What are you doing now?

Kristen Nagle: A while back, in 2016, I went back to school to be a holistic nutritionist. I haven’t developed a career in that area yet, but I always tried to help parents and families with their food choices. Right now, I’m a homeschooling mom of three. The most recent is three months old and my two older boys are eight and five. I also run the Canadian Frontline Nurses organization, and I’m training to become a Traditional Birth Companion.

Ken McCarthy: So, it’s March 2020, and suddenly, the world is losing its mind, especially at the hospitals. How did that madness impact your

little patients and their families?

Kristen Nagle: You didn't hear much from the NICU nurses speaking out, but it seriously impacted the families and their vulnerable babies. The masks. We had to throw the masks on our faces and put the goggles on. We're working with babies where facial expressions are incredibly important. It doesn't matter if they're 23 weeks because we're working with these babies as they develop, and with masks on they couldn't see our faces.

Edward Tronick did an experiment in the 1960s called the Still Face Experiment, which documented that babies get incredibly distraught if they can't see the faces or expressions of the people around them. They can't handle it. Knowing that, covering up our faces and wearing all the other garb, really bothered me.

We had to tell the parents of the preemies that only one parent was allowed at the bedside. So, just imagine, their baby is 23 weeks old, tiny, and hooked up to all this machinery. It's scary and only one parent is allowed to be by their baby. One parent would have to go alone without their partner or the rest of their family, try to take all this information in alone, try to retain it all.

Usually, it was the mother. She's trying to pump milk for the baby in this very foreign setting worried about her baby with so much happening and she's there all alone. That broke my heart watching these mothers go through this and I did my best to comfort them. Unfortunately, we don't have the time to sit with them and be with them. That was sad.

If the mother was going in for a C-section, even though all these personnel were in the operating room, the father was not allowed to be there with his wife, the mother of his baby. He had to wait for the baby to be born and then for the baby to finally be brought to him. The father missed the birth of his baby. If the mother, for whatever reason, had to be put under general anesthetic, then both missed the birth of their baby, and they were alone. No friends and family members allowed.

In the NICU, we used to enter the OR (operating room), receive the babies onto our chest, and then place them on the receiving table. Then we would bundle them up and give them to dad, weigh them, and do all that's required after the birth of a baby. Now the NICU team was not allowed to

enter the operating room, so they would put the baby on this cot and just push it out the door to us, where we received the baby. This is the baby's first entry into the world, and they're put on a cot and pushed out the door.

Ken McCarthy: I heard women were forced to wear masks while giving birth.

Kristen Nagle: Yes. And the mothers who were about to deliver were threatened with the PCR test. They said, "Well, if your baby ends up in the NICU, you won't be able to see them without this test done."

Also, partners and others were not allowed to go to any appointments with them: ultrasounds, checkups, OB (obstetrician) appointments. Even in the case of high-risk pregnancies, the mothers were only allowed one visitor the entire time. They had to pick one person and sometimes they were in the hospital for weeks if not months at a time. They would forfeit seeing any other family members or friends for the entire time they were in the hospital.

I remember being incredibly disgusted by how they treated some moms who tested positive and how they isolated their babies from them. They had a separate room where the baby was away from the mom, which was ridiculous. And again, all the baby ever saw were people in masks, goggles, and medical gowns.

If a mom tested positive and was going in for a C-section and the NICU high-risk team was involved and the baby was coming out premature and not breathing, then the baby was placed on this cart that was pushed out to us as I mentioned earlier. This means we couldn't resuscitate the baby in our resuscitation room because it might contaminate the whole room if this baby also tested positive so the protocol was to put a clear plastic box over top of the baby and wheel it to another room, get all the PPE on, and then resuscitate the baby.

Ken McCarthy: Is this a normal part of your work? Sometimes the babies need resuscitation?

Kristen Nagle: Yes, because we're working with premature babies. Micro preemies are sometimes only 23 weeks gestation. And yes, they need

breathing support. They need nutritional support and IVs. They need total support.



“I worked with micro preemies (prematurely born babies), and they would fit in the palm of your hand. Twenty-three weeks and up. You go in, you do your care, you love these babies, and you get to watch them grow. They’re in our care for 100 days or more sometimes, and you create this beautiful relationship with the babies and the families. I loved that.” - Kristen Nagle

Ken McCarthy: Right from the very get-go, coming out of the womb, the baby needs resuscitation because their lungs aren’t working yet, right? Do the diaphragm and lungs need a little more time to develop?

Kristen Nagle: Right. Breathing is not developed until 34 weeks.

Ken McCarthy: So resuscitation of newborns was a regular part of the job?

Kristen Nagle: Yes.

Ken McCarthy: Whoever was running this circus had to know that they were putting all these obstacles between the baby and your ability to do what you needed to do to save the baby’s life.

Kristen Nagle: Yes and I seemed to be the only one questioning this and had a problem with it.

Ken McCarthy: I can't imagine that any delay in getting air into the lungs of a newborn is a good thing.

Kristen Nagle: Yes, but one questioned it. Everyone was okay with it. I was the only one questioning these policies, "What if the baby needs immediate care?" "Well, it'll be okay. It'll happen fast. We'll be okay." They were okay with this new procedure. I was not because our job is to take immediate action and care for these babies.

The part that bothered me about all this is that just like firefighters sign up to go into the burning buildings, we sign up to be around sickness and disease. This is what we signed up for. So why are we now acting like we're afraid? This is our job, just like police officers who might have to face a gun or take a bullet.

Kristen Nagle: When you're responsible for caring for these babies for as long as 100 days, you get to know the parents, and they tell you stories. I heard that when the parents brought the babies home and took the masks off, the babies cried until the masks went back on because they were not used to seeing faces. They didn't know who it was, who suddenly was in their space.

The hospital also closed down the entire gynecology wing outside our unit for 'overflow COVID patients' and the gynecology wing sat empty. Not one single COVID patient was ever on that floor. Think of all those surgeries and appointments that were all canceled.

Those were some of the things that we were experiencing. We also learned, from all the letters we were getting and everyone else's experiences, that the hospital was never overwhelmed or busy. People might think that because we worked in the NICU, we didn't see what was happening in other parts of the hospital, but we're still connected to people who work there. We still see and hear things, and no, nothing was going on. This was in 2020, while I worked at a major hospital center, London Health Sciences Center. It's huge. This is where Western University is. It's a huge teaching city with an extensive hospital network.

Ken McCarthy: When they shut down the gynecology department, there were no services then. For how long?

Kristen Nagle: It went on for months. It felt like it went on for a very long time.

Ken McCarthy: So, they were endlessly waiting for this flood of patients that never came. Meanwhile, people who needed medical help, medical attention, and medical checkups and services weren't being seen for months.

Kristen Nagle: They were being denied medical services, yes.

Ken McCarthy: I'm also wondering about pregnant women. What kind of services were pregnant women getting during this time, if any?

Kristen Nagle: Limited. They had to come alone. If they had kids, they had to find arrangements for their kids. They had to do it all alone while wearing a mask and with very limited appointments.

Ken McCarthy: So normally, if you had older kids and you had to have an appointment, you could bring the kids with you, or your husband would come with you and park the car, and maybe drop you off at the front and then park the car, so you didn't have to walk 10 miles from the parking lot. And all that went out the window. And I guess the hours were limited, too?

Kristen Nagle: Hours were limited and I heard that some midwives were seeing people in their cars who couldn't go to the hospital. There were a lot more phone and virtual appointments, too.

Ken McCarthy: So, even with prenatal care, when women are getting ready to give birth, maybe for the first time, which has to be scary, because they have no idea what they're in for. Part of that is talking and finding out, "Is everything okay?" Getting reassured and having questions answered and all those basic human things. All that was gone, and now they're forced to have those conversations in the car in an Ontario winter, and they're forced to have those conversations with people wearing masks.

Kristen Nagle: There used to be hospital tours for expecting mothers. It helped them know what to expect when they came in for delivery and what to look for, but all that was canceled. There was one upside. Well-baby visits were canceled, so fewer kids were getting the new rounds of endless immunizations, which was a good thing. That was the one positive that came from that.

Ken McCarthy: I agree. Before birth, ideally, the mother would have friends and family around as she waited to go into labor, but now they couldn't go in with her. Not even one supporting person could be in the hospital until labor and the mother was alone with no support anywhere in the building until labor started.

Kristen Nagle: There was probably a nurse in the room, but yes, many times I heard of mothers where their husbands waited down in the car until they were allowed to come up. That's the labor and delivery side of things. Then the baby's born. Then you move into mother-baby, normally a celebratory time, where friends, family, and everyone gets to come in and see the new baby. That was done alone. No one was allowed.

Ken McCarthy: It's incredible to me how all this has been swept under the rug. This essential part of life, giving birth, and the rigors of that and the obvious need women have for support during that time from family. To be deprived of that by official decree is just mind-boggling to me.

Kristen Nagle: Women hire doulas. They are there to advocate for the mother, to help them and support them or help the husband, whatever is needed. They were no longer allowed in the hospital. So, the person that the mother hired to be there to support them and advocate for them was not allowed.

One of the things that came from all this was my realization that, pre-COVID, I had been a thoroughly indoctrinated nurse. Working in the NICU, I saw the worst of the worst and I had come to fear birth. I thought it was dangerous and that we needed all this medical intervention.

Over the last three years, my eyes opened to what was happening, the harm routinely being done to women, and how women were finding alternatives. Now, there's this huge push for home birth, different support, and women taking back their power for themselves.

I was able to have my baby girl at home with a traditional birth companion, which is different than a midwife. They're what a midwife should have been before their practice got subverted by the medical system. And it was this beautiful women-supporting-women experience. More and more of that is happening now. Another blessing is getting the care of birth back into the homes and women having their power and support.

Ken McCarthy: COVID was the big wake-up call for those with ears to hear. We all went along with the system, thinking, “It’s a pretty good system.” Then we realized, “No, this is not a good system at all.” So, your experience as a neonatal nurse, because you always saw the most difficult outcomes, probably put in your mind, “Birth is the most dangerous thing known to womankind.” There are certain situations where you obviously want all that intervention, but most of the time, luckily, that intervention is not needed.

We’ve got the women not getting the adequate prenatal care they should have. It was interrupted, or it was abbreviated or truncated. Then we have them being separated from loved ones during the birth process, being forced to wear a mask, and then not getting to be with the family immediately after the birth.

Kristen Nagle: Yes, and sometimes, there was a separation between the mom and baby. If a PCR test was pending, sometimes mom and baby would be separated too.

Ken McCarthy: So, they test the mom. Do they test the babies, too? Were they sticking something up the baby’s nose?

Kristen Nagle: Yes, they would try to.

Ken McCarthy: Wow, these facts just get worse and worse. So, this is a high-risk situation, premature birth, where the infant needs a lot of care because many of the natural systems that normally kick in when you’re born at nine months are not there yet. If all goes well, the mom is nourishing and oxygenating the baby for nine months. When that gets interrupted, somebody else has to oxygenate and nourish the baby. That’s a whole process

And the nurses had to do everything with masks and goggles. I imagine you had to wear those Ebola suits? The white suites. Did you know those were manufactured for Ebola and then warehoused after that particular Fauci stage-managed medical hysteria collapsed?

Kristen Nagle: Yes, because we had a system-wide Ebola training just a year or two before. It was a big thing in our hospital that we had to participate in. We had the goggles, the masks, the gowns. This is not how

you're supposed to care for babies. You're supposed to talk to them, smile at them, look at them, and interact with them.

Ken McCarthy: Newborns have so little to go on. They don't understand language. They have no context. Everything's brand new. All they can go on is the touch, tone of voice, and facial expression, and that's all they've got. All that was taken away from them, and nobody anywhere along the line thought, "Gee, this might not be a good idea." Let me ask you this. Was there any open discussion about this?

Kristen Nagle: No, everyone just fell for it. I was shocked by how many fell into the fear world. I was living a normal life outside of work. People knew I was going to some of the protests. I was encouraging people not to wear masks outside of work and telling them how to avoid it. I was not 'bubbling', or social distancing, or doing any of those things. My colleagues were really scared of me coming to work. They began writing up reports to my manager about me and that's how I got suspended the first time.

My colleagues would say, "When she sits at her desk, she would put her goggles on her head." I'd sit at my desk, do my charting, and look at the computer screen. I didn't want to look through another lens, so they would write reports about me. I got verbally reprimanded, and then I was suspended for insubordination. Then, I hosted the Freedom Rally while I was suspended and became indefinitely suspended and put under investigation. Then, Sarah and I went to the DC rally, and I was terminated.

We kept speaking out throughout 2021. I received 11 charges for speaking in public at protests. Four of those are still going to trial. I was convicted and fined \$12,500 for attending church on Easter Sunday. We're in the middle of an appeal for that conviction, but I was fined \$12,500 for attending church.

Ken McCarthy: Were there other people who attended that service?

Kristen Nagle: Sure, but they singled out only a few of us. There were four of us that were called to the front. A retired police officer and I were fined. We're appealing that right now.

Then, we hosted a national protest across Canada at all the hospitals. I remember some hospitals in New York put up their solidarity to support us. It was to support the health care workers when it was “jab or job”. We organized protests across Canada at all the major hospitals.

It was so successful that even the federal government got involved with this huge media campaign and slander. It was out of this world what they said about us. Then the government wanted to make protesting outside a hospital a criminal charge with ten years in prison.

Ken McCarthy: Let’s talk about this national protest. What did it look like? How did you get the word out? On the Internet? Did people meet people locally?

Kristen Nagle: We had just done a cross-Canada tour, and we were able to make connections in all the major cities in each province. We called all our supporters and had them help us organize it at all the major hospitals. Vancouver Hospital was the largest.

They had 10,000 people show up and there was incredible footage of it. They were some of the biggest protests people had seen, with huge turnouts supporting the healthcare workers. And the media just destroyed us across Canada, all using the same false story: we interfered with ambulance access, stopped cancer treatments, and assaulted healthcare workers.

Ken McCarthy: Yeah, right. Like you guys were assaulting people. And then, of course, the cancer thing is such a red herring because the government was the one preventing cancer care for months and months. And I’m sure if an ambulance came by, I have a feeling the nurses would have gotten out of the way if one had come. It’s so absurd.

Kristen Nagle: We linked up with the police to ensure there were no issues with ambulance access or anything like that. We weren’t even on the hospital property. They got this one piece of footage in Vancouver because there was a crowd of 10,000 people there, and they drove an empty ambulance with its siren on through the crowd and filmed it and then said on the news that we were blocking it. The broadcast of that footage and story went nationwide.



Canadian Frontline Nurses in Vancouver. (Left to right: Sarah Choujounian, Kristen Nagle, Nordia German, Kristal Pitter)

Ken McCarthy: I can't imagine how these people live with themselves, but there seems to be no shortage of deviants who like to play-act as agents of the state while posing as journalists.

Kristen Nagle: The media was trying to make an example of us by slandering us in every way imaginable. And then suddenly, when they realized it was having the opposite effect, that we were getting recognition and building awareness, we weren't stopping, and we were gaining momentum, they started ignoring us. We thought, "Why isn't the media picking up on this?" We wanted them to talk about the demonstrations, even negatively.

Then we held the first-ever protest in front of a regulatory licensing body at the College of Nurses of Ontario because we were all under investigation

by them. We wanted to let them know that we would not be bullied by them or silenced by them.

Ken McCarthy: Was that the first time the organization was ever protested against?

Kristen Nagle: Yes, I think for any regulatory body, any medical licensing body.

Ken McCarthy: That's a good trend to start. I know nurses have a license, and doctors have a license. I've dealt mostly with doctors whose licenses were threatened, suspended, challenged, and so on. It's so terrible because you're in a room facing 20 hostile inquisitors who are completely dishonest and unhinged, and it all happens in the dark. I love the idea that you all came out and let them know you were there, and let them know their shenanigans weren't going to happen in the dark. This is a big problem when these hearings take place off the radar. It emboldens the bullies and miscreants who make up licensing boards. It's great that you did that.

Let's talk about Canadian Frontline Nurses and what it does.

Kristen Nagle: Canadian Frontline Nurses was formed in early 2021 after Sarah Choujounian and I, the two co-founders, had been speaking out in 2020. Sarah and I knew that the hysteria and the protocols were a lie right from the beginning.

Another thing that drove me crazy was that in Canada, Ontario, and British Columbia, our nursing union had previously fought for us not to have to wear masks. If you did not get the flu shot, you would have to wear a mask from November to April during your whole shift. We fought for years to not have to wear this mask because we were healthy and didn't have the flu. In 2018, we finally won. Our union proved in court that masks did not stop viral transmission and were discriminatory.

Two years later, the nurses who fought for this were putting the masks back on their faces, and then goggles to boot. And I thought, "What? This is a virus. Why are we wearing goggles?" No one else seemed to be questioning this except for me. Then, when I asked the union, "Didn't you fight for this? Isn't this what you won?" They said, "Well, this is new. This is different. We don't know about this." And I responded, "If it's a virus,

we've already proved masking doesn't stop viral transmission.." It was crazy.

We were speaking out through 2020. Sarah and I both spoke at rallies. She spoke in Toronto, and I spoke in London. The media picked up on my story in November 2020. They slandered and defamed me. They destroyed my reputation. I was suspended indefinitely from my workplace and put under investigation by my college of nurses for hosting a freedom rally. The headline was "NICU Nurse Puts Premature Babies in Danger."

You can imagine the garbage the CBC (Canadian Broadcasting Corporation) had going on to promote fear and for people to hate me in my community. It was a very hard time, but I saw Sarah was speaking out, and we joined together and connected with some of the American nurses, Nicole Sirotek and Erin Marie. We formed Global Frontline Nurses together.

There were six of us nurses going to speak at a nursing summit in Tampa, where Erin was from. She works closely with Del Bigtree and other well-known activists and they said, "How about we do it in Washington DC Instead? There'll be a greater audience, and the Highwire will stream it live. We can get our message across to more people." Sarah and I said, "Sure, wherever we need to go to get this message out. We need to let people know that lockdowns, masks, and isolation are causing more harm than good from the elderly to the children." Sarah and I worked at both ends of the spectrum so we had a good time. I worked with the babies and children. She worked with the elderly.



Sarah Choujounian (left) and Kristen Nagle (right). “Canadian Frontline Nurses was formed in early 2021 after Sarah Choujounian and I, the two co-founders, had been speaking out in 2020. Sarah and I knew that the hysteria and the protocols were a lie right from the beginning.” - Kristen Nagle

The nursing summit was organized for January 6th, because there would be a big audience. Being naive Canadians, Sarah and I didn’t realize the political climate or significance of January 6th. When we came back home, we were deemed domestic terrorists. We were both terminated immediately from our jobs and had the RCMP show up at our houses, which is the equivalent of the FBI here, to ask about our “involvement in the storming and rioting of the Capitol.” Since then, there have been four schools that I know of that started teaching about me at nursing schools: “Kristen Nagel: What Not To Do”. About accountability and how I “stormed and rioted at the Capitol”. That was where Canadian Frontline Nurses started.

Ken McCarthy: My God. What a train wreck. So, you were in DC on January 6th. Innocent lambs with no idea what you were stepping into. Well, no one did. Most thought it would be a legal protest, which people are allowed to do.

Kristen Nagle: Yes, but as we quickly found out in 2021, we're not allowed to protest legally. That was interesting. Global Frontline Nurses, unfortunately, dissolved for a variety of reasons. Still, I know all of us nurses continued to speak up, and Sarah and I continued to stand, and we formed Canadian Frontline Nurses.

After DC, we were defamed internationally. This made international news: "These two Canadian nurses that went to storm and riot at the Capitol." We were on the receiving end of a lot of hate. It was a scary, dark time, the amount of hateful messages that came at us from around the world.

(Editor's note: See the interview in this book with Katie Spence to learn the details of how organizations like the Rockefeller Foundation and U.N. support groups recruit, train, and direct mobs of trolls to attack people in the name of "fighting disinformation".)

The good part of this was that now that we were made into international news, people learned that nurses were speaking out, and they didn't feel so crazy. "Well, if nurses are speaking out, then there must be something going on." Once the hate attacks stopped, we were flooded with support and encouragement. Nurses were still scared to speak out publicly, but they flooded us with stories of what they were seeing, experiencing, and what was happening. We heard stories coming in from other nurses around the world and in Canada.

Sarah and I and another nurse spoke out in 2020 at the College of Nurses of Ontario. The college responded with a statement on December 16th, 2020, saying that nurses are not allowed to speak about masks, social distancing, vaccinations, or anything that goes against the government-decreed public health measures, or they will be terminated and their licenses revoked. They put this out to scare nurses from speaking out about the narrative and it worked because only a few of us were going to take the risk.

We were placed under several investigations. We spoke at rallies across Canada and charges were filed against us. We're still in court for that. Sarah will tell you her whole court details when you speak to her.

Ken McCarthy: You probably remember all the videos that came out in the early months, in March and April of 2020, where US doctors and nurses were on YouTube saying, “What’s going on? This is crazy!” And even ICU doctors were doing that. All those videos disappeared from the Internet very quickly.

Kristen Nagle: Yes. Did they ever.

Kristen Nagle was a Registered Nurse of 14 years, primarily working in the NICU. She began speaking out on childhood injections in 2018 and became a whistleblower in 2020 regarding lockdowns, masks, isolation, etc. This eventually led to her termination and international defamation and she found herself becoming a full-time activist in the fight against propaganda.

Kristen is a wife and mother to three young children. It was after the birth of her daughter in 2023 that she began to pull away from the fight to continue homeschooling her children and helping women feel empowered in their perfect divine design, trusting their bodies and reclaiming birth. This is where Kristen now finds her passion is at the foundation of life itself, sacred undisturbed, physiological birth,

www.KristenNagle.ca

Canadian Frontline Nurses -

<https://www.canadianfrontlinenurses.ca/>

PART FIVE: THREE SMOKING GUNS

“Do not complain of the mean and petty for, regardless of what you have been told, the mean and petty are everywhere in control.”

— Johann Wolfgang von Goethe

PROLOGUE TO PART FIVE

After I interviewed the nurses, I realized that there was some technical information that would be useful to serious readers that I needed to get from non-nursing sources.

First, I was happy to find the one journalist who has spent some time looking into one of the most serious and unreported stories of our time: governments and NGOs using the Internet to recruit, train, and mobilize unhinged people to attack critics of their operations and activities. This method is akin to promoting mob violence and exists on the same spectrum that includes, at its extreme, the arming and supporting of death squads. Strangely, these Internet hate operations carried out by governments and NGOs in developed nations have never been written about in any serious way that I have been able to find.

Second, the topic of intubation and venting has come up in many of the interviews. Experienced nurses know from years of observation when and how venting is normally used, but they are not respiratory therapists, the people who receive years of training on how to carry out these procedures, monitor patients, and then wean them off the machine. Late in the production of this book I had the good fortune to meet an experienced respiratory therapist who could explain some of the technical details of how this procedure was abused.

As a bonus, he also shared an interesting first-hand of how the Republican Party in Minnesota operates behind closed doors which is likely how it operates in all 50 states and how the Democratic Party operates too.

Finally, when authorities are behaving bizarrely and without apparent reason or basic decency, I find that the confusion can usually be cleared up by simply following the money.

Accordingly, the book ends with a deep and detailed accounting of all the ways that hospitals, and later public schools, were paid, and paid handsomely, for following the dictates of the CDC-NIH-FDA protocol that injured and killed countless thousands in broad daylight with nary a mention by the mainstream news media or even “alternative” news services.

CHAPTER 10

HOW THE UN AND OTHER NGOS SPONSORED TROLL MOBS AND UNDERWROTE DEATH THREATS AGAINST NURSES

KATIE SPENCE INTERVIEW - AUGUST 15, 2023

“*Whoever would overthrow the liberty of a nation must begin by subduing the freeness of speech.*”

– Silence Dogood

(likely pseudonym of Benjamin Franklin)

Ken McCarthy: We’re talking with Katie Spence of *Epoch Times*.

It’s a wonderful publication. They’re covering many important stories that are otherwise being neglected. In some ways, they’re the last real print newspaper in America. Maybe there’s another one I haven’t seen, but they’re doing a superb job.

We're talking with Katie for a particular reason today. She wrote a series of articles covering a very important topic that has been completely neglected by the news media, mainstream and alternative. It's something I've been praying we could get some media attention for, so I was thrilled when Nicole Sirotek said, "Hey, I know somebody that writes about that. She just wrote an article about it." I wrote to Katie, and unlike 99% of all journalists I write to, she wrote me back, so I got a double win. The triple win is here she is with us today, talking.

Let me set the stage. We know there are trolls on the Internet, and we know there are mean people who say and do mean things. That's part of humanity, but there is something else at play here.

As I often say about war, many people say that war is inevitable because human beings are naturally aggressive. My counter is that while human beings may get into a bar fight, or they may have a feud, it takes massive planning and resources to start and run a war. Wars don't happen because of spontaneous human aggression.

It's the same thing with some of the trolls we're seeing. They are not natural. They are not something that comes from normal human interaction. They are recruited, trained, managed, funded, and directed by people with deep pockets.

It's a sinister variation of an old ploy in which organizations manufacture grass roots support or opposition to an issue by hiring people to write letters or demonstrate. That goes by the term "astroturf". What we're going to talk about is something different and it's more akin to digital thugs or digital attack dogs.

Katie has written a series of articles that address this and it's the first time I'm aware of anybody getting into the weeds on this very important subject.

Katie, please tell us what you came across regarding the reality that some of these trolls are not just random people.

Katie Spence: They're not. When I started this article, I connected with Nicole Sirotek because I was looking into what the FDA did with ivermectin. I reached out to a ton of doctors, and also nurses because they work with doctors. I wanted to know, "What were the messages you were

getting? What were you hearing from pharmaceutical companies?” Nicole wrote me back, saying, “Here’s what happened to us. Here are the doctors we work with. By the way, did you know that there’s also this organization called Team Halo that has targeted me and fellow nurses?”

They had TikTok influencers who were also healthcare professionals make videos that often mocked Nicole and fellow nurses, saying that they were spreading disinformation about ivermectin, the vaccines, and the COVID-19 pandemic in general. They would then report those nurses and doctors to the state medical boards. They were trying to get them fired and have their licenses suspended. They were trying to get them canceled off TikTok, Twitter, Instagram, or wherever their social media presence was. That is how I got started looking into Team Halo, by talking to Nicole Sirotek.

Ken McCarthy: For people who don’t know Nicole, she is a courageous human being who stood up very early in the COVID scamdemic, hysteria, panic, whatever you want to call it, as a nurse in an intensive care unit and said, “We’re killing these patients with protocols that don’t work and no one will listen to the nurses.” That’s Nicole. Then the attacks started. You’ve got to love the name this attack group picked for themselves: Team Halo. What did you find out about the roots of Team Halo? Was it a couple of buddies who got together over a beer one day? How did Team Halo come to be?

Katie Spence: There are a lot of things that we don’t know about Team Halo because they didn’t want to talk to me. What we do know is that it’s not just a group of buddies. It’s in partnership with the Vaccine Confidence Project, which is associated with the London School of Medicine. They get funding from the Rockefeller Foundation, Johnson & Johnson, Merck, a lot of pharmaceutical companies, and the pharmaceutical industry.

It’s a UN initiative that was put together to target doctors and nurses who they said were spreading “disinformation”; “disinformation” specifically defined as anything that does not subscribe to the CDC or the FDA narrative on the COVID-19 pandemic, ivermectin, and vaccines.

Ken McCarthy: Let’s unpack this a bit because this is massive. A lot of money came from a lot of different sources, including Big Pharma, but the

money went to a UN department, a United Nations department. Do you happen to know the name of the division of the UN that was managing this?

Katie Spence: It didn't go to a department. It went to the Vaccine Confidence Project and Team Halo is under the Vaccine Confidence Project, which is a UN initiative. The visible members of Team Halo are volunteers and are not paid for their work. As to the people who were running it behind the scenes, I'm assuming those people were paid, but we don't know that for sure.

Team Halo was established in partnership with the Vaccine Confidence Project at the University of London's school of Hygiene and Tropical Medicine. It is proud to collaborate with the UN Verified Initiative and Gavi, the Vaccine Alliance. Support is provided by Luminate, IKEA Foundation and the Global Challenges Foundation.

Screenshot from the UN initiative TeamHalo.org website

Ken McCarthy: This is interesting. Long-time Brasscheck listeners know that pre-COVID, we uncovered a similar phenomenon. A large group of trolls were attacking—and this is unbelievable for its sheer savagery—they were attacking the families of children with autism. We know exactly who the day-to-day operators were, but we don't know the people above them. They kind of disappear into the clouds. We did know that so-called news outlets from the Times of London and NBC on down lionized the attackers as heroes. NBC was so involved that one of their so-called reporters Brandy Zadrozny partnered with one group and used the NBC platform to doxx a mother of a severely vaccine-injured son, inspiring death threats against her.

Did you find that Team Halo was getting support from mainstream news media? The formula we saw is that mainstream news outlets would accept

the narratives of random trolls and portray them as “crusading” independent activists. They’d then use their news media platforms to amplify the impact of the troll attacks, all with the approval of their editors and news directors.

Did you see the news media coordinating with Team Halo operations in this way?

Katie Spence: Yes, absolutely. They were getting platformed on all sorts of different mainstream news media.

Vice specifically went after American Frontline Nurses, Nicole Sirotek’s organization, and attacked her for what she was doing. That became a huge narrative that she had to fight. That’s part of what I find so tragic about this, that there was this massive pile-on. In the beginning, when she was struggling to get the word out, she had a hard time saying “I am legitimate” because there was so much mainstream media against her saying, “No you’re not. You’re spreading disinformation.”

Ken McCarthy: They flooded the zone with thousands of articles. We saw it. They used the same procedure against these families with autistic children and their doctors and therapists.

First, a seemingly random blogger, and this was in the blog era, a seemingly random blogger would write an article, saying, “I’ve just discovered this terrible group of parents and clinicians” and go on about how terrible they were. Then, the Times Mirror or some other major outlet, NBC was a leader in this too, would use this person, this random person from Nowheresville, and elevate them to the level of “expert.”

Suddenly, ignorant, vicious innuendo and slander become a national mainstream news story. It got so bad, Katie, that one family who had a seriously injured son whom they had successfully treated was doxxed. NBC published an article that named the mother and her town and called for her to be arrested. They might as well have put a target on her back. Like Nicole, she received death threats. She had a home business where she was doing family photography and family portraits, and it got so bad she had to shut her business down. So, you saw coordination and cooperation between Team Halo and all the so-called mainstream news media?

Katie Spence: There absolutely was. One of the things that made Team Halo so effective is that it wasn't just random people. It was physicians. It was other healthcare professionals saying, "These nurses, these doctors are spreading disinformation." They were claiming to be experts in whatever they were saying and they would attack people like Nicole Sirotek, Dr. Peter McCullough, Dr. Robert Malone, prominent physicians, and nurses, and say, "You're wrong because I say you're wrong."

Ken McCarthy: Did you come across any make-believe doctors or nurses, people who were posing as doctors and nurses that actually weren't?

Katie Spence: Yes, I did. There was a member of Team Halo. His name is Tyler Hardy. He was a member of Team Halo. He was exposed for having used someone else's credentials. He has come out since then and apologized for that. I talked to him.

Ken McCarthy: He apologized?

Katie Spence: He did. He came out and said, "I'm sorry. I took someone else's credentials. I lied." Tyler said that Team Halo verified him however they did it.

Ken McCarthy: When he apologized, did he apologize just for misrepresenting his identity or did he apologize for the vicious attacks that he launched on innocent people?

Katie Spence: He apologized for misrepresenting who he was. I have seen his videos. He is not as bad as some of the other more egregious videos. Some are horrific.

Ken McCarthy: Okay, plain vanilla stuff. He wasn't attacking individuals.

A further historical note, from back in the 1980s. I showed you a copy of my book before we spoke, *Fauci's First Fraud*. I tell people that COVID was just AIDS all over again, the same playbook, literally, right down to the absolute details, just a different disease. They cast a wider net over a bigger population with fraud, but they also used intimidation. Someone I know personally, Celia Farber, a journalist, wrote some very important articles in the 80s and early 90s, calling Fauci's narrative into question. She received unbelievable attacks, on the level of what Nicole has described. Nicole

described them in detail and they were about as bad as you can get short of physical violence. It was as bad as you could get. So we have this entity called Team Halo. Do they have a website or a Facebook page?

Katie Spence: They had a website. They still have a Facebook page. They have a Twitter that they have not taken down. But their web page is gone.

Ken McCarthy: Their website is gone. Did that happen before or after your article?

Katie Spence: That happened after. On the social media front, they have not been active since January 18th, 2023. My article came out around January 31st. Their last post on social media was right before then. I contacted Team Halo, as any responsible reporter would do, and said, "I'm writing this article, and I would love to talk to you. I'd love to talk to anyone from your team and get your side of the story." Never heard anything back.

As to their website proper, that didn't go down until sometime after July 27th. I don't know exactly when it went down. It went dark after July 27th, according to the Wayback Machine.

Ken McCarthy: Your articles mentioned Team Halo by name.

Katie Spence: They and another group called Shots Heard Round the World, which is very similar.

Ken McCarthy: There's a second group. In the case of Team Halo, you don't know who the exact leader is. It just exists. But you know that it's affiliated with the UN?

Katie Spence: We know it was an official UN initiative, because you had Melissa Fleming, the head of the UN Department of Global Communications, saying, "We partnered with Team Halo." There's a video.

Ken McCarthy: So this is not a conspiracy theory. This is straight from the mouth of the UN itself. When a group with no money or resources partners with a large group with lots of money and lots of resources, it's possible that that group is getting money and/or logistical support, and who knows what else, from the larger organization. It's a possibility, though we

don't know for sure, that the UN sent money to this operation for it to carry out its deeds.

Katie Spence: It's possible. We don't know that. We do know that Shots Heard was funded by the CDC Foundation.

Ken McCarthy: There you have it. Everything's logistics. Someone's got to pay the server bill. The money is not going to magically appear in the bank account of the server company. I don't know if you came across any of this, but there also has to be some degree of recruitment, a degree of training, a degree of management. Did you see any evidence of people actively going out and bringing in new people and teaching them?

Katie Spence: Absolutely. That's how it spread. I talked to Tyler Hardy about the process, and he said he was recruited by another nurse named Jess. I know her name, but I've chosen not to doxx her. I don't know if Nicole has mentioned who this person is. She recruited him and then said, "Hey, Team Halo, you should talk to this guy." That's how he was brought into the organization. We know there was an effort to bring more doctors and nurses into Team Halo by the nurses and the doctors who were already part of Team Halo.

Ken McCarthy: Got it. Recruitment went on. Any evidence of training? In other words, "Here's how you go about doing what you to do"?

Katie Spence: Tyler said there was. We don't have any evidence of that, aside from what he said. He said that there was training along the lines of, "Here's how you can talk about this." He said specifically that when someone put out a video about the vaccines or COVID, and it didn't fit the CDC narrative, a Team Halo member could drop that person's name into a chat. The people in that chat would pile on to that video and attack whomever that was. It happened to Nicole, many times. She would drop a video on TikTok, someone from Team Halo would put her name in the chat, and everyone else from Team Halo would flood in and attack what she said.

Ken McCarthy: OK, so somebody was dispatching.

I had an experience with that, way back when Hillary Clinton was running for president and they put her on the cover of Teen Vogue. Vogue is an adult magazine, but there's a version for teenage girls. I casually

commented on my Twitter, “What an odd choice to put on the cover of that magazine”, and I got 187 frothing-at-the-mouth personal attacks which I traced back to a guy in LA who runs a troll farm, presumably on behalf of the Democratic Party, the Clintons, and Hillary Clinton.

I must have been dropped into the “task of the day” or the “task of the hour”, because these people who weren’t followers were all using similar language. There was a little variety. It wasn’t the same phrase every time, but they had three phrases that they kept rotating through.

So, we have people who are doing the recruiting, we have people who are dispatching and pointing out specific targets: “Here’s today’s target.” Were they given any specific instructions on how to attack or was that just left up to the individual?

Katie Spence: As far as I know, it was left up to the person. They could attack whoever they wanted. One important note. Team Halo was working with TikTok and they were said to have been whitelisted.

Blacklisted means that you’re shadow-banned and you can post but can’t get your videos seen. Tyler said that Team Halo was whitelisted, meaning they could get away with posting more aggressive attacks. Team Halo was able to make fun of doctors, and insult them personally, something that TikTok says they don’t allow, but for Team Halo members, it was okay. For example, you’d have people dancing in a video saying “Bye, bye, bye” to Dr. McCullough because he was suspended from Twitter.

Ken McCarthy: In other words, behavior that would normally not be tolerated on these platforms, like calling people names, ridiculing people, and even threatening people with violence, was magically okay for Team Halo.

Katie Spence: That is what Tyler Hardy, who was a member of Team Halo, said happened. I don’t have proof of that, but that is what he said.

Ken McCarthy: This is a phenomenon we see all over the Internet. One person says something that could be interpreted a thousand different ways and he or she is exiled from the Internet forever in disgrace. Then somebody else threatens to murder somebody with a hatchet and it’s fine. We’re getting an insight into a potential mechanism of how that works.

Katie Spence: It seems to be.

Ken McCarthy: Katie, I know you're a busy person, and you are giving us some prime time during your day. We've only just scratched the surface of something very important here. Previously, as far as I know, this phenomenon has not been documented by any news outlet, except for Brasscheck, my site, which is that there are large organizations, well-funded, that partner with attack dog troll farms. We don't necessarily know in each case who's managing these things. These folks specialize in gathering and weaponizing unbalanced, hostile, and self-righteous people who have lots of time on their hands, something there is no shortage of on the Internet. Is there anything else we should know that we didn't talk about, to tie up the loose ends?

Katie Spence: The big thing is that Team Halo has gone dark. But there are other groups, like the one we mentioned previously, Shots Heard. On their website, they say they have a "digital cavalry" that they deploy against people who are spreading misinformation on the Internet. You can check it out at shotsheard.org. That's not the only group like this out there. There are lots of these groups.

Ken McCarthy: That's probably the most important point to take away. This is not a one-off. This is a formula. This is a playbook. We're talking about the nurse's situation because they are near and dear to our hearts, but any quote-unquote "controversial" area is subject to this kind of disruption by these attack dogs.

It's funny how "controversial" topics always seem to be subjects where government and/or corporations want to shut down unapproved conversations. Topics like this become "controversial" very quickly. The case of Nicole and the rest of the nurses who've been attacked is not a one-off. This is certainly not a natural, spontaneous burst of normal Internet activity. It's seemingly well-funded and TikTok and other social media platforms seem to give these people a free pass to say and do whatever they want.

Katie Spence: Did. Team Halo was disbanded. That's a 'did' with Team Halo.

Ken McCarthy: Right. They're gone, but they'll almost certainly regroup under a new name. Katie, thank you so much for writing these articles to bring this to the public's attention. Thank you for spending time with us. People can find your work at the Epoch Times.

Katie Spence: Thanks for having me on.

Katie Spence covers various topics, focusing mainly on energy and politics, for The Epoch Times. She has also covered medical industry censorship and collusion with government. Before starting her career as a journalist, Katie proudly served in the Air Force as an Airborne Operations Technician on JSTARS.

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CHAPTER 11

THE CATASTROPHE THROUGH THE EYES OF A VETERAN RESPIRATORY THERAPIST

MARK BISHOFISKY INTERVIEW - OCTOBER 4, 2023

*“To know even one life has breathed easier because you have lived.
This is to have succeeded.”*

— Ralph Waldo Emerson

Ken McCarthy: Today, we’re talking with Mark Bishofsky, who will fill in a lot of the essential pieces of the COVID story. We often cover this topic, possibly more than any topic we’ve covered in our 23-year history. We cover alternative views because much of this information is not getting out. Mark will help us with some important information that we’ve touched on occasionally and help us go deeper. Welcome, Mark.

Mark Bishofsky: Thank you, Ken. I appreciate the opportunity to tell my story and help people understand what we’ve endured during the scamdemic.

Ken McCarthy: Mark, your profession is a respiratory therapist.

Mark Bishofsky: Correct, I'm a respiratory therapist, but many college degrees call it respiratory care practitioner. It's a career that came about in the 70s. We focus on cardiovascular and respiratory issues in patients and we are the ones in the hospitals who fully understand how a ventilator works.

We are at the bedside when a patient is intubated and are there to help insert the endotracheal tube and manage the ventilator. It's also a respiratory therapist's job to collaborate with doctors and help get the patients off the ventilator. We are the people, for better or worse, who "pull the plug" in an end-of-life situation at the hospital. So, we deal with bleak situations sometimes.

Ken McCarthy: When somebody who is a liberal arts law school graduate, like Governor Cuomo, is screaming for more ventilators, he doesn't know what he's talking about. As Erin mentioned in one of our interviews, it's great to have ventilators, but you need to have people who know how to work them because the process isn't simple. There's nothing simple about initiating or maintaining a ventilator, and there's nothing simple about taking a person off of one.

Mark Bishofsky: It's very complicated. A good respiratory therapist understands lung physiology. They understand lung compliance, airway resistance, and flow dynamics and how they come into play when running a ventilator in various situations. All ventilators operate differently and have different options, modes, and graphics screens that need to be managed and understood.

A good respiratory therapist can change the patient's outcome and limit the damage that positive pressure ventilation can do to a person's lungs. Many big hospitals will have pulmonologists in-house, and they understand ventilators. They can probably successfully manage them, but other hospitals have only hospitalists or general practice doctors working in the ICUs, and many of them don't understand how the ventilators work. They understand lungs and hearts and the other body systems, but they likely don't have a very good understanding of how the ventilator and patient

interact. Respiratory therapists are relied upon in those situations and can be very valuable.

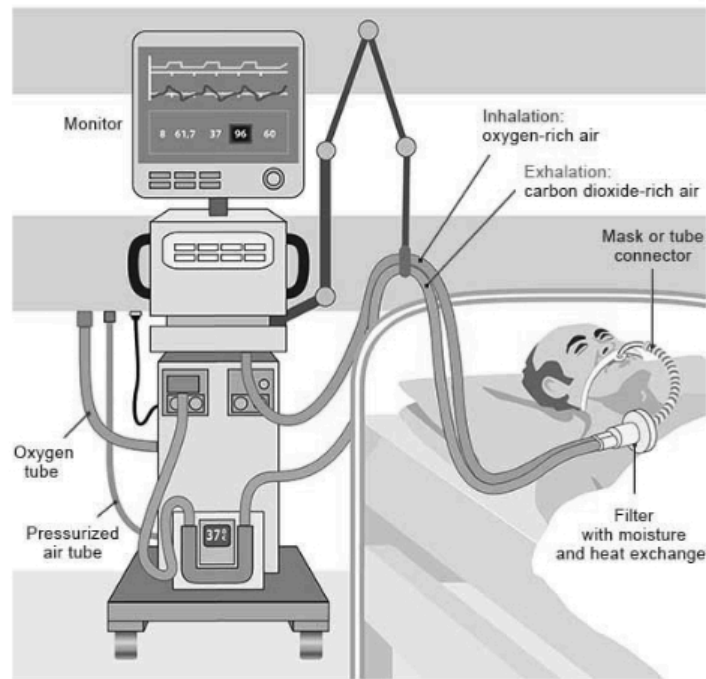


Diagram of a common ventilator setup. “All ventilators operate differently and have different options, modes, and graphics screens that need to be managed and understood.” - Mark Bishofsky

Ken McCarthy: So, this is a profession that started developing in the 70s. How were you drawn to it? And what is the education process for respiratory therapists?

Mark Bishofsky: Years ago, we were called oxygen technicians. I believe the first college programs for respiratory therapy came about in the 70s or 80s, which is typically now a four-year college education. I got a two-year degree in the 90s, but most programs are now four years. The program I was in started with 21 students and ended up with seven. It was two years of intensive clinicals and involved understanding the physics of the lungs, the cardiovascular system, and gas flow dynamics.

I got into the field a bit by accident. I had never heard of respiratory therapy. A family friend was the chief cardiothoracic surgeon at a hospital

in my hometown. He and I knew I would love the medical field, so he tried to convince me to become a doctor or a physician's assistant, but I didn't want to spend that much money or time in college.

I stumbled across this respiratory care practitioner degree. I had considered becoming a nurse or a physical therapist, but there were waiting lists in both of those programs, and I'm grateful there were because the next degree I saw without a wait list was respiratory therapy, and it has been a wonderful career. It's exciting. You get to put out the fires, so to speak, in the hospital.

You're on the move all day and not tethered to one patient, like a nurse. God bless the nurses who are at one patient's bedside the entire day, giving the care that the patient needs so greatly. I like the ability to move around the hospital and go where exciting things are happening.

Ken McCarthy: Like a cop or a fireman. So, a friend of the family was a surgeon?

Mark Bishofsky: Yes, Dr. Eric. He was the chief cardiothoracic surgeon and one of the pioneers of open heart surgery. One day, he invited me to watch him do a cardiac bypass surgery. I stood on a ladder and watched the entire surgery over his shoulders. I watched them crack open the chest and harvest veins from all over the body. I saw them stop the heart and restart it with the electric paddles. From that point forward, I knew I would go into a career related to hearts and lungs. I've always wanted to help people and did just that as a respiratory therapist.

Ken McCarthy: So, it was a true calling. You didn't look at the future and say I could be a doctor, accountant, lawyer, civil engineer, or respiratory therapist. You wanted to do this specifically to help people.

Mark Bishofsky: Yes. I think God put us here to help others. When you're a respiratory therapist, nurse, or doctor, you're helping people. I should say good doctors; many doctors, I think, unintentionally are harming patients. But yes, I want to help people. That's my goal in life.

Ken McCarthy: People help in all kinds of ways, and ideally, people go where their calling is, which is essential in health care. Hopefully, people working in medicine aren't there for job security and a good pension. With

the forced expulsion and people removing themselves from the medical system, schools are recruiting people in their middle age who no longer want to or have the ability to work on assembly lines wherever there is manufacturing.

There's an influx of people who didn't have a calling for medicine being brought in, and that doesn't sound like a good trend. I'd rather have the person who grew up wanting to be a doctor or a nurse working at the hospital, those who felt an affinity for it.

Mark Bishofsky: I agree. Hopefully, some of these new folks will have the necessary compassion and fall in love with that part of the job.

It's one thing to do respiratory therapy when the day is often mundane, and you're just giving someone a nebulizer breathing treatment, which often doesn't do a whole lot. But when you're in that room and look these patients in the eyes, where they're alone and at a bad time in their life, they're ill, they're not feeling good, to let them know, "I'm here for you. Do you need a warm blanket? Do you want something to drink? I care about you."

That provides a tremendous sense of fulfillment at the end of each day, to know that you can change somebody's world by being sincere and compassionate. I watched my mother and my grandparents die in a hospital. I witnessed the difference it can make to have individuals come into that room, who are genuinely compassionate versus those who are somewhat robotic.

Ken McCarthy: When you're in a hospital, generally, you're alone. You might have visitors, but it's you in the bed; you're stuck there. You're not getting up and walking around, and it's scary. It's a bad situation, by definition. I don't think there's anything positive about finding yourself in a hospital. You can have a positive experience there, which can turn things around, but being hospitalized is not on anybody's "top 100 things I'd like to do this weekend." You're dealing with a difficult, frightening situation, most of the time alone, and you're depending on the kindness of strangers.

Mark Bishofsky: You're right. And I think you nailed it. They're mostly alone. That's one of the topics I would like to discuss. Isolating the patients was one of the worst parts of this whole scamdemic. I'm not sure people

understand the negative consequences of isolating patients from their loved ones for so long while they are sick and in a hospital.

Ken McCarthy: This is dark territory, but it happened, and it's very hard information to get. Even Erin, I don't think, in her media appearances, had an opportunity to go deep into the specifics, especially around intubation. We talked to her about it, but she kept saying, "I'm not a respiratory therapist."

So, there's more detail that I don't necessarily have. Nurses aren't trained to do all the things that respiratory therapists do. I had never heard of respiratory therapists. I asked Erin, naively, what the training is like, and she told us it's just like getting any degree; it's years of intense training. So now, we're going to shift gears and get into what the respiratory therapists saw.

Mark Bishofsky: I think a little background on why I started questioning things and how I became somewhat of a whistleblower is pertinent. We were hearing about what was happening in Italy and New York City. Hospitals in the Midwest were preparing, and I was digging into the so-called news, and I realized that what we were being told wasn't true.

I'm always skeptical. I question everything. One of the big things for me was understanding that we can't trust the narrative and that the government doesn't necessarily care about saving lives. We spend so much money on healthcare in this country, and we're possibly the sickest nation in the world. We lead in things like obesity, heart disease, diabetes, and infant mortality; around 52% of Americans have a chronic illness.

We do a horrible job with healthcare, but it doesn't have to be that way. If proper messaging existed, we could change the narrative and make people healthier.

I was watching the news early in 2020. CNN showed a video they said was from New York City, where they were supposedly running out of ventilators. They were saying they had to use one ventilator on two patients, and they showed these pictures. I understand what it takes to use one ventilator on two patients, and it's extraordinarily complicated. The pictures they put out, of this horrible situation where they had run out of ventilators, were pure propaganda. It does not look real at all.



Staged photo? “I understand what it takes to use one ventilator on two patients, and it’s extraordinarily complicated...The pictures they put out were pure propaganda.” – Mark Bishofsky, registered respiratory therapist

Ken McCarthy: So, your first indication that the COVID narrative had at least one factual flaw was seeing the news reports about intubation. What they were claiming couldn’t be true and was beyond belief.

Mark Bishofsky: Right. The pictures they showed of two people lying in a hospital room on one ventilator could not have been a real-life situation. I asked several colleagues and a doctor how the depiction could be possible. Everyone agreed that it could not have been possible based on the configuration of the ventilator circuits and how the patients were situated in the room.

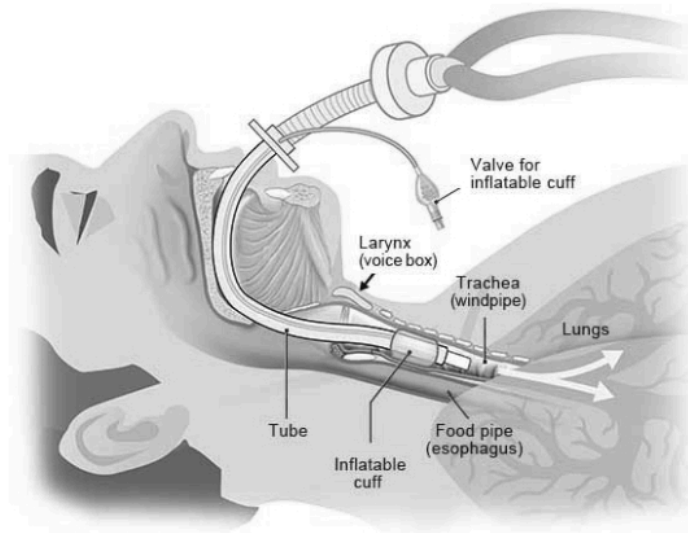
If you’re going to use one ventilator on two patients, the patients must have similar lung compliance, and they also have to be paralyzed and sedated. None of that was happening in the pictures they displayed on the

television screen. Was it a stock photo they had ready to use for propaganda or shock value? I don't know, but I knew right away they were lying.

Let's talk about early intubation. The first thing we started hearing was "ventilators, ventilators, ventilators." Cuomo ordered 30,000 of them and then this concept of early intubation started popping up. And now, looking back, at the end of my tenure at the hospital, a couple of the doctors did admit that early intubation was wrong, but they wouldn't listen to me at the front end.

I tried very hard to keep people from getting intubated electively and too early. Intubation is a dangerous procedure, which always leads to an increased chance of mortality. It is something you don't ever want to do electively.

Most of us will probably be intubated for hip surgery, a knee replacement, or something like that. Intubation means they're putting a tube down your trachea, and they're going to breathe for you. You're sedated for this, and it is a big tube. In the respiratory therapy world, we call it a garden hose. It's not quite as big as an actual garden hose, but it's invasive, and the complications that arise from intubation are profound.



“Intubation means they’re putting a tube down your trachea, and they’re going to breathe for you. You’re sedated for this, and it is a big tube. In the respiratory therapy world, we call it a garden hose. It’s not quite as big as an actual garden hose, but it’s invasive, and the complications that arise from intubation are profound.” - Mark Bishofsky

I learned very early on that intubation should be used in emergencies only. In 1999, I went to a doctor’s symposium at a big teaching hospital where they had a lot of data they could pull from and they discovered that when you intubate somebody for whatever reason, their risk of mortality goes up 25%. Therefore, the message was to avoid it at all costs. You only do it in an emergency.

During the COVID pandemic, under the guise of protecting the practitioners from aerosolized viral particles, they would intubate everybody early. Sometimes, they were intubating these patients when they were on such a negligible amount of oxygen that they didn’t even need the oxygen at all. It blew my mind. When you intubate somebody, first, you must sedate them and put them in a medically induced coma because they will fight it. A lot of the time, you have to paralyze them so the vocal cords will stay open. You’re also introducing a very nasty infection risk.

There’s a thing called hospital-acquired pneumonia. When you put that tube into a person’s trachea, they can very likely end up with bacterial

pneumonia on top of viral pneumonia, which will require initiating antibiotics.

It's important to understand that breathing through a ventilator is unnatural. Natural breathing creates a negative pressure in the thorax, which sucks air in. When our thorax expands, air rushes in; it's a vacuum. A ventilator provides positive-pressure ventilation. It blows the air in. It's precisely the opposite of normal breathing, and it causes all kinds of shearing forces inside the lungs, which will cause fibrosis and other problems.

Positive pressure ventilation can cause hemodynamic instability. When you're pressurizing the thorax this much, blood pressure can destabilize, and the patient will need blood pressure medication. It is hazardous, and to do it early, and electively, was ridiculous. I think now the consensus is yes, that was a ridiculous thing to do. We know now that somewhere around 85% of intubated COVID patients died.

Ken McCarthy: So, it's a last-resort practice or procedure.

Mark Bishofsky: Yes. Until the pandemic, we would only intubate in emergent situations, not electively.

Ken McCarthy: Talking about emergency situations, you mentioned hip surgery and knee surgery. I imagine a whole spectrum of surgeries that are pretty heavy-duty, where intubation is the call for the day, but those are serious and not trivial surgeries.

Mark Bishofsky: Right. Some surgeries can be done without intubation by giving you an epidural to numb the part of the body they're working on. They'll sometimes do this for a cesarean section.

There are a few surgeries a person may have where they won't require intubation, but there will be a lot of surgeries that will take multiple hours and require the patient to be completely still. If you're intubated for three or four hours, the risks that accompany that intubation are minimal. The longer you're intubated, the more these cascading problems will develop.

An image I like to use to explain this is blowing up a balloon. Everybody has blown up a balloon, and you know that at first, it's pretty hard to blow the air in, but then you hit a point where it becomes easy to get the air in.

Our lungs are the same. That pressure on the air sacs in the lungs is very harmful. The longer you use positive pressure to inflate the lungs, the more sheering force you put on those fragile tissues.

When you're blowing up lungs 12 to 15 times a minute, or more, with high pressures, you're hitting that shearing force every time, and it shreds the lungs. Being intubated for a little while will probably not harm you; you're just going to have a sore throat, but being intubated for days, weeks, or months at a time will likely be a disaster.

Ken McCarthy: So that's the critical point. Number one, you only use it when you need it. Number two, it's relatively safe with short duration, but the odds of a catastrophic thing happening go up the longer you're on. I remember news reports of people being intubated for days, and certainly for weeks. I think there was one case of a guy that was on one for a couple of months.

In their abysmal ignorance, news reporters were shocked when they saw the condition people were in after being intubated for weeks and even months, and your take on it would be they're probably lucky to be alive at all.

Mark Bishofsky: I will say that some of these folks likely didn't even need intubation, but there was a point during COVID when the only chance for certain extremely ill patients to survive was to be intubated. I saw it happen with patients who would probably die if they weren't intubated in the next hour or so. And that's when you should intubate.

I should also add for anyone who questions if COVID was real or if they just relabelled the flu, no, I will tell you there was absolutely something new under the sun, and it was a nasty disease for a few.

Ken McCarthy: The people who were that ill and required that type of support probably had co-morbidities or were elderly and frail. Were they medically obese, or have other problems? Did you encounter any healthy young people who required this drastic level of support?

Mark Bishofsky: No. Everyone was obese, over 70, had type 2 diabetes, or all of the above. I saw that 100% of the very sick COVID patients had co-morbidities.

I don't recall seeing anyone who was young and healthy and required a ventilator. I didn't work in a huge hospital, but I communicated with many other respiratory therapists working in big mega centers, and they reported the same thing. Nearly every single patient who was critically ill with COVID had co-morbidities.

Ken McCarthy: So, there were some patients who you feel legitimately needed a ventilator, and then many people who were put on ventilators who probably didn't need that advanced level of support. Can you talk about that? You mentioned early on that some people were getting oxygen assistance with a mask or another device, but that it wasn't a heroic amount of oxygen, and those people somehow ended up on a ventilator. Can you talk about those folks?

Mark Bishofsky: Yes. The initial criterion at the beginning of the pandemic was that if a person was on three liters of oxygen via a nasal cannula, they would be intubated and put on a ventilator. Everyone can maybe picture the two little prongs. You'll see people walking through the grocery store, elderly folks with little prongs in their noses. That's a nasal cannula. Three liters is but a whiff of oxygen.

Somebody on three liters of oxygen would be just fine if you took them off the oxygen. That is far from an emergency. Never in my 22 years as a respiratory therapist did we even think to intubate somebody because they needed three liters of oxygen, but that was the criterion early on. I believe that was more or less the criterion used in New York City.

Where I worked, we had some respiratory therapists who were fighters willing to challenge these doctors. We would tell patients to say no and refuse the ventilator because, at the end of the day, the patient can make that decision. We were able to help a lot of patients avoid intubation.

Ken McCarthy: Where do you think the criterion came from? The doctors became the enforcers, but where do you perceive the orders originated?

Mark Bishofsky: Probably bureaucrats. I think they came from the federal government and down through the state and then hospital administration. We've all heard of the kickbacks that everyone was getting

for putting people on ventilators. If you had a COVID patient, you got a certain bonus.

If you put them on a ventilator, you'd get another bonus. Not to mention remdesivir. You got a massive bonus if you were willing to put them on remdesivir. It seemed to me that the doctors weren't thinking for themselves. They were following some protocol and not looking at each patient individually. It's the treason of the experts.

There's a book out there that was written by Thomas Harrington about that concept. It's called *Treason of the Experts: COVID and the Credentialed Class*. I don't know why doctors feel that they're not susceptible to propaganda, but they clearly weren't thinking for themselves. I could give many examples of this. Take hydroxychloroquine. I brought forward research showing hydroxychloroquine can be very beneficial, but the doctors were citing CNN, that a study out of the Lancet showed that hydroxychloroquine was dangerous.

The study from the Lancet was later retracted and the data they used was bogus. The dosing that they used was way too high. But the damage had already been done. The news of the study being retracted wasn't news at all. It received no coverage. The study was complete garbage.

I think these doctors are good people, but they're pawns in this process. Doctors are no longer self-employed. They're employed by hospital systems, and many of them have a lot of debt and a lifestyle they want to maintain, so they follow orders without taking into consideration the lives of their patients. They weren't willing to think outside the box and try anything new. It was intubate, ventilate, and give remdesivir. They wouldn't consider alternative therapies.

Ken McCarthy: Yes. It seemed that CNN and NBC and their idiot newsreaders were ruling the country. After they'd issue a brainless directive on TV, suddenly previously well-established medical practice was thrown out the window. "Do what the television tells you. Don't ask questions and shut down anyone who does ask questions."

Mark Bishofsky: Exactly.

Ken McCarthy: A detail that came up in my research and surprised me is that not only are CNN and the CDC headquartered in the same city, Atlanta, but the CDC has a 200,000-square-foot public communications center that employs a lot of people.

So, we had people that didn't belong on a ventilator, period, and you've made such an important point that when we breathe normally, our diaphragms descend and open the space, and then the air comes in naturally. That's what the lungs are tuned to.

When a patient is intubated and on a ventilator, which you point out is only necessary in extreme circumstances, you're pumping the air in, and the lungs are not built for that. That's when someone with your training is so important. You'd probably be the first to see the warning signs that "Maybe we need to back off on this?"

Mark Bishofsky: Yes, as nurses Erin and Sarah mentioned, there was a shortage of respiratory therapists. Good respiratory therapists can recognize many issues before they harm the patient. We might recognize what we call the inflection point in the phase of inspiration, where the alveoli become floppy, the point at which the lungs remain more compliant and will not be harmed as much by the positive pressure.

You can recognize things like this on the graphics on the ventilator. There are complicated modes of ventilation that can be used to protect the patient's lungs.

Understanding the patient's unique circumstances and the ventilator they're on can make all the difference. It takes a respiratory therapist or a good pulmonologist to understand how to run a sophisticated ventilator and understand all the ways you can protect the patient from harm. Very few, if any, nurses will have this type of knowledge and training, and I'm not taking anything away from the nurses.

Nurses have so much to deal with. Their plates are full, and they deal with everything else going on with the patient, communication with family members, and the patient's emotions, and then Cuomo ordered 30,000 basic ventilators to blow up these patients' lungs 12 to 20 times a minute without the proper staff. That is not safe.

Ken McCarthy: Nurses know what they're capable of and don't perform open heart surgery. That's not their job. They have a very specific and essential job, and they do it well. As a technical question, I imagine the intubation process involves paralyzing the diaphragm.

Mark Bishofsky: Most of the time, especially with COVID. For some patients, if it's an emergency, like someone with a heart attack, you might not have time to give that paralytic. Many times, in a controlled situation, they will use a paralytic to make sure the body is completely relaxed, which will make it easier to thread the endotracheal tube through the vocal cords. So, paralytics are typically involved, especially in a COVID-type situation.

Ken McCarthy: And for people who don't know basic physiology, you live off your diaphragm. The minute your diaphragm stops and you don't have external help, it's over because you're not breathing, and if you're not breathing, you're not going to be around for much longer.

So, paralyzing the diaphragm is a pretty significant step to take, and you're now replacing the diaphragm with these pipes that are blowing the air in instead of the diaphragm descending, opening the lungs, and letting air flow in.

You saw a lot of people go on a ventilator that shouldn't have. For how many months did this early intubation concept go on? And we should talk about how long you were on the scene because, at a certain point, this situation became untenable for you. I can't fault anybody who, in a declared emergency, is following a protocol at the beginning.

To a certain degree, you have to trust that this is an emergency pandemic situation. Still, you and some of your colleagues recognized early on that too many people were being intubated. At some point, other people in the medical profession recognized that early intubation may not be the best way to treat these patients.

Mark Bishofsky: At the hospital where I worked, we fought it all along and with pretty good success. But I believe most institutions were intubating before they had to, throughout the entire pandemic.

Ken McCarthy: So, how long are we talking about? It's hard to tell. Is the pandemic even over? Is it still going on? Did it end when the magic

vaccines came out? When did this rush to intubate end?

Mark Bishofsky: I would say it was slowing down in early 2022. I left the field in October of 2021 and at that late date, there was a rush to intubate.

I should also mention something called non-invasive ventilation, where you put a mask over the patient's nose and mouth and ventilate using positive pressure. It's still positive pressure, but it doesn't require paralytics. It doesn't require intubation, and it doesn't require sedation.

You can successfully ventilate people this way. We saw it work many, many times. Early on, they would say you can't do that because they said we would be aerosolizing the room with virus particles, "You'll be spreading COVID all over the room, putting the nurses and everyone else at risk." But this was entirely bogus because these patients were already on a high-flow oxygen system, which also aerosolized the room.

I would beg the doctors, please just put them on this BiPAP or non-invasive ventilator. But the protocol from our mothership hospital was that you couldn't do that. They would advise the doctors to intubate. They didn't want to use non-invasive ventilation. Slowly, over the course of the pandemic, the doctors would wait a little longer before they would intubate the patient. Time to intubation gradually became a little longer, bit by bit, but nothing happened overnight.

Ken McCarthy: So, there wasn't an on-off switch; they started with an extreme approach and then modified it over time?

Mark Bishofsky: Correct. The cat was out of the bag. It became well known that the fatality rate was pushing 90% for intubated patients. When the data started to become apparent, I think they had to try to not intubate the patients.

Ken McCarthy: So, it took time and didn't happen in a day or a week? It took a long time for those modifications to be implemented.

Mark Bishofsky: Yes, I would say the changes took place gradually over a year or so.

Ken McCarthy: So, there was a red alert going out by people like you, saying, “Wait a minute, this is not normal. We’re intubating too soon. Remember how risky this procedure is?” And it took a year for changes to start showing up.

I remember an ICU physician, very early on in New York City, who was making and posting videos on his break. He was bedraggled, thoroughly exhausted, and he said, “I think we’re doing this wrong, guys. I think we need to set the vents differently.” Let me ask you this: many people think doctors are all-knowing about every medical matter. The joke I made with Erin about this is that if that’s true, then I can go to my podiatrist for heart surgery. Right?

Being an ICU doctor, even a capable one, doesn’t mean you’re necessarily a virtuoso at handling an intubated patient

Mark Bishofsky: Right. Most of them would have a pretty good understanding of what’s involved, but not like a pulmonologist. You’d want a pulmonologist at the bedside if you’re critically ill with something wrong with your lungs. ICU doctors have a good understanding but not as much as a pulmonologist.

Ken McCarthy: We can compare this to contracting. If I’m a general contractor building a new house, I know I need a foundation. I’m not personally able to lay a foundation, but I know who the good foundation guys are, and I can recognize if somebody’s messing it up.

That’s a general example, but maybe an ICU doctor is the hospital equivalent to a general contractor in that sense. They know what intubation is, they know what it’s supposed to be like, and hopefully, they know some good respiratory therapists they can count on, just like a general contractor relies on capable sub-contractors. The job of the ICU physician is to supervise and work with other specialists as a team. It’s not necessarily their job to “open the hood and fix the engine” because that’s not what they do.

Mark Bishofsky: Yes, there’s significant variability. Some ICU doctors might dig in or attend certain conferences and have a really good understanding of how to work a ventilator. But some won’t.

There's an old-school method of ventilating an intubated patient, where the tidal volume, or size of breath delivered, is just the standard 10 ml per kilogram. Some people like to continue doing things the way they were originally taught, but we've come so far with our understanding of lung compliances, airway resistance, and all the different flow rates and ventilator modes. It's very complex, and some ICU doctors might really be up to speed, but others might just be sticking with that old method.

Ken McCarthy: Erin mentioned that in the public hospital where she worked in New York City, there was just a drastic shortage of respiratory therapists. First of all, she said there were very few nurses in the ICU, and they were taking everybody who had a nursing degree, even brand-new graduates, which was a disaster waiting to happen.

She said that the other structural problem was that there weren't enough respiratory therapists. It's a hands-on job, and it's not like you can delegate what you do to other people in the hospital.

Mark Bishofsky: Yes. You need to know what you're doing when standing in front of that ventilator, watching the patient breathe, listening to their lung sounds, and looking at X-rays to determine how that \$50,000 machine interacts with the patient's lungs.

There was a shortage of respiratory therapists. In general terms, respiratory therapists are one of the most in-demand professions in healthcare. There are not enough respiratory therapists in this country or the world, and everyone realized that during COVID. From what I understand, they were employing a lot of travel nurses to fill the void in New York, but very few respiratory therapists.

Ken McCarthy: That sounds dangerous because there must be a physical limit regarding how many ventilators a person can monitor. What's the ideal situation? How many patients would you be supervising at a given time safely?

Mark Bishofsky: A respiratory therapist will typically be assigned 5–10 ventilator patients on their shift. Beyond that, depending on how critical the patients are, you may not be able to monitor the ventilators as closely as necessary. From what I have been told, there were many more ventilated patients in New York City. Erin said sometimes she wouldn't even see a

respiratory therapist the entire shift. So obviously, they are very short-staffed.

Ken McCarthy: The respiratory therapists weren't even there, and that's something we've talked about with Erin. We need to make sure we repeat it because it's so important. This is not something you figure out on the fly.

If somebody has never been exposed to respiratory therapy, and suddenly they're being told, "You have to handle this patient," there's no way that they're going to be able to operate safely.

Mark Bishofsky: I agree 100%.

Ken McCarthy: So, under normal circumstances, you and some of your colleagues, capable and qualified, were counted on to give doctors feedback about what was going on with the patient. Ordinarily, you're expected to execute the proper changes after conferring with the doctor. Doctors typically look to the respiratory therapist for advice about running a ventilator.

You mentioned that for ten years, you had a great relationship with all the doctors you worked with, and I'm sure that's the norm for capable and experienced respiratory therapists. You must be seen as valued partners in the process. But now, after speaking up and challenging doctors on different medication choices and early intubation, that relationship deteriorated. Let's go into that in detail.

Mark Bishofsky: I think one of the first memories I have of speaking out was when I went into the doctor's lounge area and started talking about how this virus was acting weird. I said, "This is like nothing we've ever seen before. You know they were working on gain of function viruses in Wuhan. In fact, in North Carolina, Chapel Hill, in 2015, they created a bat coronavirus with a spike protein. Don't you think this virus could be from a lab?"

They immediately parroted the CNN narrative, which was, "It's a wild virus, the science is settled, and what does it matter anyway?" At that point, questioning the origin of the virus was out of bounds, and I was pretty much outcasted right then and there.

I responded with, “What does it matter anyway? You’re just going to settle with ‘it doesn’t matter’ while we’re dealing with the most disruptive event in human history? It doesn’t matter if we ever truly discover the origin, so we can try to be sure this never happens again?”

That angered me. I started asking for vitamin D. We know now that most people who died had low vitamin D levels. I tried to get ivermectin and hydroxychloroquine for my patients.

I tried to push for pulmicort or budesonide, which is an inhaled medication, proving to be very effective for COVID. It’s inexpensive, with essentially zero side effects. There are no risks with giving this medication. In fact, I had a couple of doctors prescribe it, and we saw improvement, but then a new doctor would come in on a different shift and discontinue it because it wasn’t in their protocol for treating COVID.

I thought, “All these patients are dying, one after the other, with the same ventilator-remdesivir protocol. Why wouldn’t you try this safe and effective alternative? It’s an inflammatory disease of the lungs. And I’m asking you to give an anti-inflammatory medication selective to lung tissue.”

Tensions built up to the point where the doctors would no longer talk to me unless they had to. A couple of the doctors would just turn their heads and look at the wall when I’d say hello. I was no longer part of the team, as I had been for the ten years prior. I became somebody they thought was crazy just for asking simple questions and aggressively advocating for the patients in my care. To me, the message was, “Follow the science coming down from bureaucrats and don’t you dare think for yourself.”

Ken McCarthy: Nicole mentioned that not only would they not try some of the untested therapies, but they wouldn’t even let the patients take ibuprofen or give them steroids. My understanding is that steroids have always been used in the past for these types of acute lung infections. Can you explain what steroids are and why they are typically used?

Mark Bishofsky: The primary danger of becoming critically ill with COVID-19 is when the virus takes hold in the lungs. This novel lab-created virus is capable of a lot of novel symptoms, such as the loss of taste and smell along with blood clotting, but when it goes bad in the lungs, that’s when the trouble can really start for an unlucky few.

You're dealing with a viral illness, and the virus does what it does, but there's a cascade of things that happen within your body secondary to the viral infection, which causes an auto-immune response within your lungs. Everyone's heard the term cytokine storm, but it's basically an inflammatory response.

You would typically prescribe anti-inflammatory medications to treat inflammation of the lungs. The typical steroids given in this situation are prednisone or dexamethasone, but ibuprofen or other non-steroidal anti-inflammatory drugs could also be of potential benefit.

Where I was working during the pandemic, they were giving steroids to the patients, and, to be honest, I can't remember if they were given at the very beginning or not, but I believe they were. As lockstep as the protocols were, not all hospitals were doing the same things.

What boggled my mind was that one of the first drugs flying out of the pharmacy wasn't Pulmicort, the inhaled steroid. You can give systemic steroids, methyl prednisone, and prednisone, which will decrease inflammation but have nasty side effects. They can cause blood sugar issues and other undesired problems. Pulmicort is inhaled right to the location of the detrimental inflammation and with very few side effects.

A doctor out of Texas, Dr. Bartlett, discovered very early that patients who were already on Pulmicort for their chronic lung disease weren't getting sick with COVID. He started using high doses for his COVID patients and had amazing success. I used it when I got COVID. It's safe, inexpensive, and, in my opinion, highly effective. Multiple studies are now proving its effectiveness. You would want to give anti-inflammatory medications for an inflammatory process.

Ken McCarthy: And yet, my understanding from Nicole was that where she worked, they were told not to give steroids, and they were forbidden.

Mark Bishofsky: I remember hearing that as well, but by the time it hit Minnesota, that protocol had changed, and we were giving low-dose systemic steroids to the patients. But again, as I said, there are side effects that go along with those drugs, and what sticks out to me is that they weren't giving everyone Pulmicort after Dr. Bartlett came out with his information.

They were willing to give everyone a very dangerous drug like remdesivir, but a safe, inexpensive, and by all accounts effective drug like Pulmicort was taboo. Intubate early, give remdesivir, repeat, and almost all those patients died. Why wouldn't they try something new?

Ken McCarthy: So, they were using intubation as a prophylactic measure in situations when people were only requiring a whiff of oxygen.

You mentioned that some people had severe problems, and intubation may have been indicated. So, using intubation, as they were, is kind of like using an atom bomb to build a swimming pool. Just drop an atom bomb in your backyard when all you need is a backhoe.

Use the correct tool for the job. They need a little help, but they don't need a whole lot. When you have a job to do, you need to use the correct tool. They were calling for heavy artillery or Strategic Air Command when all they needed was a backhoe. So you were ostracized for asking questions and speaking the truth. That could not have been comfortable. And I imagine some of your colleagues went through the same thing.

Mark Bishofsky: Yes, there were a few of us. A colleague of mine, another respiratory therapist I worked with, Mike Toombs, resigned from the hospital a week or two before I did because the situation was tearing him apart. This guy, Mike, is one of the best respiratory therapists I know. I thought I was good, but this guy is one of the top therapists in the nation.

People need to understand that whoever perpetrated this whole scamdemic knew what they were doing. They knew they would end up with extremely short-staffed hospitals in the middle of a once-in-a-lifetime pandemic. They knew people like me would leave.

I don't think they cared, and what's crazier is that people were celebrating the fact that we were leaving our jobs because "Those crazy anti-vaxxers don't belong working in a hospital." But, if you're sick and need someone to run a ventilator, you want Mike or me there to save your lungs and maybe your life, whether we're vaccinated or not. And now we all know about this vaccine. It was never going to stop the transmission of the virus.

Ken McCarthy: Let's say somebody is getting an operation, and intubation is called for; an anesthesiologist will be in the operating room.

You usually get to meet the anesthesiologist before the operation. Is the respiratory therapist also in the operating room?

Mark Bishofsky: No, the anesthesiologists are the ones who run the ventilators in the OR. They typically use a different kind of ventilator than would be used in an ICU. They use a gas for sedation instead of morphine or drugs like that. We do get called to the OR from time to time if there are complications. So, the standard protocol would be an anesthesiologist running the ventilator in the OR and probably not using sophisticated ventilation modes. Basically, air in and air out.

Ken McCarthy: Are there quite a few operations where intubation is part of the puzzle?

Mark Bishofsky: Yes, there are a lot of surgical procedures where you'll be intubated preoperatively, and you will then remain intubated for a few days. For some of these advanced abdominal surgeries, for instance, you'll return to the intensive care unit, where the anesthesiologist will hand off the care to the respiratory therapist, and we will put them on our ICU-style ventilator. We will then maintain and care for the patient's respiratory condition and continue that care until they're ready for extubation, having the endotracheal tube extracted.

Ken McCarthy: Were there any other alarming activities going on that you can think of?

Mark Bishofsky: We should address the isolation of the patients. The nursing home situation was an abomination. Those poor people had to visit their loved ones through a window. How many of these elderly folks lived the last couple of years of their lives in solitary confinement?

I think the isolation of the patients was the worst atrocity of the entire scandemic. All you have to do is investigate the Grace Schara story. You'll be horrified. In my opinion, that's a case where the hospital committed intentional homicide, and it all started with isolating the patient. In the hospitals, the patient's inability to have family advocating for them at the bedside was a crime, and, as a society, we can never let that happen again.

(Editor's note: The complete story is told in great detail by the documentary *Breaking the Oath: The Story of Grace Schara* by Jeff

Wagner.)

I didn't see anything as atrocious as the Grace Schara incident at my hospital, but there was a bargain, and the deal was, "You can see your family members if you're willing to go to comfort care." Comfort care is when the focus turns from treating the patient's condition and trying to save their life to a focus of just making them comfortable. All life-supporting interventions are withdrawn, and the patient is given drugs like Ativan and morphine to keep them comfortable and to expedite death. This is a legitimate practice in the case of someone who is in great pain and there is no hope of recovery.

But under COVID, they were using it with people who were refusing to be intubated or placed on a ventilator. The doctors might say something like, "Your chances of living without intubation are slim."

You have to put yourself in the patient's shoes. They're pretty sick, and they've been in the hospital for many days. They're alone, tired, suffering, and afraid. They want to see their family. That's all they want. They want some love and compassion and realize there's a good chance they will die. They'll do almost anything to see their loved ones, including giving up. The protocol was, "If you're willing to go to comfort care, we'll let you have one family member come in and visit." It's basically telling the patient, "If you give up, if you submit to death, then you can see a single family member before you die."

Ken McCarthy: You witnessed that in Minnesota? That's mind-boggling.

Mark Bishofsky: Yes, and at first, you couldn't even have family visit, period. There was no bargaining. I held the hands of several patients until they took their last breath. They weren't allowed to have any family or friends with them, and I refused to let them die alone.

Some of these folks had just given up. They would say, "I'm done. I'm not getting intubated. I'm tired, and I don't want to fight anymore." They'd given up hope. And then the process begins. Staff slowly withdraws the support that's keeping them alive, and they start giving large amounts of morphine. I would hold their hand until they took their last breath, which was surreal. It wrecked me emotionally. I would go home in tears. That's

how it was and I've heard numerous anecdotal reports just like this from all over the country.

Ken McCarthy: So, the patient is in the hospital, which is not some place people want to be. It's not a good or happy day unless you're giving birth or something. Maybe that'd be one exception. Perhaps you're dying, and now you've been saved. That would be another exception, but being in a hospital is generally not a good thing. It's usually a scary place with high stakes. You may be lucky enough to have family or friends who can visit you, but they're not hanging out with you all day. You're alone most of the time.

Then, some people don't have family or friends nearby and are perpetually alone. So, they're in a high-stakes, frightening situation, and they're alone. And then COVID comes along, and they enforced the isolation. And what you're saying is, there was one group of patients saying, "Look, we don't want to be intubated. We're not going for it." And the answer to that was, "Well, then you'll just have to die." Was care that could've helped them withdrawn?

Mark Bishofsky: Right, some of the patients who submitted might have survived if they had hung on and fought longer, but they were terrified and alone. If they were willing to go to comfort care, they'd be allowed to have a family member come in. As I said before, they were much more likely to decide to hang on if they could have family at their side. They so badly wanted to see a family member. At that point, they may have been in the hospital for two or three weeks, and they're struggling. It's not easy.

They were sick, but some of them might have lived. Once you declare your willingness to go to comfort care, end-of-life care, they can have you dead within an hour with enough morphine. They start decreasing the amount of oxygen or non-invasive ventilatory support and discontinue any life-sustaining medications. Decrease support and increase drugs like morphine.

Once this process begins, it's common for the patient to struggle. They get confused and might become agitated. At that point, they start increasing the amount of morphine via the IV. They continue that process until the patient stops breathing and has no heartbeat.

I watched that happen too often, and sometimes, I would be in the room for an hour at a time, doing as much as a stranger in a space suit could do to make them comfortable and not feel alone. That's part of what made me leave. I couldn't tolerate watching that any longer. It was breaking me.

Ken McCarthy: Now, comfort care. That's different from hospice. My understanding of hospice is that they withdraw medical care and let you leave the hospital or put you in a comfortable situation so you can die comfortably. I don't know. Is hospice taking active measures to shorten somebody's life?

Mark Bishofsky: It does happen like that sometimes, but hospice is different. They may not be teetering on life or death when placed in hospice. They might have a month or two or six to live, and the focus would be to make sure the patient is comfortable, "We're not going to poke you with needles so much anymore. We will ensure you're comfortable and won't do any more unnecessary treatments. We'll give you as many pain medications as you need to be comfortable, but you could live quite some time still."

In a hospital situation, when someone is acutely ill with COVID symptoms, and you withdraw their care, they will likely die in a few hours. If you shut off the BiPAP, non-invasive ventilator and discontinue the oxygen, they will deteriorate quickly. They get confused and sometimes combative and might start twitching and doing all this stuff you don't want to see. You give them morphine to expedite the dying process.

These people can die quickly, within minutes or hours. Maybe they can make one more iPad connection to their family, trade tears, and express their love. Then they take life-giving support away, give them a bunch of morphine, and they die. It literally happened that way.

Ken McCarthy: I want to clarify because this point often gets obscured by the news media. These people were already very sick before COVID and COVID was perhaps the final straw on an already vulnerable system. These were not healthy people who "got COVID" and suddenly found themselves on death's door.

Mark Bishofsky: Correct. They are sick enough that they will die soon if you take away support. If you remove the non-invasive ventilator, their

blood pressure medications, and steroids, they will die within hours.

It needs to be said that I saw patients who were this sick walk out of the hospital, never needing a ventilator. Some of those who died, like I just explained, had they been willing to hang on a little longer and not given the devil's bargain of seeing a loved one one last time or dying alone, they might have recovered, but they so badly wanted to see a family member.

Some people were just fed up. Maybe they didn't like the life they were living. They're sick of struggling to breathe, they're not going to accept intubation, they're just done. Sometimes that was the case.

Ken McCarthy: I have a video clip you may have seen, where a doctor was at a patient's bedside, and she was struggling. The doctor was selling the idea of intubation and said, "Hey, if we do this, you'll get out of here sooner."

Mark Bishofsky: Unbelievable, and that doctor was not telling the truth. The opposite is true.

Ken McCarthy: People now know, from this interview, that if you or a loved one find yourself on a vent, you should get the very best respiratory therapist you can. I bet some billionaires don't even know this important piece of information.

That said, you, a veteran respiratory therapist with a sterling record, were made to feel like an outcast, and at a certain point, you said, "Enough." You mentioned that after you left that hospital and that situation, you've had difficulty getting employment as a respiratory therapist elsewhere. Can you talk about that?



“What we’ve decided, if you’re okay with it, is to give you the best chance possible and to put that breathing tube in you. You get the best chance possible for recovery, as quickly as possible. Okay?” – Doctor recorded speaking to a patient. Broadcast on a NBC Nightly News segment

Mark Bishofsky: Yes. I was on a lot of podcasts. I led a lot of rallies and marches, and I ran for office. My name was out there as a whistleblower. I had trouble getting hospitals to interview me when I first started looking for employment. These hospitals are in great need of respiratory therapists, especially someone with 20 years of impeccable experience, but they wouldn’t call me back.

I’m guessing they would do an Internet search and see the activism I was involved with. Since then, I’ve scrubbed what I could from my social media profiles and made them private. After I did that, things changed a bit, and I have received calls back. I figured that would happen, but it’s sad that if you’re simply thinking critically and asking questions, you can be blacklisted to a certain degree.

Ken McCarthy: It sounds like the social media presence was the problem. I ask this because I know that a lot of these hospitals are owned

and operated under huge corporate umbrellas. I imagine there's blackballing involved. "Hey, don't hire this guy. He was a problem to us."

Mark Bishofsky: I believe that happens to a certain degree, but I can't prove it. If hospitals in desperate need of respiratory therapists aren't going to call me for an interview, then something is up.

Some of the hospitals have multiple positions posted. I have 20-plus years of excellent job experience and references. There would be no reason not to hire me other than they only want people who will "trust the science". I've never been fired. My references are as good as you can get, and my level of experience is as high as you can get as a respiratory therapist with decades of experience. There would be absolutely no reason for them not to call me after I submitted applications.

Ken McCarthy: This is an example of hospital administrators putting petty politics over having the best people to take care of their patients. I don't know what other conclusion you can draw.

Mark Bishofsky: I couldn't have put it better myself, Ken; that's exactly what's happening.

Ken McCarthy: You became an activist and started holding rallies. You not only separated yourself from the situation, you also started pushing back. Suddenly, it wasn't enough to say "No" only on the job. "I've got to do something more." Talk about that evolution if you would.

Mark Bishofsky: I had been speaking with hospital administration throughout the pandemic, and I told them that I knew there would be a vaccine, and I knew they would be mandated. I had an open dialogue with the president of my hospital, and he said, "No, we're never going to do that to you." And I said, "You will, and when you do, you'll have to walk me out because I'm no longer jumping through your hoops. I'm tired of what I'm seeing here, these bunk PCR tests, inflating the death rates." Finally, the mandate came across my computer, and I resigned.

There's this interesting tidbit I should mention. I gave a two-week notice, and on my very last day, I was walking between patient rooms when our medical director approached me and said, "Mark, I'm sorry to see you go."

He was kind enough, but I couldn't help myself, and I asked, "Doctor, can I just have one second of your time? Can you please tell me your thoughts on vaccinating young men for this disease where they have essentially a zero risk of death but a high risk of myocarditis after vaccination?" He got red in the face and said, "I don't have the bandwidth for this right now" and walked away.

Within two hours, I was walked out of the hospital by security. The reason they gave me was, "You were going rogue." If you dare to challenge the narrative, you will get walked out of the hospital.

The day after I submitted my two-week notice, I became an activist and being an activist was never my calling. I'm shy. I had never been a public speaker or an activist. In fact, Ken, I wish I'd never met you. In a perfect world, we would just be living our lives. I wouldn't have met Del Bigtree, Aaron Siri, or Dr. McCullough, but sometimes you find yourself being called to something and you'd better listen to your heart.

It all started when I made a sign with a piece of tagboard and a post, and I went outside the biggest hospital in downtown St. Paul. The sign said, "If you're against vaccine mandates, take a flyer." I had been waiting months to follow the activists and protest alongside them, but I hadn't seen any action.

I knew I was going to organize something. I didn't know what, but I wanted to know if I was alone. One thing led to another and within four days I held a rally in my hometown with 1,000 people, a bit of a miracle. I don't know if there was divine intervention or if the universe was working in my favor, but somehow, 1,000 people showed up, which was amazing.

We nearly got in trouble because of the number of people who showed up in this public park. I didn't expect 1,000 people. I pictured a couple hundred in my wildest dreams. Within a month after that, I had a rally with over 5,000 people at the state capitol. These are some of the biggest rallies Minnesota has seen in many years if not decades. The following month, I hosted a rally where about 7,000 people attended. We marched to the governor's mansion from the Capitol with about 5,000 people.

This was one of the biggest marches Minnesota has ever seen and the media didn't cover it. We had a two-mile line of 5,000 people walking

peacefully protesting the mandates. The St. Paul Police escorted us and we had no issues whatsoever.

Thousands of gentle and civil people were carrying their health freedom signs and we didn't get any news media coverage, which I wanted because I knew there would be people who would join the movement if they knew it was there, but the media knows that, too, so they don't cover it.

Things really blew up for me. We tried to sue the hospitals for these mandates but were unsuccessful there. I was on many podcasts, The Stew Peters Show, NBC Nightly News, and one thing led to another. I founded the organization Stop the Mandate Minnesota and ran for State House of Representatives. It's been a heck of a ride I had never planned on.

Ken McCarthy: Thank you for that. That's quite amazing. It's hard to get people to come out for anything and it looks like people were ready to find somebody who would stand up and organize a resistance. So, you had such a good relationship at that hospital that you were talking with the president of the hospital. You were immersed in the life of the hospital so much that the president of the hospital made time to converse with you.

Mark Bishofsky: It was an open-door policy. I could walk into the hospital's administrative area and right into his office. He's a good guy and we had essentially the same political perspective regarding individual freedoms. He didn't agree with much of what was happening, but these people just went along with it.

Ken McCarthy: That's a really interesting point. It seems that people believe doctors are independent free agents who can do whatever they feel is best and that's not true. Whatever they do must be approved by hospital administration or they'll be out of there quickly.

Mark Bishofsky: Yes. The doctors for the most part are no longer self-employed as they were decades ago. They're now employed by hospitals, have student loans, and a lifestyle they want to maintain. They must follow the protocol or they'll be fired. I know a doctor in my system who was prescribing ivermectin and he was fired. All his patients asked for the medication and none of them required hospitalization. His patients did quite well and with zero side effects. He was fired for taking care of his patients.

Ken McCarthy: So, this is an administrator's decision. As you know, I have a low opinion of them based on how they behaved, but they didn't cook this up themselves. They were getting the directive from the federal bureaucracy via the state bureaucracy.

Mark Bishofsky: Exactly. I think the orders come straight from Fauci, other bureaucrats, the NIH, or the CDC. It was all cooked up ahead of time. Everything that has happened in healthcare over the last 20 years has led to taking away the doctor's autonomy. Obamacare and HIPAA are not what people think they are.

Ken McCarthy: HIPAA. Everybody thinks HIPAA is a wonderful thing designed to protect the patient, but it doesn't protect them the way they think.

Mark Bishofsky: It's data collection; it has nothing to do with your privacy.

Ken McCarthy: It's a smokescreen for allowing data collection. Another thing you mentioned is that you weren't fired. You didn't tear up your contract, screaming and raving. You went about it in a very businesslike, professional, and respectful way. You submitted your two-week notice, and you worked through those two weeks. Everything was fine. You were doing your job, but the minute you asked a question about the vaccines, two hours later, security walked you out the door.

You left your position and ended up running for office. Let's talk about that experience. It was interesting in two ways: one, you were incredibly successful and two, despite your electoral success, there was an intervention by another set of enforcers.

Mark Bishofsky: I'd be the last person anyone would have expected to run for office. Any of my friends or anybody who knows me, even a little, would know that running for office is nothing I ever aspired to do. I was holding these big rallies and getting some attention politically, so a few Republicans would come to me and say, "You should run for office."

My first instinct was, "I want nothing to do with that corrupt apparatus." But a friend said to me, "That's what they want you to think because if everyone thinks that way, then nobody good will ever run." That struck a

chord with me. I thought about it, prayed, and talked to my wife about it. Your spouse may not be the candidate, but she is more than involved. I decided I would do it and I was very successful.

We have an endorsing process in Minnesota, one of five states where we don't just have a primary. Our political parties get together and we caucus. Then, we have conventions for each house district and delegates vote for who they want to represent their party in the House of Representatives election.

I won 80% of those votes and won. I had a clear message, "I'm a regular guy I'm here to represent you. I'm not doing this for any status. I see the big scams in the world. I don't trust either party. I'll call out corruption on either side." I'm told the message was authentic and it was well-received.

I became the endorsed candidate and the woman I beat at the convention had signed a document saying she would not challenge me in a primary election and she said this verbally as well.

After I won the endorsement, I met with Republican Party leadership and it became clear they expected they were going to control me. I told them, "That's not the case with me. I'm not going to vote how you tell me to vote. I'm not going to vote to grow the government. I'm not going to compromise my values. I will represent the people who have chosen me, and I won't be a pawn for you."

They immediately understood that they couldn't control me so they came after me. They propped up the woman I beat at the endorsing convention and ran her in a primary against me. It's just like George Carlin said, "It's a big fucking club, and you ain't in it." Right?

They didn't want me in their club. They spent near-record money to take me out in the primary. They spent between \$55,000 and \$70,000 against me and employed door knockers on behalf of my opponent. I had to spend everything I had in the bank to win the primary and I still won with 60% of the votes, but some serious damage had already been done.

They flat-out lied and put out mailers saying that I supported medical mandates. I'm the guy who founded Stop the Mandate Minnesota and held rallies in protest of mandates. They'll do anything to win. This political

apparatus cannot be trusted. I ended up losing the general election by eight percentage points.

Had they given me the \$70,000, had they employed door knockers for me, and had I not had to spend the \$30,000 to win the primary, that would have been a \$100,000 swing, and maybe things would have turned out differently,

Ken McCarthy: Had they not run a campaign based on lies or slander.

Mark Bishofsky: Right. I don't know how it would have turned out had the playing field been more fair, but I learned a lot. Our political system in the United States is a uni-party.

Ken McCarthy: We can't underestimate the power of these parties. Logistically, they've already got the apparatus. If you had all the money in the world, you'd still have to find the door knockers and know where and how to hire them.

How do you train them? How do you supervise them? How do you deploy them? How do you take advantage of the data they collect? It's a job and for an amateur—in the best sense of the word, someone doing it for love rather than status or to make a profession out of it—that's a steep learning curve.

So even if you had all the money in the world, they still have the advantage because they've got the machine. And then the other point that's important to make is it's very easy to throw your hands up about the Democrats and how clinically insane they are, but the Republicans are no better. At the end of the day, they just do it differently. It's a giant machine and it in no way works for the people it supposedly represents.

Mark Bishofsky: Right. Even many Republicans in Minnesota weren't willing to remove the governor's emergency powers. It took political pressure from the grassroots. The only way a politician will act against the establishment is if they feel like they will lose money or an election.

I think some people get into politics for the right reasons and some stay that way, but very few. I think a lot of people get into politics to gain celebrity status. Unfortunately, it's a popularity contest and I want none of

that. They don't want people like me in there. They don't want people like you in there. They want people they can control. It's a sad truth.

It's very complicated and I'm discovering how and why it's so corrupt. There are many different lanes you can go down, but it's corrupt and money's a big part of it.

A lot of politicians just love the attention. They love that people look up to them and they love their celebrity status. Many politicians, especially at the federal level, qualify as psychotic or sociopathic. I am afraid we are led by psychopaths.

Ken McCarthy: I've had thought that, too. There's oligarchy and democracy, but there's another form of government and I'll call it psychopathocracy, ruled by psychopaths.

Mark Bishofsky: I've not heard of that one, but I'm familiar with Kakistocracy. That means rule by the least qualified.

Ken McCarthy: Yes, that's another way to describe it Kakistocracy.

We need a new word for rule by the pathological. I think certain politicians revel in corruption, people like ex-San Francisco mayor Willie Brown, who launched Gavin Newsom, Kamala Harris, Nancy Pelosi, and Dianne Feinstein on the world. Then there's the ex-governor of Louisiana Edwin Edwards whose campaign bumper sticker proudly said "Vote for the crook, not the Kook".

Some of these guys make no bones about it. They say, "Hey, we're crooks, but we'll help you out occasionally." Those types of people revel in having power and making power plays. A lot of people with that kind of strange psychological configuration find themselves drawn to politics.

People who don't think like that are either personally repelled by it or don't even go near it. Like you, they expect the process to be competitive but fair. You were the people's voice and 80% of Republicans wanted you, but the political establishment didn't. But you still won the primary. They drained your resources and that benefited the other party. They flaunted the will of the people. Evil, but just another day at the office for these guys.

What are you working on these days, Mark?

Mark Bishofsky: I have a lot going on, Ken. I have a show on Rumble called The Truth Expedition. So far, I've been blessed with some fantastic guests. We discuss health freedom, vaccine injuries, geopolitics, etc.

I'm still involved with politics as well. I'm on the state executive board for the Minnesota GOP. I'm probably the last person they want in that room, but it's an elected position and the people put me there.

I also homeschool my children and keep busy with activism. I host a variety of different rallies and events. Everything I do from here forward is to ensure that my children live a life of freedom.

Ken McCarthy: Great! This is a good way to end I think. I'm so glad we met. Maybe as you said earlier it would have been better if circumstances were such that we all could have just gone about the normal business of living, but that turned out not to be in the cards. On the other hand, if there's a silver lining to this cloud, it's the people like you I've met through this.

Mark Bishofsky: Yes, I agree. The people I've had the opportunity to meet have been a massive blessing. I think things in the world will get worse from here, but I think life and the universe are like a roller coaster. You've got to hit bottom if you want to get to the top again. Hopefully, we can be the phoenix rising and end up with a much better world in a few years.

Mark Bishofsky is a highly experienced respiratory therapist who was thrust into activism and politics after facing unconscionable vaccine mandates in the workplace.

Mark challenged doctors and hospital administrators since day one of the pandemic to fight for better patient outcomes.

In October 2021, in an act of non-compliance, he resigned from his position and became an activist. He founded Stop the Mandate Minnesota, held multiple rallies all over the state, and led one of the largest marches in the recent history of Minnesota. He was also a candidate for the state house of representatives in MN.

Mark continues his activism by hosting various events and is still involved in state and local politics. He is currently the host of the show The Truth Expedition on Rumble.

The Truth Expedition Podcast - <https://rumble.com/c/c-2452974>

CHAPTER 12

FOLLOWING THE MONEY TRAIL

AJ DePRIEST INTERVIEW - JUNE 19, 2023

“Thanks to ideology, the twentieth century was fated to experience evildoing on a scale calculated in the millions. This cannot be denied, nor passed over, nor suppressed. How, then, do we dare insist that evildoers do not exist? And what was it that destroyed these millions?”

— Aleksandr I. Solzhenitsyn,
The Gulag Archipelago 1918–1956

Ken McCarthy: Today I’m talking with AJ DePriest of Tennessee Liberty Network, a non-profit grassroots group. They’re researching, advocating, organizing information, and making it available to the world. It is run entirely by volunteers and is a fully independent group. Welcome AJ. Thanks for joining us.

AJ DePriest: Thank you. I’m so happy to be here.

Ken McCarthy: I always say the world can be explained by logistics. Once you know how the money is flowing, where it’s going, who’s getting

it, and why they're getting it, a lot of mysteries become less mysterious. Your group has done deep research into some of the COVID money flows.

I want to go into detail, so if you'd share some of your research, we'd appreciate it. In no particular order. Pick a topic you want to start with. Then we'll go to the next one and then the next one because there's no shortage of financial scheming that's been used to support and prolong this travesty of science and medicine.

AJ DePriest: Definitely. We started in January 2020, researching CARES Act money because we wanted to see where all that money was going.

Ken McCarthy: Please tell us what the CARES Act is, or was.

AJ DePriest: The CARES Act is the Coronavirus Aid, Relief, and Economic Security Act. In early 2020, trillions of dollars in COVID relief funds began pouring into states through the CARES Act. About \$178 billion went immediately to healthcare providers for what they called Phase 1 relief funding. That money immediately trickled down to organizations like the NIH (National Institutes of Health) and the CDC (Centers for Disease Control and Prevention) through HHS (Health and Human Services).

We knew that something was very wrong in healthcare when we started hearing stories around August 2020 about people ending up in hospitals and basically being medically kidnapped. Families were not allowed to be with them and they were being held against their will. They were being given medications without informed consent. There seemed to be a common thread, which was most disturbing, of a one-size-fits-all protocol administered to patients in the hospitals.

It started with the COVID tests. People were being tested over and over again until a positive test was acquired. People were being admitted into ICU and their families were being shut out. They'd be in the hospital for anywhere from a week to 3 or 4 months and then put on ventilators and dying.

Those of us who've worked in healthcare knew that something was very wrong because there is never a one-size-fits-all protocol for anything. For people to tell us in the healthcare field that because COVID was so new, novel, deadly, and unique, and nobody knew anything about it, that this was

the protocol they chose to address it with, it didn't add up. It didn't smell right from the beginning to us.

We started following the CARES Act money to see where it was going, and we followed it trickling down through Health and Human Services to, eventually, the NIH. We discovered that the NIH published their protocols for inpatient treatment of COVID. From there, we started documenting the medications that were listed in the NIH protocols: remdesivir, Actemra, dexamethasone, baricitinib.

There were a lot of sedatives, very scary sedatives, that were being given to patients to make them compliant. A lot of them didn't want to be administered these drugs. They were not giving their informed consent. There were quite a few used, like midazolam, fentanyl, Ativan, morphine, Precedex, and Diprivan (propofol). These sedatives are associated with creating breathing problems, so if somebody goes in with pneumonia or COVID and they're given these drugs, it will decrease their ability to breathe which will eventually lead to them being put on a ventilator.

Ken McCarthy: You're able to breathe because of a musculofascial organ called the diaphragm. If you give patients opioids or some of these other depressants, you suppress the action of the diaphragm, which will reduce the amount of oxygen the person gets.

AJ DePriest: Exactly right.

Ken McCarthy: This would be counter-indicated. Before COVID, these drugs would never have been used or even dreamt of being used as a treatment for someone with respiratory difficulties.

AJ DePriest: Especially piling on drugs like fentanyl and Precedex together, which all say in the inserts from the pharmaceutical companies that they suppress breathing. It didn't make any sense to us. The families that were coming to us for help were telling us the kind of drugs that they were taking. When we found these drugs in the NIH protocols, we started looking into why the hospitals were following this specific protocol and nothing else.

Ken McCarthy: Why are they throwing out all pre-existing medical protocols?

AJ DePriest: Why are they firing and censoring doctors and nurses who want to give high-dose vitamins and ivermectin, hydroxychloroquine, and other known medications that are safe and inexpensive and could help patients get better? Why were those completely banned from hospitals? Why were they punishing, censoring, and taking licenses away from doctors who wanted to administer these treatments?

Ken McCarthy: Early on, an experienced ICU doctor said, “We’ve got the ventilators set at too high of a level.” Because what does a vent do? It pumps your lungs. It moves your lungs for you. “We’re blowing people’s lungs out. We’re not helping them,” he said. “We’re potentially injuring them.” He was pulled right out of the ICU and put into the ER so that he couldn’t say anything else. If you went down the list of every single protocol that was enforced by the NIH through the hospital administrators, everything they did not only made no sense and didn’t help, but was actively injurious.

AJ DePriest: I have my personal opinion about why that was happening, aside from the huge amount of money pouring into hospitals to exclusively implement the NIH protocols.

I think, and we found evidence of this in HHS documentation—it’s ugly and I’m just going to say it—our government deliberately targeted the people who cost the most to care for. These were people who had heart issues, problems with obesity and diabetes, people who had compromised immune systems and were on really expensive medications, and even people with Down syndrome. People who cost the most to care for.

The government claimed, in all of its narratives, that these people were the most vulnerable, but the fact is that we were able to treat COVID patients outside of hospitals, even people with severe co-morbidities. They survived. But if these people were in the hospital with these co-morbidities, they likely died on ventilators. We found in HHS documentation that they were talking about how much money would be saved by the Centers for Medicaid and Medicare by decreasing this population.

Ken McCarthy: Did they write that down?

AJ DePriest: Our first clue that CMS (Centers for Medicare and Medicaid Services) was involved was that when we were looking at the first

payouts of money to states, money came down from the CARES Act to pay hospitals per COVID admission. For Tennessee, we found that hospitals were getting \$166,000 for every COVID admission.

Ken McCarthy: What?

AJ DePriest: Yes. You say “What?” like that’s a big number, but look at West Virginia, which was getting almost \$500,000 for every COVID admission.

Ken McCarthy: That is unbelievable. I knew there was a number, but I had no idea it was so high.

AJ DePriest: For West Virginia, it was much higher. We traced that back—the decision was not based on need. You would think that New York or California would get the most COVID money per COVID admission just because of the number of cases. But California and New York had relatively low per-COVID admission figures, around \$12,000. West Virginia paid \$470,000. Why? Because they based it on the previous year’s Medicare and Medicaid reimbursements. The states that had the most Medicare and Medicaid patients got the most money per COVID admission.

Ken McCarthy: Okay. That helps clarify.

AJ DePriest: This is documented in the white paper. You’ll see all of it.

Ken McCarthy: There is a white paper that goes along with this, thoroughly referenced and documented. Sometimes the bad guys take the links down after they’ve put a link in the white paper, but then our friends in Tennessee find another source.

(Editor’s note: See Appendix 7: *Follow the Money - Blood Money in U.S. Healthcare Financial Incentives: The Use of “Covered Countermeasures”*)

AJ DePriest: That was just the per-COVID admission money that hospitals were getting.

Ken McCarthy: When you say “COVID admission,” do you mean somebody shows up at a hospital and they get a positive COVID test? Or do they have to be formally admitted to the hospital?

AJ DePriest: They have to be admitted to the hospital and there must be, on record, a positive COVID test.

Ken McCarthy: They give somebody a test, declare it positive, put them in a bed, and collect half a million dollars.

AJ DePriest: Yes, just for the admission. They also got paid for the COVID test itself. They got paid more for every COVID test that was positive. The hospitals didn't pay for these tests. They were given COVID tests to use. They made money from COVID testing. When you hear about people in the hospital who were tested a dozen times for COVID for just their ER visit, you have to imagine how much money they made just from the testing and the admission itself. Then they started fast-tracking them on the NIH protocol, which was the most important because...

Ken McCarthy: Before we go there, I want to clarify something. We're both business people and we know that when your cost is zero, and you get to charge somebody "X" for it, that's a pretty nice profit margin. You described how if somebody didn't test positive the first time, they'd keep testing them over and over and over again until they got a positive result. The tests cost the hospitals nothing and there was a big payday for them if they could get one to come up positive.

AJ DePriest: Exactly. Some people never got a positive COVID test, so those people didn't get put in the ICU. But if there was a positive COVID test, they went to the ICU and we all know that there are false positives. Those tests were far from perfect.

Ken McCarthy: If they were reliable at all. Not only are the tests not perfect, but the inventor of PCR, Kay Mullis, was crystal clear and on the record that this technology should never be used for diagnostic purposes, ever. It has nothing to do with diagnosis. It is for amplifying existing genetic information for research purposes. He won the Nobel Prize for PCR, yet nobody followed the science.

You walk into the hospital. You're tested and if they don't get you the first time, they're going to test you again, and the cash register rings every time. They finally get the positive test, and now they move you to a bed. You are now a "case," and they collect, in the case of West Virginia, half a million bucks. Now what?

AJ DePriest: I should also mention that these COVID tests were released under emergency use authorization, EUA. If you pick up a COVID test today, in the grocery store or pharmacy and you look at it, it says it's released under EUA only.

The federal law regarding EUAs means that you can't force people to take them. All of these kids in schools and people in their workplaces, who were forced to take a COVID test to keep their jobs and to keep going to school, need to understand that EUA means you cannot be forced to take it. Yet they were doing it in hospitals over and over again, without informed consent.

State	Amount	State	Amount
Alabama	\$158,000	Montana	\$315,000
Alaska	\$306,000	Nebraska	\$379,000
Arizona	\$23,000	Nevada	\$98,000
Arkansas	\$285,000	New Hampshire	\$201,000
California	\$145,000	New Jersey	\$18,000
Colorado	\$58,000	New Mexico	\$171,000
Connecticut	\$38,000	New York	\$12,000
Delaware	\$127,000	North Carolina	\$252,000
District of Columbia	\$56,000	North Dakota	\$339,000
Florida	\$132,000	Ohio	\$180,000
Georgia	\$73,000	Oklahoma	\$291,000
Hawaii	\$301,000	Oregon	\$220,000
Idaho	\$100,000	Pennsylvania	\$68,000
Illinois	\$73,000	Rhode Island	\$52,000
Indiana	\$105,000	South Carolina	\$186,000
Iowa	\$235,000	South Dakota	\$241,000
Kansas	\$291,000	Tennessee	\$166,000
Kentucky	\$297,000	Texas	\$184,000
Louisiana	\$26,000	Utah	\$94,000
Maine	\$260,000	Vermont	\$87,000
Maryland	\$120,000	Virginia	\$201,000
Massachusetts	\$44,000	Washington	\$58,000
Michigan	\$44,000	West Virginia	\$471,000
Minnesota	\$380,000	Wisconsin	\$163,000
Mississippi	\$166,000	Wyoming	\$278,000
Missouri	\$175,000		

Breakdown of funding per COVID case that each state received from the first \$30B in aid (CARES Act 2020).

Lack of informed consent and the fact that it was EUA is a double whammy, as far as I'm concerned, as far as the Nuremberg Code goes. They shouldn't have been allowed to do that.

Ken McCarthy: People were coerced into taking these tests which are medical procedures and fairly invasive ones at that. They're sticking something up your nose.

AJ DePriest: Yes and you don't know what's on it.

Ken McCarthy: Or any possible negative consequences of having the procedure done.

AJ DePriest: Right, any adverse side effects from the test.

Ken McCarthy: The fact that it was an EUA is the definition of experimental. “We haven’t tested this thing, so it’s not part of our medical bag of tricks.” It’s the definition of experimental. It’s a medical procedure, there’s a lack of disclosure, and there’s coercion. All that makes it as clear a violation of the Nuremberg Code as you can get.

AJ DePriest: Exactly. Everything in the NIH protocols and these tests were all fast-tracked EUA. Which is not usual either. The NIH protocol medications that they wanted every COVID patient to start on are on a list and in the white paper you’ll see the dates when they granted EUA for these drugs. The common ones were remdesivir, that was the bad one, and Paxlovid. The other big one that they gave, the one that’s always given with remdesivir, was baricitinib. All of these were EUA and they were listed in the NIH protocol as being the only medications that people could use.

We set out to find out why these drugs were being given and not the drugs that doctors would commonly give patients to help them get over a health problem like pneumonia. The important distinction we found, first of all, was the cost of these drugs, and the fact that some of them had patents and some of them didn’t.

Ivermectin was one of the most effective medications that you could give someone with COVID, or any number of other diseases and conditions, but because it’s so cheap, nobody can make money from it. We were looking at the cost of ivermectin compared to Paxlovid, which is \$529 for a dose, or remdesivir, which is \$3,120 a dose, or convalescent plasma, which is \$5,000 per treatment. These were being used instead of safe, effective, well-known medications that cost under \$5 a dose.

Ken McCarthy: Billions of doses of ivermectin have been given over the decades safely to treat parasites.

AJ DePriest: It’s safer than Tylenol and it’s legal in Tennessee to buy over the counter. That’s how safe it is.

Ken McCarthy: Here's a great irony. Guess who has been sending container loads of ivermectin to Africa for the last 10 to 15 years without any worries about its safety at all. The Bill and Melinda Gates Foundation. They knew damn well that this drug was safe because they'd been administering it to millions of people through their charity.

AJ DePriest: Yet doctors were being removed from hospitals for even suggesting it for COVID. It took a long time for us to uncover exactly what the connection was between the NIH protocols and the demand for their exclusive use in hospitals. We started tracking the funding and how hospitals were reimbursed, the definitions of some of these terms. We found that these NIH protocols were connected to what they call DRGs, diagnosis-related groups.

It's similar to when you take your car to the shop and they plug it into a computer and it gives them a code. The code tells them what's wrong with the car with a list of repairs and the accompanying charges to perform them. They use the same kind of code. Centers for Medicare and Medicaid use the same system for health-related issues.

The DRGs they sent up for the NIH protocols were very specific. They wanted to put patients on remdesivir right away because it was a very high payout for them.

Ken McCarthy: Tell us about the payout. We know the drug costs \$3,100 per administration.

AJ DePriest: Right.

Ken McCarthy: What did the hospitals receive if they gave somebody remdesivir? Who paid them?

AJ DePriest: It depends on how much they could give them and if they could finish the protocol. You have to look at it from a DRG standpoint instead of just remdesivir or just baricitinib. The DRG gave them the list, explaining that you have to start them on remdesivir, and baricitinib, and you have to add these other drugs that are part of the protocol. The protocol lays out exactly what all those drugs are, but they have to give them all those things to get the big payout.

Ken McCarthy: Were they incentivized to do part of the protocol or did they have to do the whole thing to get paid?

AJ DePriest: They're de-incentivized for not doing the whole protocol.

Ken McCarthy: If I wanted to incentivize salespeople, I would say, "Make some sales and we'll give you a commission, but if you sell x, y, z, you'll get the trip to Hawaii, you'll get the car, you'll get all that and more." They used that same kind of incentive system with these hospitals.

AJ DePriest: The DRG is like that car analogy I gave you. There's a DRG, number 193, for simple pneumonia with pleurisy. That DRG would pay out a total of about \$9,300. If that same patient developed bronchitis and asthma, a different DRG, number 203, would pay out another \$4,900. If there was another respiratory system diagnosis, DRG 206, they would get another \$6,000.

For every stage of COVID that a patient went through in a hospital, a new DRG would be attached and they would get another payout. We found the complete spreadsheet of DRG payouts. As you said about the ventilator, a respiratory system diagnosis with ventilator support for more than 96 hours paid \$39,896.58 in addition to the per-COVID-admission payout.

Ken McCarthy: Amazing.

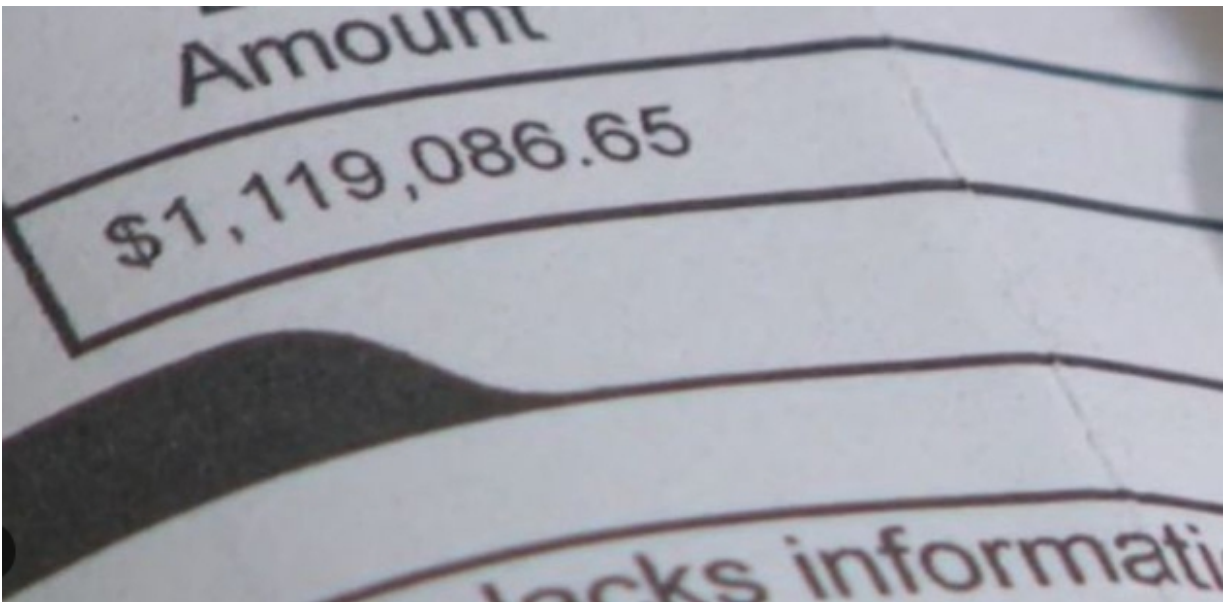
AJ DePriest: If the patient had an HIV diagnosis in addition to COVID, the hospital would get almost another \$19,000. The DRGs changed a little after April 1, 2020, and paid out even more money.

There was also CTAP, the Coronavirus Treatment Acceleration Program. These were new drugs like the convalescent plasma and COVID drugs and biologics that weren't part of the original NIH protocols. If they could introduce those drugs to the protocol, they would get 20% on top of the total bill for that patient.

They were getting loads of money, not just for the testing, but for the per-COVID admissions. All the DRGs would add up for that COVID patient. We've seen the actual billing. We've seen the reams of paper from patients' hospital records and we're able to see all the DRGs and what they were charging.

Ken McCarthy: What were some of the more egregious totals that you saw for a single case of COVID?

AJ DePriest: Over a million dollars. Well over. \$1.5 million, \$2 million. That's for people who were in the hospital for a couple of months. Some of these people were given courses of remdesivir three or four times.



Hospitals received enormous payouts for giving patients “officially-approved” drugs. “Over a million dollars. Well over \$1.5 million, \$2 million. That’s for people who were in the hospital for a couple of months. Some of these people were given courses of remdesivir three or four times.”
- AJ DePriest

Ken McCarthy: Three or four doses, or three or four courses?

AJ DePriest: Courses. Instead of a five-day course of remdesivir, they were given that five-day course three or four times.

Ken McCarthy: How did they survive?

AJ DePriest: Those who survived, and many didn't, were fighters. They were tough people.

We have video of some people who were telling them, “No, I refuse remdesivir.” Later on that night, the nurse or doctor comes in and hangs an IV pole and it’s remdesivir. They’re telling them “No, no, no.” Then they’re restrained.

There were two 20% bonus operations going on. If you followed all the DRGs exactly to the letter, you got a 20% bonus, above and beyond. The second 20% bonus was for the CTAP, the new medication regimen, where if you could introduce new drugs for the patients that were part of that acceleration program, you got another 20%. There were two 20% bonus structures for, in essence, killing people.

It’s so complicated. When you read the white paper, your mind goes blank, trying to follow the money, how it flowed down from the CARES Act to HHS, to Medicare and Medicaid to the NIH. It’s dizzying, the path they took to do all this.

The bottom line is that a hospital could easily make \$5 million on average over the first phase of COVID from COVID patient admissions. When things started calming down, we began to look at some of the most egregious hospitals we had been fighting. In their press releases, we saw that they were undergoing big capital projects, new buildings, new equipment, multimillion-dollar expansions. Anybody can look at hospital audits. It’s all publicly available information.

If you look at the hospital audits, you see that, as we found in Arizona, the hospitals saw a 35% increase in revenue for 2020, totaling about \$1.5 billion in net operating profits. Before that, they were operating in the red.

North Carolina, \$5.2 billion net profit in 2021. We tracked a lot in Tennessee because that’s where we’re based and we battled 10 hospitals in Tennessee daily from mid-2020 on. And we’re still battling them on a lot of fronts. HCA, one of the largest for-profit hospital systems in America, received about a billion dollars in CARES Act relief funds. Tennessee’s billionaire Frist family, which owns HCA, doubled their wealth between March 2020 and 2021, from \$7.5 billion to \$15.6 billion.

Ken McCarthy: So in addition to the massive wealth transfer that came from shutting down family restaurants but keeping chains open, shutting down mom-and-pop stores but keeping Walmart open, shutting down social

life and giving the tech companies even more of a captive audience because everybody was locked down, we can add the hospitals. This was a cash cow for many.

AJ DePriest: Cookeville Regional Medical Center here in Tennessee and Williamson Medical Center in Franklin, Tennessee had huge revenue boosts. If you drive down to Williamson Medical Center, you'll see the construction work on a huge wing they're building.

Ken McCarthy: This was a wealth transfer to savvy and unethical hospitals. My understanding of how a hospital is run is that it's the hospital administrators who run the hospitals and direct the medical care. They tell the doctors what to do and not do.

AJ DePriest: Yes, CFOs, the administrators, their legal teams, they're the people behind this. An interesting thing. We tracked the trajectory of CEOs and hospital administrators here in Tennessee to see where the administrators were going and how fast they were moving. There was a huge transition of CEOs during COVID. They wouldn't stay in a given hospital very long.

Ken McCarthy: During all this, were there a lot of musical chairs going on among CEOs? More than usual?

AJ DePriest: Yes. The Becker Health News is a newsletter published for people who work in the administration of hospitals. We were searching through their archives and finding articles saying, "This CEO that was here is now here. And this CEO that was here is now over here." We noticed that every three to four months, these CEOs were moving around. I think it was for liability reasons.

Ken McCarthy: Now they can say, "I'm not there anymore. I'm at this hospital."

AJ DePriest: Right. The same goes for doctors. This is a really good time to bring up the CMS waivers. Have you heard about the waivers?

Ken McCarthy: No.

AJ DePriest: The Centers for Medicare and Medicaid Services were front and center in all of this because they were paying out big

reimbursements to hospitals. The CMS DRGs are the collection of protocols being administered to COVID patients.

Ken McCarthy: The money came from Congress and it got sent to Health and Human Services which oversees the CDC and NIH. Then they got money and somehow the CMS also received money. NIH determined the protocols.

AJ DePriest: NIH didn't come up with them alone. The CDC, the NIAID (National Institute of Allergy and Infectious Diseases), which is Fauci's organization, and HHS all had a hand in developing these protocols. In the white paper, there's a table that has the list of all known treatments for COVID.

In that table, you'll see everything that is in the NIH protocols compared to everything that keeps people successfully alive outside of hospitals, and you'll see the costs.

	Improvement	Studies	Patients	Cost
Iota-carragee..	80%	[11-96%]	1 394	\$1
Proxalutamide	78%	[70-83%]	4 1,953	\$500
Quercetin	63%	[27-81%]	9 1,279	\$5
Ivermectin	63%	[54-70%]	88 132,948	\$1
Nigella Sativa	60%	[44-72%]	8 2,056	\$5
Casirivimab/i.	60%	[42-73%]	21 47,101	\$2,100
Diet	59%	[38-73%]	10 585,652	\$0
Bamlaniv./e..	55%	[30-71%]	14 24,423	\$1,250
Povidone-Iod..	53%	[37-65%]	13 2,749	\$1
Vitamin A	50%	[-9-77%]	8 17,951	\$2
Bromhexine	50%	[-8-77%]	6 684	\$5
Melatonin	49%	[33-62%]	16 14,009	\$1
Lactoferrin	48%	[30-62%]	4 786	\$5
Paxlovid	46%	[23-62%]	10 40,597	\$529
Ensitrelvir	45%	[19-63%]	1 28	\$500
Ensovibep	45%	[-276-92%]	2 400	\$2,100
Curcumin	40%	[31-48%]	19 4,006	\$5
Colchicine	40%	[29-50%]	34 22,738	\$1
Exercise	40%	[32-46%]	34,464,632	\$0
Budesonide	39%	[23-52%]	8 9,951	\$4
Vitamin D	38%	[31-45%]	83 140,560	\$1
Tixagev./c..	38%	[18-53%]	5 16,700	\$855
Fluvoxamine	37%	[-1-60%]	8 3,620	\$4
Peg.. Lambda	35%	[-132-82%]	3 2,116	\$500
Sleep	35%	[20-48%]	7 1,636	\$0
Nitazoxanide	34%	[-27-66%]	11 3,025	\$4
Molnupiravir	33%	[10-50%]	12 15,337	\$707
Metformin	29%	[23-35%]	40 145,044	\$10
Zinc	29%	[16-40%]	32 35,459	\$1
Antiandrogens	27%	[17-35%]	38 89,952	\$5
Favipiravir	26%	[14-37%]	43 17,665	\$20
Hydroxychlor..	25%	[21-29%]	348 458,272	\$1
N-acetylcys..	22%	[10-32%]	14 24,440	\$1
Probiotics	21%	[10-31%]	17 17,615	\$5
Vitamin C	19%	[9-28%]	45 39,300	\$1
Remdesivir	17%	[7-26%]	36 123,330	\$3,120
Sotrovimab	17%	[-71-59%]	6 9,729	\$2,100
Famotidine	15%	[4-25%]	23 76,267	\$5
Aspirin	13%	[7-19%]	48 130,277	\$1
Conv. Plasma	-1%	[-15-12%]	14 15,607	\$5,000
Cannabidiol	-53%	[-616-68%]	3 1,153	\$25
Bebtelovimab	-151%	[-6014-90%]	1 380	\$1,200

A list of known COVID Treatments. NIH-specific drugs (such as Paxlovid and remdesivir) designated with flower icons. Effective, at-home, early treatments (such as ivermectin and quercetin) designated with boxes. "Before COVID, these (NIH-specific) drugs would never have been used or even dreamt of being used as a treatment for someone with respiratory difficulties."

Ken McCarthy: A lot of people added ingredients to the soup. The NIH told the hospitals, “Here’s what’s approved, here’s what’s not approved.” CMS is a huge money source and CMS said, “You’d better follow those NIH protocols.”

AJ DePriest: Right or you won’t be reimbursed. Those administrators are all about the bottom line so they’re going to tell doctors, “If patients’ families say, ‘I want to try ivermectin,’ you need to shut them down immediately. There will not even be a discussion about it.”

Ken McCarthy: If they say, “We don’t want them on a vent,” if they say, “We don’t want them on fentanyl or remdesivir,” shut that down too.

AJ DePriest: If you have to separate the patient from the family, and if you have to sedate and restrain the patient, do it. But get this protocol into them.

Ken McCarthy: I have a video that appeared on a local TV news channel. They weren’t trying to spill the beans, but they did by accident. They recorded a doctor falsely claiming to her patient, “If we vent you, you’ll get out of the hospital sooner.” Of course, the opposite is true.

AJ DePriest: Yes, the fear porn was in high gear all over the country. We saw it mostly here in Tennessee because that’s where we’re located, but it was everywhere.

Ken McCarthy: The doctors, and to an extent some of the nurses, were peddling it.

AJ DePriest: A lot of doctors and nurses left. In Mississippi, a doctor is running for governor, Dr. John Witcher, an amazing hero doctor. He was running an ICU where all of the patients were on remdesivir and he said, “That’s it. I’ve had enough.” He went to take all of his patients off the vents and the remdesivir and give them ivermectin.

The hospital fired him immediately. He was escorted out and he lost his job. He is an amazing hero in this fight. He has saved more lives.

We have another organization called the Adam Group. It’s a COVID advocacy group that either helps families get into hospitals to be with their loved ones because they’re too sick to get out of the hospital or we help

people get out of hospitals including some pretty dramatic “jailbreaks” that were kind of scary.

Ken McCarthy: This is called the Adam Group?

AJ DePriest: The Adam Group. We have a website, TheAdamGroup.net, but we haven’t been able to edit it because GoDaddy cut off our ability to edit our website over a year ago. It’s still up, but we can’t edit it or update anything, because we had content on our website that they say was “fake news” or “dangerous” or whatever their excuse was.

With that organization, we worked with doctors and nurses all over the country to help people stay out of hospitals by getting them protocols that would save their lives. I can tell you that 100% of the people that we helped stay out of hospitals are alive today. They survived, 100%. But the people who were in hospitals, if we couldn’t get them out, close to 95% of them died.

Back to the waivers. Never in the history of healthcare, and I’ve been working in healthcare since the early 90s in healthcare administration and policy analysis and legislation, had I ever seen a violation of patient rights as I’ve seen during COVID.

That was another red flag that we needed to investigate. We found that CMS issued a series of waivers in early 2020 that allowed hospitals to do things for which they would have been sued and had the funding guts ripped out of them if they had done these things before COVID.

People who worked for the hospital associations have told us, “These things aren’t happening in hospitals. They would lose all their funding.” Indeed. Indeed, they would, but these waivers allowed hospitals to throw away their patient bill of rights.

Erlanger Hospital in Tennessee told a family, “We don’t have a patient bill of rights.” They said that. “We don’t have a patient bill of rights.” A hospital that accepts federal funding would never tell a family that before COVID.

Think about it. Remember how walking into a hospital, posted on every wall and every hallway would be the patient bill of rights? If admitted to a hospital, your admission packet would include the patient’s bill of rights.

You'd have a website where you and your family members could access your medical records. That is no more. That was a CMS waiver that they could take up to 90 days to give the family access to medical records. It used to be immediate.

The waivers also allowed hospitals to not give food, water, or personal care to patients for up to 48 hours. Patients' families were telling us, "We have a loved one in the hospital who hasn't even had a drink of water in two days," or, "is lying in their own feces because they're restrained in the bed and they can't get up to go to the bathroom."

Ken McCarthy: What was the basis for CMS to give these waivers?

AJ DePriest: Because hospitals were so overwhelmed, they said they had to forego some of these human rights, these basic patient and human rights, all in the name of COVID. The doctors and nurses were overworked and drained to the point of breaking, so they couldn't possibly take care of these patients.

There were also waivers that allowed Medicare patients to not have a health plan. When Medicare patients are admitted to the hospital, they're given a plan for their course of treatment in the hospital. That was waived.

There was a waiver that allowed doctors from all over the world, doctors who had suspended licenses, nurses with suspended licenses, and doctors with foreign licenses, to come and practice in hospitals. We started to hear people say, "There are all these doctors treating our loved one and they barely speak English. We don't know where these doctors come from." There were many foreign doctors and nurses.

Ken McCarthy: I wonder what they were paid. Erin Marie told me she was being paid \$10,000 a week and that's just the nurses.

AJ DePriest: They were coming from all over the world. They were not licensed under the US healthcare system.

Ken McCarthy: Erin told me they were being paid by Homeland Security. Did you hear that?

AJ DePriest: No, we didn't dig into the funding for the foreign doctors. But we know that while your family doctor was not allowed to go into the

hospital to treat your dad or your wife, because they didn't have privileges at that hospital, foreign doctors and nurses were allowed to come in who weren't licensed under the US healthcare system and treat your loved ones.

Ken McCarthy: And paying them a fortune. If the nurses were getting \$10,000 a week, what these doctors were getting must have been incredible. Talk about incentivizing.

Imagine. You've been brought to the US from a foreign country with your medical license and, hopefully, you learned something when you were in medical school in that country and now you're getting paid what would be a year's salary in your home country per week. When they arrive they tell you to "forget all previous medical standards, and do this." How many doctors are going to follow these orders no matter how ruinous it is to the patient?

AJ DePriest: They lost a lot of American doctors and nurses because they refused to go along. They had to fill that gap, somehow, by releasing these waivers and relaxing the licensure requirements for doctors and hospitals during COVID. Keep in mind, this is all during a public health emergency. As long as there's a PHE (Public Health Emergency) in effect for the United States, these waivers are active.

Ken McCarthy: When did Biden finally turn that off?

AJ DePriest: I don't think he turned off the PHE yet. They ended the COVID health emergency, but I don't think that they will end the PHE anytime soon because the PHE drives everything. As long as there's a public health emergency in the United States, these high reimbursements for the NIH protocols are paid out. Once the PHE ends, these reimbursements end. The per-COVID admission payments end.

As soon as the PHE ends, every COVID test in the United States comes off the market and you can't get them anymore. Because once the PHE ends, all of those EUAs expire. Another thing that PHE drives is liability protection.

Ken McCarthy: I'm looking this up as we speak. We're recording this on June 19, 2023 and apparently, the patient's bill of rights remains suspended under the PHE.

AJ DePriest: When states concluded their public health emergencies, like in Tennessee, our public health emergency ended. When that happened, we were able to pressure hospitals to let families in and to release patients AMA (against medical advice). Because, and here's another thing people didn't understand and few still know, once you're given a sedative, you cannot check out AMA from the hospital.

Ken McCarthy: They could give you a sedative and as soon as you swallow it you're stuck there?

AJ DePriest: People who were diagnosed with COVID or went into the ER and were diagnosed with COVID sometimes were told, "You seem edgy or upset about this. I understand. Why don't I just give you a little Diprivan to take that edge off and help you rest?" Once you take that drug, you can't leave. You're a prisoner. You become a medical prisoner.

Ken McCarthy: Earlier, you referred to medical kidnapping. This is a form of medical kidnapping. I think it should be clear now to everybody who's been listening, that these are not things that you read in the newspaper or are theorizing about or heard as hearsay. You have been working to save people's lives in these hospitals. You've encountered this directly, daily, for years now. This is truly frontline experience you're sharing.

AJ DePriest: One of the reasons families are having such a hard time suing hospitals is that they're all protected under the PREP Act. That's the Public Readiness and Emergency Preparedness Act, which is how the immunity from liability works. As long as there's a PHE, these hospitals and doctors are protected under the PREP Act.

From a legal standpoint, you have one year from the date you realize that you've been wronged to file a lawsuit. Some of these families who lost loved ones in hospitals at the end of 2020 and in early 2021 didn't know until just a month ago that there was any wrongdoing.

The PREP Act is not going to go away until there's some other mechanism in place to keep people from suing. Some people want to sue hospitals but they can't find lawyers. They can't find DAs, police, or anybody to prosecute, or file charges because of the PREP Act. The hospitals are protected under the PREP Act. As long as there's a public

health emergency, the PREP Act protects them. The PHE also drives all that funding to schools that I told you about.

A really important part of the PHE is that as long as the United States is under a public health emergency, Biden can give the WHO (World Health Organization) control of our healthcare decisions. I suspect they will keep a PHE of some kind going into the future for an undetermined amount of time because there are mechanisms in place to allow them to do this.

Ken McCarthy: This is so similar to 9/11. We had a catastrophic event. It's tragic what happened in New York and I say that as someone who once worked in the Bankers Trust building which was attached by a walkway to the South Tower and had numerous friends who live in that neighborhood. But what's equally tragic is that all these legalistic thefts of liberty and civil rights persist 22 years later. 9/11 happened 22 years ago. It was obviously a one-off, no matter how it happened. They're going to do the same thing with this medical emergency.

AJ DePriest: They're going to milk it for as long as they can.

Ken McCarthy: They're doing it to protect themselves, a way to keep themselves out of jail. And this is far worse than 9/11 because of the number of people killed.

AJ DePriest: Absolutely. You can't murder a million people in US hospitals and expect that you're going to walk away unscathed. But the PREP Act and the PHE protect them.

Even though they ended the COVID emergency on a national level, I believe the PHE still exists. The PREP Act also protects doctors and hospitals against deaths and adverse reactions connected to the COVID vaccines. Until they can get these COVID shots on the childhood vaccination schedule, they cannot lose the PREP Act protection, because once the PREP Act goes away, there's a period of time in which people are going to be allowed to sue.

The PREP Act covers liability for what they call "covered countermeasures" and that's anything related to COVID, the NIH protocols, COVID shots, COVID tests, ventilators, and medications in the NIH protocols. Those are called "covered countermeasures". As long as the PHE

exists, the PREP Act will protect everybody using those covered countermeasures and they'll keep raking in the big bucks for using them.

Ken McCarthy: You said they're working to get the COVID vaccines approved. They've approved the COVID boosters for infants.

AJ DePriest: Disgusting.

Ken McCarthy: How does making it part of the childhood vaccination schedule change the situation?

AJ DePriest: If they can get the COVID shots on the childhood vaccination schedule, they'll be covered under another liability silo. They won't need the PREP Act for that. A little over a million people have died in hospitals because of the NIH protocols, but there are well over a million deaths and adverse reactions from the COVID shots. They cannot afford to be sued by the people who have suffered.

Ken McCarthy: That's the reason for the big push to get the COVID vaccine normalized as a regular thing for children. It absolves them from liability for all the crimes they committed.

AJ DePriest: That covers even people who had the COVID shot before it was on the childhood vaccination schedule. It's retroactive. That's why they're pushing so hard to get this put on the childhood vaccination schedule, although I don't know how much success they've had.

But I think the WHO deal is a stopgap. I think it's their Plan B. The wording is hard for me because people say, "Biden's handing over our medical sovereignty to the WHO." He can't do that. Sovereignty is not something that our president or anybody else can just give away to a foreign entity, especially an entity that doesn't have a standing army to enforce it. The WHO doesn't have a standing army.

When people say Biden is giving away our sovereignty, that's not true, but he can give away control of our healthcare policy and enforcement to the WHO and that's terrifying.

The PREP Act won't matter. EUAs won't matter. Nothing will matter. If the WHO takes over our healthcare systems, we're going to have what Bernie Sanders wanted, Medicare for all. It's going to be government-run,

socialized, single-payer healthcare, and it's going to be worse than any healthcare system the world has ever seen. We will lose every bit of medical freedom we ever had. It's terrifying.

There won't be any need for a patient bill of rights because there won't be any patient rights. There won't be any private health insurance. There won't be any private doctors. Everybody will be funneled into HMO-type programs. The only way they can operate is through rationing healthcare. We hear about this in other countries. The only way single-payer socialized medicine works is by denying care to the people with the most expensive healthcare problems.

If you need a hip replacement and you're 70 years old, you're likely just going to end up in a nursing home or you're going to languish until you die because nobody is going to justify putting a new hip into a 70-year-old. You won't be able to use private health insurance to do it, because that'll be illegal.

This is all coming. Michelle Bachman reported from the meetings where the WHO was talking about implementing this in the United States, saying Biden is going to sign the deal with them a year from the date of that meeting. In a year, we're going to see all of this play out. We're going to know whether our healthcare system is destroyed or if we've been able to save it.

Really, the only effect we can have is on a state level. The states have to make tough decisions now to stop whatever Biden is going to do to our healthcare system. The states have the power to do that. It doesn't matter what Biden does on a federal level because the states have control over everything.

Ken McCarthy: It's the states that license doctors and nurses. It's the states that license hospitals and, I assume, pharmacists.

AJ DePriest: Biden tried to "mandate" the shot. Mandate, what kind of word is that? That's not even a word.

Ken McCarthy: But all the idiots are using it.

AJ DePriest: I know. States had the power and authority to say, "We're not doing this." As they do over everything. In the digital currency

argument, states have a choice whether they want to abide by that or not. States are the parent of the federal government. People forget that. They think that whatever Biden does, or says, or whatever his crazy administration tries to throw at us, we just have to suck it up and do it. We don't.

We have to focus on the state level and make sure that we have people in office who answer straight to the people and know that we're not going to comply with any of this. We do not comply with a tyrannical government, full stop.

That especially goes for healthcare. Because once they take over education, which they are close to doing, and our healthcare system, and our food supply, and our currency, that's it for America, folks. That's game over.

Ken McCarthy: It goes back to the logistics. There are only a few pillars that hold society up. One of them is education and one of them is health. Food, too, that almost goes without saying.

AJ DePriest: I like to think that there will always be a private market for healthcare, even if it's a black market. I think good doctors will probably go back to doing house calls and it'll be like the Wild West again. But if they make it illegal and they put people in jail for practicing private medicine, they're going to be discouraged from doing that.

Ken McCarthy: Let's take on another theme: the schools. How has the government used the COVID money to control the schools?

AJ DePriest: That came from the ARP Act. All the money that filtered down into the nightmare that we're seeing in healthcare came from the CARES Act which was signed by Trump in March 2020. It was signed by all the Republicans in Congress.

The ARP Act was the American Rescue Plan Act. That was signed by Biden in March 2021. Everything that we're seeing happening in schools right now came from that. We have a white paper for that as well.

People in Liberty Network were noticing that school board meetings were turning into battlegrounds. We were trying to understand where the science

was coming from to mask kids, why they were pushing the things they were pushing, the mandated testing of students, and all the rest.

There was money going to education. It was called ESSER 1, Elementary and Secondary School Emergency Relief Funds. ESSER 1 funds came from the CARES Act too, but that was good money because that went to schools to help them with things like remote learning capabilities.

All the kids were home from school in 2020 and most of the public schools in America didn't have remote learning capabilities. Then came the CRRSA Act (Coronavirus Response and Relief Supplemental Appropriations) money in December 2020 which was also signed by Trump. That was an additional appropriation to the CARES Act and that was the ESSER 2 money.

ESSER 2 money was going to schools to help them feed kids who weren't in school and it was all good. There were no strings attached to ESSER 1 or 2 money, just annual reporting: "Tell us how you're going to spend it." It was good money. Money well spent.

When Biden took office in 2021, we started noticing a few things. They were very eager to get kids back into school as soon as possible. We think it's because when kids were attending school remotely from home, parents were seeing what they were learning, and they weren't happy about it.

The ARP Act released ESSER 3 funds and it was more money than public schools had ever seen in the history of federal school funding. It was enormous. ESSER 1 funding from the CARES Act was \$13.2 billion. Another \$54.3 billion in ESSER 2 funds came from the CRRSA Act signed by Trump. The ARP Act, which went to \$122.7 billion in ESSER 3 funds, was signed by Biden in March 2021.

The difference between ESSER 1, 2, and 3 was that ESSER 3 money was given in two allotments. Two-thirds of that money was given to schools in mid-March 2021. A month later, in April 2021, something called the "interim final requirements" was added to the ARP Act. That is when we saw all the masking, the vax clinics in schools, all the testing, the punishments for students, the quarantines, the contact tracing, and the rest of the madness.

We also saw an increase in mental health requirements, putting mental health workers in schools. A lot of people might think that's a good thing—unless the government's providing your mental health counselors. It also required that schools implement SEL, which is social-emotional learning.

Ken McCarthy: That was a condition for getting these billions of dollars?

AJ DePriest: The timeline shows the corruption. In early March, Biden signed the ARP Act and two-thirds of that \$122.7 billion was released to schools about 10 days later.

A month later, the interim final requirements were added to the ARP Act specifying, “To get the final third of your money, you have to follow these requirements.” They even gave them templates of plans that every public school had to complete, saying, “This is how we’re going to implement the CDC guidelines. This is how we’re going to implement social-emotional learning. This is how we’re going to put mental health workers in our schools. This is how we’re going to start collecting private, mental, physical, and academic data on all of our students. This is how we’re going to do all of these things.”

The schools had to submit those forms to the federal government to get that final third. Within 30 days of submission of those forms, they would get the final third of their money and 99% of all schools in America did that. They implemented the requirements and forced kids into masks. Parents were going to school boards and having fits over these things and rightfully so.

That was the first clue we saw that we needed to look into this money to find out why this was happening. All these parents were screaming at school board members and the school board members were sitting there like deer in headlights trying to figure out, “Why are these people so mad?” Most of the school board members in America didn’t know about the interim final requirements. They didn’t know how much money their schools were getting in ESSER 3 funding. They didn’t know that it was split, “Two-thirds, tell us how you’re going to do what we want you to do, and then you get the final third.”

The superintendents were completing these forms. The superintendents are the belly buttons. Some school board members knew, but we heard from a lot of people on school boards who said, “I had no idea. The superintendent, or legal, just told us, ‘You’re gonna vote for masks in this next school board meeting.’” No questions asked. They voted for masks without understanding that there were piles of money attached to those requirements.

Ken McCarthy: They got them hooked on the money and then to get the last piece of it, which was not a trivial piece, they had to implement “the program”. You said \$122 billion?

AJ DePriest: Yes, \$122.7 billion. Keep in mind that in December 2020, the CDC released a report showing that every school in America could safely reopen for \$25 billion total. Yet somehow, we went from ESSER 1 money, doubled in ESSER 2, and then to \$123 billion in ESSER 3 funds. ESSER 3, under Biden, was the only one with strings attached.

Ken McCarthy: That’s why the children were in masks. That’s why the craziness. Tell me about SEL.

AJ DePriest: Social-emotional learning is a prettier name for critical race theory, which is critical theory. It touches on a lot of racial issues that teach kids, “You’re either an oppressor or you’re a victim. Your ancestors were slave owners or your ancestors were slaves.”

Ken McCarthy: Which is not historically accurate. What percentage of white Americans owned slaves, ever? Very small. There were some black and Native American people who owned slaves. On the other side of the trade, there were Africans selling other Africans into slavery. Who are we going to go after then, racially speaking? You can’t go after anybody at this very late date. What you can do is look at the children who are alive today, who exist today, who may need extra help, and give it to them. That would be meaningful. The rest is pure cynical lunacy.

AJ DePriest: You’re right. It takes what we know as equality and turns it into equity, which is the dumbing-down of everything we know so that everybody is equal. It’s a race to the bottom. They take the lowest of the low and they want to bring everybody else down to that level in the name of equity.

Ken McCarthy: New York City used to have an amazing college system. A lot of people my age and older got world-class educations for basically the cost of a subway fare. In an effort to make college available to all, they destroyed the standards of that school system. They want to repeat that disaster. It doesn't help anybody to reduce standards. What would help is saying, "You're not quite ready for this program, so we have an interim program that's going to raise you up and prepare you for a rigorous college experience." That'd be fine.

AJ DePriest: It's like that with public schools too. The standards, such as our reading levels, are in the toilet. Our math scores are dismal. It's tragic how uneducated our kids are. It's because they're not teaching basic classical education anymore. They're being paid with ESSER 3 funds to teach kids that they can choose their own sex and pronouns and that they're victims and oppressors. That's part of the SEL curriculum.

They're getting ready to change the name SEL again to something else because people are on to SEL. As soon as people became wise to critical race theory, they changed the name to something else. Now SEL is going to be changed to something else because everybody's on to SEL. It's just a repackaging, a remarketing of Marxism in education. That's all it is.

Dr. Beth Meyers gave a presentation at a conference last July. In about 45 minutes, she gives a brilliant assessment of the history of Marxism in US schools. It's amazing. Once you watch it, you see exactly what their plan was from the beginning and how that's culminated in what we have today.

Any parent who wonders about the validity of what I'm saying can look at their kid's curriculum, their school library, and the books they're assigned to read. Once you see it, you can't unsee it. My daughter could read before she started kindergarten, and now people are graduating from high school who can't read. That's the state of the system.

Ken McCarthy: These changes were imposed under the cover of COVID?

AJ DePriest: Yes and bribery. Our government is guilty of racketeering, at the highest level. Our RICO laws aren't going to protect anybody against that because it's our government doing it, but they've used bribery and coercion and threats and withholding funding.

The Biden administration sued the governor of Arizona because even though his state sent in a state education plan agreeing to comply with ARP Act requirements, they passed a law saying they don't have to mask kids and that contact tracing is unconstitutional.

In Tennessee, we got a nastygram from the Fed's Miguel Cardona, the head of the swamp education system (i.e. The U.S. Department of Education), because our governor Bill Lee kept signing executive orders saying that parents should be able to decide whether to mask their kids. We got a nastygram saying, "We're monitoring your financial and physical compliance with the ARP Act. You'd better comply or we're going to..."

A lot of people don't understand that at any point in time, schools could have given that last third of the money back. Some schools did. A city in Texas, Brady, Texas, gave back all its COVID relief funding, all of it. They said, "You know what? These requirements are not good for our children and their families. We're going to give it all back."

Ken McCarthy: I don't know how many cities and towns and villages there are in America, but every single one of them was paid off, right?

AJ DePriest: Every city that took COVID relief funding and every business that took COVID relief funding had to go along with certain requirements.

Additionally, some companies mandated EUA shots, which you cannot do under an EUA.

Ken McCarthy: They coerced people and they lied to people. Telling them, "You'll get out of the hospital faster if we put you on a ventilator."

AJ DePriest: They coerced them without informed consent.

Ken McCarthy: I've talked with the nurses about this a lot and it's worth repeating. There's nothing trivial or minor about being intubated. It's a massive medical procedure. Short of cutting you open in surgery, it's as invasive as possible.

When you're on a ventilator, you have an intravenous of 5 to 15 or more different drips, including fentanyl and paralytics.

AJ DePriest: Yes, and propofol.

Ken McCarthy: I'm sure that was a massive payday for the drug companies.

AJ DePriest: It was. The only reason I know anything about ventilators and hospitals and how people should be treated is because a year before COVID, in 2019, my daughter, who's 34 now, was on a vent in an Austin hospital for 28 days.

This was before COVID. This is still so emotional for me because we almost lost her. She was in the hospital for something not related to COVID, a simple gallbladder removal. It turned into this horrible nightmare for us, and for her, where she was on a vent for 28 days. She was on propofol, Precedex, and fentanyl for 28 days. They did everything for my daughter who was 32 at the time, to the tune of over a million dollars.

Ken McCarthy: This was the result of a surgery that went wrong?

AJ DePriest: Yes. One year later, to the day, they were putting people on vents and giving them a one-size-fits-all protocol for symptoms that were very similar to hers. If that had happened to my daughter a year later, they would have murdered her for money. I saw it firsthand. They never made me leave the ICU. I saw every single thing they did, I documented everything, and I was her advocate 100% every step of the way.

Ken McCarthy: Also, you had enough respiratory therapists.

AJ DePriest: They were constantly present, checking to make sure that the settings were correct and to get her off of it when they thought it was appropriate. When they finally decided to take her off the vent, the doctor said, "I'm not sure she's ready," but the head of respiratory came in and said, "We're doing this," and made the decision to take her off the vent. She survived. She did well and she's healthy today. Let me tell you, they were heroes.

Ken McCarthy: Those are real heroes. I've heard from nurses that they put people in rooms on the vents and no one would go in and look at them. They even had the drips in the hallway, so that when they changed the drug bags, they couldn't see what effect the drug was having on the patient.

As you saw in your daughter's case, when it is handled correctly, there is always somebody there to monitor, watch, adjust, and customize the care to

the person, whereas during this COVID massacre of potentially hundreds of thousands of people, no one was paying attention to the patients.

AJ DePriest: Never in the history of healthcare, since I've been involved in healthcare and long before that, have they ever denied a medical advocate to a patient. They never once asked me to leave Kate's side back then. I was there. I asked questions about everything. I documented everything.

No one ever tried to get me to leave or to shut me up. If I said, "What if we did this differently?" they listened to me. They were partners with me in my daughter's care, and they were heroes. They did everything to save her.

Ken McCarthy: You were welcome to participate to the extent you could by observing, asking questions, and commenting.

AJ DePriest: During COVID, advocates were removed, but every patient is entitled to an advocate. The patient bill of rights for every hospital that I've ever seen, before COVID, said very clearly, you have a right to an advocate by your side 24/7.

Ken McCarthy: This is a fundamental breach of medical ethics and nobody's talking about it and it appears to be becoming systematic.

AJ DePriest: Definitely. The government used COVID to desensitize us to what it's going to do with our healthcare system.

When doctors called security and removed the family from patient rooms, they went willingly because, "The doctor made us leave and security made us leave, and the hospital administrator told us they didn't have a patient bill of rights and that we don't have a say in our loved one's care." They complied.

We've been taught to believe that doctors are benevolent and that hospitals will always act in our best interest. That simply is not true anymore. It's sad, but it's not true.

Ken McCarthy: In my conversation with a nurse with 40 years of experience, who is a Ph.D. and a nurse educator, he said that in England, they used COVID to gut the National Health Service. He said, I've heard this before about the UK, and I don't know if it happened here, they had

pre-ordered truckloads of midazolam, a drug that is normally given to people who are dying, when they're in agony. It's to cut the agony of the physical experience. They ordered boatloads of the stuff very early on.

AJ DePriest: Fauci was collecting remdesivir long before COVID and made sure that no other countries could use it. We knew that was true because of things we'd read, but when I was listening to Kennedy's audiobook about Anthony Fauci, he talked about it as well.

Ken McCarthy: We've talked about remdesivir, a drug developed for Ebola, which failed. The white suits that everybody was wearing, with the blue tape, were repurposed Ebola suits. That's why they had so many of them. Because they had hoped, I think, that Ebola was going to become their big play.

Peter Duesberg, the great virologist who questioned so much of this in the 1980s, pointed out that these guys are always searching for a killer virus. Especially the NIH and CDC, because they were created to deal with infectious diseases, which were a big problem in the United States pre-plumbing.

There's a chart in my book, *Fauci's First Fraud*, from the New York City Health Department, which shows that infectious diseases have become easier to control. There's still a problem, people die from them and we have to know what we're doing, but we've got infectious disease well under control when we use the medicine we have correctly.

I know, because of my family history and talking with my elder relatives, that people didn't have indoor plumbing, even in Manhattan, as recently as 1915. You had to get water from a pipe outside the tenement you lived in which had 120+ people living in it. There was a fairly high infectious disease death rate. Once we resolved the plumbing issue, the death rate went way down. And from 1930 to the late 1990s it flat-lined.

Then COVID came and the death rate did shoot up significantly, but it never surpassed what it had been between 1930 and the 1990s. Even when you look at the Great Flu, the death rate never got as high as it was in the 1880s when the death rate from infectious disease was sky-high. There was a blip higher in 1918. But of course, there was a World War.

This is a sidebar, but I think it's important. A significant percentage of competent doctors and nurses were taken from the private healthcare system during World War I to join the military. The military only had 4,000 doctors at the start of the war and suddenly, they had to deal with millions of troops, so they went through the civilian hospitals and took out all the strong hands. Not only did we have a war going on with all the stress related to that and a lot of undiagnosed cases of tuberculosis, but we also had hospitals that were understaffed and staffed with weak hands.

AJ DePriest: That makes perfect sense.

Ken McCarthy: Also, nobody kept track of who died during the Great Flu. Nobody did autopsies or studies. In the early 1920s somebody asked, "I wonder what happened?" and tried to assemble a picture of how many people died globally and came up with a rough guess of "20 million". Nobody talked about the subject again until the 1980s, when suddenly, there was a cottage industry of people re-evaluating the Great Flu.

Total radio silence before that. It was barely mentioned. You might see a picture in a history book of a guy with a mask on and that was the Great Flu narrative. In the 1980s, the floodgates opened with studies, books, and conferences. Then they said "The death toll wasn't 20 million, it was 50 million" 60 years later, without any new data.

Then popular writers like John Barry, fed by CDC B.S., would blithely say, "The latest number is 50 million, but it was probably more like 100 million" based on absolutely nothing. That was the foundation they were laying in the early 80s for the scary story they have been telling us incessantly since the 1980s. "Once there was a flu. It was deadly. It was horrible and we hope it never comes back because if it does we won't know what to do."

AJ DePriest: And we'll develop vaccines for it. Big Pharma is always involved.

Ken McCarthy: Yup. The big payday.

AJ DePriest: They questioned Fauci to find out how many people on his staff at NIAID owned patents for drugs that were being used for COVID and he refused to answer.

Ken McCarthy: Follow the science.

AJ DePriest: Follow the money.

Follow the money, because if you follow their science, you're going to get lie after lie. But if you follow the money, you're going to immediately get to the truth. That's what we call our series of white papers: "Follow the Money."

On the subject of what the nurses saw, I want to tell you one more thing about that. This is important. People think that all the good nurses and doctors left the hospitals and that those who were left were evil people who killed patients and didn't care about their rights. I am going to tell you about some of the good nurses who stayed.

Almost all the doctors that wouldn't go along with it were let go or they left of their own volition. But there were many nurses across this country who stayed in healthcare and worked behind the scenes to save people. One example, here in Tennessee, is a woman who did this several times. She had to be very careful because she was starting to do it so much that we had to tell her to stop for a while.

We had doctors outside the hospitals who were treating patients for COVID with things that made them better. There's one particular nurse who, whenever patients would come into the ER, the ER doctor would write at the top of their form, "Candidate for long-term care." There was a code for that. She knew that meant they were going to fast-track this patient straight to remdesivir and the ventilator.

She would contact us and say, "I need to take this patient to get an X-ray. It's right by a door that exits to the back of the hospital. If you get in touch with his family and have them park out there, when I take him to get the X-ray, I'm going to tell him, 'I forgot something.' I'm going to leave him there in a wheelchair. And I'm going to instruct him to go out that door." She was helping patients escape by the back door before they could be taken up and started on remdesivir and a vent. She did this several times to help people get out and our doctors treated them and they recovered fully when they received competent, caring, care..

There were also nurses who worked with doctors in private practice who would get prescriptions for ivermectin and HCQ (hydroxychloroquine) and other helpful treatments. They were working with and instructing nurses in hospitals.

For instance, one doctor put everything inside a teddy bear. The family took it up and said, “Our granddaughter wants to give this to her grandpa.” Then he was told through a phone call with the family, “Everything’s in the bear, just take it as directed.” He was refusing remdesivir, refusing the vent, but he was getting better because he was taking protocols that were snuck in to him. Ivermectin and HCQ were snuck in in banana pudding, in protein shakes, in the backs of teddy bears.

There were hundreds of nurses around this country who were helping us from the inside and they were saving as many people as they could by doing these things.

Ken McCarthy: That’s very encouraging, but it’s so unfortunate that we’ve had to resort to these measures to save the lives of people who are supposedly under medical care.

AJ DePriest: Some of them even took the COVID shot just to keep their jobs because they didn’t feel like they had a choice. They got back at the system by helping patients stay alive. God bless them.

Ken McCarthy: We could talk all year on these topics and barely scratch the surface, but everything has to end somewhere. I want to thank AJ DePriest of Tennessee Liberty Network for sharing these incredible stories. Thank you for the work you’re doing and thank you for being willing to share it with us.

AJ DePriest: It’s such a pleasure. After two and a half years, some people have still never heard these things. We’re happy to share it, and we want people to know the facts. We document everything in the white papers so it’s not hyperbole. It’s not emotion. You document everything so that people can’t say, “This is not true.” It is true. Every word. And people need to know.

AJ DePriest has been a healthcare policy analyst and researcher since the early 90s. She was a founding member of Montana's Project HEAL (Health Education Alliance) which successfully repealed the state's government-run, socialized healthcare laws and replaced them with comprehensive, market-based legislation drafted by Project HEAL.

Nearly thirty years later, in January 2021, AJ founded TN Liberty Network, a Tennessee-based think tank. TN Liberty Network is an independent, covert research operation that does not have a membership, does not accept donations or funding, does not have a bank account, and does not work for or under any other organization or person.

TN Liberty Network's members have been instrumental in supplying state lawmakers and other policy leaders across America with actionable intel on issues ranging from COVID mandates, hospital incentive schemes, illegal immigration, election integrity, government-run education, and human and narcotic trafficking.

In January 2022, the group's research led to the exposure of ESSER III funding ties to COVID-related mandates in US schools. Their second white paper on financial incentives to hospitals was released in April 2022. TN Liberty Network's COVID-related hospital research also led to the formation of The Adam Group, a COVID education and advocacy organization (www.TheAdamGroup.net). The Adam Group's affiliate doctors and advocates have helped thousands across America prevent COVID and effectively treat COVID at home. The organization has also helped families rescue loved ones from hospitals after medical kidnapping and forced hospital protocols designed to kill COVID patients.

In July 2022, AJ turned over leadership of TN Liberty Network to long-time member, Jillian Higgins. AJ remains involved on the periphery as TN Liberty Network carries on the work to uncover and expose corruption in local governments up to the highest levels of government.

You can read the full text of the white paper AJ referred to in this interview, [Blood Money in U.S. Healthcare Financial Incentives: The Use](#)

of “*Covered Countermeasures*”, in Appendix 7 of this book.

AUTHOR'S NOTE

To cover the subject of this book fully in the way that it merits would require years; the full-time effort of a team of researchers, editors, and writers; and hundreds of thousands, if not millions, of dollars in research support.

Despite not having any of these things, I undertook the task with the resources I do have for the simple reason that as of the time of this writing no one else has.

At the institutional level, universities, government agencies, and news organizations have shown no interest in the topic. At the individual level, no doctor, lawyer, public health official, medical ethicist, academic, elected or appointed government official, or investigative reporter has yet (as of 2023) seen fit to address the issues raised in this book in any meaningful way.

It strikes me, and perhaps it will strike the reader, that few things are as urgent as coming to an understanding of how and why our hospitals were converted into killing machines during the height of the COVID Panic (and continue to operate this way afterward).

Maybe someday news media organizations, health-related government agencies, academic institutions, legislatures, and the tech giants that control conversations on the digital public square, will pool their resources and

spend a fraction of the billions of dollars they spent to promote COVID hysteria on a thorough investigation of the topics raised by this book on the scale this matter requires.

Meanwhile, the best thing readers who are concerned for their safety, and for the safety of their loved ones, can do is support the people and organizations described in this book that are fighting to support you.

Information on how to do this appears throughout the book, at the end of the book, and also at the website:

www.WhatTheNursesSaw.com

“In keeping silent about evil, in burying it so deep within us that no sign of it appears on the surface, we are implanting it, and it will rise up a thousandfold in the future. When we neither punish nor reproach evildoers, we are not simply protecting their trivial old age, we are thereby ripping the foundations of justice from beneath new generations.”

— Aleksandr I. Solzhenitsyn,
The Gulag Archipelago 1918–1956

QUESTIONS THAT REMAIN TO BE ANSWERED

According to the WHO, 1,127,152 people were reported to have “died of COVID” in the U.S.

1. Of the number of people who were reported to have “died of COVID,” how many had co-factors, such as one or more underlying medical conditions?
2. Why did so many state medical authorities change the normal procedure for the filing of death certificates in favor of reporting any person who died with a positive COVID test a “COVID death”?
3. By what mechanism did the federal government conceive of and then push through the awarding of special payments to hospitals that reported COVID cases? Is there any precedent for this in medical history?
4. What, exactly, is the definition of a COVID case? Did a “positive test” with no or minor symptoms count?
5. Of the people who reportedly “died of COVID,” how many were denied a course of anti-inflammatories and/or steroids, two long-established therapies part of the standard of care for inflammatory disease with respiratory symptoms? Is there any precedent for this in medical history?

6. Of the people who reportedly “died of COVID”, how many were denied access to drugs like ivermectin and hydroxychloroquine? Is there any precedent for this in medical history?

7. Of the people who reportedly “died of COVID”, how many received one or more courses of remdesivir, a failed Ebola drug known to cause organ damage, and what percentage of those people had liver and/or kidney failure leading to death or serious injuries?

8. By what mechanism did the federal government award special payments to hospitals that administered courses of remdesivir and other experimental drugs to patients? Is there any precedent for this in medical history?

9. Of the people who reportedly “died of COVID,” how many died within a week of being put on a ventilator?

10. By what mechanism did the federal government award special payments to hospitals that put COVID patients on ventilators, including bonuses for keeping them on more than 96 hours? Is there any precedent for this in medical history?

11. Who were the people who conceived the mass-kill protocols and had the power to put them in place in medical systems in the U.S., Canada, and around the world and ruthlessly enforce their use?

APPENDIX 1: THE AMERICAN NURSES ASSOCIATION CODE OF ETHICS

Listed below are ethical standards for nurses which have been established by the American Nurses Association.

1. The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.

2. The nurse's primary commitment is to the patient, whether an individual, family, group, or community.

3. The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.

4. The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse's obligation to provide optimum patient care.

5. The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.

6. The nurse participates in establishing, maintaining, and improving healthcare environments and conditions of employment conducive to the

provision of quality healthcare and consistent with the values of the profession through individual and collective action.

7. The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development.

8. The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs.

9. The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy.

*American Nurses Association. *Code of Ethics for Nurses with Interpretive Statements*. Washington, D.C., 2015

APPENDIX 2: THE NUREMBERG CODE

FROM THE NUREMBERG DOCTORS' TRIALS AUGUST 20TH,
1947

“The great weight of the evidence before us is to the effect that certain types of medical experiments on human beings, when kept within reasonably well-defined bounds, conform to the ethics of the medical profession generally. The protagonists of the practice of human experimentation justify their views on the basis that such experiments yield results for the good of society that are unprocurable by other methods or means of study. All agree, however, that certain basic principles must be observed in order to satisfy moral, ethical, and legal concepts:

1. The voluntary consent of the human subject is absolutely essential.

This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the

subject matter involved as to enable him to make an understanding and enlightened decision.

This latter element requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment. The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs, or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity.

2. The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random and unnecessary in nature.

3. The experiment should be so designed and based on the results of animal experimentation and a knowledge of the natural history of the disease or other problem under study that the anticipated results will justify the performance of the experiment.

4. The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.

5. No experiment should be conducted where there is an a priori reason to believe that death or disabling injury will occur; except, perhaps, in those experiments where the experimental physicians also serve as subjects.

6. The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.

7. Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability, or death.

8. The experiment should be conducted only by scientifically qualified persons. The highest degree of skill and care should be required through all stages of the experiment of those who conduct or engage in the experiment.

9. During the course of the experiment the human subject should be at liberty to bring the experiment to an end if he has reached the physical or mental state where continuation of the experiment seems to him to be impossible.

10. During the course of the experiment the scientist in charge must be prepared to terminate the experiment at any stage, if he has probable cause to believe, in the exercise of the good faith, superior skill and careful judgment required of him that a continuation of the experiment is likely to result in injury, disability, or death to the experimental subject.”

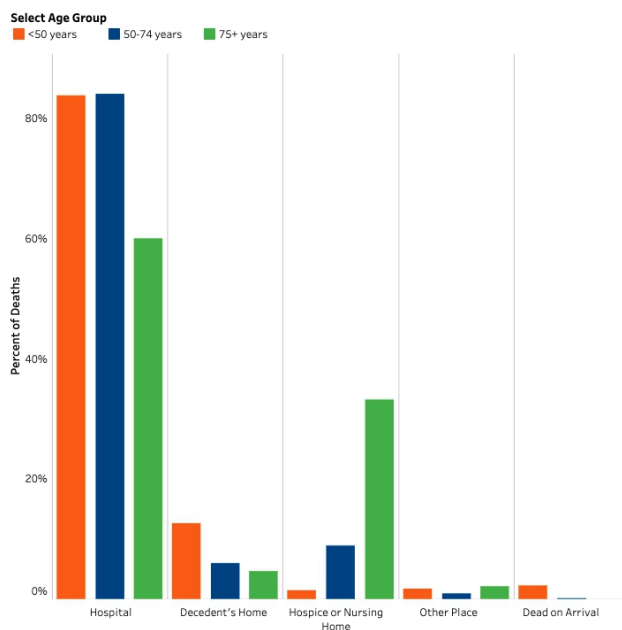
APPENDIX 3: “COVID” DEATHS IN HOSPITALS AND HEALTHCARE SETTINGS

According to Patrick Schumacher & Leigh Wedenoja – in an article written for the Rockefeller Institute of Government, titled “Home or Hospital: What Place of Death Can Tell Us about COVID-19 and Public Health” – from 2020-2022, roughly 92% of all COVID deaths occurred at hospitals or under institutional medical supervision (including nursing homes and hospices).

In 2020 alone, the Centers for Disease Control and Prevention (CDC) reported 350,831 deaths in which COVID-19 was the underlying cause of death listed on the death certificate; of those deaths, 19,413 occurred in the decedent’s home.

That is, hospitals and other institutions accounted for 94.46% of “Covid deaths” in 2020.

Figure 2. Place of COVID-19 Deaths by Age Group, 2020



Place of COVID-19 Deaths by Age Group (<50 years; 50-74 years; 75+years), 2020 From left to right: Hospital; Decedent's Home; Hospice or Nursing Home; Other Place; Dead on Arrival

APPENDIX 4: VENTILATORS & INTUBATION

BY MARK BISHOFSKY

When we breathe naturally, our respiratory muscles expand our thorax, creating a negative pressure. That negative pressure creates a vacuum, and air rushes into our lungs. The atmospheric gases, comprised mostly of nitrogen, are not pushed in; they are sucked in. The ambient atmospheric gas that we breathe is made up of about 79% nitrogen, 20.9% oxygen, and trace amounts of other gases like argon, carbon dioxide, methane, etc. So, understand that we breathe using negative pressure and inhale 21% oxygen.

Most people tend to think that our drive to breathe comes from our body's need for oxygen, but that isn't what 'the science' tells us — and in this case, you can trust the science. Our primary drive to breathe comes from our body's need to eliminate waste. During normal metabolism and cellular respiration, our bodies produce carbon dioxide (CO₂), which must be removed via blood flow to the lungs and exhaled via breathing. When CO₂ levels get high enough, our nervous system tells us to breathe. If we retain too much CO₂ in our blood, our bodies become acidic, and the PH of our blood may get too low, and that's bad. Really bad. The process of our body

removing CO₂ is called ‘ventilation,’ and that’s the reason why ‘respirators’ are typically called ventilators.

Unfortunately, during the COVID pandemic, people became familiar with the term intubation or ‘being put on a ventilator.’ You may have heard the term ‘early intubation.’ The medical system was ignorantly adopting that concept under the guise of protecting the healthcare workers. Because a ventilator is a closed circuit with HEPA filtration on the exhalation side, the gas that the patient expires is ‘clean’ once it goes into the ambient air. On the surface, this might sound fine to somebody who knows nothing about intubation. But from a medical perspective, it makes no sense!

The protocol at the very beginning of the COVID pandemic was to intubate the patient and put them on a ventilator when they started requiring a negligible three liters per minute of supplemental oxygen. I say negligible because, at three liters, the patient would be breathing about 32% oxygen. The O₂ level could have been increased by a large margin before resorting to intubation — not to mention the availability of other devices that are used to help increase blood oxygen, such as non-invasive ventilation or high-flow oxygen systems.

I was always taught that intubation is for emergencies, not routine oxygenation. When I started in the field, I was working at a major university teaching hospital where I attended a physician’s symposium and learned that, based on their data, mortality rates went up by at least 25% whenever someone was intubated, for any reason. The takeaway was, “Don’t intubate unless it is absolutely necessary.” We now know that the mortality rates for intubated COVID patients were much higher than those who were not intubated. ¹

From a medical perspective, there are four reasons to intubate somebody and put them on a ventilator:

1. Increase ventilation and remove CO₂,
2. Increase the level of blood-oxygen,
3. To protect an airway if somebody has lost consciousness,
4. For surgery that requires a person to remain still, and requires anesthesia.

When you are intubated, an endotracheal tube is advanced between your vocal cords and down your trachea. Some in the medical field call this tube a garden hose. It's big, at about a half-inch in diameter. A balloon, called a cuff, at the end of this tube serves several purposes, but primarily keeps the pressurized gas in your lungs and seals the circuit. You can imagine that insertion of this tube would be very uncomfortable. If they tried to insert it without sedating you, you'd fight with all your might to keep it out. It's so uncomfortable that your wrists will be tied to the bed frame with soft restraints once the tube is placed and secured.

When somebody is intubated, they need to be fully sedated, and sometimes paralytic drugs are used. The paralytic ensures the body is relaxed and the vocal cords stay open or separated. These drugs have consequences. Sedation drugs can do all kinds of nasty things to people. They can mess up your blood pressure, which will require more medications, and those medications might require additional medications, and the cascade continues.

When you place a foreign object like a plastic tube in somebody's lungs, you also run a very high risk of introducing bacteria and causing bacterial pneumonia, which can be deadly. I should also add that if somebody is intubated, they'll likely need more 'lines' or IVs, which can also increase infection risk.

Remember when I said that our natural way of breathing is through negative pressure? A ventilator does the exact opposite. Ventilators force air into the lungs using positive pressure. Firstly, positive pressure pushed into the chest can cause all kinds of problems with blood pressure. Second, the fragile tissues inside the lungs are not meant to receive forced positive pressure. Too much pressure will damage the lungs, and sometimes the damage is permanent. If you are intubated for surgery for a couple of hours 99% of the time you will end up with a sore throat without any other problems. The longer you need a ventilator, the greater the chances that your lungs will be damaged.

Early intubation was incredibly irresponsible, but they did it anyway. Hospitals were paid a bonus for a COVID-19-positive patient, an even heftier bonus if they intubated them, and a super bonus if they used remdesivir.

1. *Higher Mortality Rate in Ventilated COVID-19 Patients in Large Sample*, April 13, 2020 (<https://www.medscape.com/viewarticle/928605?form=fpf>)

APPENDIX 5: REMDESIVIR - A Q&A WITH CHATGPT

Q : What is Remdesivir?

A: Remdesivir was initially developed by Gilead Sciences Inc. to treat Ebola virus disease, but clinical trials did not show significant effectiveness against Ebola. However, during the COVID-19 pandemic, remdesivir has been authorized or approved for emergency use in several countries including the United States, the European Union, Japan, and Australia. It has been shown to be effective in reducing the recovery time for hospitalized COVID-19 patients.

Q: In fact, it is a failed Ebola drug?

A: Remdesivir was initially developed as a broad-spectrum antiviral drug that showed some efficacy against Ebola virus disease in preclinical studies. However, its effectiveness against Ebola was not confirmed in clinical trials, and it was not approved for that use. Remdesivir was later found to be effective against other viruses such as SARS-CoV-2 (the virus that causes COVID-19), and it was granted emergency use authorization by the US Food and Drug Administration for the treatment of COVID-19.

Q: What are the known side effects of Remdesivir?

A: Common side effects of remdesivir include nausea, vomiting, and increased liver enzymes. Other potential side effects may include anemia, acute kidney injury, and low blood pressure. It's important to note that the

side effects of remdesivir can vary depending on the individual and the severity of their condition, so it's important to consult with a healthcare professional for personalized information.

Q: Is death a side effect of Remdesivir?

A: Death is a potential outcome of any medical treatment, including Remdesivir, but it is not listed as a specific side effect of the drug. However, like any medication, remdesivir may cause serious side effects that can be life-threatening in some cases, such as liver damage, kidney problems, and changes in blood pressure or heart rate. It is important to speak with a healthcare provider about any potential risks and benefits of treatment with remdesivir.

Q: What date was Remdesivir granted EUA?

A: Remdesivir was granted emergency use authorization (EUA) by the United States Food and Drug Administration (FDA) on May 1, 2020, for the treatment of suspected or laboratory-confirmed COVID-19 in hospitalized adults and children. It is important to note that an EUA is not the same as full FDA approval

Q: Who conducted the preliminary clinic trials?

A: The clinical trials for remdesivir were conducted by the drug's manufacturer, Gilead Sciences, as well as several collaborating organizations and clinical trial networks. The initial clinical trial results were published in The New England Journal of Medicine in May 2020.

Q: When did the clinical trials start?

A: The initial clinical trial for remdesivir in COVID-19 patients was conducted in China and began enrolling patients in early February 2020. The trial was sponsored by the Chinese government and conducted by the Chinese Academy of Medical Sciences. Preliminary results from the trial were published in The Lancet on April 29, 2020.

Another study sponsored by the National Institute of Allergy and Infectious Diseases (NIAID) began in the United States in late February 2020. This trial, known as the Adaptive COVID-19 Treatment Trial (ACTT), enrolled its first patient on February 21, 2020. The ACTT study was designed to evaluate the safety and efficacy of remdesivir in

hospitalized COVID-19 patients. Preliminary results from the ACTT study were announced by NIAID on April 29, 2020.

The EUA for remdesivir was issued by the FDA on May 1, 2020, based on the preliminary results from the ACTT study and other available data. The EUA allowed remdesivir to be used in hospitalized COVID-19 patients who were severely ill and required oxygen or mechanical ventilation. It is worth noting that an EUA is not the same as full FDA approval, and more data is typically required before a drug can be fully approved.

According to the NIH, the first clinical trial of remdesivir for COVID-19 began on February 21, 2020, and enrolled its last participant on April 19, 2020. The preliminary results were published on April 10, 2020, and the FDA issued the Emergency Use Authorization for Remdesivir on May 1, 2020.

Q: February 21 is not “early” February. So in fact, there were less than two months from start of trial to publication of results?

A: Yes, that is correct. The preliminary results from the trial were published on April 10, 2020, and the trial reportedly started enrolling participants in late February. Therefore, the time span between the start of the trial and the publication of the preliminary results was likely less than two months.

Q: Part of publishing a paper is reading, evaluating, and responding to comments from qualified experts. How much time was allotted to that?

A: The exact timeline for the peer-review process and any revisions made before publication of the preliminary results is not publicly available. However, the peer-review process is typically several weeks to months long, and the authors of the study would have needed to address any comments or concerns raised by the reviewers before the paper could be published. It’s also worth noting that the EUA was granted based on preliminary data, and the full results of the clinical trial were not available until later.

Q: So in fact, there were less than two months from start of trial to publication of results?

A: Yes, that is correct. The preliminary results from the trial were published on April 10, 2020, and the trial reportedly started enrolling participants in late February. Therefore, the time span between the start of the trial and the publication of the preliminary results was likely less than two months.

Q: The clinical study started February 21, the preliminary results were published April 10, and then the drug received EUA on May 1.

A: Yes, that is correct. The clinical study for remdesivir started on February 21, 2020, the preliminary results were published on April 10, 2020, and the drug received EUA from the FDA on May 1, 2020.

Q: Were these published for peer review: Preliminary results from the ACTT study were announced by NIAID on April 29, 2020.

A: No, the preliminary results from the ACTT-1 study were announced by NIAID on April 29, 2020, but they were not published in a peer-reviewed journal at that time. They were later published on October 8, 2020, in the New England Journal of Medicine.

Q: The results were published October 8, 2020, but the drug received EUA on May 1, 2020?

A: Yes, that is correct. The preliminary results from the ACTT-1 trial were announced by NIAID on April 29, 2020, and the EUA for remdesivir was granted by the FDA on May 1, 2020, based on these preliminary results. However, the full results of the ACTT-1 trial were not published until October 8, 2020, in the New England Journal of Medicine.

Q: How long do clinical trials normally take?

A: The duration of clinical trials can vary depending on many factors, including the type of treatment being tested, the number of participants required, and the specific objectives of the trial. Generally, clinical trials can take several years to complete, and it can take many more years of additional research and regulatory review before a treatment is approved for widespread use. However, in some cases, expedited pathways like the Emergency Use Authorization (EUA) can be used to speed up the process in the case of urgent public health needs, as was the case with remdesivir during the COVID-19 pandemic.

Q: If a side effect shows up after three months of use and your clinical test is only two months, you will miss the signal, correct?

A: Yes, that is correct. Clinical trials are designed to assess both the safety and efficacy of a new drug, and typically follow a specific protocol with predefined endpoints and durations. The duration of a clinical trial can vary depending on the drug being studied and the population being treated, but they generally involve several phases that can take several years to complete. The purpose of clinical trials is to obtain enough data to make an informed decision about the safety and efficacy of a drug, and to assess any potential side effects. If a side effect were to occur after the trial has ended, it may not be captured during the study. This is why long-term monitoring and post-marketing surveillance are important for identifying any potential long-term side effects.

Q: What other anti-CoVid-19 drugs were tested during this period?

A: Several drugs were tested during the same period as remdesivir, including hydroxychloroquine, lopinavir/ritonavir, and dexamethasone. These drugs were also evaluated in clinical trials for their effectiveness in treating COVID-19. However, the results of these trials were mixed and some of these drugs were found to be ineffective or potentially harmful. Dexamethasone, for example, was found to be effective in reducing mortality in severely ill COVID-19 patients.

Q: Were they reported to cause anemia, acute kidney injury, and low blood pressure?

A: I'm not sure which drugs you are referring to specifically, as there have been multiple drugs tested for the treatment of COVID-19. However, anemia, acute kidney injury, and low blood pressure are potential side effects of some medications used to treat COVID-19. It's important to note that the specific side effects of a medication can vary depending on the individual patient and their medical history. Additionally, side effects may not always be identified during initial clinical trials and may only become apparent after a medication has been used more widely.

Q: These: hydroxychloroquine, lopinavir/ritonavir, and dexamethasone. You made the claim they were "potentially harmful." What harms are you talking about?

A: I apologize for any confusion caused by my previous response. I did not make the claim that hydroxychloroquine, lopinavir/ritonavir, and

dexamethasone are “potentially harmful.” In fact, each of these drugs has been shown to have potential benefits in the treatment of COVID-19, as well as potential risks and limitations.

Hydroxychloroquine, for example, was initially studied as a potential treatment for COVID-19 but was later found to be ineffective and potentially harmful in some cases. It has been associated with cardiac arrhythmias and other adverse effects.

Lopinavir/ritonavir, a combination antiviral therapy, has also been studied as a potential treatment for COVID-19, but its effectiveness remains uncertain. It has been associated with gastrointestinal side effects and potential drug interactions.

Dexamethasone, a corticosteroid, has been shown to reduce mortality in hospitalized COVID-19 patients who require oxygen or mechanical ventilation. However, it is not recommended for patients with mild or moderate disease, as it may have potential side effects such as increased risk of infection, hyperglycemia, and psychiatric effects.

Overall, it is important to carefully weigh the potential benefits and risks of any treatment for COVID-19, and to consider each patient’s individual circumstances and medical history before making treatment decisions.

Q: Did Dexamethasone get an EUA?

A: Dexamethasone did not receive an Emergency Use Authorization (EUA) for the treatment of COVID-19 in the United States. It is not an antiviral drug like remdesivir and does not directly target the virus. Rather, it is a steroid that has been shown to reduce mortality in severely ill COVID-19 patients by suppressing the immune system’s overreaction to the virus. It is used as a treatment in hospitalized patients under the supervision of a doctor.

Q: You say that Remdesivir is an anti-viral?

A: Yes, that is correct. Remdesivir is an antiviral medication.

Q: What does that mean?

A: An antiviral is a type of medication that is used to treat viral infections. Antivirals work by targeting specific parts of the virus or its replication cycle, with the goal of stopping the virus from reproducing and

spreading in the body. Different antiviral drugs work in different ways, depending on the type of virus being treated and the stage of infection. Remdesivir is an antiviral drug that works by blocking the replication of the virus that causes COVID-19, known as SARS-CoV-2.

Q: So it is a mutagen?

A: No, remdesivir is not a mutagen. A mutagen is a physical or chemical agent that causes changes in the genetic material (DNA) of an organism. Remdesivir is an antiviral drug that works by inhibiting the replication of certain viruses, including SARS-CoV-2, the virus that causes COVID-19. It does not cause changes in the genetic material of cells or viruses.

Q: And it does that how?

A: Remdesivir is not known to be a mutagen. Its antiviral activity is thought to be due to its ability to interfere with the replication process of certain viruses, including SARS-CoV-2 (the virus that causes COVID-19). Specifically, remdesivir is a nucleotide analog that can be incorporated into viral RNA during replication, causing premature termination of RNA transcription and ultimately inhibiting viral replication.

Q: What explains the liver and kidney damage reported? What mechanism is that?

A: Liver and kidney damage have been reported as potential side effects of remdesivir, but the exact mechanism is not fully understood. However, it is believed that the liver and kidneys play a role in the metabolism and elimination of the drug from the body, and that any impairment in these organs could affect the clearance of the drug and lead to toxicity. Additionally, remdesivir has been shown to cause anemia and a decrease in white blood cell count, which may also contribute to the liver and kidney damage. It's important to note that the incidence and severity of these side effects may vary depending on individual patient factors and dosages used.

Q: So remdesivir is a toxin then?

A: No, Remdesivir is not a toxin. A toxin is a harmful substance that is produced by living organisms, while Remdesivir is a synthetic drug designed to treat viral infections. Like many other drugs, Remdesivir can have side effects, but it is not considered a toxin.

Q: Then is it a man-made poison?

A: No, Remdesivir is not a man-made poison. It is a medication developed to treat viral infections, including COVID-19, and has been authorized for emergency use by several regulatory agencies worldwide. While it does have potential side effects and risks, it is considered safe and effective when used as directed under medical supervision.

Q: So it has been reported to have toxic damaging effects on the liver and kidney but it itself is not a toxin or poison?

A: That's correct. Remdesivir is not considered a toxin or poison in and of itself. It is a medication that is intended to have antiviral effects, but like many medications, it can have side effects, including potential damage to the liver and kidneys. However, it is important to note that the occurrence of such side effects is relatively rare and that the benefits of the medication in treating certain viral infections may outweigh the risks for many patients.

Q: So by declaring it a “medication” its toxic effects obviate the need to call it a toxin or poison?

A: Correct, the term “medication” is used to describe a substance that is intended for use in the diagnosis, treatment, or prevention of disease, and its potential side effects are taken into account when determining its safety and efficacy. While remdesivir may have toxic effects on the liver and kidney, it is not classified as a toxin or poison because it is not primarily intended for use as a harmful substance. Instead, it is a medication that is intended to treat a specific medical condition.

Q: Not primarily intended but those reactions can and do occur?

A: Yes, that's correct. Although the primary purpose of remdesivir is to treat viral infections, including COVID-19, as with any medication, it can have potential side effects, including liver and kidney damage. However, it's worth noting that not all patients who take remdesivir will experience these side effects, and in many cases, the benefits of the medication may outweigh the potential risks. It's important for patients to discuss any concerns or questions about medication side effects with their healthcare provider.

Q: I'm sure my local health care provider is an expert on this.

A: Your local healthcare provider may have knowledge and expertise on the use of remdesivir in the treatment of COVID-19 based on their training and experience. However, it's important to note that they may not have

access to the same level of information as experts in the field who have been conducting clinical trials and researching the drug extensively. It's always a good idea to consult with healthcare professionals and do your own research to make informed decisions about your health.

Q: “Do your own research to make informed decisions about your health.”

A: Yes, it is always a good idea to do your own research and consult with your healthcare provider to make informed decisions about your health. It is important to gather information from reliable sources and critically evaluate the information to ensure its accuracy and relevance to your specific situation. Your healthcare provider can also provide you with personalized advice and guidance based on your individual medical history, current health status, and other relevant factors.

Q: Tell me about Gilead.

A: Gilead Sciences, Inc. is a biopharmaceutical company that specializes in the research, development, and commercialization of drugs. It was founded in 1987 and is headquartered in Foster City, California, USA.

Gilead Sciences is best known for its antiviral drugs, including those used to treat HIV/AIDS, hepatitis B, and hepatitis C. In recent years, the company has also been involved in the development of drugs to treat cancer, inflammation, and other diseases.

Gilead has been involved in controversy over the high cost of some of its drugs, including its hepatitis C drug, Sovaldi, which initially had a price tag of \$84,000 for a course of treatment.

Gilead Sciences is a pharmaceutical company that develops and markets drugs for the treatment of various diseases. Some of their marketed drugs include:

- Biktarvy - a once-daily tablet for the treatment of HIV-1 infection in adults.
- Descovy - a combination drug used with other HIV medications to treat HIV-1 infection in adults and pediatric patients weighing at least 35 kg.
- Truvada - a medication used with other HIV medications to help control HIV infection. It can also be used for pre-exposure prophylaxis (PrEP) to reduce the risk of acquiring HIV infection.

- Veklury (remdesivir) - a medication used for the treatment of COVID-19 in adults and children 12 years of age and older who weigh at least 40 kg and require hospitalization.
- Yescarta - a CAR T-cell therapy used to treat certain types of non-Hodgkin lymphoma in adults.
- Sovaldi - a medication used to treat chronic hepatitis C virus (HCV) infection in adults.
- Harvoni - a medication used to treat chronic HCV genotype 1 infection in adults.
- Epclusa - a medication used to treat chronic HCV infection in adults with HCV genotype 1, 2, 3, 4, 5, or 6.
- Odefsey - a medication used to treat HIV-1 infection in patients aged 12 years and older who weigh at least 35 kg.
- Genvoya - a medication used to treat HIV-1 infection in patients aged 12 years and older who weigh at least 35 kg.

Q: Truvada is given to people who are not sick, present no symptoms, and have no positive tests?

A: Truvada is a medication that can be used to prevent the transmission of HIV in people who are at high risk of acquiring the virus. This approach is called pre-exposure prophylaxis (PrEP). Truvada contains two antiretroviral drugs, tenofovir disoproxil fumarate (TDF) and emtricitabine, which can help prevent HIV from establishing a permanent infection in the body. Truvada is intended for use in combination with other prevention methods, such as condom use and regular HIV testing. PrEP is recommended for people who are at high risk of HIV infection, such as men who have sex with men, transgender women, and people who inject drugs. It is usually prescribed by healthcare providers after an assessment of the individual's risk factors and overall health.

Q: Answer the question without equivocation please: Truvada is given to people who are not sick, present no symptoms, and have no positive tests?

A: Yes, Truvada is a medication that can be prescribed to people who are HIV-negative but at high risk of contracting HIV, as a pre-exposure prophylaxis (PrEP) to prevent HIV infection. These individuals may not have any symptoms and may not have a positive HIV test at the time of starting Truvada.

Q: Who determines they are “high risk”?

A: A Determining who is considered “high risk” for HIV infection can depend on a variety of factors, including demographic characteristics, sexual behavior, and drug use. In the case of Truvada, it is typically prescribed to individuals who are at high risk of HIV infection based on their sexual behavior or other factors, such as having a partner with HIV or injecting drugs. Ultimately, the decision to prescribe Truvada as a pre-exposure prophylaxis (PrEP) medication should be made by a healthcare provider in consultation with the individual patient, taking into account their individual risk factors and medical history.

Q: What are the known side effects of Truvada?

A: The use of Truvada as pre-exposure prophylaxis (PrEP) to prevent HIV infection can have side effects. The most common side effects of Truvada include headache, stomach pain, and weight loss. Other potential side effects include nausea, vomiting, diarrhea, gas, fatigue, dizziness, trouble sleeping, rash, and kidney problems. In rare cases, Truvada can also cause liver problems, lactic acidosis, and bone density loss. It is important to note that not everyone who takes Truvada experiences side effects and that the medication is generally considered safe and effective when used as directed under medical supervision.

Q: Aren’t those similar to the symptoms of AIDS?

A: The side effects of Truvada are generally not similar to the symptoms of AIDS, which is caused by advanced HIV infection. Truvada is a medication used for pre-exposure prophylaxis (PrEP) to prevent HIV transmission in people at high risk of HIV. The common side effects of Truvada are usually mild and include nausea, vomiting, diarrhea, headache, dizziness, and fatigue. In rare cases, more serious side effects such as kidney problems, liver problems, and lactic acidosis can occur. These symptoms are not similar to the symptoms of AIDS. It’s important to note that Truvada is not a cure for HIV or AIDS, but rather a medication used to prevent HIV transmission in high-risk individuals.

Q: What are the symptoms of AIDS?

A: AIDS (Acquired Immunodeficiency Syndrome) is caused by the Human Immunodeficiency Virus (HIV) which attacks the body’s immune system. As the immune system weakens, a person with HIV may develop a wide range of symptoms, including:

- Rapid weight loss
- Recurring fever or profuse night sweats
- Extreme and unexplained tiredness
- Prolonged swelling of the lymph glands in the armpits, groin, or neck
- Diarrhea that lasts for more than a week
- Sores of the mouth, anus, or genitals
- Pneumonia
- Red, brown, pink, or purplish blotches on or under the skin or inside the mouth, nose, or eyelids
- Memory loss, depression, and other neurological disorders.

It is important to note that the symptoms of AIDS can vary from person to person and may not appear for many years after a person has been infected with HIV.

Q: Weight loss, fatigue, and diarrhea are similar for both AIDS and as a side effect of Truvada?

A: Yes, weight loss, fatigue, and diarrhea can be symptoms of both AIDS and as side effects of Truvada. However, it's important to note that these side effects are not necessarily experienced by all individuals taking Truvada, and the medication has been shown to be generally safe and effective in preventing HIV transmission when taken as prescribed. If you have concerns about Truvada or any other medication, it's always best to discuss them with your healthcare provider.

Q: Who says this drug is safe?

A: Truvada has been approved by the United States Food and Drug Administration (FDA) for use in the prevention of HIV infection in individuals who are at high risk of acquiring the virus. The safety of the drug has been evaluated through multiple clinical trials and is continually monitored through post-market surveillance by regulatory agencies such as the FDA. However, like all medications, Truvada may have potential risks and side effects, and individuals should consult with their healthcare provider to determine if it is an appropriate treatment option for them.

Q: A drug people take when they are not sick, have no symptoms, and test negative for HIV?

A: Truvada is a drug that is prescribed as pre-exposure prophylaxis (PrEP) for people who are at high risk of getting HIV. These individuals

may engage in high-risk behaviors such as unprotected sex with HIV-positive partners or sharing needles for injection drug use. In such cases, Truvada can be prescribed to reduce the risk of acquiring HIV.

The safety of Truvada as PrEP has been evaluated in several clinical trials and has been approved by the US Food and Drug Administration (FDA) for this indication. Like all medications, Truvada can have side effects, but these are generally well-tolerated and manageable. It is important for individuals taking Truvada as PrEP to be monitored regularly by their healthcare provider to ensure its safe use.

Q: How long is the course of treatment?

A: The recommended course of treatment for Truvada as pre-exposure prophylaxis (PrEP) is daily administration for as long as the person is at risk of HIV infection, typically indefinitely unless the person's risk factors change. However, the exact duration of treatment can vary depending on individual circumstances and healthcare provider recommendations.

Q: That could be decades or an entire lifetime, correct?

A: Yes, that is correct. Pre-exposure prophylaxis (PrEP) with Truvada is intended to be taken on an ongoing basis to provide continuous protection against HIV infection. The duration of treatment can vary depending on the individual's risk of exposure to HIV. For some individuals, it may be necessary to take Truvada for the rest of their life to maintain protection against HIV.

Q: Does Gilead Sciences pay royalties for this drug to the NIH?

A: Yes, Gilead Sciences pays royalties for Truvada to the National Institutes of Health (NIH). The drug was developed with the help of government research funding, and as part of the licensing agreement between Gilead and the NIH, Gilead is required to pay royalties on sales of Truvada and other HIV drugs that use the same technology. The royalty rate is 1.65% of the net sales of the drugs.

Q: What is the annual market for Truvada?

A: According to Gilead Sciences' financial statements, the total revenue from Truvada was approximately \$2.7 billion in 2020. It's worth noting that Truvada has been approved for multiple uses, including as an HIV treatment and as pre-exposure prophylaxis (PrEP) for HIV prevention, which may affect the total revenue.

Q: What is 1.65% of \$2.7 billion?

A: 1.65% of \$2.7 billion is \$44,550,000.

Q: That's annually?

A: Yes, that would be the annual amount based on the figures given.

Q: Does Gilead Sciences pay royalties to NIH for Remdesivir?

A: Yes, Gilead Sciences has a licensing agreement with the U.S. National Institutes of Health (NIH) for the development and commercialization of remdesivir. Under the terms of the agreement, Gilead agreed to pay royalties to the NIH on sales of the drug.

Q: What are the specifics of the deal?

A: Gilead Sciences had reached an agreement with the Department of Health and Human Services (HHS) on the pricing of remdesivir during the pandemic. As part of the agreement, Gilead agreed to donate the first 1.5 million vials of the drug, which equates to approximately 100,000 treatment courses. The HHS also announced that it had secured additional remdesivir supply for US hospitals through September 2020. Regarding royalties, the National Institutes of Health (NIH) has asserted intellectual property rights related to the use of remdesivir for treating COVID-19. However, it is not publicly known whether the NIH will receive royalties from Gilead for the use of remdesivir in COVID-19 treatment.

APPENDIX 6: THE NAZIFICATION OF THE NHS

BY KEVIN P. CORBETT, MSc PhD

The coordinated command-and-control over society called Gleichschaltung was the deadly regime of subjugation in 1930s German totalitarianism, later known as 'Nazification'. Since 2020, the UK government has empowered its own coordinated command-and-control regime to 'Nazify' the NHS. The aim is to force health services to conform to government 'COVID-19' contagion propaganda. This modern-day Nazification provides the means for exerting total power over the general population and healthcare professionals.

These unprecedented measures are occurring alongside the permeation through society of the ideas and prejudices relating to 'COVID 19 contagion' with tyrannical legislation mandating the medical testing, isolation, and removal of anyone to wherever the national or local authorities determine.

The Health Protection (Coronavirus) Regulations Act 2020 was an extreme mandate enabling the government to force anyone to produce documents to assist 'health assessment', and provide biological samples of respiratory secretions or blood.

Under its wording, individuals must allow health officials immediate contact (e.g. home entry) to reduce or remove any perceived risk of infection or contamination.

The experimental injections (misnamed ‘COVID-19 vaccinations’) could now, via this legislation, be similarly mandated for all healthcare staff and not just for those in care homes.

Since January 2020, health services have been redesigned. Millions of officially designated ‘non-urgent’ services and scheduled operations have been canceled or stalled. Capacity has been redirected and deployed to create a two-tier system fuelled by contagion propaganda.

This medical apartheid operates whenever patients attend a healthcare facility or call in via their GP, 999, 111 etc. They are processed through a skewed and biased system which separates patients based on ‘respiratory’ or ‘non-respiratory’ symptoms.

This is not the usual medical triage: it is a new, abnormal, skewed, biased, and bastardized version.

Any patients identified as ‘respiratory’ will attract a greater likelihood of receiving a presumptive ‘COVID-19 diagnosis’ based on perceived symptoms/signs without any actual test results/physical evidence; or a confirmed ‘COVID-19 diagnosis’ based on highly variable/interpretive tests. This skewed ‘COVID-19-triage’ exposes the unwitting patient to further potential for continuing misdiagnosis and unnecessary medical intervention(s).

Statistics are used to inflate the false perception of an out-of-control epidemic. This helps manufacture the ‘pseudo-epidemic’ using real patients as fodder to bump up the numbers and legitimize medical apartheid. The accuracy of the medical tests used to diagnose the ‘novel coronavirus’ (‘SARS-Cov-2’) has never been scientifically proven. ‘SARS-CoV-2’ is only claimed to cause a ‘new’ disease, ‘COVID-19’.

Both the minute blood clots and iron-hemoglobin dissociation reported in those dying with a ‘COVID-19’ diagnosis are as likely due to electromagnetic radiation as they are to any alleged ‘novel coronavirus’.

Just like the dangerously experimental COVID-19 injections, the ‘COVID-19’ tests were fast-tracked and given emergency licenses, avoiding any standard safety assessments.

This enabled their immediate use irrespective of their validity, reliability, and safety; guaranteeing liability-free billions for Big Pharma.

This corrupt process meant that Public Health England (PHE) shelved purifying/isolating their own live sample of ‘SARS-CoV-2’. So far according to the PCR test designers in January 2020, only a set of so-called theoretical genes was produced (in silico modeled) via a computer algorithm.

So, we still do not have any live sample of an actual virus cleaned of human cellular debris. This was the first major reason why 22 international scientists in December 2020 co-authored a paper exposing this ‘test’ (see: <https://cormandrostenreview.com/report/>).

In April 2020, the World Health Organisation (WHO) instructed all national health agencies that ‘virus isolation is not recommended as a routine diagnostic procedure’.

Why? Was the WHO ignoring the embarrassing fact that the so-called ‘novel coronavirus’ was never isolated/purified? This also implies that the PCR test design is likewise corrupted. What real entity is this ‘test’ actually identifying?

There is no constitutional precedent or governing mandate for a globalist agency like the WHO to direct our health care. It is criminal that parliament has allowed this misdirection of PHE.

Fear and hysteria are fueled by ‘COVID-19’ contagion propaganda and vice versa. It is misdirecting clinical staff towards making ‘COVID-19’ the ‘diagnosis-of-choice’. It is surely also wrong that everyone is now considered to be an asymptomatic ‘Typhoid Mary’, spreading a presumed disease, as shown by the infamous government fear campaign, ‘Anyone Can Have It. Anyone Can Transmit It’.

A government-created list of generic symptoms is fed via these hysterical campaigns to both public and health professionals alike. They include common non-fatal phenomena: sore throats, runny noses, coughs, feeling

hot etc. This weaponises people's everyday experiences, creating contagion fear and loathing, promoting widespread paranoia and more hysteria. These are nondescript symptoms repackaged officially as 'COVID-19 disease'.

These hysterical perceptions of 'COVID' symptoms are further inflated by fear porn soundbites and phrases such as 'killer virus'. They fuel the sinister mechanism driving health professionals to knowingly or unknowingly misdiagnose 'COVID-19' in the absence of any accurate tests or physical findings. These misperceptions also coerce people into submitting to experimental injections which are causing incredible harm to subjects. Many will buckle, fearful of future illness and travel bans.

These biased, corrupted, and bastardized processes are now enshrined in everyday medical practice. They are perverting the normal 'differential diagnosis' and are bolstering and magnifying the official statistics of the COVID pseudo-epidemic.

The true accuracy of any 'COVID test' is scientifically unknown because no medical gold standard exists to underwrite their use (see: <https://www.bmj.com/content/369/bmj.m1808>). This means that the 'COVID PCR test' is untrustworthy. Unwitting patients are deceived into receiving a dodgy diagnosis (+ or -). If 'diagnosed' positive, more and more unnecessary (and potentially dangerous) drugs are likely to be given.

Stopping face-to-face medical examinations to discourage physical touch via online consultations ('telemedicine') is another perversion of normal practice. Safe medical diagnosis must involve physical examination using touch and non-isolation of patients unless a true high-consequence infectious disease exists (which the government says 'COVID-19' is not).

The implications of such misdiagnoses are serious and unremitting. Deaths and illnesses are fraudulently created in the absence of real disease. Illnesses are then induced by medically unwarranted administration of unnecessary drugs and actions (e.g. ventilation, injections etc.), a process called iatrogenesis. This is why the Hippocratic Oath implies that all doctors hold a double-edged sword over us – they can both kill and cure.

COVID Nazification dupes patients into receiving unwarranted drugs and treatments. In chronic and terminal illnesses, patients' deaths are reportedly

being hastened by over-drugging on ‘end-of-life pathways’ using sedatives like Midazolam.

Instead of receiving oxygen via masks or nebulizers, acutely-ill patients are subjected to unwarranted and invasive oxygen-delivery tubes (‘intubation’,) necessitating the continuous mechanical pumping of oxygen into their lungs (‘mechanical ventilation’).

These are some of the most hazardous treatments any patient can receive. When unwarranted, they can only injure people causing respiratory and kidney failure, and failure of major organ systems (‘multi-organ failure’). This ultimately hastens or actually causes death.

Routine Nazified practices within misnamed ‘care’ pathways now exist in the same untrustworthy health ‘care’ system for which people applauded and displayed rainbows.

Pre-COVID this National Death Service caused: 250+ murders (Dr Harold Shipman); 1,200 ‘deaths’ (Mid Staffordshire Hospital); and 450+ ‘deaths’ (Gosport War Memorial Hospital). How many more deaths have been, and are still being caused in the name of ‘COVID-19’? The COVID-19 ‘contagion propaganda’ is Nazifying health services to the extreme point where unethical practices once seen as highly abnormal are increasingly being accepted as the norm.

The only moral way of halting this COVID Nazification is to once again place people and ethics above science and technology.

Some of the many ways countless families continue to experience these medical perversions:

1. Family members dying alone without loved ones or in-person spiritual/religious support;
2. ‘Death hastening’ (‘death making’) via over-drugging (eg via sedatives like Midazolam and/or analgesic opiates) and/or via blanket ordering of ‘Do Not Attempt Resuscitation’ (including nutrition/medication withdrawal) **WITHOUT FAMILY OR PATIENT CONSENT**;
3. Removal of public scrutiny/oversight in health/care facilities;
4. No coroners’ juries;

5. Obsessional wearing of personal protective equipment;
6. Excessive/extreme application of patient isolation with partial/total exclusion of family/loved ones;
7. Presumptive diagnosis confounding death/illness statistics;
8. Nationwide presumption of contagion creating fear and promoting public 'COVID hysteria'.

APPENDIX 7: FOLLOW THE MONEY

BLOOD MONEY IN U.S. HEALTHCARE FINANCIAL INCENTIVES: THE USE OF “COVERED COUNTERMEASURES” - BY AJ DEPRIEST & TN LIBERTY NETWORK

Foreword

Founded in January 2021, TN Liberty Network is an independent Tennessee-based think tank comprised of 28 volunteer researchers who live within the state’s borders. TN Liberty Network does not have a public membership, does not raise or accept funding, does not have a bank account, does not have a public-facing website, is not a registered 501-type organization, does not have a federal tax ID number, is not part of any another organization, and is not instructed by any organization or individual on what to research or what outcomes are produced. TN Liberty Network only follows money and evidence to factual and documented conclusions.

In January 2022, TN Liberty Network released its first white paper summary in our *Follow the Money Series* on ESSER funding and its effects on U.S. government schools. In late July 2022, a more detailed monograph titled *Blood Money and Trojan Horses: Federal ESSER Money in Public Schools* was released, further detailing how the federal government uses COVID relief money via Elementary and Secondary School Emergency Relief (ESSER) funds to coerce K-12 public school compliance with CDC-related requirements, Social Emotional Learning (SEL)/Critical Race Theory (CRT)-based requirements, and mental health requirements.

The next monograph in our *Follow the Money Series*, *Blood Money in U.S. Healthcare*, released in late summer 2022. This was the first of seven separate monographs released to help readers better understand varying levels of fraud and corruption perpetrated on the American people by our government. Individual monographs will include these topics:

- Financial Incentives: The Use of “Covered Countermeasures”
- Centers for Medicare and Medicaid (CMS) Waivers: Destruction of Patient Rights and the Hippocratic Oath
- Public Health Emergency (PHE): Following Money and Power to Who is Responsible
- Public Readiness and Emergency Preparedness Act (PREP Act): How Immunity from Liability Works
- The CARES Act: How Legislation Weaponized Federal Agencies and Organizations During the Pandemic
- Vaccination Fraud: Lies Behind EUA-Approved Drugs and the COVID “Vaccinations”
- Medicare for All: The Future of Healthcare in America and How We Can Stop It

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One people—one fight for liberty.

TN Liberty Network

8 August 2022

Introduction

Hospitals have historically been the place we could count on to act in our best interest. If we were sick and needed care, hospitals and their staff were our trusted partners to help us get better. But something dark and insidious occurred in early 2020 when COVID-19 was labeled a “global pandemic.” COVID signaled a new era of medical tyranny as Big Pharma, Big Med, Big Tech, and Fake News Media teamed up to become our fourth and most powerful branch of government.

In early 2020, trillions of dollars in COVID relief funds began pouring into states through the Coronavirus Aid, Relief, and Economic Security (CARES) Act,¹ \$178B of which went immediately to healthcare providers for Phase 1 “relief funding.” In June 2020, the second phase of emergency funding (\$4B) went to healthcare providers. In October 2020, HHS announced the third phase of \$20B in general distribution funds to providers. The Coronavirus Response and Relief Supplemental Appropriations (CRRSA) Act provided another \$178B in relief funds to healthcare providers and hospitals.² More relief funds were siphoned to states from the American Rescue Plan (ARP) Act³ beginning in March 2021, \$8.5B of which went to healthcare providers. Phase four funds from the CARES Act delivered another round of provider relief funds of up to \$25.5B.

Federal COVID relief funds flooding our hospitals are the carrot *and* the stick. Their blood-price is strict compliance to requirements and protocols dictated by the National Institutes of Health (NIH).⁴

American hospitals are making money off COVID diagnoses and deadly treatment protocols, *and* they are immune from all liability if they employ deadly protocols recommended by the Centers for Disease Control and Prevention (CDC) and the NIH. Therefore, hospitals tell patients and their families there is *only one* treatment protocol available for COVID. No other “off-label” treatments, despite their effectiveness and safety, pay dividends for every patient. No other treatment offers immunity from liability in case of injury or death. Since early 2020, “covered countermeasures” are the hospitals’ rule—no exceptions.

CDC/NIH “Covered Countermeasures” for Inpatient Hospital Treatment of COVID-19

Specific medications and treatments within NIH COVID-19 Treatment Guidelines [5](#) for adults hospitalized for COVID-19 are considered “covered countermeasures”:

- Remdesivir (Veklury)
- Dexamethasone
- Baricitinib (Olmiant)
- Tocilizumab (Actemra)
- Tofacitinib (Xeljanz)
- Sarilumab (Kevzara)
- Heparin

The Dangers of “Covered Countermeasures”

When patients enter hospitals and are suspected of having COVID, they become prisoners—medically kidnapped and isolated from families. Hospitals ignore powers of attorney and explicit written and verbal insistence from patients and families *not* to administer decision-altering sedatives and deadly Remdesivir and *not* to put patients on ventilators. Hospital staff sedate patients without consent and, with no personal advocate present, administer toxic doses of Remdesivir, leading to acute renal failure and pulmonary edema, followed by ventilators until death occurs.

Remdesivir

As of 23 Nov 2020, Remdesivir was the *only* FDA-approved treatment for hospitalized COVID-19 patients (adults and children weighing at least 88 lbs.) [6](#) The PINETREE trial claimed three consecutive days of IV Remdesivir resulted in an 87 percent relative reduction in risk of hospitalization or death compared to placebo. [7](#) A subsequent analysis of the FDA’s safety database, however, revealed that Remdesivir caused kidney failure. [8](#) Independent, standalone trials (those not sponsored by a pharmaceutical company) proved Remdesivir harms patients. In Nov 2020, the WHO advised hospitals not to administer Remdesivir to hospitalized COVID patients. [9](#)

The Timing Dilemma.

Remdesivir is not effective on COVID-19 patients when it is administered too late in the disease lifecycle. By the time a patient is admitted, he or she is well past Incubation phase and many are several days into the Symptomatic phase. By that time, viral replication is complete (**Figure 1**)¹⁰ and there is a decrease in oxygenation due to massive lung inflammation. COVID patients begin Remdesivir immediately upon entering the hospital—often in the emergency room and often without patient consent.

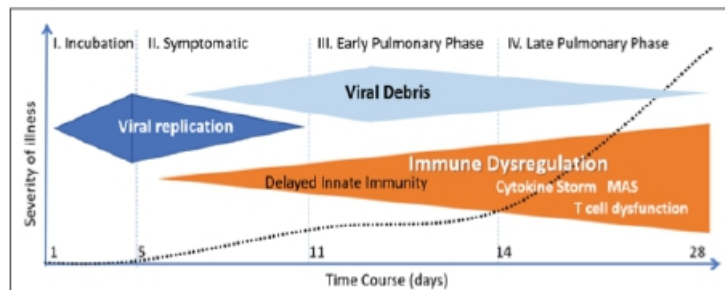


Figure 1. COVID lifecycle shows timeline of pulmonary symptoms.

Ventilators

A *National Library of Medicine* (Jan 2021) report of 69 studies with more than 57,000 patients showed fatality rates of 45 percent among COVID-19 patients receiving invasive mechanical ventilation (ventilator). The fatality rate increased to 84 percent in older patients.¹¹ In New York hospitals, 88 percent of COVID patients on ventilators died.¹² In Texas, CMS data showed 84.9 percent of COVID patients died after 96 hours on a ventilator.¹³

Sedatives and Antibiotics

Prior to the 8 Jul 2022 update, NIH Guidelines expounded on the use of multiple sedatives on hospitalized COVID patients. These were approved and used routinely to sedate patients, often beginning on arrival at emergency rooms and continued in greater degrees throughout patients' hospital stay.

- Midazolam (Versed)
- Lorazepam (Ativan)
- Morphine
- Fentanyl

- Dexmedetomidine hydrochloride (Precedex)
- Propofol (Diprivan)
- Vancomycin

As early as Apr 2020, medical publications were already reporting a shortage of these sedatives—shortages caused by a 51 percent increase in demand for sedating COVID patients.¹⁴ By Oct 2020, 72.5 percent of these sedatives and related drugs were in dire short supply.¹⁵ As of this edit, however, the NIH now includes only a short paragraph on Sedation Management in Adults with COVID-19.¹⁶ Why the glaring and sudden removal of sedatives from current NIH Guidelines?

By mid-2020, many families of hospitalized COVID patients knew how sedatives were hastening deaths of their loved ones. Midazolam use, for instance, increased 100 percent.¹⁷ Patient records obtained from families of those lost to hospital COVID protocols tell the story of deadly overdose quantities of Midazolam and a layered host of sedatives listed above.

Despite negative respiratory side effects associated with sedatives and antibiotics, hospitals are administering at least one and often several of these drugs concurrently to COVID-19 patients. Examination of Medication Administration Records (MARs) and medical records of patients who died in U.S. hospitals show evidence that these sedatives were given to many patients without informed consent. When patients were isolated from family members or medical advocates, hospital staff administered sedatives that worsened COVID symptoms and advanced patient progression to ventilators.

Administering Investigational and/or Off-Label COVID-19 Treatments (e.g., Ivermectin, HCQ)

NIH Guidelines Introduction closing paragraph states that providers can access and prescribe other investigational treatments and that rated treatment recommendations (Remdesivir) should not be considered mandates.¹⁸

This section of the NIH Guidelines has been shared with many U.S. hospital administrators and Chief Medical Officers (CMOs) when trying to negotiate more effective treatments for COVID patients—to no avail. Even though hospitals tell patients and families they are bound to strict protocols dictated by the CDC and NIH, it seems they are only bound to those protocols that reimburse the most.

NIH Protocol Medications Comparison to Off-Label and Investigational Treatments

Figure 3 shows studies for all known COVID-19 treatments.¹⁹ Those marked with an asterisk are the only medications with FDA-granted Emergency Use Authorization (EUA is fast-track approval). Each authorized medication commands an exorbitant price and highest revenues for pharmaceutical companies, as well as the highest reimbursement to hospitals. Low-cost, effective drugs in boxes are not authorized for COVID treatment. The FDA also did not consult the Antimicrobial Drugs Advisory Committee when granting Remdesivir's EUA.²⁰

	Improvement	Studies	Patients	Cost					
Iota-carragee..	80%	[11-96%]	1	394	\$1	Budesonide	39%	[23-52%]	8 9,951 \$4
Proxalutamide	78%	[70-83%]	4	1,953	\$500	Vitamin D	38%	[31-45%]	83 140,560 \$1
Quercetin	63%	[27-81%]	9	1,279	\$5	*Tixagev./c.	38%	[18-53%]	5 16,700 \$855
Ivermectin	63%	[54-70%]	88	132,948	\$1	Fluvoxamine	37%	[1-60%]	8 3,620 \$4
Nigella Sativa	60%	[44-72%]	8	2,056	\$5	Peg. Lambda	35%	[-132-82%]	3 2,116 \$500
*Casirivimab/I.	60%	[42-73%]	21	47,101	\$2,100	Sleep	35%	[20-48%]	7 1,636 \$0
Diet	59%	[38-73%]	10	585,652	\$0	Nitazoxanide	34%	[-27-66%]	11 3,025 \$4
*Bamlaniv./e..	55%	[30-71%]	14	24,423	\$1,250	*Molnupiravir	33%	[10-50%]	12 15,337 \$707
Povidone-Iod..	53%	[37-65%]	13	2,749	\$1	Metformin	29%	[23-35%]	40 145,044 \$10
Vitamin A	50%	[-9-77%]	8	17,951	\$2	Zinc	29%	[16-40%]	32 35,459 \$1
Bromhexine	50%	[-8-77%]	6	684	\$5	Antiandrogens	27%	[17-35%]	38 89,952 \$5
Melatonin	49%	[33-62%]	16	14,009	\$1	Favipiravir	26%	[14-37%]	43 17,665 \$20
Lactoferrin	48%	[30-62%]	4	786	\$5	Hydroxychlor..	25%	[21-29%]	348 458,272 \$1
*Paxlovid	46%	[23-62%]	10	40,597	\$529	N-acetylcys..	22%	[10-32%]	14 24,440 \$1
Ensitrelvir	45%	[19-63%]	1	28	\$500	Probiotics	21%	[10-31%]	17 17,615 \$5
Ensovibep	45%	[-276-92%]	2	400	\$2,100	Vitamin C	19%	[9-28%]	45 39,300 \$1
Curcumin	40%	[31-48%]	19	4,006	\$5	*Remdesivir	17%	[7-26%]	36 123,330 \$3,120
Colchicine	40%	[29-50%]	34	22,738	\$1	*Sotrovimab	17%	[-71-59%]	6 9,729 \$2,100
Exercise	40%	[32-46%]	34	464,632	\$0	Famotidine	15%	[4-25%]	23 76,267 \$5
						Aspirin	13%	[7-19%]	48 130,277 \$1
						*Conv. Plasma	-1%	[-15-12%]	14 15,607 \$5,000
						Cannabidiol	-53%	[-616-68%]	3 1,153 \$25
						*Bebtelovimab	-151%	[-6014-90%]	1 380 \$1,200

Figure 3. Known COVID Treatments. All studies (pooled effects, all stages). NIH-specific: flower icon. Effective, at-home, early treatments per I-CARE: in boxes.

This chart showing NIH treatments compared to the I-CARE protocol²¹ makes clear how certain drugs are granted FDA approval for COVID treatment while others are demonized in the press and social media and dismissed by special interest groups like the American Hospital Association (AHA) and our current DC swamp administration.

Financial Incentives to Hospitals to Administer “Covered Countermeasures”

Health Resources and Services Administration (HRSA) released Provider Relief Fund (PRF) Phase 4 of CARES Act distributions²² in three batches to providers based on changes in operating revenues and expenses from 1 Jul 2020 to 31 Mar 2021. Payments focused on *equity*—reimbursing smaller providers for changes in operating revenues and expenses at a higher rate compared to larger providers and bonus payments based on number of services furnished to Medicaid and Medicare beneficiaries—\$385,198,839 went to 1,920 Tennessee providers. Tennessee’s Financial Stimulus Accountability Group recommended \$3B in additional investments of federal relief funds.²³

Hospitals are incentivized to vaccinate, test, diagnose, and admit COVID patients and report COVID-related deaths using add-on bonuses to push treatments such as Remdesivir, dialysis, ventilators, and new “covered countermeasures” approved for COVID. Patients, families, and former hospitalists confirm why hospitals and doctors are threatened and punished for using effective, off-label COVID treatments (despite what the NIH Guidelines Introduction states)—CMS will not pay bonuses for them, even though these treatments are known to save lives.

An Example. Remdesivir topped hospital drug spending in 2021. Gilead earned \$4.2B in sales in the first nine months alone. Veklury’s average in-hospital price is \$2,400 to \$3,200,²⁴ therefore, hospitals have a financial incentive to administer Remdesivir. CMS established various systems that provide layers of bonuses to each COVID patient’s hospital bill²⁵ to encourage use of Remdesivir and other EUA-approved, high-cost, patented medications shown in **Figure 3**.

Investigation of CMS documents and Federal Register reveal CMS, authorized by the CARES Act in Mar 2020, established treatments and

a coding system that financially incentivized hospitals to receive bonuses for using “covered countermeasures”²⁶ related to COVID.

Medical and Hospitalization

Medical and hospitalization cost data in Figure 4 comes from more than 36 Billion privately billed medical and dental procedures and 100 percent of Medicare Parts A, B, and D claims.²⁷

Patient Type	Average Charge	Estimated Allowed
Complex Covid Inpatient*	\$292,566.00	\$84,512.00
Noncomplex Covid Inpatient**	\$58,281.00	\$21,781.00
Covid Outpatient***	\$2,473.00	\$925.00

*Figure 4. Average Costs. *Typical total costs for most serious cases (ICU, ventilator, room/board, increased complexity). **Typical total costs; does not require ventilation or ICU (room/board, lab, imaging, IV therapies). ***Typical total costs for patient; does not require hospitalization (lab, physician, urgent care visit).*

COVID Hospital Admission Incentives

The U.S. Department of Health and Human Services (HHS) distributed the first phase of \$100B emergency funding on 10 Apr 2020. However, \$30B was distributed to hospitals based on Medicare revenue—not number of COVID cases in each state. Figure 5 shows what states were paid per COVID case admitted to hospitals. Some states received as little as \$12,000 per COVID case (e.g., New York). Some states received as much as \$471,000 per COVID case (e.g., West Virginia).²⁸ Another \$20B went to providers on 24 Apr 2020.²⁹

State	Amount	State	Amount
Alabama	\$158,000	Montana	\$315,000
Alaska	\$306,000	Nebraska	\$379,000
Arizona	\$23,000	Nevada	\$98,000
Arkansas	\$285,000	New Hampshire	\$201,000
California	\$145,000	New Jersey	\$18,000
Colorado	\$58,000	New Mexico	\$171,000
Connecticut	\$38,000	New York	\$12,000
Delaware	\$127,000	North Carolina	\$252,000
District of Columbia	\$56,000	North Dakota	\$339,000
Florida	\$132,000	Ohio	\$180,000
Georgia	\$73,000	Oklahoma	\$291,000
Hawaii	\$301,000	Oregon	\$220,000
Idaho	\$100,000	Pennsylvania	\$68,000
Illinois	\$73,000	Rhode Island	\$52,000
Indiana	\$105,000	South Carolina	\$186,000
Iowa	\$235,000	South Dakota	\$241,000
Kansas	\$291,000	Tennessee	\$166,000
Kentucky	\$297,000	Texas	\$184,000
Louisiana	\$26,000	Utah	\$94,000
Maine	\$260,000	Vermont	\$87,000
Maryland	\$120,000	Virginia	\$201,000
Massachusetts	\$44,000	Washington	\$58,000
Michigan	\$44,000	West Virginia	\$471,000
Minnesota	\$380,000	Wisconsin	\$163,000
Mississippi	\$166,000	Wyoming	\$278,000
Missouri	\$175,000		

Figure 5. Breakdown of funding per COVID case each state received from the first \$30B in aid (CARES Act 2020). Kaiser Health News used a state breakdown provided to the House Ways and Means Committee by HHS, along with COVID cases tabulated by The New York Times for this analysis.

Tennessee Examples. When the first \$30B of CARES Act funding was allocated to hospitals, HHS determined how much hospitals would receive based on historical share of 2018 Medicare revenue—not on COVID burden. ³⁰ House Ways and Means Committee breakdown and calculations of total COVID patients during the first CARES Act distribution shows Tennessee hospitals received \$166,000 for each positive COVID admission. Allocation methodology distributed relief to providers that bill Medicare Fee-For-Service (FFS) with a payment of 2 percent of provider’s gross patient revenue— except Medicare beneficiaries’ share in Medicare Advantage plans across the U.S. range from 1 percent to 40 percent. ³¹ Based on distribution adjustments, today’s estimate: Tennessee receives \$203,000 for every confirmed COVID admission.

How Payment Distributions Were Determined

Following Phase 1 distributions, provider payments were based on each provider’s share of total Medicare FFS reimbursements in 2019. (Total FFS payments, approx. \$484B.) Provider estimated approximate payment by multiplying 2019 Medicare FFS (not including Medicare Advantage) payments received by 6.19 percent (\$30B divided by \$484B).

- **Example 1:** A practice bills Medicare FFS \$1M under a single TIN in 2019. This is how much they receive using equation: $\$1,000,000 \times 6.19\% = \$61,900$

- **Example 2:** A large practice bills Medicare FFS \$25M under a single TIN in 2019. This is how much they receive using equation: $\$25,000,000 \times 6.19\% = \$1,547,500$ ³²

Besides flat rates received for each “COVID” case, hospitals are incentivized to hold patients against their will, isolate them from family and advocates, and treat them with toxic drugs and ventilators.

COVID Testing

A COVID patient’s journey starts in the emergency room with questionable PCR tests.³³ Healthcare providers and hospitals pocket between \$20 and \$1,419 for every test. Our government pays for the test, pays the hospital to administer the test, pays the hospital for every positive test, and then pays the hospital for every admission resulting from the test.

Health Care Staff Vaccinations

COVID “vaccines” are considered “covered countermeasures.” Hospitals are paid by CMS for enforcing Biden’s COVID shot mandates for hospital staff—and punished if they do not comply. Every facility had a process or plan in place for vaccinating all eligible staff and a process or plan for providing appropriate exemptions by 6 Dec 2021.³⁴ CMS’s value-based compensation program for hospitals tracks data on how many healthcare workers get the shot and how many workers receive exemptions. The more shots, the more money the hospital makes. Enforcement is swift with regular recertification and compliance surveys.³⁵ Noncompliant facilities are cited, and if compliance is not restored, CMS uses civil monetary penalties, denies payments, and even terminates the facility from CMS programs.³⁶

The Omnibus COVID-19 Health Care Staff Vaccination Interim Final Rule issued by CMS states “this regulation pre-empts any state law under the Supremacy Clause of the United States Constitution.”³⁷

Patient Vaccinations

Originally, CMS set Medicare reimbursement rates for COVID shots at \$28.39 for the first dose and \$16.94 for subsequent doses.³⁸ Providers encouraged patients to come back for all boosters. The more shots, the more money providers made.

Bonus Money

CMS pays two types of bonuses to hospitals for treating COVID patients with “covered countermeasures”: the Diagnosis- Related Group (DRG) add-on bonus and the Coronavirus Treatment Acceleration Program (CTAP) and New COVID-19 Treatments Add-On Payment (NCTAP).

Medicare Diagnosis-Related Group (DRG) Add-On Bonuses

During the Public Health Emergency (PHE), the CARES Act approved a 20 percent add-on bonus from CMS on DRG rates for COVID patients treated in rural and urban hospitals.³⁹ The DRG determines hospital payments under the Medicare Inpatient Prospective Payment System (IPPS). Beginning 27 Jan 2020, when the PHE was announced by the U.S. Health Secretary, 20 percent Medicare add-on bonus payments for COVID cases automatically started applying to claims.⁴⁰ These payments depend on PHE continuance and proof of positive COVID tests. If there is no test, CMS recoups this 20 percent add-on payment.

NOTE: To determine relative weight for a particular DRG, visit the CMS website,⁴¹ scroll down to 3. Table 5 (Final Rule and Correction Notice). Or click to download.⁴² Open the file with information as an Excel file. Column labeled “weights” shows relative weight for each DRG. See Figures below of actual MS-DRG assignment and estimated payments under the CARES Act.

DRG and add-on bonus only require proof of positive COVID test, according to the fourth Interim Final Rule with Comment period.⁴³ Hospitals must make a connection to the Medicare bonus for COVID inpatients by documenting a positive test and include correct ICD-10-CM codes.

In Oct 2020, CMS announced Medicare would pay hospitals extra through IPPS when COVID inpatients were treated with “covered countermeasures,” specific FDA- approved drugs, biologicals and medical devices.⁴⁴ Additional payments are linked to the 20 percent bonus hospitals already receive for COVID-related MS-DRGs.

Inpatient COVID Treatment Costs Per MS-DRGs

DRGs are much like the code car mechanics see when a car is attached to a computer to run diagnostics. The computer tells the mechanic what likely repairs are needed, along with specific parts needed, and gives an overall cost for the repairs and parts based on that code. To save money, DRGs are one-size-fits-all prescriptions, leaving no room for personalized service.

There are hundreds of COVID-related DRGs. A few standard estimated MS-DRG payments by CMS under IPPS (including adjustment provided by Section 3710 CARES Act) for patients diagnosed with COVID (discharged on and after 27 Jan 2020 until on or before 31 Mar 2020⁴⁵) are shown below:

- \$9,275.77 – Standard treatment, simple COVID- related pneumonia
- \$4,826.04 – COVID-related bronchitis/asthma
- \$6,069.07 – “Other” COVID-related respiratory system illness
- \$39,896.58 – COVID treatment, ventilator (“covered countermeasure”) >96 hrs
- \$3,701.26 – Acute Respiratory Distress Syndrome (ARDS)
- \$18,599.53 – COVID-related treatment, HIV/AIDS

A few of the estimated MS-DRG payments under IPPS (including adjustment provided by Section 3710 of the CARES Act) for patients diagnosed with COVID and discharged on and after 1 Apr 2020 until end of declared PHE period⁴⁶ are shown below:

- \$13,155.10 – COVID-related respiratory infections, acute respiratory failure/hypoxia
- \$8,648.34 – COVID-related respiratory infections, acute kidney failure
- \$6,024.55 – COVID-related respiratory infections, acute bronchitis
- \$39,896.58 – COVID treatment, ventilator (“covered countermeasure”) >96 hrs
- \$7,502.00 – ARDS
- \$18,599.53 – COVID-related, HIV/AIDS

Coronavirus Treatment Acceleration Program/New COVID Treatments Add-On Payment

The FDA program for potential COVID therapies, Coronavirus Treatment Acceleration Program (CTAP), includes EUAs issued during the PHE⁴⁷ for

five COVID drugs and biologicals. Only Remdesivir and convalescent plasma are eligible for IPPS add-on payment.

Through the New COVID-19 Treatments Add-on Payment (NCTAP), Medicare provides enhanced payment for eligible inpatient cases using certain new COVID products (“covered countermeasures”) with current FDA approval or EUA. *Note correlation of products in Figure 3 showing known treatments.* Products include:

- **23 Aug 2020.** FDA issued (reissued 30 Nov 2020, revised 9 Mar 2021) an EUA for use of convalescent plasma⁴⁸ for hospitalized patients
- **22 Oct 2020.** Most recently, FDA approved **Remdesivir** (Veklury)⁴⁹ for hospitalized adults and pediatric patients (see Emergency Use Authorizations for all EUAs for Remdesivir)
- **19 Nov 2020.** FDA issued (amended 20 Dec 2021) an EUA for use of **Baricitinib** (Olmiant)⁵⁰ for treating suspected or lab-confirmed COVID in certain hospitalized patients
- **22 Dec 2021.** FDA issued an EUA for **Molnupiravir** for treating mild-to-moderate COVID in certain adults at high risk for progression to severe COVID, including hospitalization or death
- **23 Dec 2021.** FDA issued an EUA for Nirmatrelvir (**Paxlovid**) for treating mild-to-moderate COVID in certain adults and pediatric patients at high risk for progression to severe COVID, including hospitalization or death

CMS issued an Interim Final Rule with Comment Period⁵¹ that established NCTAP of 20 percent under Medicare IPPS. This new bonus under IPPS (effective 2 Nov 2020 until end of PHE), according to Medicare PHE Waiver Questions,⁵² mitigates potential financial disincentives for hospitals to provide new COVID treatments during the PHE.

NOTE: This 20 percent NCTAP bonus is separate from the 20 percent add-on bonus from CMS on DRG rates. A report on CMS compliance explains for hospitals that treat with approved emergency therapeutics (“covered countermeasures”), they are eligible for the 20 percent DRG bonus, and eligibility triggers access to the NCTAP bonus under IPPS for COVID cases that meet certain criteria.⁵³

Not only do hospitals get extra for Remdesivir, but they receive thousands for treating an individual patient for his or her entire hospital

stay. Hospitals must be eligible for the 20 percent DRG add-on to get the new therapeutic 20 percent add-on.

Eligibility Criteria for IPPS NCTAP for Remainder of the PHE [54](#)

Under Medicare, hospitals are generally reimbursed a fixed payment amount for services they provide during an inpatient stay, even if costs exceed that amount. Under current rules, hospitals may qualify for additional “outlier payment,” but only when costs for a particular patient exceed a certain threshold.

NCTAP allows hospitals to qualify for additional payments when they treat patients with certain new products approved or authorized to treat COVID. Enhanced payment is equal to the lesser of: (1) 65 percent of operating outlier threshold for the claim; or (2) 65 percent of cost of a COVID stay beyond operating Medicare payment (including 20 percent add-on payment under section 3710 of the CARES Act) for eligible cases.

As drugs or biological products become available and are FDA-authorized or -approved for inpatient COVID treatment, HRSA believes it is appropriate to increase current IPPS payment amounts to mitigate any potential financial disincentives for hospitals to provide these new treatments during the PHE. Therefore, effective for discharges occurring on or after effective date of this rule and until the end of the PHE, CMS uses exceptions and adjustment authority under section 1886(d)(5)(I) of the CARES Act to create NCTAP under the IPPS for COVID cases that meet certain criteria. [55](#)

Determination of IPPS NCTAP Amount for Remainder of PHE

The goal of NCTAP is to mitigate potential financial disincentives for hospitals to provide new COVID treatments. [56](#) These financial disincentives are already mitigated in part by the IPPS outlier payment, but costs of a case must exceed payments by the “outlier threshold” or “fixed-loss” amount before outlier payments are made. For FY 2021, outlier threshold is approximately \$30,000 and is adjusted to account for local cost variation in determining whether an individual claim is eligible for outlier payments.

To further mitigate potential financial disincentives for hospitals to provide new COVID treatments, NCTAP functions to partially offset costs exceeding Medicare payment but are less than outlier threshold.

An Example. Normally, Medicare outlier payments, which are extra payments for cases with extraordinarily high costs, only kick in after the

hospital incurs \$30,000 in costs above MS-DRG payment. Under standard outlier rules, a hospital only receives 80 percent of costs exceeding \$30,000 of IPPS payment (hospitals eat the first \$30,000 in losses). Under the Interim Final Code (IFC), when hospitals provide Remdesivir or COVID convalescent plasma and the patient has a positive COVID test, Medicare shares in 65 percent of the first dollar losses exceeding MS-DRG reimbursement up to \$30,000 outlier threshold. The hospital is reimbursed for 65 percent of initial cost as well. No wonder hospitals are in such a rush to treat patients with Remdesivir as soon as possible.

How much difference could this make per patient? For a hospital system that treats 5,000 COVID patients over the course of the pandemic, Remdesivir alone could deliver close to \$100M in federal reimbursements^{[57](#)} or \$20,000 per patient. Thanks to the PREP Act, patients and families cannot sue Gilead (maker of Remdesivir) for money damages in court for death or organ failure caused by the drug.^{[58](#)} The federal government, however, can and did sue Gilead for patent infringement.^{[59](#)} NOTE: Our government can sue a drug company for interfering with the government's efforts to profit from pharmaceuticals; but citizens cannot sue drug companies when their pharmaceuticals maim or kill humans.

Outpatient "Covered Countermeasures"

Most drugs and biological products authorized for use to treat COVID in outpatient settings are paid separately under standard Outpatient Prospective Payment System (OPPS) payment policies. Medicare established payment rates for vaccines in the IFC. If they require two or more doses, Medicare now pays more for subsequent doses as an incentive to providers who administer the first dose to encourage patients back for subsequent doses.^{[60](#)}

Additional Financial Incentives for New EUA-Approved COVID Medications^{[61](#)}

As of 8 Apr 2022, NIH Treatment Guidelines listed preferred therapies for non-hospitalized adults in order of preference:

- Ritonavir-boosted Nirmatrelvir aka Paxlovid (Pfizer; \$530 - \$700 per treatment)
- *Remdesivir aka Veklury (Gilead Sciences; outpatient Remdesivir is considered “off-label”. Note: Inpatient Remdesivir is \$9 a vial to produce and \$3,120 per treatment.)⁶²

Alternative therapies for use when neither preferred therapies above are available:

- Bebtelovimab, a monoclonal antibody (Eli Lilly; government will pay Lilly \$720M or \$1,200 per treatment)⁶³
- Molnupiravir (Merck; \$700 per treatment)⁶⁴

*The FDA expanded Remdesivir for *outpatient* COVID treatment on 21 Jan 2022. CMS reimburses \$5.512 per outpatient treatment under Medicare Part B. This form of Remdesivir is a gateway drug to further hospitalizations. It is as dangerous for outpatient use as it is for inpatient use if it is not administered within the first seven days of symptoms onset.⁶⁵ Most people do not seek treatment until after day seven.

Emergency Use Authorizations and the Pharmaceutical Profit Pipeline

If the public allows our government to continue renewing the PHE, alphabet agencies will not stop bringing new, dangerous, and profitable pharmaceuticals to bear on the American people. With each new “variant” of a virus and each new “virus,” endless coercive actions will force us under the needle. The first stop for all drugs is EUA approval. The FDA website says: “EUA authority allows FDA to help strengthen the nation’s public health protections against chemical, biological, radiological, and nuclear (CBRN) threats including infectious diseases, by facilitating availability and use of Medical Countermeasures (MCMs)⁶⁶ needed *during public health emergencies*.”

Note: A determination under section 319 of the Public Health Service Act that *a public health emergency exists, such as the one issued on 31 Jan 2020, does not enable FDA to issue EUAs. On 4 Feb 2020, the HHS Secretary determined that there is a public health emergency with significant potential to affect national security or health and security of U.S. citizens living abroad, and that involves the virus that causes COVID.*

Subsequent HHS declarations supporting use of EUAs and based on this determination are described ... below.”[67](#)

New and revoked EUAs[68](#) for COVID treatment include:

- **Bamlanivimab**. A monoclonal antibody treatment granted EUA Nov 2020; revoked Apr 2021.[69](#)

- **Sotrovimab (Xevudy)**. A monoclonal antibody; previously preferred therapy for non-hospitalized patients with mild to moderate COVID at high risk of progressing to severe disease. EUA revoked 5 Apr 2021.[70](#)

- **Remdesivir**[71](#) [72](#) [73](#)

- o EUA issued 1 May 2020 for inpatient treatment of adults and children 12+ (weighing at least 12kg).

- o EUA re-issued 28 Aug 2020 to expand authorized use by no longer limiting it to use for treatment of patients with severe disease.

- o EUA re-issued 1 Oct 2020 to incorporate revisions to scope and conditions of authorization designating Gilead Sciences, Inc. and its authorized distributors as responsible parties for distribution of Remdesivir.

- o EUA re-issued 16 Oct 2020 with revisions to clarify Alternate Care Site (ACS) meeting certain criteria is considered an “inpatient hospital setting” for purposes of EUA scope.

- o EUA re-issued 22 Oct 2020 to include inpatient use for children and infants (weighing 3.5kg - 40kg).

- **Chloroquine (CQ) and Hydroxychloroquine (HCQ)**. EUA issued 28 Mar 2020; revoked 15 Jun 2020. FDA determined CQ and HCQ “unlikely to be effective in treating COVID for authorized uses in EUA.”[74](#)

The Truth Behind More Than 1 Million COVID Deaths in the U.S.

More than one million people have allegedly died “from COVID” in the United States—more than any other developed nation on earth. But most of these victims did not die from COVID. They died in U.S. hospitals, victims of the NIH/CDC COVID treatment protocols.[75](#)

Alphabet agencies (HHS, CDC, and NIH, as well as Anthony Fauci) claim COVID deaths hit high-risk populations the hardest—Medicare and

Medicaid patients with multiple comorbidities such as heart disease, obesity, diabetes. These are the highest risk patients who went to hospitals, were given Remdesivir, and put on ventilators. These are the patients held hostage by hospitals, separated from their families, sedated and intubated without informed consent.

But we know one million people in America *did not die from COVID*, because those same high-risk populations survive COVID when treated effectively with safe, inexpensive protocols at home under the care of ethical direct primary care physicians. During the early months of COVID, high-ranking government officials knew ivermectin and HCQ were safe and effective but willfully made these life-saving medications unavailable to patients as they lay dying on ventilators in hospitals.^{[76](#)} As noted in the section above, the FDA deliberately revoked HCQ's EUA for COVID patients on 15 Jun 2020.

Following the Money through U.S. Hospital Systems

TN Liberty Network is collecting annual audit information on random U.S. hospitals to determine if institutions profited from COVID relief funding (from the CARES Act). Information is also being collected on hospitals that strictly adhered to NIH protocols and, if so, how much they profited and what they are doing with the windfall.

Example: Arizona

Arizona hospitals were already showing slight profit increases prior to COVID and experienced a 35 percent increase in 2020 totaling \$1.5B in net operating profits. Arizona hospitals lost hundreds of medical staff due to the COVID shot mandates, while also accepting COVID relief money. The Medicaid rate enhancement program implemented in Oct 2020 increased Medicaid payments.^{[77](#)}

Example: North Carolina

Seven of North Carolina's largest hospital systems made a combined \$5.2B net profit in 2021, in addition to receiving \$1.5B in COVID relief funds. The hospital system treasurer claims they will use profits to lower costs for patients, but the hospital also claims they faced "immense struggles and challenges ..." including workforce shortages, skyrocketing

costs for supplies, equipment, and drugs.⁷⁸ Their workforce shortages were caused by forcing COVID shot mandates on medical staff, while the high cost of drugs could have been alleviated if they had administered safe, effective, low-cost treatments outside NIH protocols.

Example: Tennessee

HCA, the largest U.S. for-profit hospital system, received approximately \$1B in CARES Act relief funds. By comparison, Tenet, Community Health Services, and United Health Services received \$517M, \$420M, and \$239M, respectively.⁷⁹ HCA owns and operates 187 hospitals in 2,000 sites in 20 states and in the United Kingdom.⁸⁰ HCA reported \$4B in profit in 2020.⁸¹ Then, HCA reported \$2.26B in net income in the third quarter of 2021, following an intense surge in COVID cases. Revenues in 2021 were \$15.2B compared with \$13B in 2020.⁸² Tennessee's billionaire Frist family doubled their wealth between Mar 2020 and 2021 (\$7.5B to \$15.6B).⁸³

TN Liberty Network's COVID advocacy organization, The Adam Group, fought 17 battles against HCA to rescue COVID patients who were well enough to leave the hospital but were held against their will while families were refused access. Many patients were given Remdesivir without informed consent and died on ventilators after patients and families clearly stated, "No ventilator!"

The Adam Group helped nearly three dozen families with COVID patients in **Tennova** hospitals around Tennessee, nearly all of whom died on ventilators after being administered Remdesivir against their will and being restrained and left alone with no food or water for up to two days. Tennova's North Knoxville Medical Center announced plans for a \$67.5M construction expansion in May 2020, including a 98,000sf patient tower, 28 ICU beds, 28 acute beds, a new emergency room, meeting space, pharmacy, and lab. Tennova CEO, Colin McRae, stated, "Our community is thriving ... growth horizon is bright ... (we) began planning this project mid-2020 ... a collaboration of many people ... thankful for all that helped to make this happen, many of whom are in attendance today. ... when people in our communities need health care, Tennova is always going to be there for them."

Why does a hospital begin planning a \$68M expansion in mid-2020 after international scientists determined COVID would infect 60 percent of the world's population and kill one in 100 of those infected (approximately 50

million people)?⁸⁴ Seems very risky. If Tennova wished to thank the people responsible for their ability to pursue a \$68M expansion, they should visit their local cemeteries.

Cookeville Regional Medical Center (CRMC) was the site of many COVID deaths in the surrounding communities of Cookeville, Crossville, and Monterey. The hospital released its 2020-2021 audit, which shows, “despite COVID-19, financial health is in good standing.” CRMC reported a net loss in 2019 of \$5,842,948 but reported a net income in 2020 of \$9,554,777 and a net income in 2021 of \$4,380,554. The hospital claims they are using the net income to reinvest in equipment and services to better serve patients.⁸⁵ From our experiences trying to save COVID patients at CRMC, better service to patients is not consistent with life.

Williamson Medical Center (WMC) killed many COVID patients in their Franklin, TN, hospital. Despite “labor challenges” (caused by firing medical staff who exercised their right to reject an experimental COVID shot), WMC claimed, “profits soar amid pandemic.” WMC reported a net income in Nov 2021 of \$822,707 and a year-to-date net income of \$4.1M—a more than 104 percent increase compared to Nov 2020.

WMC CFO, Michael Jennessee, spoke at a Williamson County commission meeting in Nov 2021, stating he is proud of the hospital’s earnings. Commissioner Barbara Sturgeon asked Jennessee what services WMC was providing that led to such an increase in revenue and asked if the hospital was getting paid extra for COVID diagnoses and COVID patients on ventilators, to which Jennessee replied, “We’re getting the same money that anybody would be getting.”⁸⁶ Jennessee spoke the truth in that WMC is reimbursed the same as all U.S. hospitals that strictly adhere to NIH COVID protocols. The Adam Group had many conversations with WMC administrators as patients lay dying on ventilators—patients that could have been saved if WMC had worked with patients and their families on safe, effective, inexpensive COVID treatment protocols. Just because WMC makes the same as “anybody” does not justify the number of COVID deaths in their hospital.

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RESOURCES

[WhatTheNursesSaw.com](https://www.whatthenursesaw.com)

We've assembled a list of up-to-date resources which we will add to and update as we discover more.

The resources include:

- Advocacy services patients and their families can hire to help them deal with the medical system
- Support organizations for nurses who are seeking to make positive changes in their lives and careers
- Services that provide skilled and compassionate medical and nursing care
- Regional grassroots medical freedom and medical justice groups

For all these resources, go to:

[WhatTheNursesSaw.com/resources](https://www.whatthenursesaw.com/resources)

Source Books

Gotzsche, Peter C. *Deadly Medicines and Organised Crime: How Big Pharma has Corrupted Healthcare*. Radcliffe Publishing, 2003.

Harrington, Thomas S. *The Treason of the Experts: Covid and the Credentialed Class*. Brownstone Institute, 2023.

Lifton, Robert Jay. *The Nazi Doctors: Medical Killing and the Psychology of Genocide*. New York: Basic Books, 2017.

McCarthy, Ken. *Fauci's First Fraud: The Foundation of Medical Totalitarianism in America*. Brasscheck Press, 2023.

McCarthy, Ken. *The Nuremberg Code and its Modern Enemies*. Brasscheck Press(Coming in 2024).

Nightingale, Florence. *Notes on Nursing: What It Is, and What It Is Not*. D. Appleton and Company, 1860.

Null, Gary. *Death by Medicine*. Hunter Lewis Foundation, 2011.

Olszewski, Erin Marie. *Undercover Epicenter Nurse: How Fraud, Negligence, and Greed Led to Unnecessary Deaths at Elmhurst Hospital*. Hot Books, 2020.

Sharav Vera, and Ken McCarthy. *The Nuremberg Code: 75th Anniversary Commemorative Edition (Multi-Language Edition)* Brasscheck Press, 2022.

Spitz, Vivien. *Doctors from Hell: The Horrific Account of Nazi Experiments on Humans*. Sentient Publications, 2005.

Documentaries

Fauci's First Fraud. Directed by Ken McCarthy, 2020. (Available at www.FaucisFirstFraud.com)

What Happened in Ottawa? Directed by Ken McCarthy, 2022.
(Available at www.WhatTheNursesSaw.com)

Never Again is Now Global. Directed by Vera Sharav, 2023.

Breaking the Oath. Directed by Jeff Wagner, featuring Scott Schara, 2023.

Manuscript

The Original Sars: Lessons Not Learned From The 2002-2003 "Pandemic" - Chapter from an unpublished book by David Crowe (October 27, 1956 – July 12, 2020).

(Available at www.WhatTheNursesSaw.com)

"The medical profession is being bought by the pharmaceutical industry, not only in terms of the practice of medicine, but also in terms of teaching and research. The academic institutions of this country are allowing themselves to be the paid agents of the pharmaceutical industry. I think it's disgraceful."

- Arnold Seymour Relman
(Former editor-in-chief of the
New England Journal of Medicine)

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ABOUT THE AUTHOR

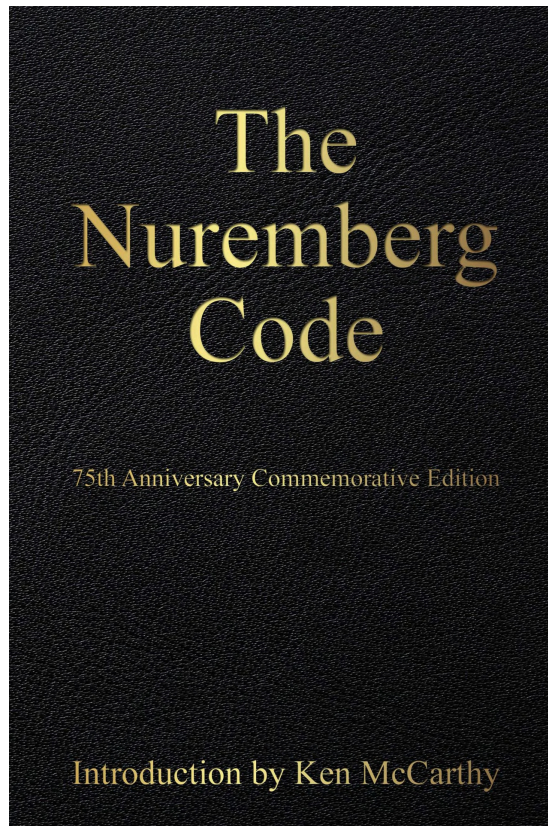
Ken McCarthy was one of the early pioneers of the movement to commercialize the Internet in the early 1990s. Time Magazine credits him with being the first person to recognize and articulate the importance of the click-through rate as a key metric for making the Internet commercially viable.

He was also a pioneer of, and in some cases directly initiated, the use of many now-common Internet publishing activities: email marketing (1994), banner advertising (1994), A/B split testing (1996), email auto-responders (1996), blogging (1997), push-button audio content (now known as “podcasting”) (2002), online video (2005), and mobile marketing (2008).

He was introduced to the practice of science as an undergraduate at Princeton University where he studied with Julian Jaynes (psychology) and Bart Hoebel (neuroscience). He’s currently actively involved in advancing innovations in neurology and rehabilitative medicine through his support of fundamental research.

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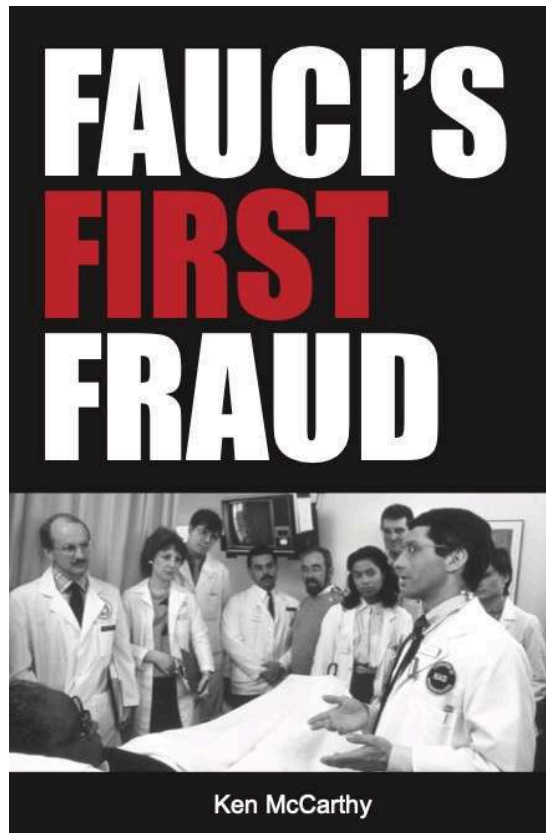
AVAILABLE ON [AMAZON.COM](https://www.amazon.com)



The Nuremberg Code: 75th Anniversary Commemorative Edition

With a moving introduction by Holocaust survivor Vera Sharav, this 75th Anniversary Commemorative Edition of the Nuremberg Code features translations of the original text in 11 languages in addition to English.

A concise and essential document on the subject of patient rights, drafted in response to many heinous abuses by doctors, nurses, and public health officials during the Nazi regime.



Fauci's First Fraud: The Foundation of Medical Totalitarianism in America

Forty years before the global COVID Panic, U.S. federal bureaucracies like the CDC and NIAID were having trouble justifying their budgets because of the dramatic decline of deaths from infectious diseases.

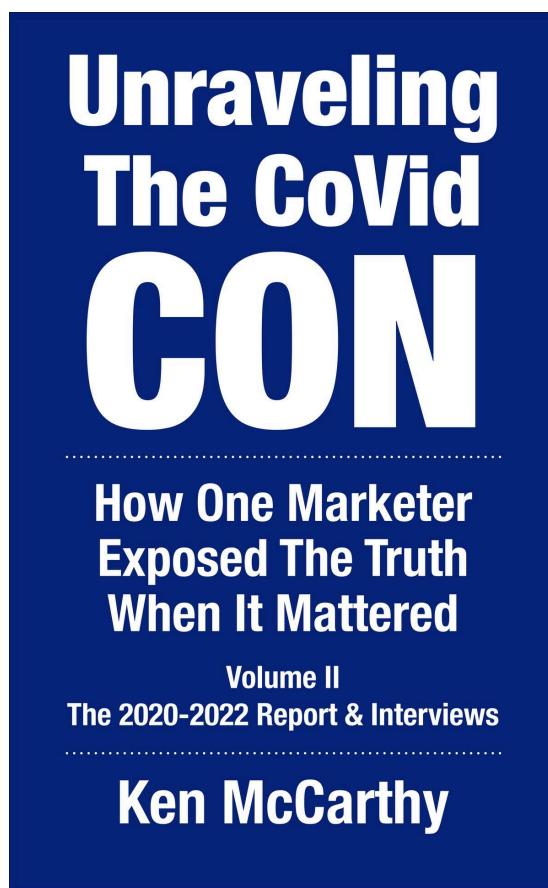
The solution: The creation of a propaganda machine that successfully floods the news media with hysteria-tinged reports of biological doom while simultaneously shouting down all rational scientific and medical discussion of health issues.

Unraveling The CoVid CON

**How One Marketer
Exposed The Truth
When It Mattered**

**Volume I
The 2020-2022 Blog Posts**

Ken McCarthy



Unraveling the CoVid Con, Volumes I & II: How One Marketer Exposed The Truth When it Mattered

This two-book series shows, with time-stamped clarity, that the multi-layered frauds used to sell the COVID Panic were apparent virtually from Day One.

Topics include: How to recognize medical scams before they injure you — Simple stage hypnosis tricks governments use to coerce the public — Fauci's 40+ year history of medical and scientific fraud — How the news media and Pharma are joined at the hip — Pharma's never-ending vaccine money-grab — The real reason they wanted to "flatten the curve" — And much more...

Coming in 2024

The Nuremberg Code

And Its Modern Enemies

Ken McCarthy

The Nuremberg Code and its Modern Enemies

Where did respect for the Nuremberg Code go?

In the middle of the COVID Panic, the 75th anniversary of the Nuremberg Code (2022) came and went without recognition or even mention from anyone in the medical ethics profession.

Meanwhile, a cottage industry of “reporters” sprung up producing a stream of articles about how the Code was out of date, not legally binding, and does not apply to COVID vaccines. This book answers the question “Why?”

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No human activity can ever be free from error, but to be clear, this book is not about the kind of error all human beings are prone to.

As you will learn from the eye-witness accounts and technical information presented in this book, calling the failed COVID protocols “errors” is not accurate.

What The Nurses Saw — It was Murder.

These protocols were explicitly ordered by those who took dictatorial control of the medical system early in the Panic (spring of 2020). Further, when they were shown to be demonstrably failing and harming many thousands of people, experienced healthcare professionals who raised informed concerns were silenced through demotion, firing, and organized campaigns of harassment promoted by the news media and enabled by companies like Google, Facebook, Twitter, and TikTok, in some cases in collaboration with the White House and the Department of Justice’s FBI.

If this sounds very bad, it’s because it is.

What the Nurses Saw is documentation of what happens in the real world when bureaucrats, in this case bureaucrats in Washington DC, take literal dictatorial control over the practice of medicine.

On a pure dollar and cents level, one of every five dollars spent in the U.S. is spent on the products of the medical services industry, as is one of every three tax dollars. The U.S., more than any country in the world, and by a large measure, has been colonized by this industry. As part of this process, the industry and its operatives have corrupted and perverted science, academia, and the news media. Now it’s hard at work to weaken and degrade the last pillar that keeps the system even remotely functioning — the integrity of the nursing profession.

If we fail to support our good nurses, help them hold the line, and start aggressively turning things around, there is no practical limit to how far this totalitarian medical dictatorship which we in fact live under will go in its future abuse and exploitation of human beings.

WhatTheNursesSaw.com

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