Hospitals and Care Facilities are Federally **Mandated** Killing Fields

Grace Schara's death at the hands of medical personnel reminiscent of the Holocaust's beginning

ASCENSION NE WI ST. ELIZABETH HOSPITAL, APPLETON, WI
CONSULTATION REPORT

PATIENT NAME: SCHARA,GRACE N REPORT NO: 1007-0140

we would plan to continue that for up to 10 doses while she requires supplemental oxygen therapy.
6. We briefly discussed the possible use of tocilizumab. Currently, the patient does not meet criteria for. She is on Vapotherm, flow rate of 20 and things seem to have calmed down and she is improving, so at this time, she does not require this. She is going to her own research on this drug whether she wanted to use or not and things were to worsen and we will just kind of reassess things from there. At this time, she does not meet criteria for tocilizumab.
7. I stressed the importance of proning, continue with supplemental oxygen and time and we will have to kind of see how things proceed as we move forward here.
8. Unfortunately, I think the patient probably would not be here if she has been fully vaccinated.

We will plan to follow with you.

Thank you for allowing me to participate in the care of your patient, please call if there are any questions.

JOB ID: 1053286

cc: Karl Baum MD
Trans: RI
ZEIA /escript

Dict: 10/07/21 1153
Tran: 10/07/21 1220

Electronically Signed: ANTHONY P ZEIMET DO 10/07/21 1643

FINAL ORIGINAL IN COMPUTER PATIENT RECORD

See 17 for PATIENT COUNSELING INFORMATION

Revised: 06/2013

----------CONTRAINDICATIONS----------

None (4)

----------WARNINGS AND PRECAUTIONS----------

- Monitoring: Continuously monitor patients while receiving Precedex. (5.1)

From Grace's Death Certificate:

41. PART II. The conditions listed are the diseases, injuries, or complications that caused death. Conditions leading to the immediate cause are listed sequentially and the underlying cause is listed last.

Immediate Cause: (a) ACUTE RESPIRATORY FAILURE WITH HYPOXEMIA

Due to or as a consequence of: (b) COVID 19 PNEUMONIA

Reference ID: 3326669

8 Minutes That Changed Our Lives (page 853 of 948)

RUN DATE: 03/04/22 — Affinity Health System **LIVE** OE — PAGE 59
RUN TIME: 1345 — Discharge Report
RUN USER: ASDUESTE

PATIENT: SCHARA,GRACE N — **A/S:** 19 F — **ADMIT:** 10/07/21
ACCOUNT NO: E39547554 — **LOC:** E.2-C — **DISCH/DEP:** 10/13/21
RM: E.2029 — **STATUS:** DIS IN
ATTEND DR: BECK MD,DAVID — **BD:** 1 — **UNIT NO:** E000365038

CODE STATUS: No Code

Order's Audit Trail of Events

1	10/13/21	1056	GSHOK003	Order ENTER in POM
2	10/13/21	1056	GSHOK003	Ordering Doctor: SHOKAR MD,GAVIN
3	10/13/21	1056	GSHOK003	Order Source: POM
4	10/13/21	1056	GSHOK003	Signed by SHOKAR MD,GAVIN
5	10/13/21	1108	HMCINNIS	order acknowledged
6	10/13/21	1137	LREYN026	order viewed
7	10/13/21	1946	LRITTMEY	order viewed from Order Management
8	10/14/21	0129	JCAST126	order viewed from Order Management
9	10/14/21	1142	RJANZEN	order viewed from Order Management
10	01/19/22	1024	ABUSHMAN	order viewed

10:48 a.m. – Max dosage Precedex (this after chemically restraining Grace with Precedex for 4 full days prior)
10:56 a.m. – Illegal DNR by doctor
12:57 p.m. – Dr. Shokar dictated notes for the day (always dictated end of shift prior)

Category	Procedure	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR	INSFT	20211013-0458	10/13/21				VO	IPR	SHOGA

Other Provider : **Sig Lvl Provider :**
Tube Type: Nasogastric (NG)
F9 To View Options

Order's Audit Trail of Events

1	10/13/21	1111	HMCINNIS	Order ENTER in OM
2	10/13/21	1111	HMCINNIS	Ordering Doctor: SHOKAR MD,GAVIN
3	10/13/21	1111	HMCINNIS	Order Source: Verbal Ord/Read Back
4	10/13/21	1111	interface	order's status changed from TRANS to ACTIVE by NUR
5	10/13/21	1137	HMCINNIS	order acknowledged
6	10/17/21	2302	GSHOK003	Signed by SHOKAR MD,GAVIN

Conclusions:
1. Was DNR put on Grace 8 minutes after maximum dose Precedex because they thought she would be taken out then?
2. If a DNR was suggested, why not contact Cindy (POA) to sign DNR since they had 6 1/2 hours before Grace was killed?

From: Garrett, Jennifer E - DSPS <jennifer.garrett@wisconsin.gov>
Sent: Monday, December 5, 2022 1:14 PM
To:
Cc: Cieslewicz, Greg - DSPS <greg.cieslewicz@wisconsin.gov>
Subject: question response

Dear Mr. :

As you are aware, the Medical Examining Board Screening Panel (Panel), staffed by Department legal counsel, re-reviewed the allegations set forth in the complaint filed by Mr. Schara. The re-review was completed on October 4, 2022.

After careful consideration, the Panel reaffirmed their decision to close the complaint without further action.

Among the allegations that the Panel reconsidered and thoroughly discussed was the allegation that the attending physician violated Wis. Stat. § 154.19. The purpose of a written DNR as outlined in chapter 154 of the Wisconsin Statutes, Advance Directives, is to direct care provided in emergency department and out-of-hospital emergency settings so that the medical care provided in those settings is consistent with a patient's wishes and an attending physician's authorization. They are sometimes referred to as "community" DNRs, which is reflective of their purposes.

Chapter 154 of the Wisconsin Statutes does not apply to physicians operating in a hospital, non-emergency room setting such as the one in question. The exercise of judgment by a physician working in a non-emergency hospital setting is informed by many variables, including but not limited to patient prognosis, expected medical benefit of the considered care, and patient and family wishes expressed contemporaneously through a living will, or through a health care power of attorney agent empowered to make decisions on behalf of a patient.

While the decision of the Panel does not likely provide any comfort to the grieving family, the allegations were thoroughly considered on multiple occasions by members of the Medical Examining Board and the Department. Again, the Medical Examining Board and Department offer our condolences to the family.

Jennifer Garrett | Assistant Deputy Secretary
Department of Safety and Professional Services
Jennifer.Garrett@wisconsin.gov
608.266.1352
Follow us @WI_DSPS

Why? What is the legal authority?

Eugenics Protocols

Implementation of the Population Reduction Agenda

Eugenics: Excluding people and groups judged to be inferior or promoting those judged to be superior. "Survival of the fittest" has been proactively practiced since ancient times.

The Affordable Care Act (ACA), a/k/a Obamacare, was signed into law on March 23, 2010. Obamacare laid the groundwork for the current degradation of healthcare set in motion over 100 years ago by the Rockefellers.

Ezekiel Emanuel, one of the country's most influential bioethicists and a prime architect of Obamacare, wrote as far back as 1996 that health care "services provided to individuals who are irreversibly prevented from being or becoming participating citizens are not basic and should not be guaranteed."

Individuals or institutions refusing to participate in "assisted suicide, euthanasia, or mercy killing" may not be discriminated against by government, entities receiving federal financial assistance under this Act, or health plans created under this Act (p. 141, [section] 1553). This protection, however, explicitly does not apply to or affect "any limitation relating to: (1) the withholding or withdrawing of medical treatment or medical care; (2) the withholding or withdrawing of nutrition or hydration; (3) abortion; or (4) the use of any item for the purpose of alleviating pain even if such use may increase the risk of death as long as such an item is not furnished with the purpose of causing, or the purpose of assisting in causing, death, for any reason."

SEC. 1553. PROHIBITION AGAINST DISCRIMINATION ON ASSISTED SUICIDE. 42 USC 18113.

(a) IN GENERAL.—The Federal Government, and any State or local government or health care provider that receives Federal financial assistance under this Act (or under an amendment made by this Act) or any health plan created under this Act (or under an amendment made by this Act), may not subject an individual or institutional health care entity to discrimination on the basis that the entity does not provide any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing.

(b) DEFINITION.—In this section, the term "health care entity" includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.

(c) CONSTRUCTION AND TREATMENT OF CERTAIN SERVICES.—Nothing in subsection (a) shall be construed to apply to, or to affect, any limitation relating to—

(1) the withholding or withdrawing of medical treatment or medical care;

(2) the withholding or withdrawing of nutrition or hydration;

(3) abortion; or Abortion.

(4) the use of an item, good, benefit, or service furnished for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as such item, good, benefit, or service is not also furnished for the purpose of causing, or the purpose of assisting in causing, death, for any reason.

(d) ADMINISTRATION.—The Office for Civil Rights of the Department of Health and Human Services is designated to receive complaints of discrimination based on this section.

SEC. 1554. ACCESS TO THERAPIES. 42 USC 18114.

Notwithstanding any other provision of this Act, the Secretary of Health and Human Services shall not promulgate any regulation that—

(1) creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care;

(2) impedes timely access to health care services;

(3) interferes with communications regarding a full range of treatment options between the patient and the provider;

(4) restricts the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions;

(5) violates the principles of informed consent and the ethical standards of health care professionals; or

(6) limits the availability of health care treatment for the full duration of a patient's medical needs.

CHARTER

MEDICARE EVIDENCE DEVELOPMENT & COVERAGE ADVISORY COMMITTEE

COMMITTEE'S OFFICIAL DESIGNATION

Medicare Evidence Development & Coverage Advisory Committee (MEDCAC)

AUTHORITY

42 U.S.C. 217a, section 222 of the Public Health Service Act, as amended. The Medicare Evidence Development & Coverage Advisory Committee, is also governed by the provisions of the Federal Advisory Committee Act Public Law (P.L.) 92-463, as amended (5 U.S.C. Appendix 2) which set forth standards for the formation and use of advisory committees.

OBJECTIVES AND SCOPE OF ACTIVITIES

The MEDCAC provides advice regarding the clinical evidence presented to CMS on topics under review by Medicare. The Secretary, and by delegation, the Administrator of the Centers for Medicare & Medicaid Services (CMS), and the Director of the Center for Clinical Standards and Quality, CMS, are charged with deciding which medical items and services are reasonable and necessary, or otherwise covered, for Medicare beneficiaries under title XVIII of the Social Security Act.

DESCRIPTION OF DUTIES

The Committee's purpose is to support the evidence-based determination process for Medicare's coverage policies. The Committee provides advice to CMS on the strength of the evidence available for specific medical treatments and technologies through a public, participatory and accountable process. The Committee will work from an agenda provided by the Designated Federal Official (DFO) that lists specific issues and will develop technical advice in order to assist CMS in determining reasonable and necessary uses of medical items and services. The Committee may be asked to develop recommendations about the quality of the evidence for specific issues of Medicare coverage or related policies, to review and comment upon proposed or existing Medicare coverage policies, and/or review and comment on the evidence that is used to support the policies. CMS may also ask the Committee to comment on pertinent aspects of proposals being considered and/or other policies.

- One industry representative;
- One patient advocate;
- The remaining members of the panel roster are chosen from the standing pool of at-large members. There will be no more than 15 MEDCAC members serving on a panel for a particular meeting.

A quorum is required for all meetings and shall consist of a majority of the members designated for service at each meeting. Each Committee meeting may also include guests whose expertise pertains to the meeting topic.

SUBCOMMITTEES

Subcommittees composed of members of the MEDCAC and other subject matter experts may be established with the approval of the Secretary or designee. The subcommittees must report back to the parent committee and not provide advice or work products directly to the agency. The Department Committee Management Officer (DCMO) will be notified upon establishment of each standing subcommittee and will be provided information on its name, membership, function, and estimated frequency of meetings.

RECORDKEEPING

The records of the Committee, established subcommittees, or other subgroups of the Committee, shall be managed in accordance with General records Schedule 26, Item 2 or other approved agency records disposition schedule. These records shall be available for public inspection and copying, subject to the Freedom of Information Act (5 U.S.C. 552).

FILING DATE

November 24, 2022

APPROVED

November 23, 2022
Date

Xavier Becerra
Secretary of Health and Human Services

How do they get the facilities to kill?

The Love of Money?

Ascension Health System Exposed

Was the culture of pursuing money over patient care the cause of Grace's death?

	Fiscal Year 2020	Fiscal Year 2021	Increase	Percentage Increase
Revenue	$ 25,300,000,000	$ 27,200,000,000	$ 1,900,000,000	8%
Profit	$ 1,200,000,000	$ 5,700,000,000	$ 4,500,000,000	375%
Cash	$ 17,000,000,000	$ 26,000,000,000	$ 9,000,000,000	53%

It's impossible to increase profit by more than the sales increase without a significant outside event!

Ascension Health System (nation's largest Catholic health system) Facts:

CEO Compensation	$ 13,000,000	
Federal Bailout Grants Received	$ 1,800,000,000	
Taxes paid ("Not for Profit")	$ -	
Number of hospitals	142	
Number of hospital beds	28000	
Estimated CARES Act bonus payments	$ 8,300,000,000	explains cash increase (outside event)
Estimated COVID death payments	$ 109,000,000	

Steal from the poor and give to the rich!

From a nurse: ***"My mom was very vocal, a fighter, and I watched as they stole her voice and then killed her. I had always felt this was medical murder and the goal was never focused on getting her well. First, they rob you of all your assets and then murder you. At least this is what I have come to believe. And I really have come to believe there is an intent to rob one of all their money by recommending all kinds of expensive medical treatments and surgeries before murdering you."***

Estate Recovery

State Medicaid programs must recover certain Medicaid benefits paid on behalf of a Medicaid enrollee. For individuals age 55 or older, states are required to seek recovery of payments from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services. States have the option to recover payments for all other Medicaid services provided to these individuals, except Medicare cost-sharing paid on behalf of Medicare Savings Program beneficiaries.

Under certain conditions, money remaining in a trust after a Medicaid enrollee has passed away may be used to reimburse Medicaid. States may not recover from the estate of a deceased Medicaid enrollee who is survived by a spouse, child under age 21, or blind or disabled child of any age. States are also required to establish procedures for waiving estate recovery when recovery would cause an undue hardship.

States may impose liens for Medicaid benefits incorrectly paid pursuant to a court judgment. States may also impose liens on real property during the lifetime of a Medicaid enrollee who is permanently institutionalized, except when one of the following individuals resides in the home: the spouse, child under age 21, blind or disabled child of any age, or sibling who has an equity interest in the home. The states must remove the lien when the Medicaid enrollee is discharged from the facility and returns home.

Effective February 1, 2023, the Coronavirus Tracker has switched from LIVE to Daily Updates.
As a number of major countries have now transitioned to weekly updates, there is no need anymore for immediate updates throughout the day as soon as a new report is released. On January 29, 2020, Worldometer started tracking the coronavirus, providing the most timely and accurate global statistics to all users and institutions around the world at a time when this was extremely challenging. We thank everyone who participated in this extraordinary collaborative effort.

The day is reset after midnight GMT+0. The list of countries and their regional classification is based on the United Nations Geoscheme. Sources are provided under "Latest News." **Learn more about Worldometer's COVID-19 data**

Report coronavirus cases

MAIN WEEKLY TRENDS

Now Yesterday 2 Days Ago Columns Search:

All Europe North America Asia South America Africa Oceania

#	Country, Other	Total Cases	New Cases	Total Deaths	New Deaths	Total Recovered	New Recovered	Active Cases	Serious, Critical	Tot Cases/ 1M pop	Deaths/ 1M pop	Total Tests	Tests/ 1M po
	World	685,060,968	+28,870	6,838,161	+80	657,894,249	+44,207	20,328,558	39,652	87,887	877.3		
1	USA	106,376,396		1,157,022		104,206,409		1,012,965	1,779	317,726	3,456	1,175,297,234	3,51(
2	India	44,768,172		531,000		44,200,079		37,093	N/A	31,827	377	922,856,486	65(

Money is both the Tool and the Excuse

for something much more Evil!

Stated financial motivation to kill us: The 2021 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, dated August 31, 2021, concluded: "The financial projections in this report indicate a need for **substantial** changes to address Medicare's financial challenges."

In Nazi Germany, one of the main reasons Hitler was able to implement his agenda was the cost of reparations from WWI. In the U.S., 39% of the federal budget is for direct expenses related to the elderly and disabled – there were more than 62,000,000 Americans on Medicaid and Medicare before COVID.

100 Million Americans To Be On Medicaid By March 2023, Think Tank Projects
Authored by Ryan Morgan via The Epoch Times

- **62,000,000 went to 100,000,000 in 38 months - on purpose!**
- **Why? COVID relaxed rules facilitating the signup necessary for mass euthanasia.**
- **What does that look like?**

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8014292/

Determining Frailty in People With Intellectual Disabilities (ID)

"Across the world, frailty is part of the guidelines that are being developed in the COVID-19 pandemic **for triaging** in crisis situations. The Clinical Frailty Scale (CFS) evaluates the ability to perform daily tasks to identify frail individuals, potentially excluding those from intensive care (IC) treatment.

Since no data are available to determine whether the CFS is not suitable to evaluate the "probability of survival" in individuals with ID, we additionally assessed the predictive value for 5-year survival with Cox proportional hazard models, adjusted for age, sex, level of ID, and Down syndrome."

Are you kidding? No. Why?

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7828855/

"Like the Canadian Medical Association's framework, a COVID-19 triage protocol drafted by Ontario Health gives lower priority to patients who are unlikely to survive acute illness or who have a low probability of surviving more than a few months regardless. In the worst-case scenario, the not-yet-approved protocol recommends denying critical care to anyone with a less than 70% chance of survival, including anyone who scores as even mildly frail due to a progressive illness or condition."

As you can see, critical resources go to healthier patients, the opposite of who might need them most. The U.S. had to be the leader in "COVID Hospital Deaths" to successfully roll out the next level euthanasia agenda!

Research provided by Robert Paiser

California's End of Life Option Act - 2016

INTRODUCTION[1]

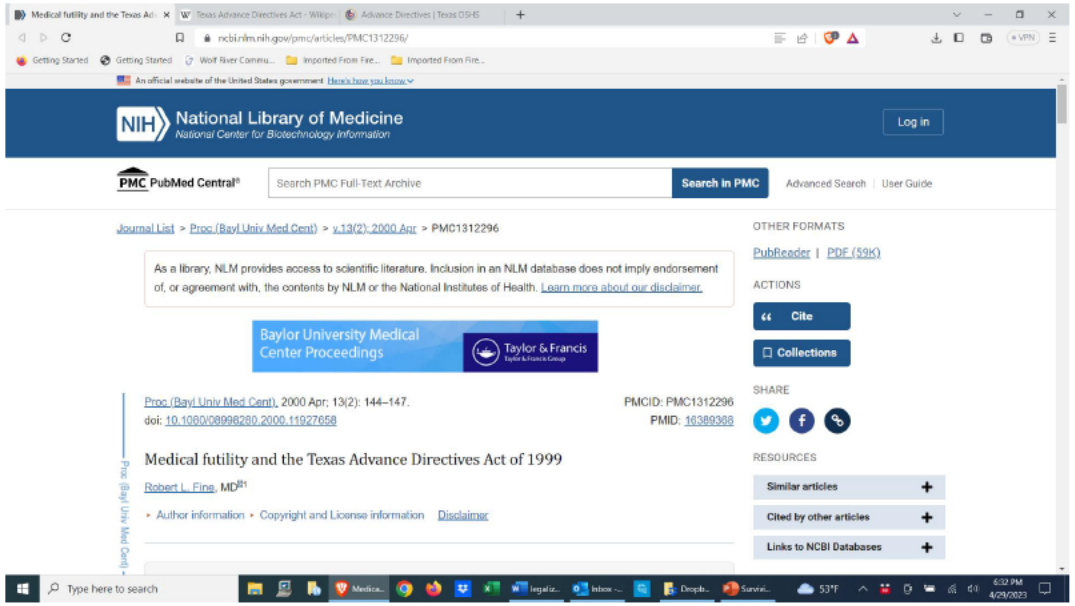
1. The Plaintiff organizations and individuals bring this action to stop the Defendant government agencies and officials from running a deadly system that steers people with terminal disabilities[2] away from necessary mental health care, medical care, and disability supports, and towards death by suicide under the guise of "mercy" and "dignity" in dying.

2. Physician-assisted suicide is not only a revival of old eugenic ideologies, it also violates federal disability rights laws and federal constitutional provisions which protect persons with disabilities from discrimination, exclusion, and life-threatening governmental laws and policies. Under federal law, a public entity may not withhold services or make services available on unequal terms on the basis of disability. The State and local government Defendant agencies and officials named in this action fund and operate systems of public health, social services, medical profession regulation, and law enforcement to provide protective services for people who express suicidality, and to prevent medical professionals, caregivers, and family members from taking advantage of or encouraging a person's impulse for self-harm or suicide. Through the State's physician-assisted suicide law, however, that entire protective network of services is withheld from the Plaintiffs and their members—solely on the basis of a doctor's "good faith" diagnosis of terminal disability.

3. Nine U.S. states and the District of Columbia have passed laws legalizing physician-assisted suicide (Montana also permits the practice through a

[1] This lawsuit addresses suicide. Suicidal thoughts or actions (even in very young children, older adults, and people with life-threatening illness/disability) are a sign of extreme distress and should not be ignored. If you or someone you know needs immediate help, call or text the Suicide & Crisis Lifeline at 988.

[2] This complaint uses the term "people with terminal disabilities" to describe people who have a medical condition that some doctors would describe as an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months—with or without medical care.



Fact:

The Texas Advance Directives Act (1999), also known as the Texas Futile Care Law, describes certain provisions that are now Chapter 166 of the Texas Health & Safety Code. Controversy over these provisions mainly centers on Section 166.046, Subsection (e), which allows a health care facility to discontinue life-sustaining treatment ten days after giving written notice if the continuation of life-sustaining treatment is considered futile care by the treating medical team.

From the NIH Article:

AMA guidelines: "At the end of the process, if no resolution was achieved and no transfer to a willing provider could be arranged, the council noted that by ethical standards it was acceptable to halt futile treatments."

Regarding the Texas Law (conclusion): The law creates a legal safe-harbor for the treatment team and institution if the provisions of the law are followed.

Conclusion:

The same 'treating medical team' incentivized to end your life determines what "futile" means!

PALLIATIVE CARE NETWORK OF WISCONSIN

FAST FACTS AND CONCEPTS #243
PALLIATIVE CARE FOR PATIENTS WITH DOWN SYNDROME

Jane E Loitman MD and Gail Gazelle MD

Background Down syndrome (DS), or Trisomy 21, is the most common chromosome abnormality among liveborn infants, characterized by dysmorphic features, impaired intellectual ability, various cardiac septal defects, short stature, and a reduced life expectancy. This *Fast Fact* discusses the natural history of DS and issues specific to palliative and end-of-life care for patients with DS. *Fast Facts* #192 & 193 discussed end-of-life care for patients with developmental disabilities in general.

Causes of Morbidity and Death in DS Patients with DS frequently live to 60 years of age, men somewhat longer than women.

- Childhood mortality is most often associated with congenital heart defects or leukemia. The risk of developing childhood acute lymphoblastic leukemia is ten to twenty times higher in DS than the general population. Leukemia is treatable, although recurrences typically occur with an aggressive and terminal course (3-5).
- Midlife mortality is associated most often with pulmonary disease and problems related to congenital cardiac defects. The incidence of coronary artery disease and solid-tumor malignancies is actually lower in people with DS than in the general population.
- People with DS have a much higher incidence of dementia of the Alzheimer's type (DAT) than the general population, and tend to develop DAT in their 40s and 50s. By age 60, 75% of individuals with DS have developed DAT. Brain autopsies reveal amyloid plaques and neurofibrillary tangles; this may be due to chromosome 21 housing the amyloid precursor protein gene.
- In addition to cognitive issues, other common medical issues may include hearing impairment, cataracts, sleep apnea, dental issues, congenital cardiac septal defects, thyroid dysfunction, seizures, arthroses, osteoporosis, chronic constipation, GERD, incontinence, congenital hip dislocation, behavioral issues, and recurrent respiratory infections (6).
- Partial or tonic-clonic seizures are most common in the first year of life and in or after the third decade (7,8). Once seizures occur, the pace of functional decline often increases.
- Routine symptom management principles apply to patients with DS, acknowledging communication limitations that can limit comprehensive assessment. Polypharmacy can contribute to or exacerbate issues so rigorous care must be paid when medications are started or stopped.

Psychosocial issues Psychosocial domains include communication, self-care, grief, and family circumstances. In addition, there are unique issues that may complicate end-of-life decision making.

- Patients with DS and their loved ones and caregivers have experienced a lifelong disease trajectory, which includes mental retardation, medical, and psychosocial issues. The lifelong toll on families is high. Part of a robust plan of care includes acknowledgment of this toll by healthcare providers.
- Many people with DS reside in institutional settings where the primary caregivers are not family members. Many have lost parents to death and sometimes have no contact with other family. While it is not known how people with DS process these losses, maximal supports regarding grief and loss should be put in place.
- Issues such as guardianship and advance care planning should be addressed as early as possible with caregivers of people with DS.
- Whenever possible, decision makers for people with DS should be encouraged to use substituted judgment to make key palliative care decisions. All efforts should be made to determine the preferences of the patient, however because of lifelong cognitive impairment, the views of the person with DS may not be known. There may also be disability rights concerns that make proxies/ guardians wary of not instituting all life-sustaining measures. Intensive education needs to be provided regarding the benefits and burdens of any medical interventions, with particular emphasis on how these will impact quality of life. Healthcare providers need to make sure that their own views about quality of life do not interfere with respecting the wishes of designated decision-makers – see *Fast Fact* #193.

Key teaching points

AMA Code of Medical Ethics 2.1.1 Informed Consent

Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well considered decisions about care.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The News Release
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Never Again is Now Documentary
Remembering Our Grace
A Very Special Message ...
One Last Time?
Whiteboard Explainer Video
Turn to God and Do Not Comply
Click here for the Story
Urgent
Hospital Hostage Hotline
888-C19-EMERgency

Follow Grace's story…we're not waiting for WWIII to end to take action!

Our family filed a landmark lawsuit on April 11, 2023 to shine a light on this evil agenda.

Grace did not die in vain…Genesis 50:20.