

# How Hospitals Turned on Their Patients During COVID

A Senate hearing exposed what was done to the unvaccinated inside America's hospitals—and why the system drives out the doctors patients most need.



A MIDWESTERN DOCTOR

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## Story at a Glance:

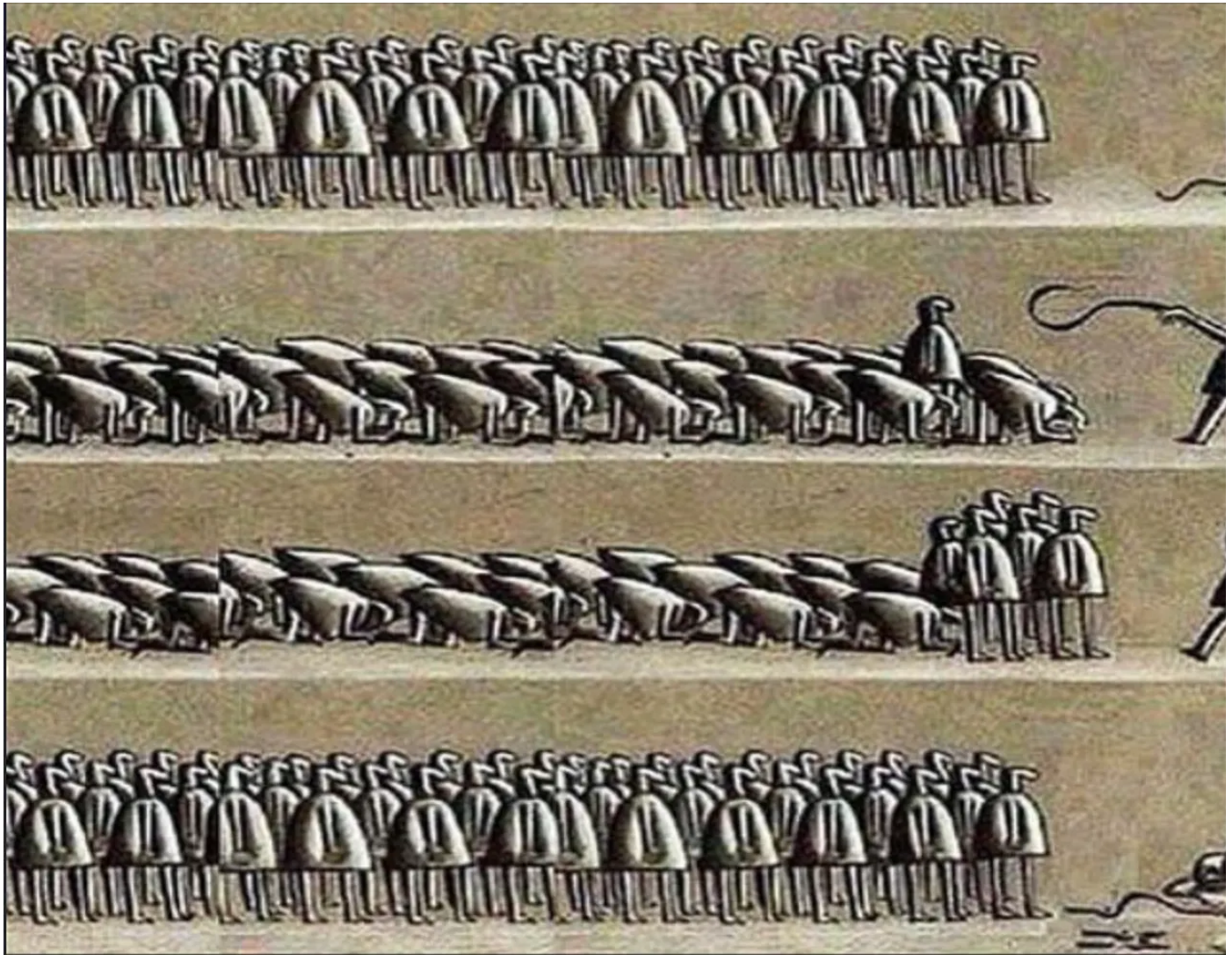
- Throughout history, ruling elites have relied on a recurring playbook (manufactured crises, public examples, bought-out hierarchies, and economic coercion) to keep populations compliant, and nearly every tactic was used during COVID.
- Federal policies paid hospitals tens of thousands of dollars per COVID admission, boosted reimbursement for ventilated patients, shielded providers from liability, made remdesivir the standard of care, creating powerful incentives for harmful protocols.
- At a recent Senate hearing, families shared strikingly consistent tragic stories of unvaccinated patients being isolated, told they would die, denied safe repurposed drugs, given remdesivir over their objections, and pushed onto ventilators and DNRs.
- An attorney who sued hospitals on behalf of 212 families reported that only 72 of the 72 patients who received court-ordered ivermectin died, while every one of the 140 who didn't get it died—making suing hospitals one of the most effective

treatments in history.

- Trauma surgeon James Miller testified that his hospital was never overwhelmed despite the headlines, inflated its COVID numbers, and had infectious disease doctors who seemed to know remdesivir was harmful, and he was driven out of surgery after opening a free clinic for the unvaccinated.

- Because the system steadily removes the doctors who will break a failing pattern to save a patient, trust in physicians and hospitals fell from 71.5% to 40.1% between 2020 and 2024, and it will only return if medicine becomes honest and starts doing things that work.

The ruling elite typically aims to accumulate an immense amount of wealth, which often can only be obtained by extracting it from a large number of people, hence requiring each of those people sacrifices their quality of life to meet the elite's goals. An excellent meme, in turn, synthesizes the challenge ruling elites seeking this excessive wealth and power have faced throughout history:



Since it is not economically feasible to directly force an entire population into submission (e.g., the estimates I've found put 3-5% of the population as the maximum number of soldiers a society can afford to support), a variety of other tactics have been reused throughout history to keep the population compliant. These include:

- Use crises (e.g., war, plague, famine, or financial panic) to justify emergency measures, mute ordinary skepticism, and recast dissent as sabotage. The pattern is ancient: when a problem arises, the public demands protection, and the apparatus claiming to protect it expands—all while fear makes the population far easier to divide and control.
- Make public examples of non-compliant individuals so everyone is scared into compliance.

compliance, or maintain a system for punishing (and monitoring) dissenters that everyone feels is always hanging over their shoulder. This goes hand-in-hand with making the legal and bureaucratic system so complex it can't be navigated without specialists the system itself trains (raising the cost of challenging it) and that everyone is technically in violation of something—which allows the law to be selectively applied so only those who challenge vested interests are arrested or prosecuted.

- Reward compliance, as careers, grants, titles, access, and prestige for those who along are just as important as the examples made of the defiant (since most people would rather climb the existing hierarchy than tear it down).

- Create a rigid social hierarchy everyone defers to, and then buy out its top (e.g. having a few select “prestigious” medical journals, “impartial” guideline panels, regulatory agencies, or “experts” be deferred to for medical guidance while everyone else is ridiculed as “uncredible”—despite each of them typically taking significant pharmaceutical money and only supporting industry narratives).

*Note: one major problem in medicine (which is ingrained through numerous compliance mechanisms) is that the majority of doctors are not willing to deviate from standardized protocols and guidelines—even when it is clear they will not produce an acceptable outcome for the patient (instead, in those situations, they will simply insist they did their best and it was “nothing we could do”).*

- Structure the system so everyone is forced to work within that hierarchy (e.g. physician employment, reimbursement, and immunity from lawsuits depends on following the “standard of care” and requiring all other healthcare workers to defer to their judgement to physicians).

*Note: I believe this accounts for the aggressive push to move doctors from independent to corporate practice. For example, Obamacare was structured to facilitate this, as immediately prior to its passage, 60-70% of physicians were in independent or doctor-owned practices.*

whereas by 2024, only 35-42% were<sup>1,2</sup> (e.g., [a 2024 article](#) was titled “Doctors continue away from private practice, citing insurer payment rates and regulatory issues”).

- Make accumulating money be a guiding principle everyone in the society strives for and then use economic incentives (since they can easily be changed from the top down) to create the desired behavior in the population (e.g., Biden’s federal policies led to most workers being told they would be fired if they didn’t vaccinate).
- Have every media source parrot the same message needed to maintain the status quo (as this persuades most of the population since people like to follow the crowd) often paired with well crafted propaganda that effectively misleads the public.
- Create a devout belief in the state or its leader, which not only makes people compliant but also leads them to attack those who aren’t, thereby making the population police itself.
- Create a robust social framework everyone is expected to fit into that requires compliance at each step while simultaneously training people to be compliant (from school to go to college to get a job to get married).
- Atomize the population. Independent bases of loyalty (e.g., extended family, clan, guild, or town) are much harder to extract from than isolated individuals, so weakening them leaves people facing the state and the market alone—at which they are far easier to message, hire, saddle with debt, and shame.
- Whenever something awful and unacceptable will be done, first test and refine it on a marginalized group that cannot advocate for itself, and once it succeeds, use that success to normalize it so it can be done to the general population. This is why it’s critical not to ignore it when this happens to others, as beyond that apathy is immoral, it often sets people up to be subjected to the same thing once it has gained much momentum it can no longer be easily opposed (best synopsis by the [feminist](#)

[Holocaust poem](#) where the speaker did not speak up for each successive group targeted because he did not belong to it, which concludes with “Then they came, And there was no one left To speak out for me”).

*Note: pages could be written about how this applies across the medical field (e.g., prior to COVID, one of my longstanding frustrations was helping people who'd been severely injured by a pharmaceutical that never should have been in general use, as despite the immense harm no one really cared because not enough people were affected). Likewise, I've recently been thinking about the broader implications of the [Ukrainian government's decision](#) to sacrifice its population and country to keep the war going so they can continue enriching themselves from it.*

- Normalize and gradually increase the exploitation so people view it as a fact of life rather than noticing (let alone questioning) it. For example, since the medical system is structured to continually produce costly proprietary drugs patients must take over long periods (if not permanently), treatments which compete with this model are suppressed. When DMSO was discovered in the 1960s, it was better than any other therapy for many illnesses, yet it was dismissed for “insufficient evidence” compared to “proven cures” (many of which were later pulled from the market), and it remained suppressed despite tens of thousands of studies showing its utility and foreign healthcare systems (e.g., Russia and Ukraine) adopting it. Most importantly, when we drew interest back to it **sixty years later**, it was still more effective than any other therapy for many ailments (which is why that series got so much traction). Another reason I've put so much work into it, in turn, was to show that the primary obstacle to solving many of the illnesses we face is the structure of the medical system itself.

*Note: I think one of the major mistakes the ruling class has made recently, in the pursuit of further profit, was to escalate the exploitation so rapidly that the public is now noticing it.*

- Distract and preoccupy the populace so they don't focus on the major issues.

them (e.g., with “bread and circuses” or by dividing them so they blame another segment of society rather than the ruling class actually creating their problem

*Note: one of my major fears about AI is that it effectively solves the problem elites have struggled with for centuries (being able to afford enough soldiers to police the population since AI is much cheaper than a full time soldier and hence makes it feasible to exert greater degree of control over each member of the population.*

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## The COVID-19 Pandemic

Since people are uncreative, the above playbook also explains exactly what happened during COVID.

In my own case, through internet posts, I believe I became aware of a problem coronavirus circulating in China in late December (based on checking my calendar I think it was around December 19th, but when I looked up the timeline it appeared on the internet around December 31st). I subscribe to the view that pandemics are always massively hyped up to support the biopreparedness industry (detailed [here](#)). In this case, I instead broke from my preconceived biases and became increasingly concerned about this virus as:

- It seemed to be quite dangerous and highly transmissible
- It seemed highly likely it was an lab-made weaponized pathogen.

- Despite more and more signs accumulating that it was the deadly pandemic 1 industry had been waiting decades for, rather than hype it up, the media (and 1 Democrat party) continually downplayed its significance and attacked those w raised concerns about it—even once it had spread to Europe and created a sim wave of problems to what was seen in China.

Given what Fauci and the health system had done to the (marginalized at the t community during AIDS (where as much fear as possible was generated about virus while everything that worked [was suppressed, and a toxic and ineffective was pushed through despite public and Congressional pushback](#)), I assumed F those behind him would do the same thing during COVID. As such, my sense if I did not find a way to treat this illness (as I had no faith the medical system people I knew were going to die, and likewise, if an effective cure could not be a lot of really bad stuff was going to happen (most of which subsequently did). *Note: I initially thought COVID would be an issue for about a year before it mutated much more benign variant (as this is what always happens), but once I saw how meas being taken to prevent the population from developing herd immunity to protect the r the vaccine ([which was later admitted by HHS officials](#)), I realized this would drag on longer, particularly since the design of the vaccines [also prevented the population from developing herd immunity](#).*

Because of this, in the months leading up to COVID hitting America, in addit looking down every alley I could for a viable solution to COVID, I tried to aler colleagues to the problem we were facing (almost none of whom believed me) eventually, in the middle of March, one working in NYC sent me this text (aloi many more describing the catastrophe they were facing and the climate of fea

*Note: one of the most common debates about COVID was if “it really mattered.” My assessment is that the original variants (that many did not see) were much more dangerous than the later ones, individual susceptibility greatly varied, it only hit certain areas really (I still don’t know why this is, but my best guesses are either that harmful variants were there or a collective fear in the area worsened the disease), and that as time went on a culture of denial had established itself but the virus became less dangerous, more and more than anything else done to justify the industry perpetuating itself (e.g., relabeling flu or automobile injuries as COVID and using harmful hospital protocols to significantly inflate the death rate). As a result, depending on which part of that picture you focused on, COVID could appear to be either very dangerous or completely harmless.*

Likewise, once the pandemic started, I was inherently skeptical of sending people to hospitals, as:

- While hospitals are excellent at addressing many serious ailments, they often

poorly with viral disease (as most effective antiviral therapies are not patentable hence rejected by medicine).

- Hospitals are very quick to give up on patients and say “nothing can be done.”
- Hospitals are highly resistant to allowing people to try alternative therapies, when everyone agrees that patient will die and nothing can be done (which has more cases than I can count of people being snuck alternative therapies in the back and then “miraculously” recovering).
- There was a climate of fear amongst medical professionals (as for the first time in their careers, they felt they were in danger too) so they wanted to minimize their interactions with patients as much as possible (which would lead to even worse care). Likewise, I was expecting below average care because the hospital systems were overwhelmed and locked into a triage mindset.

*Note: generally, these issues tend to be much worse with large “prestigious” hospitals than small rural ones (which mirrored what I saw during the pandemic). For this reason, I previously wrote an article on the dangers of hospital care and how one can best navigate it [here](#)*

Likewise, I was also alarmed by two federal policies (that were likely shaped by pharmaceutical lobbyists):

- First, to combat COVID, a series of (well-intentioned) policies were enacted, including the government [covering COVID hospitalizations for the uninsured](#) (incentivizing hospitals to admit more “COVID” patients and diagnose admitted patients with COVID), [shielding healthcare providers from malpractice when treating COVID](#) (thereby incentivizing poorer care and the use of unsafe countermeasures), and the Trump administration doing all they could to secure ample ventilators for Americans (which incentivized ventilating patients who weren’t good candidates for ventilation and needing people without adequate ventilator training being needed to operate many of them—both of which increased mortality).

*Note: one of the least appreciated facts about COVID was that since the spike protein*

[disrupting zeta potential](#)) caused microclotting throughout the body (which disproportionately affects the smallest vessels) blood oxygenation was much poorer in the periphery than internal organs. Since oxygen saturation is measured in the finger tips, many patients had critically low blood oxygenation (which requires intubation) despite them clinically fine, and since it took a while for the medical field to recognize many of these patients need ventilation (and that ventilation often resulted in death), for a prolonged period, were inappropriately vented and died.

**Most importantly**, to make up for the money hospitals had lost (because they had fewer patients for other things due to the lockdowns), grant subsidies were given to make up the shortfall. While these were initially automatic and first based on a hospital's previous year's revenue (and then increased so the total came to about 2% of total patient revenue), those that followed were allocated to hospitals in high COVID impact areas (hospitals that had higher numbers of COVID admissions), where, in addition to their standard reimbursement billing, hospitals received \$76,975 per COVID admission, and then, after 4 months, \$50,000 instead (as this policy program incentivized more "COVID" admissions—corroborated by a senior HHS official in a media call stating that the reduced funding is due to the number of such admissions surging from about 50,000 in the first round to more than 400,000 by the time of the second round<sup>1</sup>). Likewise, the March 27 CARES Act required Medicare to increase reimbursement for COVID hospitalizations by 20%.<sup>1</sup>

*Note: prior to COVID, Medicare's average payment for someone hospitalized for a respiratory infection was \$13,297, \$17,437 if they were also vented for less than 4 days, and \$40,000 if vented for over 4 days, so venting patients long-term effectively tripled the reimbursement (before the 20% add-on was included).*<sup>1</sup>

- Second near the start of the pandemic ([4/29/2020](#)) Fauci announced to the world that the antiviral remdesivir would be the standard of care for COVID, not unlike how he made the antiviral AZT be the standard of care for AIDS (despite minimal evidence).

efficacy, and significant evidence showing it made AIDS worse). Beyond the A parallels, it was also a red flag that remdesivir was a non-specific antiviral that a home (as it had not worked for Ebola) rather than a therapy specific to COVID the existing data for remdesivir was very poor (Fauci even cited fairly lackluster benefits to justify it being the standard of care), and that like AZT, safety concerns existed with the drug.

*Note: in contrast to remdesivir, the monoclonal antibodies were new drugs **that were to COVID**, and in turn, they actually worked quite well (which not surprisingly led to access being increasingly restricted, as being able to treat COVID disrupted the existing business model).*

Because of Fauci's pronouncement, I felt hospitals would aggressively push rem protocols as following the standard of care significantly shielded them from liability. More importantly, in November 2020, Medicare created the New COVID-19 Treatments Add-on Payment (NCTAP) to 'mitigate potential financial disincentives for hospitals to use remdesivir, which paid hospitals 65% of whatever a COVID cost beyond the standard Medicare payment (capped at 65% of the outlier threshold—but only if remdesivir or a small number of other drugs was billed on the claim; the code could be used even if the hospital got the drug for free)<sup>1</sup>. In turn, giving remdesivir to a patient headed for a long ICU stay meant Medicare would cover all of the losses that would otherwise come out of the hospital's pocket, and the sooner the patient became (which remdesivir's toxicity helped bring about), the more that was worth. This was a huge deal, as normally a hospital had to absorb the first \$10,000 of losses on an expensive Medicare case before outlier payments kicked in,<sup>1</sup> so for a remdesivir patient, this returned up to roughly \$19,000 the hospital would have otherwise lost—making it a no-brainer decision virtually every hospital would push a patient to get it to shield them from the massive potential loss they faced from more costly patients (which is normally counterbalanced by the profitable ones). Likewise, replacing remdesivir with something like ivermectin removed the cost barrier.

triggered the payment, so it was actually fiscally worth it for hospitals to go to stop its administration.

So, in the early part of the pandemic, I quickly concluded the most valuable thing hospitals could do for COVID was provide oxygen (and hence sourced a lot of oxygen concentrators for people), and then went through a very nerve-wracking process of treating people across the country at home (who'd only contacted me late in illness) and having to repeatedly make the call on whether home care would work or we had to take the risk of a hospitalization (where things became much more complicated due to how frequently things were mismanaged and us not having colleagues at the hospital who could address them for us). Much of this came from the fact that in addition to me expecting the hospitals to be unprepared to correct COVID, they were also incentivized (and equipped) to aggressively hospitalize for COVID and have them fare poorly enough to require extended ventilation (which was often fatal).

Later, right before the vaccines came out, for many reasons I've detailed in this newsletter, I was concerned they would be unsafe and ineffective—which most colleagues refused to consider, as they were desperate for the solution the vaccines offered (as everything previously, possibly by design, had abjectly failed to mitigate the pandemic). So, once the failures of the vaccines became readily apparent, rather than admit it, the medical system kept on doubling down on them, leading to this

As public resistance to the vaccines increased (due to both their toxicity and ineffectiveness), increasingly aggressive measures were taken to promote them included staff-vaccination mandates (in November 2021 CMS made COVID-19 vaccination a Condition of Participation for Medicare and Medicaid hospitals facility that did not require eligible staff to be vaccinated could be terminated those programs and lose that funding<sup>1</sup>) and medical professionals (and medical students), along with many on the left, openly holding the unvaccinated in con

On one hand this was alarming as it went against every principle of medical ethics. Doctors are taught to have compassion and understanding for a combative drug user (who has an addiction related hospitalization and may carry hepatitis or HIV) but the media's portrayal of the unvaccinated as a threat did not surprise me, as in the 2015 measles outbreak (where 117 people got measles and one previously vaccinated person died<sup>1</sup>), the media incited a hysteria about the disease (presumably to enable the subsequent push for highly unpopular mandatory vaccination laws) at which point, I saw numerous physicians (and a few medical students who had just cycled through) that had branded themselves as “highly compassionate” and “valuing every patient’s life as sacred” wish death upon the children of parents who would not vaccinate them.

*Note: I feel one of the major shortcomings in medical education is the minimal focus on ethics (despite physicians carrying a massive ethical responsibility), and as a result, “whatever is billable is a billable procedure” or “maximizes revenue” often becomes the guiding principle in medical ethics—which I believe explains why contradictory positions are frequently taken such as promoting late-term abortions where the fetus is viable but simultaneously mandating childhood vaccines to “protect the child” (or why many existing ethical principles were thrown out the window during the pandemic because so much money was to be made from fee-for-service people through the hospital pipeline).*

In turn, the media began promoting the message that if you did not vaccinate, you did not deserve to take up a bed at a hospital and medical professionals became quite condescending or hostile to hospitalized patients who had not vaccinated—all of which became worse once most of the justifications for COVID vaccination had been lost and a pivot was made to them protecting against severe illness (e.g., Fauci, the CDC director repeatedly claimed that 98-99% of patients in hospital and dying from COVID were the unvaccinated<sup>1</sup>)—despite the trials not being able to determine this, numerous studies showing vaccinated had a higher hospitalization rate,<sup>1</sup> and later studies showing the benefit was mostly seen for the early variants in the elderly for at least 12 months after vaccination. Because of this, I frequently heard stories of unvaccinated

patients being treated poorly in the hospitals (and pushed towards the ventilator pathway), and I began hearing of cases of people lying and stating they were vaccinated to get better care.

*Note: I always suspected the unvaccinated numbers were inflated (as the extreme mortality claims did not match what I was seeing), and eventually learned through one activist I had been able to show their hospital was inflating their percentage of COVID admissions in unvaccinated patients. Later, I found out through Pierre Kory that the EMR they used (EPIC, one of the largest ones in the country) made vaccination status “vaccinated” or “unknown” (which was typically the status patients who vaccinated outside the hospital ended up in—and quite difficult for providers to correct), but “unknown” was then interpreted by the CDC to mean “unvaccinated” (all of which is detailed in [his excellent article](#) on the topic). So in essence, rather than unvaccinated increasing your probability of being admitted to a hospital, being admitted to a hospital significantly increased your likelihood of being reclassified as unvaccinated. Most tellingly, [EPIC corrected this](#) (so the unvaccinated disappeared and it was easy to change) after the need to increase unvaccinated numbers decreased.*

So, if we take a step back, two things should be apparent:

First, many of the tactics the elite have used throughout history to exploit the population were at play here.

Second, many incentives were in place for hospitals to do bad things which went against the ethical conceptions most people hold of how the medical field could act.

## COVID Hospital Protocol Hearing

Senator Ron Johnson (who understandably wanted to retire) made the decision

for a third term in 2022 because he was appalled by what was happening during COVID and by the fact that almost no one was advocating for those injured by COVID vaccines.

From the start of COVID, he sent (mostly ignored) oversight requests to HHS, committee chair, began hosting Senate events questioning how things were being handled, beginning with [11/19/2020](#) and [12/8/2020](#) Senate hearings on using repurposed drugs to treat COVID before the hospital stage. Then, after he lost the chairmanship (as Senate control flipped in 2021), he held a series of roundtables and panels on COVID vaccine injuries, early treatment (which was the only solution to the problem and hence stonewalled by the medical system), and the other numerous ways that the COVID response was mishandled<sup>[1,2,3,4](#)</sup> (along with additional events outside the Senate<sup>[1,2,3,4](#)</sup>). Finally, in 2025, once Republicans regained control of the Senate, he became Chair of the Permanent Subcommittee on Investigations (the Senate's investigative body with broad subpoena powers), and began both aggressively reviewing federal records that would reveal the malfeasance during the pandemic and he held a series of poignant Senate hearings on the same topics (along with childhood vaccine injuries and the healthcare system in general).<sup>[1,2,3,4,5,6,7](#)</sup>

This week, he hosted a gripping hearing on the hospital protocols used throughout COVID that, due to how much many people related to the horror in it, [went viral on Twitter](#) (with many clips receiving hundreds of thousands to a million views). While these hearings are long, I believe many will find this one worth watching in its entirety (especially with the context I previously mentioned factored in).

In the hearing, family members of patients who died in the hospital shared the surprisingly consistent stories alongside doctors and nurses who worked inside the system. In case after case, an otherwise healthy patient walked into the hospital, was isolated from their family. Once staff identified them as unvaccinated, they were told some variation of “you’re going to die” or “you’re unvaccinated, what did you expect?” Requests for ivermectin, hydroxychloroquine, vitamins, or monoclonal antibodies were refused (and in several cases cut off right after the patient began improving on them).

Some of the doctors seemed to know this was wrong (e.g., one, when asked why he wouldn’t try anything else, teared up and said “I used to save lives”), but said their hands were tied, and in one instance, an Orlando hospital system had sent its doctors a memo recommending against steroids, hydroxychloroquine, ivermectin, or any preventive measures while recommending routine remdesivir. Remdesivir

was given anyway, often over explicit objections and frequently followed by kidney failure (in one case, to a patient with pre-existing kidney damage whom staff told his mother did not have an active infection).

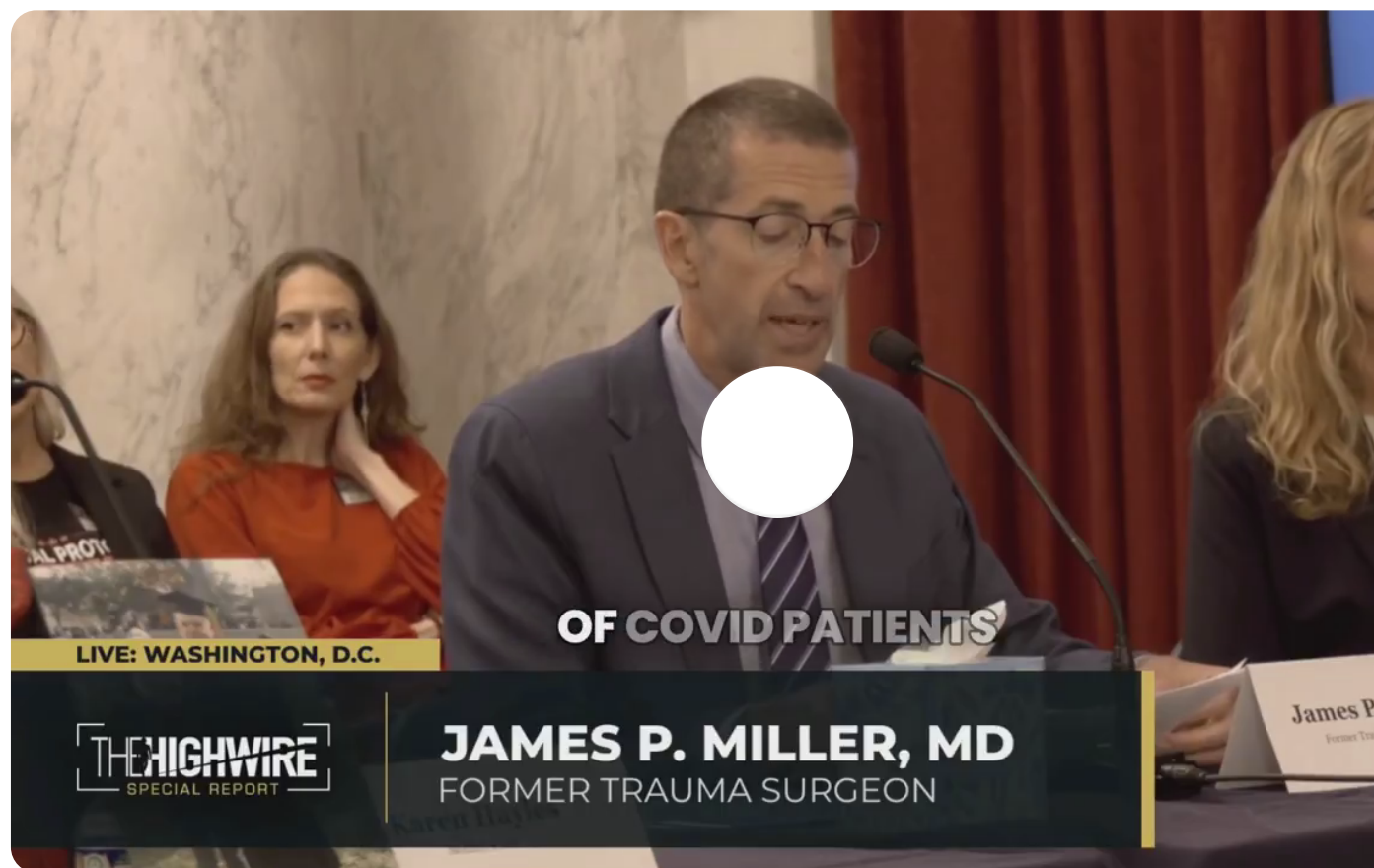
Patients were pressured or forced onto ventilators, and families were pushed to sign DNRs (in one case, to donate the organs of a man who was not an organ donor). Likewise, one patient was told she could only see her priest for last rites if she accepted remdesivir, and another family was told they *might* be allowed to visit if they switched their father to a DNR. Basic care such as food, water, hygiene, and clothing was neglected for days, and one physician shared that the only way he could get families in to visit was to write in the chart that each of his patients would die within 24 hours.

Getting out was no easier. One husband had to endure a six-hour standoff with police to bring his wife home (where she fully recovered on the treatments the hospital refused her), a court order to give ivermectin was simply ignored (after which a hospital employee warned the wife that the doctors were angry she'd defied them and might let her husband die to prove ivermectin didn't work), and families resorted to smuggling medicine in (e.g., in a stuffed novelty pillow or crushed into a feeding tube).

Likewise, the attorney who sued hospitals on behalf of 212 families shared that in 72 cases where he got ivermectin administered, only three patients died, whereas in one of the 140 where he couldn't get it, the patient died (making suing hospitals amongst the most successful medical interventions in history). Meanwhile, the clinicians described being fired, reported to their licensing boards, subjected to sham peer review, fined, and ordered into psychological counseling for giving patients what they'd asked for.

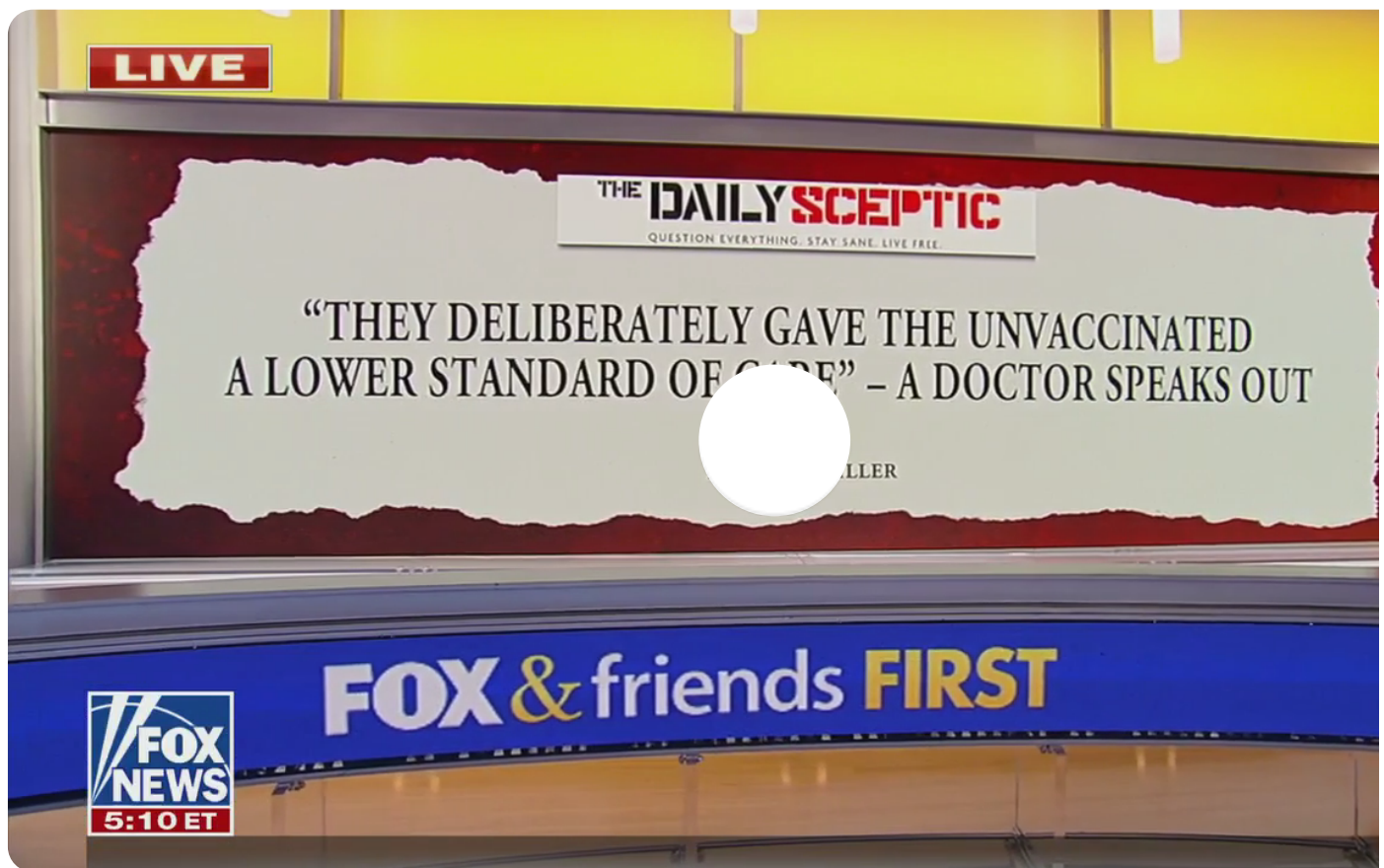
## James Miller

Since this hearing is too long for many people to go through, I wanted to draw attention to one of its most widely seen parts—[James Miller's testimony](#):



Many readers here are familiar with Dr. Miller, both because he helped me write an article on [the gradually disappearing art of surgery](#) and because I've repeatedly highlighted the remarkable results he's had with DMSO in his new practice. What many don't know is that I got to know him very early in this publication's history. Traumatized by what had happened to him in Washington, he reached out to me, and we began corresponding because I really liked where his head and heart were at (he had [capacity](#) to see things for what they were and break from the crowd to do the right thing). Since I felt his story needed to be heard, and he both has a great deal of integrity and is an excellent communicator, I offered him a platform, and once ready, did what I could to get his story seen—beginning with [the first article I published](#) which went viral and was featured nationally on Fox News, followed

three others we put together<sup>1,2,3</sup> (including [a detailed affidavit](#) of what he'd written and most recently, his Senate testimony.



I'm immensely grateful he was given a place on the panel, as few things are more important to break the narrative we've been stuck in than a doctor of his caliber saying on record what really happened.

## Dr. Miller's Story

Dr. Miller was a trauma surgeon and the top producer at Providence Regional Medical Center Everett (meaning he operated the most, had the best outcomes and few complications, and made the hospital the most money). Before COVID, he'd already gotten a taste of how the system treats people like him. After he raised the sta

for the surgeons while serving as interim director of the trauma team, a nurse emailed staff that “we need to get Dr. Miller,” eleven baseless complaints were against him in two weeks (including one accusing him of racism for waving he maintenance worker in a hallway), and the email was then deleted from his int

*Note: those years also gave him a front-row seat to how robotic surgery had hollowed surgical training (e.g., none of the hospital’s 7-8 urologists could remove a kidney with robot, so he had to be given emergency privileges to do it). Those same urologists then the leaders of the hospital’s safety committees, redefined “competence” so it had noth with patient outcomes, and drove out those who objected.*

In February 2020, his hospital admitted the first diagnosed COVID patient in and shortly after, the CDC sent it remdesivir, which leadership pitched to Miller other physician leaders as a powerful antiviral everyone should wait for. In practice did not work, and the hospital’s infectious disease doctors seemed to know it (when Miller brought them a young trauma patient who was a textbook remdesivir candidate, the on-call infectious disease physician told him not to give it to her because she “seemed like a nice girl”).

Likewise, his hospital’s COVID wave peaked around March 17, 2020, and it ne faced a shortage of beds, staff, or equipment—yet it kept promoting the idea it overwhelmed. At one point in July 2020, Miller and his colleagues were drinking at the nurses’ station of an ICU that was 30% full (with nurses being sent home of patients) when someone pulled up a news story saying their ICU was overru which point the ICU director panicked and called the administrators to strate about the crisis. Death certificates, in turn, defaulted to COVID and were cum to change (e.g., an elderly dialysis patient who came in with a brain bleed was repeatedly tested until she finally tested positive, and when she died from the Miller was prevented from correcting her death certificate).

Once the vaccines rolled out, things got darker. The head of infectious disease Miller he was working with the governor's office to make driver's license renewal contingent on vaccination (and when Miller warned this would incite violent protests he was excited by the prospect). Unvaccinated members of Miller's church began telling him they'd been refused care by primary care and urgent care doctors (including diabetics who could no longer get their prescriptions), and when he raised this with the medical group's chief medical officer, he was told it was the appropriate policy: "keep the staff safe."

So Miller opened a free clinic through his church, and of the more than one hundred patients he and a few nurses (including his wife) cared for, only one died—after taking her to the ER for oxygen and she was sent home without it. After that, they obtained oxygen concentrators for the clinic, and every other patient recovered. Meanwhile, once the federal directives began dictating hospital care, the unanticipated mortality in the hospital's trauma patients doubled, yet when the administration was shown the data it made no changes.

In January 2022, Miller resigned but agreed to stay for 7 more months at the request of the Chief of Trauma to help orient new hires. Four days later, the hospital launched an internal peer review against him for a "microaggression" that had occurred a month earlier—asking an OR charge nurse to stop watching cat videos on her phone while on-call team so they could operate on a patient who'd been waiting over nine hours for surgery to untwist his intestines. Subsequently, his colleagues were told not to talk to him if they valued their jobs, his four requests for a fair hearing were denied, he was told he was suspended and would be arrested if he set foot on hospital grounds even to collect his personal belongings (until his whistleblower attorney sent a letter at which point he was told he had never actually been suspended and that the letter the hospital's CEO had sent him was a "typo"). A month later, having sold his home, he was exonerated by two separate investigations and told

to work within the week—with the warning that any further accusation of “microaggressions” or similar offenses would get him reported to the national provider databases (which would end his ability to practice). When he asked for a mediator to rebuild trust with his surgical team, the hospital paid out over \$100k rather than agree to a mediator, and then offered him more money if he signed an order (which he declined).

*Note: roughly two thirds of that hospital’s surgical ICU nurses left, not from “burnout” but from moral outrage over what they’d been made to do to patients.*

Dr. Miller, in turn, chronicled the many disturbing things he witnessed (which set the course of the pandemic) in a far more detailed affidavit, which can be read [here](#).

## The Price of Truth vs. Deception In Healthcare

A MIDWESTERN DOCTOR • JUNE 5, 2024



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# The Doctors We Lose

For the most part, surgeons can only operate under the umbrella of a hospital (hence at the mercy of its administrators), so leaving Washington meant Dr. M. to give up the specialty he'd spent over a decade mastering. He now practices in Florida, which has been great for him (as he can finally do what he knows how to help his patients, and has had remarkable results with DMSO and with a variety of therapies for over a hundred vaccine-injured patients). For patients, however, the loss is immense, as a trauma surgeon of his caliber takes years to train, is exactly what you want operating on you, and is often the only person around who can fix the mistakes less competent surgeons make.

Sadly, his story was not an anomaly. Almost every clinician at the hearing who was fired, reported to their board, put through sham peer review, or forced out, and Pierre Kory and Paul Marik (who embody the best of doctors anyone would want caring for them) were likewise [driven out of hospital medicine](#). As a result, the system steadily removes the doctors who will deviate from the failing protocol to keep you alive, and keeps the ones who will follow it and tell your family “nothing more could be done.”

Johnson put it well at the end of the hearing—it doesn't take many people being hanged in the town square before everyone falls into line—and noted that many doctors who privately whispered their thanks to him couldn't afford to step out for themselves (e.g., because they had \$400,000 in student loans and families to support). This is a major reason why, as mentioned earlier, whenever we can safely do it, we should prioritize getting patients who are on the border of being hospitalized well at once. Once someone is admitted, the doctors who would break protocol to save them are increasingly no longer there.

# Conclusion

In the middle of COVID, a colleague told me he'd realized COVID was the De version of the Iraq War. Both were sold to the public through lies and a fear ca every media outlet parroted, both were used to justify sweeping emergency po recast anyone who questioned them as a threat (or a source of "misinformation both allowed a small group of insiders behind the party to loot the country wh countless people were harmed (e.g., Halliburton's subsidiary KBR received \$39 in Iraq contracts,<sup>1</sup> while Pfizer became the first pharmaceutical company to b \$100 billion in a year, \$56.7 billion of which came from its COVID vaccine and Paxlovid<sup>1</sup>). Likewise, in both cases, almost no one responsible has been held accountable.

Despite spending more than any other nation to fight COVID, America ended one of the worst outcomes in the world (over a million deaths), whereas Africa could afford very little of what we did, fared far better (as even after accountin underreporting, its mortality rate remained lower than Western Europe's<sup>1</sup>).

Given all of this, between April 2020 and January 2024, the share of Americans lot of trust in doctors and hospitals fell from 71.5% to 40.1%<sup>1</sup> (which the study' framed as a barrier to getting people vaccinated)—trust the medical industry h worked for decades to create (as its entire business model depends upon it). Si much of that trust was created by public relations and media manipulation, th medical field has tried to solve the problem with more of the same.

However, since so much of the public watched what happened firsthand (and I won't swallow up a fabricated version of the past), and we have now entered ar where [the vertical monopolization of propaganda the society has depended up nearly a century](#) (media monopolized by a few large companies that all promot

same sponsored narrative) is no longer viable, as independent media has broken the monopoly (e.g., I'm nobody, but on my own limited budget I've produced numerous things seen by millions of people, and I am just one of many doing that). Because of this, no public relations campaign can fix the loss of trust in medicine that has been created. Rather, the only way that trust will return is if medicine is honest about what it did during COVID, holds those responsible accountable, protects rather than punishes doctors like Dr. Miller, and starts giving patients things that actually

Until that happens, the most important lesson from COVID is that while medicine provides numerous essential services, you cannot afford to fully depend on the system. That means learning to take care of yourself and your family (which also creates the economic pressure medicine needs to produce better outcomes so it stays in business), knowing your rights as a patient, and unless you are fortunate enough to live near a hospital you can trust, never letting a loved one go into the hospital without an advocate.

As Johnson put it at the end of the hearing, when it comes to healthcare, you have to be your own advocate—and the more of us who can do that (or better yet know when to not need much of what the medical system has to offer), the less leverage the system has over us and the more room doctors like Dr. Miller will have to practice the way they always wanted to. Given how bad things were just a few years ago, it's been incredible to see how quickly things have shifted, and I deeply thank each of you for the support that has helped make that possible.

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A Midwestern Doctor  Oct 1

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After I finished this article, I finally figured out what the massive financial incentive has caused pharmaceutical companies to do. The article has been updated to include that

push remdesivir and block ivermectin. The article has been updated to include that.

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**James Miller**  James Miller Oct 2

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I feel a little bashful commenting on this article since quite a bit is about me.... but the r  
description of the factors that led to the madness we went through combined with the  
wisdom of why this happened makes this post a masterpiece of understanding.

Not to mention the hope we reasonably can have moving forward to build a better system

Thank you.

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