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Were Conditions for High Death Rates at Care Homes Created on Purpose?

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During the COVID-19 pandemic, people in care homes have been dying in droves.

Why is this happening? Is it simply because older adults are very vulnerable to SARS-CoV-2 and therefore it's not unexpected that many would succumb?

Or do care homes deserve the lion's share of the blame, such as by paying so poorly that many workers have to split their time between several facilities, spreading the virus in the process?

Alternatively, could medical experts and government bureaucrats, with the full knowledge of at least the top tier of government officials, have created conditions shortly after the pandemic struck that contribute to the high death tolls while engendering virtually no public backlash against themselves?

This article shows that the third hypothesis is highly plausible. The people who created the conditions may be unaware of, or oblivious to, their implications. But it's also possible that at least some of them know exactly what they're doing.

After all – seeing it from an amoral government's point of view – the growing numbers of elderly are a big burden on today's fiscally strained governments, because in aggregate they're paying much less into the tax base than younger people while causing the costs of healthcare and retirement programs to skyrocket.

Here are three sets of conditions that collectively create a framework for enabling significantly boosted care-home deaths – and doing so with impunity – even while most of each set of conditions in isolation may appear to be purely for the benefit of everyone in society:

One. Bureaucrats develop extremely broad definitions of novel-coronavirus infections and outbreaks. This is coupled with the continuing presence, in a number of care homes scattered across each jurisdiction, of at least one nurse or physician who follows every letter of all definitions and rules. (Such individuals are always present in every discipline, but in the medical milieu their actions can be deliberate, deadly and very hard to detect.)

Two. Influential organizations and individuals produce hospital-care-rationing guidelines that recommend younger people receive higher priority than the elderly during the pandemic, by giving significant weight to how many years of life patients would have ahead of them if treatment is successful. Also, some guidelines bar care-home residents from

being transferred to hospital.

Three. The chief coroner and leaders of the funeral, cremation and burial industries craft procedures that fundamentally change the way care-home deaths are documented and bodies dealt with. Their stated goal is to prevent overburdening of medical staff and body-storage areas during a surge in COVID-19 deaths.

They also put them into effect very quickly with no notice to the public; this gives those directly affected very limited opportunity for input or push-back.

Among the many radical changes is death certificates are no longer completed by people who care for care-home residents; instead, they are filled in by the chief coroner's office.

Also, examination of the undisturbed death scene is prevented, as are all but a very few post-mortems and other sober second looks at the cause and mode of death.

In the background are the complicit ranks of public-health organizations, politicians, media and many other influential individuals. When the pandemic first strikes they focus on how new, dangerous and poorly understood the virus is. As one side effect, this scares many care-home staff so much they flee in fear, leaving their overwhelmed colleagues to cope.

After a short time, they also start to distract the public and victims' loved ones from uncovering the three sets of conditions by focusing on other factors in the rash of deaths among institutionalized elderly – and by insisting the solution to everything is more testing and contact tracing, along with accelerated vaccine and anti-viral development.

This article shows how the three sets of conditions were put in place in Ontario, Canada.

Variations on these conditions very likely have been crafted in other jurisdictions in North America, Europe and elsewhere. An exclusive interview with the daughter of one of the dozens of people who died during an outbreak at an Ontario care home illustrates how the three sets of conditions work in practice.

Condition set one: Broad definitions of novel-coronavirus infections and outbreaks

At the start of the novel-coronavirus epidemic in Ontario, formal definitions of infections and care-home-outbreaks weren't issued, at least not publicly.

Rather, in late March Chief Medical Officer of Health for Ontario, **Dr. David Williams**, and the Associate Chief Medical Officer of Health, **Dr. Barbara Yaffe**, described the criteria verbally during their daily press briefings.

An outbreak should be declared when two or three people show symptoms of infection with the novel coronavirus, they said.

Also, polymerase chain reaction testing for viral RNA wasn't required for confirmation.

This is a loosened version of criteria used in the province prior to the novel-coronavirus epidemic. These previous criteria defined an outbreak as either: two people in the same area of a facility developing symptoms within two days of each other (making their infections 'epidemiologically linked') and at least one of them testing positive for viral RNA;

or three people in the same area developing symptoms within two days of each other.

On March 30 the Ontario health ministry released new rules for defining and managing care-home outbreaks (with the document confusingly dated April 1). Staff at all Ontario care nursing homes were trained on the new rules via webinars two days later, on April 1.

The new rules included an even broader outbreak definition: the presence of only *one person* with just *one symptom* of a SARS-CoV-2 infection. Outbreaks were deemed confirmed when just one resident or staff member tested positive; subsequently, every resident in the care home showing any coronavirus-infection symptoms is deemed to have COVID-19.

Notably, however, there wasn't a symptom list in the document. Dr. Williams said on April 1 during that day's press briefing they deliberately did not include a list of infection.

This is because:

> "to look for those symptoms [in the rest of the care-home residents after the initial case is identified] is a challenge, particularly in seniors," […] "They may not mount a fever, they may have a lot of other symptoms and they may not have obvious symptoms. [Rather,] any change in their health condition really [can be considered a symptom]."

A few minutes later Dr. Williams added:

> I don't mind false alarms. [As a result of the looser outbreak criteria] the numbers [of outbreaks that] we see might be[come] quite [a bit] larger …. [But that's because w]e want to ramp up the sensitivity. [That] means the number of outbreaks will go up, because we've widened the definition."

One week later, April 8, a Provincial Testing Guidance Update was issued. It included the following list of symptoms (most of which are highly non-specific): fever, any new or worsening acute respiratory illness symptom – for example cough, shortness of breath, sore throat, runny nose or sneezing, nasal congestion, hoarse voice, difficulty swallowing – and pneumonia.

The document also listed several symptoms that are "atypical" but "should be considered, particularly in people over 65" [italics added]: unexplained fatigue/malaise, acutely altered mental status and inattention (i.e., delirium), falls, acute functional decline, worsening of chronic conditions, digestive symptoms (e.g., nausea/vomiting, diarrhea, abdominal pain), chills, headaches, croup, unexplained tachycardia, decreased blood pressure, unexplained hypoxia (even if mild) and lethargy.

Then on April 22 the province produced the first COVID-19-screening guidelines for care homes. It's broadly similar to the April 8 document, except that two or more of some of the symptoms – for example sore throat, runny nose and sneezing, stuffed-up nose, diarrhea – need to be present for a person to be deemed positive.

On May 2 a new testing guidance and a new screening guide were released. Both documents concede that if a person has only a runny or stuffed-up nose, *"consideration*

should be given to other underlying reasons for these symptoms such as seasonal allergies and post-nasal drip."

They also narrow the definition of falls considered diagnostic of a novel-coronavirus infection in people over 65, to falls that are unexplained or increasing in number.

However, they add to the symptom list another three that are very non-specific: a decrease in sense of taste, abdominal pain and pink eye.

There are enormous implications to having overly broad definitions of symptoms and outbreaks, particularly in combination with other rules put in place at the beginning of the epidemic.

Broad definitions very likely are used in many other jurisdictions around the world, albeit perhaps masked by the use of somewhat different terms.

First, in Ontario, in every facility with an outbreak, every resident with even just one symptom is defined as being a 'probable' COVID-19 case. This applies whether these residents had an inconclusive or negative viral-RNA test result – *or even weren't tested at all*.

Second, the cause of death of everyone who had been diagnosed with a SARS-CoV-2 infection is recorded as being COVID-19. This is a dictate of the World Health Organization and is followed throughout North America, Europe and elsewhere.

Third, COVID-19-attributed deaths are deemed 'natural' by new rules released by the chief coroner on April 9 (see 'Condition Set Three,' below). In all but an extremely small number of cases, natural deaths are exempt from any further investigations or post-mortems. (Over the last 30 years post-mortems have become rare, but to almost completely remove the possibility is another matter.)

Taken together, this may explain what the daughter of a woman who died along with dozens of others, during a COVID-19 outbreak at an Ontario care home experienced. The daughter granted the author an exclusive interview on May 13. (Under a pseudonym to shield her from possible repercussions.)

Diane Plaxton said in the interview that on April 1 she received a shocking and unexpected phone call from her mother's care home.

> "Your mother's declining. She's been having loose bowels and lots of diarrhea. There's a DNR on her chart. And we're not sending anyone to the hospital. [Likely because of 'Condition Set Two,' below] We're going to have to put her on palliative care," Plaxton recalls the head nurse telling her in a cold, uncaring voice.

Plaxton was stunned. She knew about her mother's diarrhea: it was from bowel-cleansing meds she'd been on for about nine days, after being diagnosed with a clogged bowel. Plaxton told the nurse that if her mother seemed to be declining it probably was from the diarrhea and resultant dehydration.

She suggested to the head nurse that she give mother IV rehydration. The nurse refused,

saying it would *"just prolong the inevitable."*

The head nurse didn't say the word COVID-19, nor tell Plaxton the home had been declared to have an outbreak that day.

She also didn't mention that on March 30 the province had issued new rules on novel-coronavirus infections and outbreaks, then trained all of Ontario's care-home staff on them via webinar April 1. As described above, the rules included very broad definitions of SARS-CoV-2 infections and outbreaks.

Therefore the nurse could well have been complying fully with the new rules by diagnosing Plaxton's mother with a novel-coronavirus infection based on her having diarrhea alone (and without telling Plaxton any of this).

Furthermore, since transfer to a hospital was not an option (as per 'Condition Set Two') and since COVID-19 is deemed to be very frequently fatal in the elderly, this may be why the head nurse pushed Plaxton so hard to consent to palliative care for her mother.

Shaken but unbowed, Plaxton asked the head nurse to let her speak to the nurse who had been directly caring for her mother.

Fortunately, that second nurse was kind, and agreed that palliative care was not appropriate for Plaxton's mother. She agreed instead to allow her to not take the bowel-cleaning meds, and to coax her to eat and drink to recover her fluids and strength. She also said she'd keep an eye on the slight fever Plaxton's mother had.

Over the next few days this plan worked, and the nurse told Plaxton she needn't worry.

That's why it hit Plaxton like a gut punch when on April 10 she got a call from another nurse, who was panicking. She told Plaxton her mom was struggling to breathe and "going fast."

The nurse said the care home couldn't transfer her to the hospital. She asked Plaxton's permission for the doctor to give her mother *"a shot to ease her passing."*

(The nurse didn't tell Plaxton what 'the shot' was. But it very likely was morphine, which is routinely used to relieve severe pain. A high enough dose of morphine slows people's breathing and hastens their death.)

Plaxton was reeling. She immediately consulted with her sister; together they decided to give consent for the shot. Three hours later their mother was dead.

Condition set two: Hospital-care-rationing guidelines

In mid-March, not long before Plaxton's mother died, treatment-rationing guidelines for during the pandemic started to proliferate.

For example, on March 21 the UK's National Institute for Clinical Excellence produced its guidelines.

They're based on a frailty score and on mortality probabilities across different age groups for pneumonia and underlying cardiovascular or respiratory diseases.

On March 23 the paper *"Fair allocation of scarce medical resources in the time of Covid-19"*

was published in the prestigious *New England Journal of Medicine*. The paper's first recommendation calls for:

> maximizing the number of patients that survive treatment with a reasonable life expectancy."

(Interestingly, the paper's lead author, Ezekiel Emmanuel, MD, PhD, is an oncologist, bioethicist and senior fellow at the Center for American Progress. The centre is secretive about its funders but according to a 2011 investigation in *The Nation* its supporters included dozens of giant corporations ranging from Boeing to Walmart. Today, retired general Wesley Clark and executive VP of global investment firm Blackstone Henry James are among the organization's trustee advisory board members.)

On March 27, the equally influential *Journal of the American Medical Association* (JAMA) published *"A framework for rationing ventilators and critical-care beds during the COVID-19 pandemic."*

The paper's authors assert that:

> [y]ounger individuals should receive priority, not because of any claims about social worth or utility, but because they are the worst off, in the sense that they have had the least opportunity to live through life's stages."

Ontario Health published guidelines for hospital-treatment rationing on March 28, albeit not publicly. (To this day the government hasn't made the protocol public, nor disclosed whether or when they implemented it.)

At that time a crush of COVID-19 patients crowding Ontario hospitals wasn't a realistic possibility for at least the short or medium terms (contrary to the pandemic-curve theoretical modelling), because all elective hospital procedures and surgeries had been cancelled or indefinitely postponed.

Toronto Star reporter Jennifer Yan obtained a copy of the Ontario treatment-triaging document and wrote in a March 29 article that:

> [u]nder the triage protocol, long-term-care patients who meet specific criteria will also no longer be transferred to hospitals."

Then on April 10, the Canadian Medical Association adopted all the recommendations by Dr. Ezekiel and his co-authors in their *New England Journal of Medicine* paper, and advised Canadian physicians to follow them.

The Canadian Medical Association statement (whose authors were not listed) asserted that *"the current situation, unfortunately, does not allow for"* the time for Canadian experts to create their own recommendations.

This is tendentious. Canadian healthcare providers and researchers have access to as much information about COVID-19 as do others around the world. In addition, many had direct clinical experience with a close cousin of the novel coronavirus, SARS-CoV, in 2003.

Indeed four Canadians co-authored an ethical framework for guiding decision-making during a pandemic that was based on their experience with SARS and published in 2006. They made no mention of age as a criterion for treatment triaging in that framework.

On April 17 the Canadian federal government released information to guide clinicians in rationing healthcare resources during the SARS-CoV-2 epidemic. Unlike at least some other COVID-19-related guidelines issued in the same period, it was not accompanied by a press release; therefore it has flown under the public radar.

The document includes an emphasis on age-based rationing. It also explicitly discourages transfer of care-home residents to hospitals:

> Long term care (LTC)[care-home] facilities and home care services will be encouraged to care for COVID-19 patients in place and may be asked to take on additional non-COVID-19 patients/clients to help relieve pressure on hospitals"

This is underlined in another place in the document:

> If COVID-19 does develop in LTC facility residents, they should be cared for within the facility if at all possible, to preserve hospital capacity."

Prohibiting transfer to hospital drastically narrows the treatment options available to care-home residents.

There have been transfers of care-home residents to hospitals in Canada during the COVID-19 crisis, but until very recently they have been by far the exception.

(Instead, starting in mid-March as part of the clearing out of hospitals to make room for a putative surge in COVID-19 patients, thousands of elderly people were transferred from hospitals to care homes. This likely also contributed to the care-home death toll. More than one journalist has compared care homes to the *Diamond Princess* cruise ship: virus incubators with people trapped inside.)

All of this may well be why Plaxton was told by nurses at the care home that her mother couldn't be transferred to hospital.

This also has played out at other care homes.

The medical director of the Pinecrest nursing home in Bobcaygeon, two hours' drive northeast of Toronto, strongly advised residents' family members against considering hospital transfer.

The Globe and Mail reported on March 29 that Dr. Michelle Snarr wrote families on March 21 (which was the day after three of the home's residents tested positive for SARS-CoV-2) and raised the spectre of significant suffering and possible death if the elderly people were put on ventilators.

Dr. Snarr reiterated this in a March 30 television interview.

Once we heard it was COVID, we all knew it was going to run like wildfire through the facility […] The reason I sent the email was to give them a heads-up that this is not normal times. Under normal times, we would send people to the hospital if that was the family's wishes, but we knew that was not going to be possible, knowing that so many people were going to all get sick at once and also knowing the only way to save a life from COVID is with a ventilator. And to put a frail, elderly person on a ventilator, that's cruel.

[In another interview Dr. Snarr said they weren't outright refusing hospital transfers.]

The last death attributed to COVID-19 at Pinecrest occurred on April 8; by then, 29 of the home's 65 residents had perished.

"I've never had four deaths in a day at any nursing home I've worked at," Dr. Stephen Oldridge, one of the physicians working at the home, was quoted as saying in the March 29 *Globe and Mail* article. *"You feel helpless. Because there's nothing you can do other than support them, give them morphine and make them comfortable."*

Dr. Oldridge told CBC a similar narrative on April 1:

> "There is no vaccine, we have no effective treatment other than supportive care for these folks, and obviously there's no cure. So when the infection takes hold in their lungs, in this elderly population we can just make them comfortable."

Still other media reports indicate that care-home residents' families in Canada have denied the option of transfer to hospital during the pandemic even if the residents are relatively young, do not have a DNR, and both they and their families want the option of a transfer. Instead, they are pressured to put DNRs in place. This also is happening elsewhere, such as in the UK.

Hugh Scher, a Toronto lawyer who's been involved in some of Canada's highest-profile end-of-life cases, strongly opposes this. He told the author in a telephone interview:

The notion that long-term-care-home or nursing-home medical directors can tell residents and their families that they can't or shouldn't be transferred to hospital if they need treatment for COVID or anything else – I don't agree with that.

[…]

[But unfortunately] there's now an aggressive push to say, 'Granny's already ninety-five … and sending her to hospital for a cough or a runny nose isn't going to improve her underlying condition. And so she should be made comfortable and left to die.'

Condition set three: New rules surrounding death certificates and removal and disposition of bodies

On April 9 the Chief Coroner for Ontario, **Dr. Dirk Huyer**, released rules for an 'expedited death response' in handling and disposition of bodies of people who die in care homes and hospitals.

The stated goal was to prevent infection spread, overburdening of medical staff, and overfilling of hospital morgues and body-storage areas in care homes in the event of a surge in deaths during the pandemic.

The new procedures were created jointly by Dr. Huyer's office, the Ontario Ministry of Government and Consumer Services and the Bereavement Authority of Ontario (the province's funeral-home, cremation-services and cemetery self-regulatory body).

They are a drastic sea change in the way deaths are handled in the province. Yet they were launched extremely rapidly with the only "surge" in sight one in mathematical models, and a significant body-storage-space problem based on hard data nowhere on the horizon (and still a low probability).

The new procedures went into effect immediately on April 9. Then over the next three days (the Easter long weekend), Dr. Huyer and the registrar of the Bereavement Authority of Ontario led webinars on them for staff of hospitals and care homes across the province.

> "We pushed it [writing and releasing the new rules] a little more quickly than maybe was necessary because it's a brand-new process and there's thousands of people involved," Dr. Huyer told Toronto Star columnist Rosie DiManno in explaining the haste.

As part of the new rules, the chief coroner's office now completes the death certificates of every person who dies in long-term-care homes. The office also completes some death certificates of people who die in hospitals. Up until April 9, and for good reason, death certificates in Ontario were filled in by the physicians or nurse practitioners who cared for the people before they died.

In addition, as also noted in 'Condition Set One' above, COVID-19-attributed deaths are deemed 'natural' by the new rules. And all "natural" deaths are virtually exempt from any further investigations and post-mortems.

(Dr. Huyer was quoted in a May 18 *Globe and Mail* article as saying "a number" of COVID-19-attributed death investigations have been started – including that of a man whose daughter believes he died because of neglect at a care home and who asked the coroner's office to investigate – but that he doesn't know what that number is.)

Dr. Huyer said, in a phone interview:

> "All of these things were added during this period of time to allow not only a timely approach but also an efficient approach to be able to ensure that people proceed to burial or cremation in a timely way without requiring extra storage space,"

Yet it was only 10 months ago that the official report on the high-profile Wettlaufer inquiry was released. It calls for many more checks and balances surrounding care – and more rather than less time and transparency in determining and documenting the causes of death.

Just 18 of the report's 91 recommendations have been implemented. (The inquiry probed

the killing in southwestern Ontario by nurse Elizabeth Wettlaufer of eight people, attempted murder of several others and aggravated assault of two more. All but two of the victims were LTCH residents.)

Moreover, the April 2020 rules also dictate that families must contact a funeral home within one hour of a hospital death and within three hours of a care-home death. The bodies are to be taken to the funeral home extremely rapidly, and from there to cremation and burial as quickly as possible.

This journalist wrote about the rules in a May 11 article.

Diane Plaxton found and read online the May 11 article. She suddenly understood more of what took place before and after her mother's April 10 death.

She and this journalist connected, and the May 13 interview ensued.

Plaxton related, in that interview, that three hours after she got off the phone with her dying mother on April 10, a nurse called and matter-of-factly said her mother was dead. She asked Plaxton to call a funeral home.

And about an hour later, while Plaxton was still reeling, another nurse called and again told her to contact a funeral home.

> "I got off the phone. That's when I flew off the handle," she told the author in the May 13 interview. "It's like they're treating her [body] like a piece of garbage: 'Get her out of here! Ger her out of here!'"

As if that wasn't enough trauma, at the funeral home four days later she saw COVID-19 listed as the cause of her mother's death. Plaxton believes what really killed her mother was the combination of dehydration and chronic diseases including asthma; her shortness of breath on April 10 may have been an asthma attack, Plaxton surmises.

Making matters even worse, the funeral director told her she couldn't take a copy or photo of the 'Cause of Death' form. He said she'd have to request a copy from the government and it could take months to arrive.

But the funeral director also commiserated with Plaxton. He was incredulous that her mother had gone from dehydrated to dead so fast. He also was bewildered by the requirements such as bodies having to be picked up in haste and arrangements for cremation and burial also having to be made extremely quickly.

"I'm just taking orders from the top down," Plaxton recalls the funeral director telling her.

That's the third of the three sets of conditions that can enable high death rates in care homes.

The three sets are the work of officials, experts and bureaucrats who – while being seen to serve the public interest and who could be unaware of, or oblivious to, the implications of the conditions – may in fact have hidden intentions.

Even if the latter is true, there's little chance the perpetrators will be caught or punished.

On May 19 the Ontario premier announced that an independent commission will probe why so many people have died in the province's care homes. This journalist believes it's very unlikely the commission's mandate will include scrutinizing the sets of conditions described in this article.

Perhaps the most elegant element of all is that just one or two people working at any given care home can suffice to translate the sets of conditions into actions – or inaction – that can be deadly for residents. And they'd probably be the only ones held responsible in the unlikely event any of this ever comes to light.

It's all as simple as one, two, three.

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