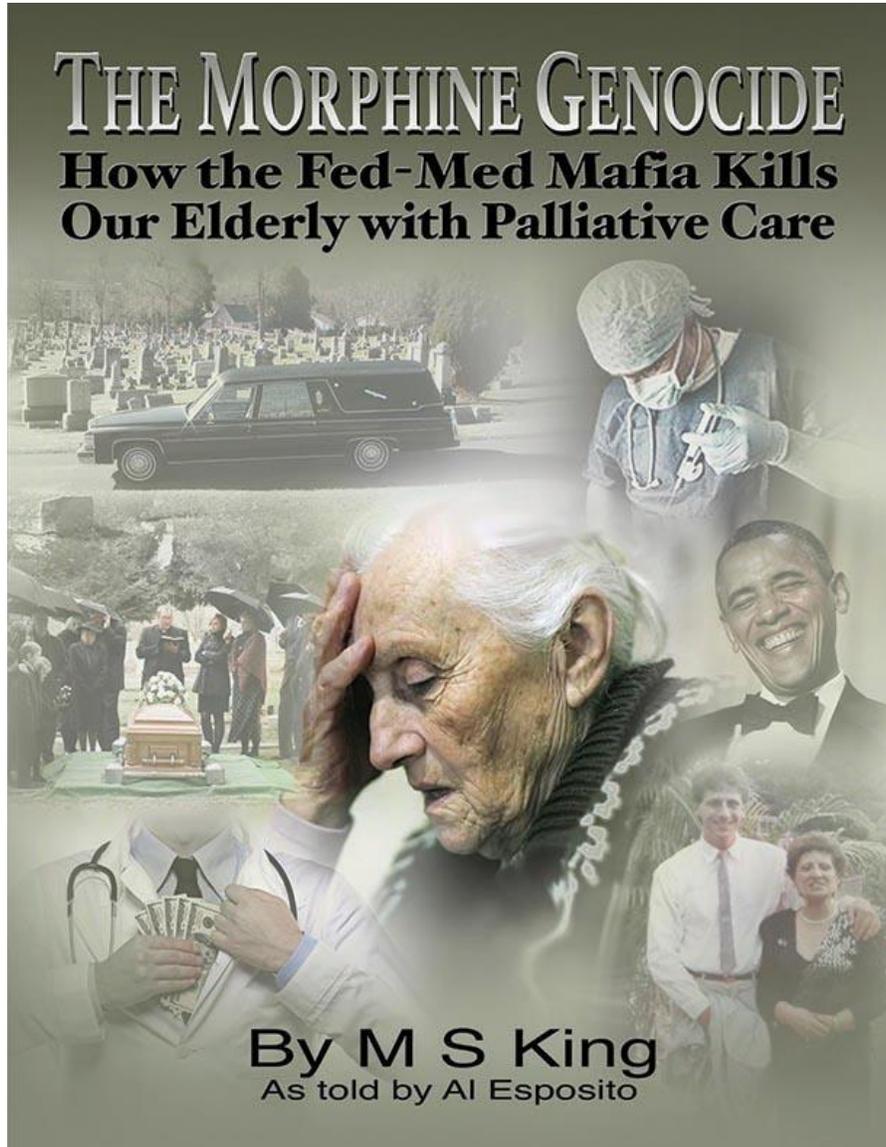


# The Morphine Genocide

*How the Fed-Med Mafia Kills Our Elderly with Palliative Care*



**By M S King**

*As told by Al Esposito*

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## INTRODUCTION

The following account, written by author **M S King** in collaboration with co-author / narrator **Al Esposito** (*a pseudonym*) is not based on a true story. It *is* a true story. One can disagree with the overall hypothesis and conclusions, of course, but the data points and events witnessed are all presented factually, with neither embellishment nor omission. Only the names, dates and places have been altered.

The use of pseudonyms for the “Esposito” family serves only one purpose, namely, to shield the elderly Mr. Esposito from the harsh possibility that his wife, Maria, was indeed deliberately, unnecessarily, callously and deceptively railroaded into her grave.

So, what should you care about the alleged medical-murder of Maria Esposito? Doesn't everyone have to go at some point? Why should old people be tortured just to artificially extend life for a little while longer? After all, she did live to the very ripe old age of 91. Get over it, Al!

Putting aside your own personal philosophical view of “palliative care” and/or euthanasia in general, here's the problem:

Neither she, nor her husband, nor any of her children ever agreed to euthanizing a strong-hearted woman who was **not** terminal, **not** brain-damaged and **not** in pain.

That would make this a case this murder by deception. Of greater interest to the reader, however, is the logical inference that follows such an allegation. You see, if this opinion is valid, then you or your own elderly parents may one day be targeted for deadly “Palliative Care” sedation upon entering an American hospice or hospital.

In remembrance of dear old mom (*affectionately known as nonna to her many grandchildren*) and as a public service to our vulnerable and

unprotected octogenarians and nonagenarians, your remorseful author - remorseful because I didn't figure out the 'big picture' until it was too late - presents:

**THE MORPHINE GENOCIDE: How the Fed-Med Complex Kills Our Elderly With Palliative Care**

# SECTION 1:

## *The Back Story of Maria Esposito*

*A quote to remember:*



*“We just have far too many old people. It’s ridiculous to be living in a country where we can put dogs to sleep but not people.”*

*“Euthanasia vans — just like ice-cream vans — that would come to your home.*

*It would all be perfectly charming. They might even have a nice little tune they’d play. I mean this genuinely. I’m super-keen on euthanasia vans. We need to accept that just because medical advances mean we can live longer, it’s not necessarily the right thing to do.”*

***Katie Hopkins*** - British television personality

This pamphlet is intended to serve as a widely-read warning to others -- not as a moving literary masterpiece or an academic tome. The reader doesn't need to know what a wonderful, warm, loving charming and good woman **Maria Esposito** was. So is everyone else's mom! But do understand that she truly was a wonderful, warm, loving charming and good woman.

Though her legs and eyes were weak; even at 91, her basic vital signs and brain functions were still going strong -- as was her ever-chattering Italian mouth! So, without further delay, let us fast-forward to the late summer of 2015 when, quite by fluke, the period of her final days began.

Mom's first hospitalization occurred after the family doctor over-prescribed potassium. Not having taken her light weight and advanced age into proper account, the pills really knocked her for a loop. We later came to learn from a different doctor that a few bananas would have sufficed! Take that as a warning about unnecessary and overly aggressive drugging.

A one-week stint in the hospital cleared her system of the toxin and saved her kidneys; but left her weakened. We checked her into a physical rehabilitation center for some extra pampering and to rebuild some of her leg strength, which had been in decline even before this incident.

When she returned home after two weeks, it was a festive occasion for us all. The pent-up talking that she couldn't get out of her system at the rehab center seemed to come out all at once. Yep. Mom is OK!

Later that very day, the next unexpected crisis hit. As she walked about the house behind her 4-wheeled walker, closely supervised by my brother Ronald and our Aunt Clara (*mom's sister*), mom fell while trying

to maneuver the walker around a tight turn. It happened so fast that my brother and aunt could not react.

Although mom didn't feel any pain from the fall, she could not stand on her feet. We wheeled her to her bed and let her fall asleep - hoping that she had only bruised a fragile muscle or something. When the following morning showed no improvement, it was back to the hospital again, where our fears were confirmed. Mom had broken her hip.

We were initially devastated at the news. But after a surprisingly quick and simple fixing with pins, mom was chattering again and even doing light rehab after a day or so. It would take a while to get her back to where she was, but another bullet had been dodged -- or so it seemed.

From the hospital it was back to the rehab center for the third blow. Mom contracted pneumonia after the first week and had to be taken to the hospital, *again*. Let's skip the medical jargon and just note that they cleared her up and returned to the rehab center after a few days. In hindsight, it was a mistake to return her to the same environment in which she contracted the pneumonia in the first place, especially in light of the fact that dad had since hired a live-in caretaker that could have nursed mom back to health.

With full-time care, a special bed, wheel-chair and air tanks in place, Mom returned home again in mid-November, 2015. But something wasn't right. She came home dazed, confused and irritable, as if in a drug-induced stupor. We naturally assumed this was caused by antibiotics and figured that her head would clear up in a few days.

Looking back with clear hindsight and knowledge of the "big picture," there had been a young Puerto Rican aide at the rehab center who had cryptically hinted to us, on more than one occasion, that elder abuse was taking place at the rehab. We dismissed her concern as just a case of

some of the Jamaican rehab workers being a little rude and impatient with the elderly patients. Truth be known, mom could be a bit of a “drama queen” at times.

I now believe it was something far more sinister, something this conscientious and empathetic young girl could only hint at, but not openly say, was taking place -- namely, the unnecessary sedation of patients for “babysitting” purposes. Indeed, there was a whole wing of that rehab center that seemed full of zombies.

Now that mom was home, we expected her to regain her mental sharpness within a day or two. But after a brief home visit by a Dr. Pock, mom turned even dopier. It cannot be said with certainty if Dr. Pock injected her with something because I wasn’t paying attention as much as I should have (*in hindsight*). But he did handle her arm at one point. Was he checking vitals? Or did he administer some sort of powerful sedative injection? Did he slip her an oral “mickey?”

The other odd thing about creepy Dr. Pock was the even creepier discussion he initiated with me about the high mortality rate of elderly people after suffering broken hips. His whole demeanor struck me as cold, heartless, insincere and downright weird. Pock seemed more interested in talking about death than about re-habilitating my mother!

In light of mom’s strong vital signs and network of support, such an exaggerated pessimism made no sense to me at the time. But as we shall see later on; there was financial incentive for Pock to “begin the conversation” about death, instead of life.

Later that evening, mom, totally doped-out, suffered some sort of weird breathing episode. Her breaths became very short and choppy – almost like a sleep apnea patient. Fortunately, I had just stopped at the home to visit. Teresa, the Polish-speaking caretaker, took me to mom and showed

me. It was not at all a panic situation. Though she was still breathing on her own, it was certainly not something which basic prudence could ignore. You know the routine: 9-1-1 -- *“Hello. I need an ambulance at 242 Berkshire St in Anytown, USA.”*

And so began the 4<sup>th</sup> and final (*and fatal*) trip to the hospital over a 10 week period. This is where the real story begins.

## **The Final Trip to the Hospital**

The paramedics stabilized mom in the back of their ambulance and gave me a sense of things being under control. They recommended that she be taken to a different branch of the same hospital system this time – an affiliate of the suburban one we normally went to. Because it was located in, shall we say, the shady part of town; I, knowing that fewer people would be inclined to visit her at an inner city hospital, hesitated at the suggestion. But the paramedics insisted that the city location was better-equipped for such cases. Whether they just wanted a slightly shorter ride for themselves or whether it really was as they said, I cannot say, even in retrospect. But why take chances. *“Let’s go downtown!”*

The facilities seemed first-rate. There was plenty of action in the emergency room – much more than at the other location. This was the place where many poor elderly city-folk, stabbing victims, gunshot victims and drug overdose victims all stumble in to get fixed up – or to die. Yes indeed, the “joint was jumpin” at the **St. Judas Iscariot** Hospital of Anytown, USA.

After waiting for about two hours or so in a small room with a television, a male doctor came to assure me that mom was stable and resting comfortably with an oxygen mask. She would be moved to the Critical Care unit the following day. After being briefed by the doctor, I left the hospital understandably worried, yet optimistic at the same time.

Mom had a strong heart and no other serious underlying problems. If we could just win this final pneumonia-related ‘battle of the breathing’, the old queen would be home for pampering in a week or so. My brother, Ronald, after a conversation with the same doctor, came away with the same feeling – concerned, but with a sense of rational optimism.

So far, so good. The next morning, mom was in and out of “sleep” (*mostly in*), but she seemed comfortable and was able to speak, though weakly. She was expected to be taken out of Critical Care within a few days and placed in a regular room – which was great news for us.



- 1: *Younger days, Mom and me*
- 2: *Did Dr. Death squirt something into Maria Esposito during his house call?*
- 3: *Repeated trips to the hospital*

## SECTION 2

# *Descent into Swelling and Dementia*

*A quote to remember:*



*“I don’t think that we can make judgments based on people’s ‘spirit.’ That would be a pretty subjective decision to be making. I think we have to have rules that say that, we are going to provide good quality care for all people. End-of-life care is one of the most difficult sets of decisions that we’re going to have to make. **But understand that those decisions are already being made in one way or another.** If they’re not being made under Medicare and Medicaid, they’re being made by private insurers. At least we can let doctors know — and your mom know — that you know what, maybe this isn’t going to help. **Maybe you’re better off, uhh, not having the surgery, but, uhh, taking the painkiller.**”*

***Barack Obama** / in answer to a question about a whether or not Medicare should pay for a 100 year old woman to have life-extending surgery.*

During this time of early cautious hope, the first of a series of strange occurrences tempered down our optimism. On what must have been Day 1 or possibly Day 2 of mom's stay, a woman in a white lab coat, presumably a doctor but possibly an administrator of some sort, approached me in the Critical Care unit. Clipboard in hand and with a very assertive look in her eye, she went into her pitch (*as best as I can remember it*):

**Clipboard Lady:** Hello. Are you the patient's son?

**Me:** Yes.

**Clipboard Lady:** My name is Anna. I am with the Palliative Care team at St. Judas. Does your mother have an advance directive?

**Me:** No. Not that I am aware of.

**Clipboard Lady:** We would like to set up a meeting to discuss hospice care options and end-of-life decisions.

**Me:** We're not interested in hospice care. My father has hired a live-in caretaker. Thank you.

And with that, I walked away in disgust. This cold-hearted bitch didn't even have the decency to *pretend* that she had any sense of empathy for my mother or me. All she wanted to do was get me to a meeting to discuss "end of life" decisions – at a time when mom was stabilizing!

Clipboard Lady's whole demeanor reeked of low level, yet quite discernable sales pressure -- more suitable to a retail store than to a hospital. On the creepiness scale, and your reporter here happens to have a very highly developed sense of emotional intelligence, she ranked right up there with the aforementioned Dr. Pock. It is often said, quite rightly, that "*the eyes are the mirror of the soul...*" By that measure, neither

Pock nor Clipboard Lady had one. More intriguing is the lesser known line that follows: “... *and reflect everything that seems to be hidden.*”

I was not only offended, but also a bit demoralized. Although mom was coming out of intensive care status, the mere mention of “end of life decisions” planted the first seed of pessimism in my mind. More such seeds were to be planted and cultivated later on.

Clipboard Lady’s insensitive antics didn’t end there. A few days later, my brother Ronald, the key point man in communicating with the hospital, casually mentioned to me that ‘Anna’ (*Clipboard Lady*) “*keeps calling to set up a meeting.*” This means that Ronald was approached and/or pitched by her at least twice. Add that to the initial attempt to get at me and that makes at least THREE attempts by Clipboard Lady to schedule an early death conference – even as my mom is stable (*but so damn sleepy!*) and out of Critical Care. What’s the heck is up with this pushy and thoroughly unlikeable saleswoman in a white coat?

I gave this little mystery some thought, and arrived at the conclusion that a very busy city hospital like St. Judas needs to have a clear plan of action in place *before* an emergency or unexpected death happens. Perhaps the best time to have certain discussions is when they do not actually appear to be necessary. It’s just a good business practice – or so one might reason. Nonetheless, Clipboard Lady’s low-level pressure tactics were as off-putting as they were unprofessional.

### **Sleep, Sleep, Sleep --- Swell, Swell, Swell**

From the very beginning of mom’s last stay in the St. Judas system, the poor woman, though stable and breathing with the occasional help of an oxygen mask, just couldn’t stay awake. She was out like a rock almost every time we went to visit her. Very well, let the old lady sleep and recover, we thought.

There were, however, times when she was awake, but dazed – and a few times when she was awake and somewhat alert. On a positive note, gone was any sound of gurgling phlegm and, presumably, the nagging pneumonia that had caused it. When awake, her voice was weak – barely audible in fact. This was likely due to intubation as much as weakness. But all in all, when awake, she seemed to be in better shape than when she checked in, and, as previously stated, out of Critical Care.

In addition to the mystery of her incessant sleepiness, there was a more troubling development that suddenly came out of nowhere. Mom’s fingers, hands and forearms had turned light purple and had swollen grotesquely, and I do mean *grotesquely*. The forearms seemed like those of the old cartoon character “Popeye the Sailorman”, and the fingers became grew so fat that one could secure business cards between them. Really gross!

A male nurse told me that it was “probably fluid retention” and it was barely discussed with us, if at all. Like clueless teen-age girls in an auto-repair shop, we just went along with the non-explanation: “*Yeah -- fluid retention. No big deal. Of course.*”



*Images above depict damaged veins. Mom’s hands were much worse.*

Constant sleep, grotesque swelling, and assisted breathing with a hard plastic tube shoved down her throat -- that was mom for about two

weeks. And still, we remained cautiously optimistic in anticipation of a “swallowing test” that the hospital had scheduled her for.

Ronald had previously called to inform me of the upcoming “swallowing test”, scheduled for Thursday, November 26. After the call, I immediately thought to myself, but only for a fleeting moment: *“How the heck can they check her swallowing capabilities if she is passed out cold and intubated 24/7?”*

In hindsight, had I dwelled on this question a bit longer, the whole mystery would have unraveled right then and there. But again, in assuming that the hospital’s goal was to save her life and then get paid by Medicare and secondary insurance, the question was shrugged off without further curiosity.

When I arrived at the hospital on Thursday, mom was sitting up in bed as Ronald held her hand and translated the instructions from the nurse. She was told to swallow, and she swallowed. She was told to say “ah”, and she belted out an “ah” as well as any opera singer. It was wonderful to see her so awake and strong – before they moved her back to her regular room for some rest. Later that afternoon, she was knocked out and intubated again. *“Let her rest,”* we thought.

That night we received horrible news. Not only had mom “failed” the swallowing test, but her breathing had stopped and she had to be resuscitated in an emergency. Several ribs, so they said, were broken in the process. Our spirits finally broken, it was time to sit down with the death panel.

## **The Death Panel Secures the Death Warrant!**

**Friday: November 27:** The meeting with the doctors of the ‘Palliative Care Team’ took place the day after my mom had been resuscitated. I

left it up to my brothers to attend the “end of life care” meeting while I took my father to an important doctor’s appointment of his own. Ronald and Gerald relayed the bad news to dad and me about our once again “comatose” mother. The doctors believed that she may have suffered cognitive impairment and that another episode of rib-breaking revival would do additional damage.

We were thus persuaded (*maneuvered*) into removing mom from her intubation ventilator and, pending dad’s final approval, placing her on *DNR (Do Not Resuscitate)* status, also known as “no code.” In the event of another heart or breath stoppage, mom would be gone.

My father, broken and beaten by the events of the past few months, declared that if she couldn’t win the battle of the breathing on her own, he wished that she no longer be resuscitated. “*Do not torture her anymore,*” were his exact words, between emotional sniffles.

Mom was set to be de-intubated the following week -- it being explained to us that she probably wouldn’t be able to breathe on her own for much longer afterwards.

**Saturday: November 28:** We took dad to the hospital to say “good bye” to his “comatose” and, as we believed at the time, brain-damaged wife. After 63 years, the great love story was about to come to an end. What a tragedy that dad had to say his last good-bye to a helpless case in some “vegetative state.” And so it came to pass that mom was finally placed on the DNR list as dad said his last good bye to the schoolmate he first met on a train back in 1940.

Dad instructed us to inform all extended family so that they could go and bid final farewell to the comatose shell that was his wife. He also stated that he didn’t want to live alone, and asked if my wife and I wanted to move in with him. Such was the looming finality of the whole sad affair.



*Clipboard Lady and friends maneuvered our family into a death meeting. Poor dad took it hard, but trusted in the hospital's judgement.*

**Sunday: November 29:** My wife Sherrie had not been to the inner city branch of St. Judas Hospital for a visit because she was still recovering from a broken leg. How unfortunate for us all, for you see, Sherrie was once a medical doctor in Europe. Though she never became licensed to practice in America, she knows her stuff. Had we been able to engage her in the process early on, the staff would not have dared to play games with us. But then again, being “babes in the woods,” we had no cause for suspicion.

Nonetheless, on the night of her final good-bye to her “comatose” Mother-in-Law, Sherrie noted that her vital signs were very good. Her opinion, admittedly based on limited knowledge of the total case, was that with good vital signs, mom’s chances of recovery were by no means hopeless. Her only concern was the possible neurological damage. Did we really want to prolong the life of a brain-damaged 91-year old woman who can’t even recognize her own family?

None of us wanted that. As for me, the decision stood: either she breathes on her own or she doesn’t. But the doubts that Sherrie raised

got me to thinking that we should wait a bit longer before putting the DNR order into effect.

**Monday (AM): December 30:** Ronald called me in the morning and asked if I could go to the hospital on Wednesday to authorize the “unplugging” of the ventilator as he would not be able to come up that day. “*Wednesday? No problem, I’ll handle it,*” I replied.

Sensing that the end was near, and hoping for some miracle at the 11<sup>th</sup> hour, I resolved to visit mom twice a day. Much like a grief-stricken elephant in denial tries to “wake” her dead calf, I would always call gently as I held her grotesquely swollen blue hand: “*Ma. Ma. It’s me, Al. Can you hear me?*” I knew I was being pathetic, but my resurrection ritual gave me a certain sense of comfort – even though I knew it would come to naught.

The mantra among all of our immediate and extended family was as predictable as it was annoying: “*She’s just like “Zio (Uncle) Corrado.”* Zio Corrado was my mom’s youngest brother who, after nearly 8 months in a real stroke-induced coma, finally succumbed on July 4<sup>th</sup>, 1983.

Like the useless Saturday and Sunday visits, I followed up on the Monday morning visit with a string of 5 or 6 Newport 100’s cigarettes – a stress-coping mechanism that works for me in times of crisis. I already had a half-full pack ready for the post Monday-night visit, which, I was certain, would also end in despair and disappointment.

# SECTION 3

## *Maria's Final Days*

*A quote to remember:*



*I once participated in a panel discussion about hospice, palliative care, living wills, end-of-life quality and, especially, pending legislation to legalize physician-assisted suicide in New Jersey. There were many arguments, for and against physician aid in dying. ....*

*I had heard these thoughts before. Then, a new idea entered the debate. In the words of a woman perched in the second row, "Well, it should be legal because doctors do it all the time."*

*"Do you mean that patients' are deliberately killed by their physicians?"*

*"Absolutely," was the answer, confirmed by the nods of a nearly unanimous audience.*

*An older gentleman clarified: "It's like wink-wink and then it's done."*

*I was flabbergasted. Giving a treatment or medication in order to deliberately cause death is not only unethical, a calamitous violation of the Hippocratic Oath, it is 100 percent illegal in all 50 states. Whether, it is a relative, a pharmacist, a nurse or a doctor who carries out such an act, whatever the reason, we have a special term for that act. We call it first-degree murder.*

***Dr. James C Salwitz, Oncologist***

**Monday (PM): November 30:** Upon approaching the bedside for the Monday night resurrection attempt, my “comatose” mother, evidently hearing me approach or seeing me with whatever was left of her peripheral vision, turned toward me and smiled!

She was breathing on her own with **no tube in her throat**. I stood there with my jaw open. Praying for a “miracle” is one thing, but my rational mind was never expecting the Great Intelligence to actually deliver on it!

Well, she may be awake, but surely her brain is only as functional as mentally retarded drunkard. Right?

*“Mom. Do you know me?”*

She nodded her head up and down in a very deliberate fashion.

Well, she may be nodding, but that’s just a reflexive nod. Surely, she has no idea what’s going on. Right? And then she spoke! Well, there was barely any sound because the intubation must have left her throat in a very weakened state. But I was able to discern, partly from sound and partly from lip-reading, the last word of the sentence:

*“ - - - - - papa ”*

*“Mom. I’m sorry but I can’t hear you.”*

She then composed herself, looked me straight in the eye, and came back even more forcefully:

*“ - - - - - papa ”*

She was asking about my father, who, due to her “unresponsive” stupor of nearly two weeks, she had not seen. So I replied with one of those noble lies we all tell to the ones we love:

*“Papa was here this morning but you are always sleeping. He misses you.”*

Mom flashed a big toothless smile and then started to silently yap again. I was so sad not to be able to hear the words. I replied:

*“Mom. I can’t hear anything. You need to rest. We’ll talk tomorrow.”*

Mom smiled again and then turned her palms upwards as if to say, *“Oh well. What can I do?”*

It was so cute. Even in her condition she maintained her sense of humor and had a hard time shutting her mouth! I stood at her side, clutching her monstrous fingers and waiting for her to nod off again. A mass of confusing thoughts ran through my mind. How can we give up on this woman?! Her vitals are good, she’s been breathing on her own, she’s energetically trying to speak, her mind is sharp and, for a woman with “broken ribs,” she doesn’t appear to be in any pain – at all!

I remember wishing that I had brought my I-phone with me – an item usually left in the car for fear of misplacing it. What an awesome video mom’s “resurrection” would have made.

I rushed back to my father’s house to tell of what had just been witnessed. I did not want to tell my father that mom was asking for him. That would have been too heavy and might have bred false optimism. But it was explained to him that mom was sitting up, breathing on her own and trying to say a few words. Dad clasped his hands together and looked up towards the heavens.

My Brother Gerald did not believe the account and suggested that it was probably just reflexive movements. It’s understandable that he would doubt what had happened. All he had seen over the past few weeks was her in a zombie state. Adding to his disbelief was the fact that I

deliberately, for my father's sake, down-played the event. But I had already decided to overturn the DNR order the following day and was not going to re-open the debate with either of my brothers, especially not in front of my father.



*Shocked and happy to see mom alert and smiling, I resolved to “pull the plug” on the death panel instead of mom!*

*(not actual images of her)*

## **Back in a “coma”**

### **Tuesday (AM): December 1:**

With happy optimism, fire in my belly and steely resolve, I marched into St. Judas hospital as my first order of business that morning. The euthanasia party would have to wait. But when your knight-in-shining armor here arrived to save the nonagenarian damsel-in-distress, just 24 hours before what was supposed to be the final disconnecting of her respirator (*which she had not been hooked up to anyway the night before when I spoke to her*), what did I see? Mom was out cold, like a bag of rocks with that wretched tube jammed down her throat again.

*“Ma! Ma! Wake up! It’s me, Al,”* I pleaded while nervously slapping her ~~hand~~ – er, bear-paw. Nothing! I waited about an hour – attempting to wake her at 15 minute intervals. Damn! Nothing. I thought to myself: *“Al, you fool. You should have kept your big mouth shut and waited to*

*see how mom progressed before telling dad anything, however understated.”*

Needless to say, I lost hope again and instead drove to a nearby park and lit up a few Newport cigarettes – a recurring habit that is, thankfully, limited only to brief times of personal stress.

After about an hour or two of cigarette-smoking and soul-searching, I arrived at the conclusion that my reservations, which were there all along, were the result of selfishness. Instead of letting mom go in peace, I was just holding on in order to avoid the inevitable grief that was coming.

If only I knew then what I know now, namely, that these reservations were *not* the manifestation of emotional immaturity – but rather, the intuitive ‘gut-feeling’ that something was rotten at St. Judas Iscariot Hospital.

### **Cousin Maggie’s Testimony**

I returned to the hospital again on Tuesday night, just to see if mom was awake. My cousin Maggie was having coffee in the waiting area. She immediately came up to me and excitedly told me:

*“Al, I was here yesterday and your mom was wide awake. We (her husband and her) were moistening her mouth with a sponge on a stick. She was very thirsty. She understood everything. I was going to call you guys but I was afraid to interfere. It would have been murder to let her die. And now she’s unresponsive again.”*

You see, Maggie and her husband, Brian, witnessed exactly what I had witnessed on Monday – only earlier. We had missed each by about an

hour or so, which means that happy mom was wide awake and breathing on her own for *at least* four hours. Naturally, Maggie also thought exactly as I had, but she felt it wasn't her place to actually call us and plead that we call off the euthanasia party. Now that mom was "comatose" again, Maggie, like me, had also given up for the final time.



*Mom's sudden and oddly temporary "resurrection," alertness and good mood also shocked my cousin.*

## **Ambushed at the Hospital**

**Wednesday, December 2:** At Ronald's request, I went to the hospital to authorize the order for the removal of the ventilator. After checking on sleeping beauty again, I called Ronald just as he had instructed. He told me to have a Dr. Blue paged, which I did.

Within minutes, Dr. Blue was at the front desk. She came into the room, introduced herself to me and then **gave mom a very quick injection** in her swollen left hand. I was then escorted me to a conference room. Soon afterwards, a social worker and Clipboard Lady arrived and took their seats across from Dr. Blue and me. Dr. Blue then asked:

*"Al. What is your understanding of what was discussed with your brothers?"*

I explained:

*“My understanding is that we are going to remove the respirator and let her breathe on her own. If her breathing should fail again, there will be no more heroic efforts to save her.”*

The members of the “Palliative Care” team sort of shook their heads in agreement. Dr. Blue then proceeded to call Ronald and Gerald. Before I knew it, we were all on a speaker conference call. Evidently, my brother Ronald had arranged for me to be ambushed. I wasn’t there *“to pull the plug”* after all. I was there because a unanimous decision was required with all three of us present.

Knowing that I held an intuitive, though indefinable distrust for the “experts” in white coats, Ronald took it upon himself to lure me into this meeting. It was really a manipulative and shitty way of doing business, but because I was already in agreement with the decision, I played dumb and went along with the game. I have since learned of many cases in which these manipulative death meetings have created civil wars within families – another consequence of the “The Morphine Genocide” that is quietly raging throughout America and Europe.

The meeting adjourned with the date and time of the true “unplugging” set for Friday morning at 10 AM – just 48 hours away. I got a bit choked up over what I thought was the *potential* finality of it all. Dr. Blue reached over and grabbed my hand with what *seemed like* a spontaneous and sincere show of empathy.

Then, from across the room, on the other side of the big table, Clipboard Lady walked over with a box of tissues. I don’t know what it was, but I continued to sense an evil aura emanating from that woman, as I did with house-call-doctor Pock. There was a frozen insincerity about her that set off alarm bells in my poetic soul. *“Thank you.”* I said, as I

pulled a tissue out of the cardboard box – presumably a standard prop for that room.

## **Another Mysterious Injection**

**Thursday Evening, December 3:** I had already visited mom in the morning. Upon returning to the hospital on Thursday night, I greeted my cousins Bernie and Angie at mom’s bedside. Angie had been crying.

We spent some time in the room, chatting and reminiscing about the good old days of pool parties at my childhood home and the lemonade and stale potato chip which mom would pass to us hungry swimmers from the basement window. Suddenly, a male nurse entered the room and injected mom in the arm. I had previously witnessed two other such injections during mom’s stay (*including Dr. Blue’s hand shot the day before*), but this particular one seemed very rushed and a bit brutal – enough to catch my attention and cause both Angie and me to wince.

Given the massive swelling in my mother’s hands, I wondered, for a very brief moment: how it could be possible to even hit a vein? -- What was she being injected with and for what purpose? The questions crossed my distracted mind for only a few seconds and we soon returned to chatting as if nothing had happened. After all, these are medical professionals who know what they are doing – right?

## **Pulling the Respirator**

**Friday Morning, December 5:** Ronald, his wife Mary, Gerald and me arrived at the hospital at 10 AM. The palliative gang was ready for us. Soon after gathering in mom’s room, a neurologist came in and waved her hand in front of my zombied-out mother, “*Maria. Maria. Hi Maria.*” She then said something very strange: “*Your mother was such a*

“sweet lady.” But how would she have known that – unless she had recently spent time with her while she was awake and talking or trying to talk? Oops.

In retrospect, (*always in retrospect!*) the brief and bizarre room visit seemed like an orchestrated Dog & Pony Show to convince us that mom was truly brain-dead. The poor old still-intubated lady must have had enough morphine in her system to floor a God-damned elephant, and this bad actor was going to resurrect her with a few gentle callouts of “*Maria. Maria.*” We all bought the act hook, line and sinker.

Heads bowed in phony reverence, Dr. Blue, Clip Board Lady and their sidekick “social worker” joined us for the Priest’s final blessing. The intubation apparatus was removed at about 11 AM, With absolute certainty, Dr. Blue reiterated to us, as she had at the death panel meeting, that mom would probably pass later that evening, or, at the latest, the next day. How she knew that, I did not know. But she was a doctor, so surely mom was not going to breathe on her own.

During group conversation at this time, Ronald mentioned that a resident had previously told him that my mother had “*the heart of a 60 year old.*” Like so many other missed clues, this bit of data caught my attention for a fleeting moment; but once again, being under the trusting influence of “medical professionals,” and wrongly assuming (*as we shall see later on*) that hospitals, like car mechanics, profit from fixing up old cars / patients, I failed to stick with the thought. Mom was a hopeless case, so why think about it?

We finally left the hospital at about 4 PM as mom appeared to rest comfortably. Dr. Blue openly assured us that she would administer morphine (*an opioid which actually **suppresses breathing***) in the event mom should manifest any signs of pain or discomfort.

## A Final Visit

**Friday Evening, December 4:** After spending time with my anxious father at the family home, Ronald and Gerald returned to their respective homes, each about an hour and a half away, while I stayed with the sad old man. Ten hours had passed without the dreaded phone call – which meant that the old lady with *“the heart of a 60 year old”* was still breathing on her own. I returned to the hospital at about 9PM to cheer for mom and hope for a miracle.

I found mom breathing slowly, but steadily. There was a discernable, though very faint inhalation, and an equally clear exhalation. For a 91 year old woman, the breathing seemed “normal” as far as I was concerned. The thought of calling my brothers and sharing the encouraging update crossed my mind, but I opted not to – figuring it was too soon to be getting everybody’s hopes up.

After sitting at mom’s bedside for only a minute or two, Dr. Blue entered the room and seemed surprised to see me. *“Oh. You’re back.”* she said. Not wanting to sound like an unduly optimistic amateur, I kept my optimism to myself and asked, *“How is she doing?”*

With a sense of subtle pessimism, Dr. Blue explained to me that she was breathing very slowly. She then told me, straight up, that she was going to **“adjust the morphine drip”** to “keep her comfortable -- and did so right then and there. I thought that was odd because mom was resting and breathing so comfortably. But who was I to question a “palliative care” doctor? And with that, I again abandoned my last hope.

Dr. Blue and I chatted for about 15 minutes or so – some of it small talk, some of it pertaining to mom; during which time she again, in answer to my question, and with unflinching certainty, reiterated that mom could pass overnight or the next day.

There was something else she mentioned that evening that, *once again*, went mostly over my tired, spinning, and emotion-filled head at that moment, only to be calmly recalled later on. Dr. Blue, evidently letting her guard down for a moment as she spoke about “end of life” decisions, said that the decision often haunts family members because *“there is always that doubt”* about whether or not the patient might have lived.

If that is so, then why kill her?

Sometime between 11:00 and midnight, I said a tearful good bye to mom and kissed her on the forehead. And still, I couldn’t help but notice that the tough old lady with *“the heart of a 60 year old”* and good vital signs was still breathing – meekly, but comfortably.



**1-** A resident doctor “went off script” and told dad: “your wife has the heart of a 60 year old.” Was this his way of warning us of the ghoulish game, just like the Hispanic nurse from the rehab had tried to? **2-**The death blow was to come via the bag, not the needle. **3-** Dr. Blue’s Crystal Ball says: “Mom will die overnight.”

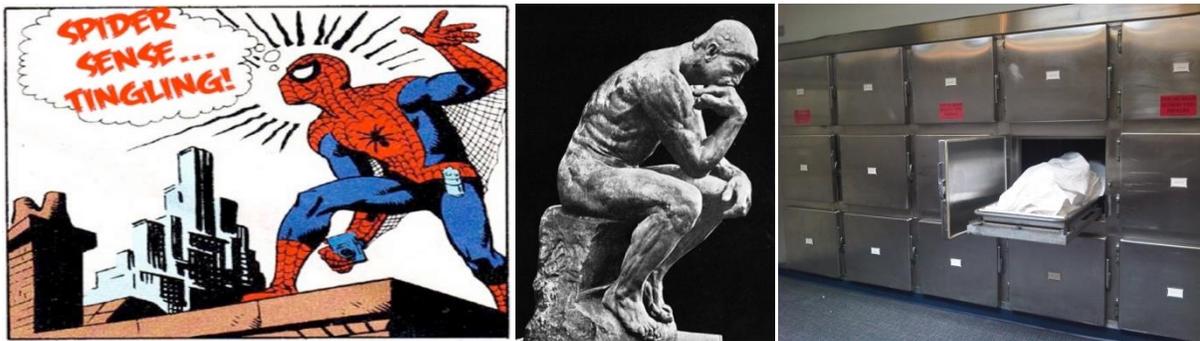
## **The Dreaded Phone Call**

We had agreed that Dr. Blue should call Ronald, no matter what the time of night, when and if the sad moment arrived. I had a disturbed sleep and woke up at about 7 AM. Still no phone call – *“maybe mom will breathe on her own throughout the day after all”*, I thought to myself?

Finally, at about 8 AM, my cell phone rang. It was Ronald with the bad, though thoroughly expected news. Dr. Blue had predicted the time of death to within just a few hours. Smart lady, eh?

I had my 60 second breakdown and then composed myself before hitting the shower before going downstairs to break the news to pop. I sat across the table from where he was sitting and simply said, “*Ronald just called*”, and then shook my head as if to say, no. Pop understood right away and began sobbing – something *waaay* out of character for this tough old mountain man who had seen everything in his life.

And so ended the final days of my mother – and so began my quest to answer the riddle of why my ‘gut instinct’ was suddenly tormenting even worse than before.



*The incessant tingling of my “Spider Man” sense got me to thinking deeply about mom’s death.*

# SECTION 4

## SUSPICIONS & QUESTIONS

*A quote to remember:*



*Your kind — mostly older white folks beholden to an absurd, inaccurate, nostalgic fantasy of what America used to be like — are dying.*

*Because you're on the endangered list. And unlike, say, the bald eagle or some exotic species of muskrat, you are not worth saving.*

*In forty years or so, maybe fewer, there won't be any more white people around who actually remember that Leave it to Beaver, Father Knows Best, Opie-Taylor-Down-at-the-Fishing Hole cornpone bullshit that you hold so near and dear to your heart.*

*There won't be any more white folks around who think the 1950s were the good old days, because there won't be any more white folks around who actually remember them,*

*We just have to be patient. And wait for you to pass into that good night, first politically, and then, well...*

*Tim Wise / Author, Left Wing Political Activist*

## How Was Dr. Blue Able to Predict Death?

Above all the other confusing occurrences we have reviewed to this point, there was one that stuck in my throat like a chicken bone, namely, Dr. Blue's repeated and amazingly accurate predictions of the time of mom's death. I witnessed mom breathing, slowly, but comfortably. With *"the heart of a 60 year old,"* lungs intact and vitals holding strong, how could anyone know that she would be gone in about 24 hours? She had just been wide awake for hours, smiling and lip-sync talking to me just a few days earlier!

The astute reader may have already caught the clues necessary to figure out what truly went down at St. Judas; and is no doubt thinking about your sleep-walking author: *"Where was your head at? Didn't you see what they were doing to your mother?"*

I've tormented myself over my blindness. All I can meekly say in self-defense is that while under the stress of running back and forth to the hospital, tending to a distraught father, taking care of a wife with a broken foot, juggling my neglected livelihood, all while wrongly assuming that hospitals earn money by prolonging life; I was not able to think clearly enough to weave together the pattern. I resolved to solve this mystery, but only after the funeral and with a cool head.



## Smashing Dr. Blue's Crystal Ball

It didn't take long for the 'gut instincts' about the *impossibility* of Dr. Blue's to-the-hour death forecast to be confirmed by research – and then later re-confirmed by actual conversations with highly competent doctors that I had personally worked with (*medical sales*) and trust.

Just one of many examples that turned up by way of the Internet -- **Professor Patrick Pullicino**, Professor of Clinical Neurosciences at the University of Kent, speaking to the Royal Society of Medicine in London:

*“Predicting death in a time frame of three to four days, or even at any other specific time, is not possible scientifically.”*

On the personal end, my wife, the non-practicing **Dr. Sherrie Bacar**, told me:

*“That doesn't sound right. Your mother was not terminal and her vital signs were strong. I don't see how they could have predicted that she was going to die that night or even died at all.”*

And finally, **Dr. Gary Roth**, a 25 year veteran Emergency Room doctor and personal acquaintance, when told of mom's post de-intubation breathing and Dr. Blue's accurate forecast, made the following salty wise-crack (*visualize comedian Jerry Seinfeld as a doctor, looking at me incredulously*):

*“Did she have a fucking crystal ball in her purse?”*

Ouch! I get your point, Doc.

There is no doubt on this question. It is a medical / scientific fact. **Predicting death and / or time of death for a non-terminal patient is**

**simply not possible.** Heck, it's even a very challenging effort when a patient *is* terminal and experiencing the death throes!

So then, how did Dr. Blue *know* what science cannot know? The conclusion is obvious. Her spot-on accurate time-of-death forecast was a self-fulfilling prophecy. Dr. Blue knew because she *herself* was the one transporting mom to the ferry station of the River Styx (*mythical Greek river that one crosses upon death*).

*“Adjusting the morphine”* -- indeed!

Before we return to the ‘scene of the crime’ at St. Judas hospital in Anytown, USA, it is necessary that we understand the ‘big picture’ context by thoroughly answering the general question:

***Is the Government-Medical Establishment steering non-terminal elderly patients into death-by-sedation?***

Let's first go to England to again hear the testimony of Professor **Patrick Pullicino** – described by *The Daily Mail* as one of Britain's “top doctors”. Excerpts from *The Daily Mail* – October 26, 2012.

## Daily Mail



*Professor Patrick Pullicino in the Daily Mail on June 20*

*“NHS (National Health System) doctors are prematurely ending the lives of thousands of elderly hospital patients because they are difficult to manage or to free up beds, a senior consultant claimed yesterday.*

*Professor Patrick Pullicino said doctors had turned the use of a controversial ‘death pathway’ into the equivalent of euthanasia of*

*the elderly.*

***He claimed there was often a lack of clear evidence for initiating the Liverpool Care Pathway, a method of looking after terminally ill patients that is used in hospitals across the country.***

*It is designed to come into force when doctors believe it is impossible for a patient to recover and death is imminent.*

*There are around 450,000 deaths in Britain each year of people who are in hospital or under NHS care. Around 29 per cent – 130,000 – are of patients who were on the LCP.*

*Professor Pullicino claimed that far too often elderly patients who could live longer are placed on the LCP and it had now become an ‘assisted death pathway rather than a care pathway’.*

*He cited ‘pressure on beds and difficulty with nursing confused or difficult-to-manage elderly patients’ as factors.*

*Professor Pullicino revealed he had personally intervened to take a patient off the LCP who went on to be successfully treated.*

*He said this showed that claims they had hours or days left are ‘palpably false’.*

*In the example he revealed a 71-year-old who was admitted to hospital suffering from pneumonia and epilepsy was put on the LCP by a covering doctor on a weekend shift.*

*Professor Pullicino said he had returned to work after a weekend to find the patient unresponsive and his family upset because they had not agreed to place him on the LCP.*

*‘I removed the patient from the LCP despite significant resistance,’ he said.*

*'His seizures came under control and four weeks later he was discharged home to his family,' he said.*

*Professor Pullicino, a consultant neurologist for East Kent Hospitals and Professor of Clinical Neurosciences at the University of Kent, was speaking to the Royal Society of Medicine in London.*

*He said: 'The lack of evidence for initiating the Liverpool Care Pathway makes it an assisted death pathway rather than a care pathway.*

***'Very likely many elderly patients who could live substantially longer are being killed by the LCP.***

*'Patients are frequently put on the pathway without a proper analysis of their condition.*

***'Predicting death in a time frame of three to four days, or even at any other specific time, is not possible scientifically.***

*This determination in the LCP leads to a self-fulfilling prophecy. The personal views of the physician or other medical team members of perceived quality of life or low likelihood of a good outcome are probably central in putting a patient on the LCP.'*

*Medical criticisms of the Liverpool Care Pathway were voiced nearly three years ago.*

*Experts including Peter Millard, emeritus professor of geriatrics at the University of London, and Dr Peter Hargreaves, palliative care consultant at St Luke's cancer centre in Guildford, Surrey, warned of 'backdoor euthanasia' and **the risk that economic factors were being brought into the treatment of vulnerable patients.***

*In the example of the 71-year-old, Professor Pullicino revealed he had given the patient another 14 months of life by demanding the man be removed from the LCP.*

*Professor Pullicino said the patient was an Italian who spoke poor English, but was living with a ‘supportive wife and daughter’. Professor Pullicino said: ‘I found him deeply unresponsive on a Monday morning and was told he had been put on the LCP. **He was on morphine via a syringe driver.**’ He added: ‘I removed the patient from the LCP despite significant resistance.’*

*The patient’s extra 14 months of life came at considerable cost to the NHS and the taxpayer, Professor Pullicino indicated.*

*After 14 months the patient was admitted to a different hospital with pneumonia and put on the LCP. The man died five hours later.*

Now, before you jump the gun and say, “*But what does England have to do with America?*” – realize that the same financial constraints afflicting Britain’s inefficient government-run health care system also apply to America’s inefficient government-run MediCare and MediCaid systems.

If it’s happening in Britain (*where the state’s Debt-to-GDP ratio stands at an appalling 111%*) – then why couldn’t it also be happening in the U.S. (*where the state’s Debt-to-GDP ratio stands at an almost equally appalling 106%*)?



*Broke-butt Uncle Sam spent so much tax revenue on Warfare Kings and Welfare Queens that there’s not enough left for the middle class people that paid into Social Security and Medicare.*

But we don't have to look to Britain to make this case. Excerpts from the following **New York Times** story, dated December 26, 2009, confirm that death-by-sedative is indeed happening in Anytown, USA:

## The New York Times

*“In some of the rooms in the hospice unit at Franklin Hospital, in Valley Stream on Long Island, the patients were sleeping because their organs were shutting down, the natural process of death by disease. But at least one patient had been rendered unconscious by strong drugs.*

*Mr. Oltzik's life would end not with a bang, but with the drip, drip, drip of an IV drug that put him into a slumber from which he would never awaken. That drug, lorazepam, is a strong sedative. Mr. Oltzik was also receiving morphine, to kill pain. This combination can slow breathing and heart rate, and may make it impossible for the patient to eat or drink. In so doing, it can hasten death.*

*Mr. Oltzik received what some doctors call palliative sedation and others less euphemistically call **terminal sedation**. While the national health coverage debate has been roiled by questions of whether the government should be paying for end-of-life counseling, physicians like Dr. Halbridge, in consultations with patients or their families, are routinely making tough decisions about the best way to die.*

*Among those choices is terminal sedation, a treatment that is already widely used, even as it vexes families and a profession whose paramount rule is to do no harm.*

There are plenty more pieces just like *The Mail* and *Times* articles above, and plenty more doctors who speak openly and even *proudly* about the practice of Terminal Sedation.

Going back even further, to 2005, a whistle-blowing Minneapolis nurse named **Mary Therese Helmueller** penned a piece titled:

***Warning - Are You Being Targeted For Euthanasia?***

In it, she revealed:

*"In 1984, while working as charge nurse in the intensive care unit, a 20-year-old man asked me, "Can you give my mother enough morphine to let her sleep away?" I was horrified. "I cannot kill your mother," I responded.*

*That was only the beginning. Recently, an 80-year-old was admitted to the emergency room and the physician said, "LET'S DEHYDRATE HER."*

***(Note: Remember, my mom was very thirsty according to Cousin Maggie)***

*One more patient was sentenced to die in hospice with NO TERMINAL DIAGNOSIS and once again, THE LIVING WILL determined the death of a 70-year-old man regardless of how he pleaded to live. I can no longer remain silent.*

*Your life may be in danger if you are admitted to a hospital, especially if you are over 65 or have a chronic illness or a disability. The elderly are frequently dying three days after being admitted to the hospital. Some attribute it to "old age syndrome" while others admit that overdosing is all too common. Euthanasia is not legal but it is being practiced.*

*Last year the New England Journal of Medicine reported that 1 in 5 critical care nurses admit to having hastened the death of the terminally ill! I believe the percentage is much higher. I have worked with nurses*

*who even admit to overdosing their parents. No one knows the exact euthanasia rate in the United States, however Dr. Dolan from the University of Minnesota states that 40 percent of all reported deaths is probably a conservative estimation. If this is true then the United States is executing euthanasia at a higher percentage rate than the Netherlands where it is also illegal but widely practiced.*

*I am a registered nurse in the St. Paul/ Minneapolis area with 15 years experience in emergency and critical care. My knowledge of euthanasia not only comes from my experience working in the critical care units throughout the Twin Cities, but also comes from a personal tragedy and loss in 1995. This is my true story. My hope is that you will educate others and protect yourselves and loved ones.*

*On Monday, February 20th, my grandmother was admitted to a local Catholic hospital with a fracture above the left knee. She was alert and orientated upon admission but became unresponsive after 48 hours and was transferred to hospice on the fourth day and died upon arrival.*

*I was in Mexico City and unable to be at her side so there were many questions upon my return. The doctors could not tell me the cause of her death so I began to search for the answers and was fortunate to obtain the hospital chart. It then became very clear that my grandmother had been targeted for euthanasia!*

*Carefully tracing the events it was evident that **my grandmother became lethargic and unresponsive after each pain medication.** She would awaken between times saying, "I don't want to die, I want to live to see Johnny ordained": "I want to see Greta walk." Johnny was her grandson studying in Rome to be a priest and Greta was her new great-grandchild. Even though over-sedation is one of the most common problems with the elderly she was immediately diagnosed as having a stroke. **When she became comatose a completely hopeless picture of recovery was portrayed by the nurses and doctors** who reported that she*

*had a stroke, was having seizures, going in and out of a coma, and was in renal failure.*

*The truth however can be found in the hospital chart which indicates that everything was normal! The CAT scan was negative for stroke or obstruction, the EEG states "no seizure activity" and all blood work was normal indicating that she was not in renal failure! How were we to know that the coma was drug induced and that all the tests were normal? Why would they lie?*

*Looking over the chart it is clear that obtaining a "no code" status was the next essential step in executing her death. This is an order denying medical intervention in emergency situations. The "no code" was aggressively sought by the medical profession from the moment of her admission but was not granted by my family until it appeared that she was dying and there was no hope. Minutes after obtaining the "no code" a lethal dose of Dilantin (an anti-seizure medication) was administered intravenously over an 18-hour period. It put her into a deeper coma, **slowing the respiratory rate and compromising the cardiovascular system leading to severe hemodynamic instability.** The following day she was transferred to hospice and died upon arrival. The death certificate reads "Death by natural causes."*

Interesting! – That’s almost *exactly* how it played out with mom.

It is a tricky ethical question. On one hand, we certainly would not want terminally ill and suffering patients to suffer all the way until the finish line. We wouldn’t even subject our dogs and cats to such misery.

The question is: how many of these cases truly represent legitimate mercy-sedations of the terminally ill versus how many are little more than brutal cost-cutting measures induced by government pressure and now, government *incentives* (more on that shocking subject later).

The potential for abuse and deception of naïve and confused family members is immense. Logic and reason now compel us to ask:

**1: *Was Maria Esposito a victim of this abominable practice?*** And:

**2: *How many seniors are being quietly killed / culled before their time?***

Now, let us return to the hospital and systematically answer all the questions that swirled through my formerly confused mind.

# SECTION 5

## CRACKING THE CASE

*A quote to remember:*



*Al,*

*I started working on the cover for The Morphine Genocide. What a subject matter – and what a coincidence! I have been watching this happen every week for the past two years. I sing every week at a nursing home / rehab / hospice next to our hospital, and I watch people degenerate so fast once they start getting fed the pills and liquids that the nurses dish out.*

*I would probably quit because of the crimes of the medical mafia but the people stuck in there have no one, sometimes it is only me willing to chat with them. And sing a few songs to escape. I play a two hour show every Tuesday, and nurses are constantly popping in to hand a patient their meds and a little cup of chocolate flavored liquid of something. Over the weeks they start to be less and less attentive, till sometimes they just roll in an invalid, the same person I was chatting with only a few weeks before.*

*One sweet little old lady who was laughing and teary eyed when she came in. Suddenly she must have been so psych-drugged, she was now sitting there like a hollow shell with no emotions at all.*

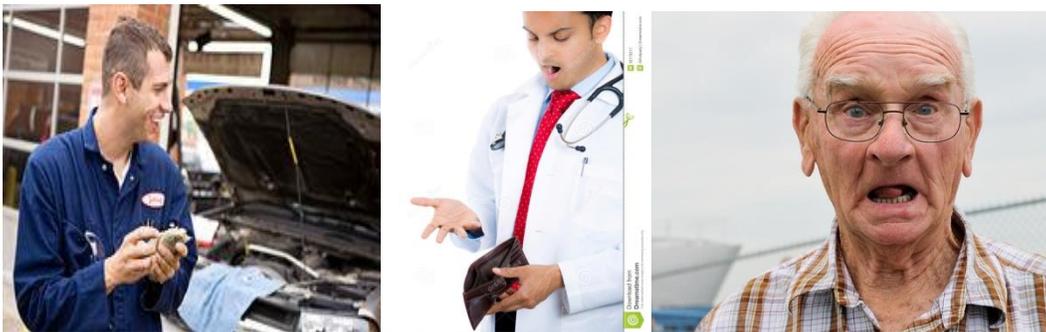
**Danny Deeson** / Graphic Artist, Musician

## **Why was Clipboard Lady pressuring for an early Palliative Care meeting?**

Clipboard Lady's subtle "sales pressure" behavior was influenced by three external factors – financial / political factors. Ah yes – money and politics; the twin roots of all evil. Who knew?

Most people generally assume that hospitals have a financial interest in keeping Medicare patients alive and comfortably housed for as long as possible. More admissions + more nights + more treatment all add up to more revenues receivable by MediCare. Right? --- Wrong. Indeed, precisely the *opposite* is true.

Medicare reimbursements were very generous for the hospitals and doctors of the 1970's – 1990's. That is why my Uncle Corrado was allowed to stay on life support for eight months in 1983 without anyone pressuring my aunt to "have a conversation" or "pull the plug." Along with the days of the almost universal single-earner family, those days are gone too.



***Newsflash Grandpa! Auto mechanics make money fixing and re-fixing old "patients." Doctors and hospitals generally do not!***

There are three little-known (*to the general public, that is*) financial incentives to 'soft-kill' the non-terminal elderly. Whether these policies were specifically designed to kill or whether they are just having that

unintended consequence is a difference without a distinction. Either way, **a deadly conflict of interest has been put into play** by the usual suspects – incompetent politicians and faceless bureaucrats.

**The three death incentives are:**

1. Due to Medicare’s policy of “one size fits all” flat-fees, an extended stay makes elderly patients like mom a financial liability to St. Judas Iscariot Hospital.
2. Medicare penalizes hospitals for readmissions (*Mom was on her 4<sup>th</sup> tour in just 10 weeks!*).
3. As of 2015, Medicare/’Obamacare’ now pays hospitals for both “end-of-life consultations / meetings” as well as the “Palliative Care” (*morphine squirts/drips*) that usually follows such meetings.

So you see, the reason that Clipboard Lady acted like a commissioned saleswoman was, in essence, because she *was* a commissioned saleswoman, after all! Using only excerpts from professional medical associations and the very “mainstream media” that the general public so obediently worships, let us briefly confirm each of the three above-listed financial realities.

**1 – FLAT FEE MEDICARE PAYMENT FOR SERVICES**

**From Health Affairs:**



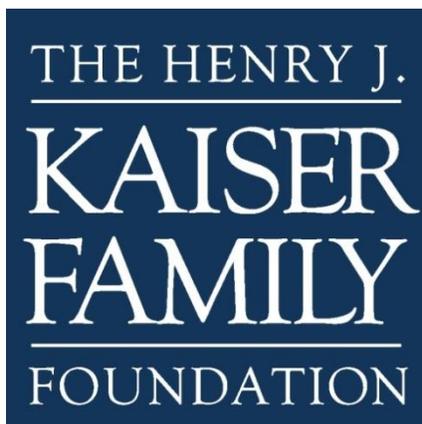
***“Payment for inpatient service: For a beneficiary admitted to the hospital as an inpatient, Medicare pays for the care under the inpatient***

*prospective payment system (IPPS). The IPPS provides a single payment for all of the services provided to the beneficiary by the hospital during the inpatient stay, including nursing staff, room and board, use of operating or diagnostic facilities, and drugs. CMS assigns each inpatient admission (or case) to a Medicare severity diagnosis-related group (MS-DRG) based on the diagnosis codes reported by the hospital. The MS-DRG assignment determines how much the hospital will be paid for caring for that patient.*

*The MS-DRG payment is based on the average cost of caring for Medicare patients with similar diagnoses and takes into consideration complicating conditions that might make it more difficult and expensive to treat a particular patient. Hospitals have discretion about what specific care is provided to each patient, and they generally do not receive additional payment for providing more services or for patients who stay in the hospital longer than usual, although hospitals can receive additional outlier payments to help pay for extremely costly cases. The MS-DRG payment includes all care provided by the hospital during the stay, regardless of the length-of-stay, and any services related to the hospital stay provided by the hospital during the seventy-two hours preceding admission, which can include items such as preoperative testing.”*

## **2 - READMISSION PENALTIES**

**From The Kaiser Family Foundation**



*Aiming for Fewer Hospital U-turns: The Medicare Hospital Readmission Reduction Program*

**Jan 29, 2015 | Cristina Boccuti and Giselle Casillas**

*“It's often said that where Medicare goes, private payers will follow. For hospitals,*

*health systems and other providers, it has been the most influential healthcare program for the industry in recent decades.*

*Medicare continues to play a prominent part in various reform movements, such as the shift from fee-for-service to value-based payments and the push for greater price transparency. The program's pay rates and policies have the potential to act as a catalyst for change nationwide, or to provoke coast-to-coast controversy*

*Medicare—through Congressional direction and Administration initiatives—has started implementing incentives to reduce hospital readmissions. One example, and the focus of this Issue Brief, is the Hospital Readmission Reduction Program (HRRP) which penalizes hospitals with relatively higher rates of Medicare readmissions.<sup>3</sup> Applying to most inpatient hospitals, the Department of Health and Human Services states that the HRRP will play a role in its new goals to tie an increasing share of traditional Medicare payments to quality or value in the coming years.*

*Across all three years of the HRRP, some types of hospitals are more likely than others to incur penalties, including major teaching hospitals and hospitals with relatively higher shares of low-income beneficiaries—two often overlapping characteristics.*

*Beneficiary readmission rates started to fall in 2012, suggesting that hospital administrators and clinicians may have initiated strategies soon after the enactment of the HRRP and prior to the application of the fines—realizing that the penalties would be based on performance in preceding years. Other factors may also have played a role these declines.*

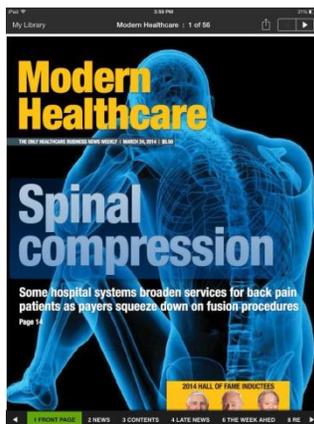
*Generally speaking, a hospital readmission occurs when a patient is admitted to a hospital within a specified time period after being discharged from an earlier (initial) hospitalization. For Medicare, this*

*time period is defined as 30 days, and includes hospital readmissions to any hospital, not just the hospital at which the patient was originally hospitalized.*

*Medicare uses an “all-cause” definition of readmission, meaning that hospital stays within 30 days of a discharge from an initial hospitalization are considered readmissions, regardless of the reason for the readmission.*

*Under the HRRP, hospitals with readmission rates that exceed the national average are penalized by a reduction in payments across all of their Medicare admissions—not just those which resulted in readmissions.”*

## **From Modern Health Care – Health Care Business News**



### ***Most hospitals face 30-day readmissions penalty in fiscal 2016***

**By Sabriya Rice | August 3, 2015**

*“Most U.S. hospitals will get less money from Medicare in fiscal 2016 because too many patients return within 30 days of discharge.*

*Only 799 out of more than 3,400 hospitals subject to the Hospital Readmissions Reduction Program performed well enough on the CMS' 30-day readmission program to face no penalty. Thirty-eight hospitals will be subject to the maximum 3% reduction, according to a Modern Healthcare analysis of newly posted CMS data.”*

### 3 - FED CASH FOR DEATH MEETINGS & PALLIATIVE CARE

From The Associated Press



*Medicare to pay for voluntary end-of-life counseling, as 'death panel' charges lose sting*

**By Ricardo Alonzo-Zalvidar and Matt Sedensky / July 9, 2015**

*“Six years ago, a plan for Medicare to cover end-of-life counseling touched off a political furor that threatened to stall President Barack Obama's health care law as Congress debated it.*

*Wednesday, when Medicare finally announced it will make the change, reaction was muted.*

*At the time, former Alaska Republican Gov. Sarah Palin's charge that voluntary counseling could lead to "death panels" dictating the fate of seniors was widely discredited.*

*But for the Obama administration, end-of-life counseling remained politically toxic, even as the idea found broader acceptance in society.*

*Dr. Joe Rotella, chief medical officer of the American Academy of Hospice and Palliative Medicine, called Medicare's move a "little miracle."*

*Rotella said this time he thinks society is going to "see the good" in the idea.*

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**From The Wall Street Journal**

**WALL STREET  
JOURNAL**

***End-of-Life Discussions Will Be  
Reimbursed by Medicare***

***Move marks a turning point after a  
similar proposal was dropped from  
the Affordable Care Act***

**By Stephanie Armour / October 30, 2015**

*"It is a delicate issue, however, because end-of-life discussions also are likely to lower health-care spending—which could lead to claims the conversations are a way to limit treatment or care. About a quarter of Medicare payments cover care for people in the last year of their life, according to a 2010 report in the journal Health Services Research.*

*About 63% of beneficiaries are hospitalized in their last few months of life.*

*But some oppose the measure because they say it would lead to billing fraud and would tax the government program. Gary Puma, president and chief executive of Springpoint Senior Living based in Wall Township, N.J., said:*

*“We would benefit by this proposed additional reimbursement from Medicare, but cannot in any way support this initiative,” he said. “We have discussions all the time when appropriate, with families, about end-of-life issues.”*

There is no doubt. The big financial squeeze is on, and the severity of the situation is not at all hidden, assuming one wants to explore the matter. America’s aging population is placing enormous pressure on the inefficient Medicare and Social Security schemes. Compounding the crisis of care are the out-of-control medical malpractice lawsuits, the explosion of Medicaid expenditures to service both the domestic and *imported* poor, the fraud and abuse running rampant in both Medicare and Medicaid, and wasted tax revenues for a military budget that is equal to what the rest of the planet’s nations spend – *combined!*

Every Senior Citizen sent to an early grave spells one less Social Security check going out each month; and no more expensive hospital visits, medications, rehabilitation, medical supplies and home-care either. Hear it from straight from the mouth of the Snake-Oil-Salesman-in-Chief himself – **Barack Obama**, who once, after being asked about his schemes might impact the elderly, famously quipped during a town hall meeting:

*"Maybe you're better off not having the surgery, but taking the painkiller."*

Though her husband and three sons have collectively paid more than \$2 million dollars in Federal and Social Security taxes over the course of their working lives; to the Feds and to the reimbursement-starved gang at St. Judas Hospital, Maria Esposito was worth more dead than alive – much more.

With the critical “dollars and cents” context behind the movement to quietly kill off our elderly now clear; let us answer the questions that should have been asked while mom was still alive.

# SECTION 6

## *SURE SIGNS OF MORPHINE ABUSE*

*A quote to remember:*



*Morphine kills people faster. I've seen how fast people go downhill once they're given morphine for pain. They rapidly become less responsive, more detached, disinterested in others, confused, they usually stop eating completely, and organ & respiratory failure seem to follow shortly after.*

*Many of these are normal symptoms of encroaching death, but I have witnessed half a dozen times just how much faster these symptoms appear once narcotics are administered. Since morphine is a CNS depressant known to inhibit respiration, it makes sense that giving a sick person heavy doses might cause their health to deteriorate more rapidly.*

*People with a critically or terminally ill family member are often in a state of shock and not thinking clearly. The sick person may be in a state of confusion and fear and unable to make good decisions about their own care.*

*- Anonymous Nurse, Kentucky*

## What are some of the known signs of morphine overdose?

There are four that would apply to mom's case: swelling of hands and forearms, suppressed breathing, extreme drowsiness and severe thirst. Let's have a look.

### **A: Extreme swelling of hands:**

**From Drugs.com**



**Drugs.com**  
Know more. Be sure.

#### **Symptoms of Overdose:**

increased thirst, extreme drowsiness, severe sleepiness, swelling of the face and fingers

**From Dr. John Shore (a professional acquaintance):**

*“Al,*

*Yes, opiate narcotics can cause swelling, and yes, a high dose of them will for sure cause this coma-like state.*

*It could just be physician incompetence. They may not have realized that your mother had been given too much narcotic. If her liver was cirrhotic or compromised in some other fashion which caused her to not be able to efficiently metabolize the morphine, it may have stayed in her system in doses high enough to suppress her breathing and cause side effects like the swelling.”*

The morphine in and of itself can cause swelling, even if taken orally. In mom's case, there was an exacerbating factor that could have made the swelling even worse, namely, the constant injections.

What the medical pros refer to as an “injection site reaction” can be caused by the puncturing of arteries and/or the damage to elderly tissues,

and that's not even taking the morphine into consideration. The swelling is often accompanied by discoloration (*mom's arms were blue*)

One of the most interesting testimonials on this subject comes to us from a website forum for anonymous junkies. After a panic-stricken drug-using member posted a photo of his girlfriend's swollen hand, a more knowledgeable user offered his advice:

*"Former heroin addict here. I think I can shed a bit of light onto this. An IV user's hands can be puffy/red for a few reasons. What I think you are referring to is when people who have been using for a long time, they have smaller, harder to find veins.*

*They might think that the blood registering in their syringe means they're in a vein and good to go, but it's not in properly and they still inject a bit of Heroin into a non-vein. The result is instant inflammation in and around the area affected.*

*Another explanation is that the area is just very tender from being poked at over and over in the search for a vein. A clean hit achieved on the first try should produce no inflammation. The truth is that everyone's veins are different, some are more prominent than others and well most IV users would agree that the arms have the largest, easiest to access veins."*

I twice witnessed my mother being jabbed in her massively swollen forearm like an animal and injected in the hand on a third occasion. There is no way that they were cleanly hitting vein each time.

## **B: Suppressed Breathing / Slowed Heart Rate**

**From the U.S. Library of Medicine:**



*“Morphine may cause serious or life-threatening breathing problems, especially at the beginning of your treatment and any time your dose is increased. ... Your doctor will adjust your dose carefully to control your pain and decrease the risk that you will experience serious breathing problems. Tell your doctor if you have or have ever had slowed breathing or asthma. Your doctor may tell you not to take morphine.*

*Also tell your doctor if you have or have ever had lung disease such as chronic obstructive pulmonary disease (COPD; a group of lung diseases that includes chronic bronchitis and emphysema), .... **The risk that you will develop breathing problems may be higher if you are an older adult or are weakened or malnourished due to disease.**”*

*(emphasis added)*

### **C: Extreme Drowsiness**

This one requires no explanation.

Why inject breathe-suppressing morphine into the arms of a 91-year-old recovering pneumonia patient who was never in any serious pain?

It cannot be emphasized enough. My mother, even on the night that she broke her hip, was never in any severe pain. Indeed, a few days later she was walking, with assistance, at the rehab center.

At worst, she may have experienced some discomfort due to a bed sore she had developed (*assuming it was a bed sore and not a bruise from*

*her epidural*). There is no sound medical reason for sedating her out of consciousness when a medical pain patch would have sufficed.

The most logical inference regarding this question is this: Mom was knocked out 24/7 in order to erect a wall of separation between her and her family, for the purpose of securing a DNR - *without her input* - before delivering the final death blow. You see, pulling the proverbial plug on your smiling chatty mother is impossible. But pulling it on a vegetative exhibit with a tube in her mouth is humane.

### **How did they manage to wake mom for her “swallowing test?”**

Simple. They merely skipped her booster injection and de-intubated her so that she could be awake for a rigged-to-fail test that was only intended to demoralize us. Why do we say “rigged-to-fail?”

Because three different doctors have since told me that intubation is very taxing on the throat muscles – especially for a 91 year old! The medical term for extreme cases is “Intubation Trauma” --- Google it. Even if her throat wouldn’t be considered “traumatized,” it certainly could not have functioned at 100% capacity after days and days of on again / off again intubation.

Again, my trusted business colleague, Dr. Shore:

*“Yes Al, intubation damage is something not often talked about. No matter how carefully you put that tube in, you can caused rips and subsequent scarring of the vocal cords. It is likely that they removed the tube and had not planned on putting it back in, but then they pumped her with opiate narcotics which subsequently affected her breathing, and they re-intubated her.”*

*There was likely a standard order to keep pumping her with them. ... There is never a need to intubate a patient unless they are having*

*trouble breathing or are being put under general anesthetic for a procedure.”*

**Why continue injecting into the hands and arms of an elderly patient with such damaged vessels and tissues?**

Because they didn't give a rat's ass. As long as her bewildered family members (*myself included*) were too negligent to investigate the bizarre arm-swelling, the boldness with which they jabbed her only intensified.

**Why was mom suddenly so awake, alert and able to breathe just days after her “rib-breaking” resuscitation and just days before she was set to be finished off?**

Evidently, one of the nurses missed a booster shot. I, and also Cousin Maggie were not supposed to have seen her awake and alert. They put an end to that.

**Why on four occasions, did nurses and doctors inject mom within 5 minutes of my arrival? (3 injections, one morphine increase from IV bag)**

It probably went down like this: *“Hurry! Hurry! One of the sons is here! Give her another injection!”*

**Why was mom so thirsty when Cousin Maggie saw her awake?**

A known side-effect of morphine is dehydration. They may also have been denying her water.

**How did the neurologist know that mom was “such a sweet lady?” (as stated on the day of mom's death)**

Evidently, she had seen my mother (*who was indeed sweet and as kind as they come*) awake and unplugged, just as Maggie and me had. Oops!

## **Why no signs of pain or discomfort from the “broken ribs?”**

I have since learned that the “broken ribs” speech is actually a common scare tactic used to induce family members to put a patient on the DNR. This is not to suggest that aggressive CPR can’t damage an elderly patient’s ribs. But given mom’s bizarre “resurrection,” big smile and energetic attempts to speak to me so soon after her alleged CPR episode, I have come to doubt the broken rib claim – or at least the severity of the injury, if there was one.



# SECTION 7

## *SUMMING UP THE CRIME*

*A quote to remember:*



*Politicians say, "we are not going to ration care." But they will set in motion many processes that reduce reimbursement under the guise of "limiting expenditures," or "keeping costs down," and these processes will result in rationing care.*

*Ultimately, many services will simply not be provided, because physicians, hospitals, and others cannot afford to provide them at the steadily decreasing reimbursement levels determined by the bureaucrats who run Medicare, Medicaid and other government-controlled health services.*

*Those on Medicare and Medicaid are already on a government-run plan and are experiencing the effects of decisions made by unelected bureaucrats in Washington, DC. We need to remember that Medicare passed into law in 1965 and is nominally a "voluntary" program. However, to assure participation by all seniors, then President Lyndon Johnson pressured all private health insurers to cancel all policies available to seniors. If seniors want to completely opt-out of Medicare, they have to give up their Social Security benefits and then pay privately for all services they receive. Only the very wealthy can do that.*

**Ron Panzer** *Founder of Hospice Patients Alliance, Author of Stealth Euthanasia: Health Care Tyranny in America*

It all makes perfect sense now. From Clipboard Lady's pressure to have a "death panel" meeting with the "Palliative Care Team" – to the 24/7 "coma" – to the hideous swelling and discoloration of the arms and hands – to the dryness of mouth – to the sudden "miracle resurrections" of a smiling and alert patient– to the sneaky injections administered immediately upon my arrival – to the "prophetic" and spookily accurate prediction of mom's almost exact time-of-death --- all within the broader context of a debt-ridden, mismanaged, communistic Federal government faced with a historic demographic crisis. Early death by stealth is a reaction to this economic crisis.

The text-book definition of "Palliative Care" - the definition that is spoon-fed to family members – sounds ethical and compassionate.

From Wikipedia:

*“Palliative care is a multidisciplinary approach to specialized medical care for people with serious illnesses. It focuses on providing patients with relief from the symptoms, pain, physical stress, and mental stress of a serious illness—whatever the diagnosis.*

*The goal of such therapy is to improve quality of life for both the patient and the family. Palliative care is provided by a team of physicians, nurses, and other health professionals who work together with the primary care physician and referred specialists (or, for patients who don't have those, hospital or hospice staff) to provide an extra layer of support.*

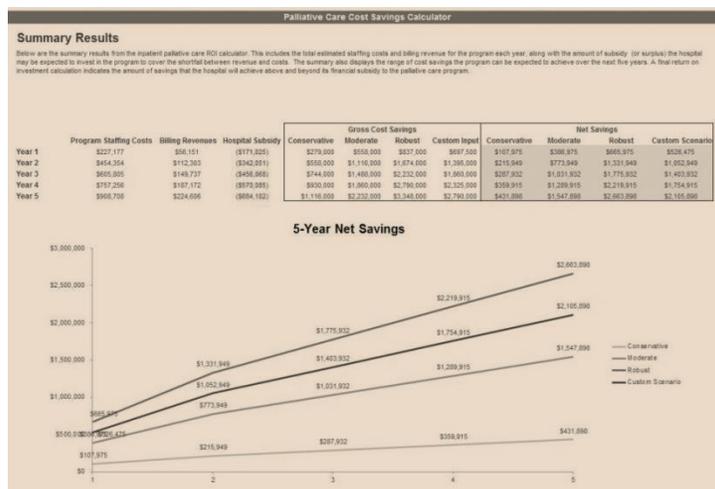
*It is appropriate at any age and at any stage in a serious illness and can be provided as the main goal of care or along with curative treatment. Therefore, although it is an important part of end-of-life care, it is not limited to that stage. Palliative care can be provided across multiple settings including in hospitals, in the patient's home, as part of community palliative care programs, and in skilled nursing facilities.*

*Interdisciplinary palliative care teams work with patients and their families to clarify goals of care and provide symptom management, psycho-social, and spiritual support.”*

Sounds good, but when medical professionals speak among themselves, the high-minded hogwash about “the patient” and “support for the family” is nowhere to be heard. From the point of view of hospital administrators, palliative care is all about dollars and cents. An Internet Search under the term “**Palliative Care Cost Savings**” is very telling in this respect.

One web-based consulting group, “The Advisory Board”, features an interactive “**Palliative Care Cost Savings Calculator** . They boast:

*“Our interactive calculator simplifies the process of estimating costs and savings related to starting or expanding an inpatient palliative care consult service within your institution.”*



*“This tool is designed to use member-supplied input data to calculate cost savings associated with inpatient palliative care programs. You'll receive estimates of the volume of patients receiving palliative care services, staffing level recommendations for your institution, and an estimate of cost savings per patient per day following the initial palliative care consult.”*

In order to read the rest of the content, one must be a member of the Physician Executive Council.

The profession's open admission (*among its members*) that a "Palliative Care Program" saves money is tantamount to an open admission that patients are indeed being euthanized. How else could such programs be cost-saving unless people are being knocked off early? Oh if only I had understood the financial angle when Clipboard Lady started hounding us like a Mary Kay cosmetics agent! Splinters from that board would still be lodged in her rectum.

A form of euthanasia may be acceptable, to some, in cases of extreme pain coupled with terminal illness. But how many non-terminal and recoverable seniors are being caught in this cost-cutting dragnet of death? With the Feds cutting so deeply on reimbursement requests for Medicare and Medicaid, how far will cash-strapped hospitals, particularly in depressed areas with a large Medicaid and Charity Care constituency, go to push an early death by morphine and collect a government payment (*reward*) for "Palliative Care?"

In my mother's case, the hospital, and before that, perhaps even the in-home doctor, went so far as to plot her unnecessary death in premeditated fashion. Palliative Care, in many cases, is murder by morphine. One recent case to make the local news in Texas opens a horrifying window as to what is going on in hospitals and hospices all across America. The only reason this case got any traction was because of the incredible stupidity of the hospice owner.



## **FBI: Frisco Hospice Owner Directed Nurses to Overdose Patients**

*"You need to make this patient go bye-bye," executive is quoted as saying."*

*"The owner of a North Texas medical company regularly directed nurses to give hospice patients overdoses of drugs such as morphine to speed up their deaths and maximize profits, an FBI agent wrote in an affidavit for a search warrant obtained by NBC 5.*

*Harris, an accountant, instructed a nurse to administer overdoses to three patients and directed another employee to increase a patient's medication to four-times the maximum allowed, the FBI said. He allegedly sent text messages like, "You need to make this patient go bye-bye."*



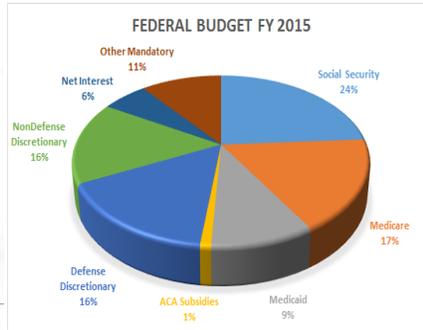
*"I just never felt good about the way she died," Kathy Wright (left), seen here with her sister, Jan Carter, said of her mother's death last year under the care of Novus Health Services.*

The Frisco, TX case is not an isolated one. There are *sooo* many other similar claims, perhaps not as overt and provable, occurring all across America and Europe. Personal acquaintances have since shared similar observations with me.

Basic accounting lesson here, folks -- for every credit there must be a debit somewhere. So: if the sanctified, beatified, exalted "*immigrants, poor and minorities*" have "*gained sharply*" under ObamaCare; then some other group or groups has to have *lost* sharply in order to pay for the "free" health care bestowed upon this rabble proletariat of Democrat voters.

The four main categories of debit-losers are:

1. Taxpayers who are paying, either through higher taxes or inflation, for the added interest-bearing deficits being piled onto existing State and National Debts
2. Health Care providers and doctors who are seeing their Medicare & Medicaid reimbursements slashed, in some cases, to near-loss levels
3. Insured workers now forced to pay high mandated deductibles and out-of pocket expenses to offset the losses which private insurers are suffering.
4. **Elderly but salvageable patients** who are being deliberately starved, dehydrated, and morphine-dripped or injected to death as bewildered and stressed-out family members are left scratching their heads.



*Debits must equal credits ---- The **percentage of the Federal Budget** allocated to Welfare/Medicaid) has nearly doubled under Obama (was 5% in 2008, 9% now).*

*Since they won't cut the bloated Department of Offense, the only way to pay for "free" healthcare is through taxes, money-printing / inflation and cutting SS & MediCare reimbursements to doctors and hospitals.*

The dynamics affecting groups 1, 2 & 3 are self-evident, and self-explanatory to anyone with a pre-Common Core 4th-grade understanding of mathematics. It is category # 4 which, due to its horrifying implications, is being kept 'hidden in plain sight' from the ageing American public.

In fairness, the mass-murders didn't begin with ObamaCare, but the killings have dramatically increased since his ascension to power. You see, the millions of younger Third World parasites now "entitled" to healthcare are causing the government to divert resources away from the elderly. As of 2015, ObamaCare actually incentivizes hospitals & doctors for "end of life" consultations (*negativity sessions*) and "palliative care" (*death by morphine*) for **non-terminal** patients. That's the 'carrot', but there is also a 'stick' involved.

Whenever an elderly MediCare patient exceeds the government's ever-shrinking hospital-stay allotment time, the hospital loses money. The pressure is growing to push granny and gramps out the door. But should

any given granny return within a period of time, the hospital is also penalized for a "readmission" on its reimbursement request. Not only does the hospital lose money for an individual readmission; but if its overall readmission rate is too high, the reimbursement deduction applies to all other reimbursement requests as well. In short, the very old have become very bad for the bottom line.



*Obama and his handlers laugh as they kill off mainly White seniors prematurely while diverting their health-care dollars to the never-ending hordes of alien invaders and their litters of newborn "citizens".*

Yes, it's true. The high cost of covering alien parasites is diverting health care dollars from grandma. From the balance sheet perspective of pressed and stressed hospital administrators, **granny is worth more dead than alive**. It's economic battlefield triage, pure and simple.

The killing scam involves the creation of a wall-of-separation between a conscious patient and the family members. That's the key! This is accomplished by keeping the patient in a morphine-induced, breath-suppressing "coma" while filling the heads of family members with excessive negativity about "quality of life," "low probabilities" of recovery, and the potential for "broken ribs."

Once the medical ghouls have secured a "Do Not Resuscitate" authorization (*in the repeated event of heart / breathing stoppage*), the dehumanized "vegetative" senior can then be deliberately juiced to death -- the cause of death to be described as "stopped breathing or heart

stopped" (*wink wink*). By the time a few of the more astute loved ones can figure out what the hell happened, it will be too late to call out the white-coated “professionals” on their bull-shine.

And don't expect any after-the-fact justice from law enforcement or the blood-sucking medical malpractice trial lawyers. Unless you have got “smoking gun” evidence (*like the aforementioned fool in Texas who sent his kill orders via text message*), the operatives of this ghoulish game can quite easily hide behind medical jargon and the plausible defense of:

*“Stressed family members are often emotional and uneducated. There is no conspiracy here. We did the best we could to keep her comfortable but there was simply no hope. After all, she was very old, you know.*

Unless you are willing to: exhume a body, shell out big bucks for an autopsy, shell out even bigger bucks for expert witnesses, and drag the family torment out for years all for the sake of an uncertain outcome before a jury that probably isn't going to get teary-eyed over the passing of a 90-something year old; then there is no fighting such a defense. This truly is “the perfect crime.”

The evidence is clear --- advanced senior citizens (85+) are the new late-term fetuses. The powers-that-be (*who will always get maximum care for themselves!*) want the old timers dead and buried as soon as possible. As America grows older and older, and government debt and expenditures grow bigger and bigger, expect the soft-kill target age to creep downwards as more hospitals and hospices become like St. Judas.

As far as the politicians are concerned, squandering medical dollars to win the votes of indigent aliens amounts to a far better electoral investment than extending the lives of *non-terminal* seniors by a few more precious years. It really is that simple, and it should come as no surprise.



*Die seniors, die. In degenerate America and Europe, any obscenity now goes.*

There was nothing humane or merciful about the protracted torture-killing of my mother a good three years (*or more*) before it was her time. She had beaten the pneumonia. She had a strong heart. **She was smiling, asking for her husband and trying to chat with us just days before the final blow.** She had a powerful support network which included a full-time live-in aid to pamper her and rehabilitate her back to walker-capable walking. She had a husband with deep financial resources, a younger sister, devoted sons and daughters-in-law, nieces, nephews, grandkids and, most importantly, *“the heart of a 60 year old.”*

All mom needed was to be left the hell alone -- free to catch her own breath without those deforming, round-the-clock, breath-suppressing, coma-inducing morphine injections; those traumatizing throat tubes; and those drug dealing doctors and administrators at St. Judas.

And if indeed it was her destiny to stop breathing in that hospital; then let the stoppage be on her own, not “assisted” by a lethal substance known to suppress the very breaths she was trying to take – and not behind the backs of confused and ignorant family members who were led to believe that she was brain damaged when she was absolutely not!

And mom's was not an isolated case, which is why this pamphlet is titled: *The Morphine Genocide*. May Maria Esposito's premature ~~death~~ murder not be for nothing. Armed with the knowledge of her experience, don't let it happen to you or someone you love – at least not while you, as a citizen of a “free” country, still have some choice left in these matters.



*Maria Esposito*

*1924 – 2015*



**Be sure to visit the alternative news / conspiracy  
website of M S King at [TomatoBubble.com](http://TomatoBubble.com)**

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