The SHIELD model Regeer ®

S Sophisticated

H Healthy

I Intelligent

E Ending

L Limit

D Disease-escalation(s)

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I explicitly advise the reader to take note of:

de SHIELD METHODE REGEER ® ***update 00.2 volgt snel in juli 2020***

SHIELD : ***S*ophisticated *H*ealthy *I*ntelligent *E*nding and *L*imitation of *D*isease -*escalation(s)*.**

1) How better and broader advice can be met on all human dimensions now and in the future and

2) How the maximum possible safety can be guaranteed medically, ethically and socio-economically for the population in the event of a virus outbreak.

Summary (see my justification in 1st document OUTLOOK April 2020)

Apparently, there are great interests in perpetuating the created myth of SARS-COV-2 as a dangerous and deadly virus at all costs. The virus is not fatal. Doing nothing is not an option, however, in my opinion, WHO medical scientists in particular can be blamed for sticking to outdated dogma and tunnel vision. New data indicate that the virus was present in the world before the outbreak in China. I predict a revolution in science, there will (must) be a new Paradigm. I also describe all new insights about the course and spread of the SARS-CoV-2, the intensity of the relatively small number of victims who are mild or severe. getting sick, the reasons why victims are from now more common at a younger age and the influence of smoker or non-smoker. A specific drug against SARS-CoV-2 simply does not exist (yet), but I do describe new trends for medication that may be active on parts of the disease. I conclude this document with the Intensive Care Unit, in my opinion doctors have too much influence here, the nurses lack autonomy and many more lives can be saved. The follow-up document "Let's breath again & Recognition of airborn spread" takes a closer look at more elements and especially the useful measures.

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SARS-CoV-2 false registration and the dubious importance of Money & Power.

Apparently, the sale of a vaccine has such great interests worldwide that the myth of a "deadly" SARS-CoV-2 virus is maintained at all costs. Nevertheless, the SARS-CoV-2 virus has an IFR = the infection fatality rate of only 0.1%, which represents the probability of dying from the infection.

SARS-CoV-2 is a completely non-life-threatening virus and to violate and vaccinate all humanity in their fundamental rights is completely madness.

Everyone remembers the disaster scenario with the many SARS-CoV-2 deaths in Italy, the overcrowded hospitals and rows of coffins. But also from my point of view I already clearly described (Outlook March 2020) that the global corona death statistics are not correct at all. . Well, in the parliaments of Italy (tens of thousands of "virus deaths) and the Netherlands (thousands of" virus deaths), the Italian health minister last month and the Dutch RIVM expert acknowledged last week that more than 99% of corona deaths are in reality did not die from this virus and that "only" 70 people died in the Netherlands without underlying diseases (of the more than 6000 "Corona deaths" in the Netherlands). Whoever reads the precise instruction from WHO: The "SARS-COV-2 Guidelines for Death Certificates and Coding" can understand the underlying reason for the high number of "corona" deaths in the world. So what is the instruction to all physicians and countries in the world in this WHO SARS guideline? The "SARS-COV-2/Covid-19 Guidelines for Death Certificates and Coding" provides precise instructions for determining when a corona death occurs. " SARS-COV-2 should not only be listed as the cause of death in deaths from the disease. Even if there is unconfirmed suspicion that the virus is a cause or has contributed to death, it still ends up in the corona statistics. Our Dutch general practitioners followed this instruction on the advice of RIVM also. A positive test result is not necessary for this. An exception is a death within two days of a serious motorcycle accident. However, if the victim dies later and is tested positive for corona, he will still end up in the daily SARS-COV-2 rates. In short, all people who die from any underlying disease are recorded as "Corona" dead, tested or untested, and any symptoms random.

Even if the doctors believe that this is incorrect from a medical point of view, they are still asked to register the "Corona" deaths as such. Everything in the interest of the comparison in international statistics, this is given priority for the WHO.

Nevertheless, in all countries, in addition to this instruction, many different other ways of registration are used. At the end of March I described this registration method and warned in my opinion document that the figures only serve to frighten the populations. Money and power are winning again and the world is plunged into misery as a result. (see my last chapter)

Incidentally, around July 1, 2020, after about 6 months, the counter on SARS-C0V-2 deaths is about half a million / 500,000 compared to the "normal number of deaths" in 6 months due to diseases in the world of 28,500,000 .

Also available on the WHO website and statistics do not include yet fatalities from famine and wars.

So the SARS-CoV-2 virus should not scare anyone and especially not panic to switch off your own feelings and slavishly follow all kinds of crazy measures. I will not deny that SARS-CoV-2 causes a temporary overload in healthcare, precisely because people and the elderly who are already ill are the most victims and die earlier than expected on the basis of their illness and / or age. That in itself is a sad truth. But .... precisely by preventing groups of people from gathering in interior spaces without good ventilation, it turns out to be the only successful and extremely simple measure to prevent such super spreading events and peak demand in healthcare.

In all sincerity, I hope that all governments and all stream media will finally declare the truth and stop spreading false information.

In this document I describe in detail all the findings and the reality of the past months.

I start with my vision on science, which really has to change, because how the hell did medical scientists managed to get the situation this far??

Science REVOLUTION NEEDED NOW! About Philosophers of Science Karl Popper, Thomas Kuhn and Lakatos

The general purpose of science is to discover objective truth, but scientists too are human beings and must realize that human knowledge is fallible. Particularly at this time, when scientific "experts" advise their governments (urgently), these governments must also realize that it can never be completely certain whether these "experts" have made a mistake. The "Experts" in WHO and Medical Task groups in all countries are also people who are under heavy pressure, who carry and feel heavy responsibility and from there hold on to the dogmas in which they have been trained in fear and (sometimes) panic. I would like to briefly summarize the phenomenon of this Corona time in the perspective of the philosophy of science, a theme that was of great importance to me in my own university studies.

First of all, there is Popper, this great 20th century philosopher, argued more or less that a theory would increase in force if that theory were tested in practice and falsified by evidence to the contrary. Then the scientist can immediately drop the theory and replaced by a better hypothesis. Popper described how scientists should behave. Philosopher Kuhn described how scientists behave in practice and was of a different opinion. Kuhn is the philosopher of the Paradigm, current science is the Paradigm of normal science, there is agreement and it is thought that there is progress. The Paradigm of science in crisis anomalies or inexplicable phenomena within the theory are openly recognized. And then finally a revolution in science leads to the New Paradigm, a new normal science, in which the validity of theories can only be within a context of other theories and experiments are demonstrated. Then the scientific philosopher Lakatos, who argues that it is not a question of whether a theory is true or false, but whether one research program is better than another. He argues that a research program consists of a theoretical core, a number of accepted experimental techniques and a collection of additional hypotheses. These additional hypotheses serve to "protect" the theoretical core of the theory from falsification. As long as a research program is progressive, it is rational for scientists to change the additional hypotheses (rather than reject the core theory) when faced with potential evidence to the contrary. So in a nutshell:

Popper's idea of science as a quest for theories with increasing falsifiability and Kuhn's idea of science as a succession of paradigms. Lakatos attaches importance to research / research programs to connect Poppers and Kuhn's idea

We need a new PARADIGMA in science:

We are in a normal science period during this Corona period. There is a paradigm of agreement between virologists (they are about the biology of the virus) and epidemiologists (they are about the spread of the virus), but at the same time a science crisis is emerging, there are demonstrably many anomalies mainly from other science disciplines , inexplicable and / or contradictory phenomena. These phenomena / demonstrable research results are demonstrated in many recent research programs (December 2019 - June 2020) in several different countries of the world, studies carried out by mostly other science disciplines, which are not involved with the "advising experts". The experts usually answer that: there is still insufficient evidence, there is no peer review fits, "only" one study, etc ... but ... if one had chosen to report these results in the time context of the corona virus to assess their value, there would not have been an economic crisis in my opinion! In the Corona period, fear, panic, political leaders and 'expert' advice only brought the world into a disastrous socio-economic crisis based on medical model thinking and the associated tunnel vision. Previously, scientific studies and experiments were mainly conducted and published from the Western world, such as the US, Europe, Canada and Australia. In this 21st century, the world has become increasingly global, but doesn't science seem ready to work together worldwide? Scientific research comes from, among others, China, Taiwan, South Korea, Hong Kong, they are appointed after long insistence, but are they treated? How come many highly relevant research results are completely ignored during this Corona era, results found and published by many disciplines such as nature biologists, sociologists, philosophers, social demographers, psychologists, psychiatrists and many more disciplines and from different countries around the world ??

Are our scientists only human and can there also be arrogance and discrimination in science?? Can those human characteristics influence opinions? ... I can't breathe??

I predict **a science revolution** that will take place very soon and that will lead to a new agreement **with a NEW PARADIGMA** in multidisciplinary science & interdisciplinary scientific cooperation in more global research and results = **a new normal science**, in which the validity of theories can only be demonstrated within a context of other theories and experiments from multiple disciplines.

More than is currently the case, science will also have to learn to cooperate from the Western World with the Eastern (Asia) World and the rest of the World.

What do we know in July 2020 that we did not know in November / December 2019 at the start of the outbreak?

About the distribution SARS-CoV-2: In spite of what the WHO, Task forces, political leaders and experts worldwide are clinging to: the 3 foot / 1.5 meter distance ... it makes no sense. Large drops fall to the ground in a second and do almost not contaminate once out of the air. The small droplets, on the other hand, float very slowly towards the ground. These aerosol mini-droplets are therefore much more dangerous when it comes to possible transmission of the SARS-CoV-2 virus. The infections mainly occur through super spreading events/ circumstances, of groups of people INDOOR in non or poorly ventilated spaces. The longer the group of people stays indoors together, the more likely those large amounts of aerosols are inhaled. The virus from one or more infected persons can settle directly in the lungs through talking, screaming, singing, coughing, sneezing and breathing. From the lungs, the virus can enter the bloodstream of humans and cause blood clots in the bloodstream and / or various organs.

The NL social geographer Maurice de Hond and others internationally (some virology and other disciplines), based on the collection of many (scientific) studies and results / findings of recent months, confirm this description above. Slowly (June 22), other official institutes are also getting confirmation, such as in Europe by ECDC (European Center for Disease Prevention), among others, and in Germany the Robert Koch Institute (after research into a major outbreak in slaughterhouse). And in a Science scientific article on June 26.

The use of air conditioning and cooling in closed and / or covered areas (for example in the tropics during windlasses before tropical rain showers) can also cause infections, even with small groups.

Total lock down of healthy people increases the risk of super spreading circumstances.

OUTDOOR in fresh outdoor air the risk of contamination decreases to almost nil, keeping distance and wearing mouth masks not imperative, but selective free choice for the people.

SARS-CoV-2 already present in the world before the outbreak in China?

A new fact: Tom Jefferson, epidemiologist at CEBM University of Oxford states that there is growing evidence that the SARS-CoV-2 virus was already elsewhere in the world before the outbreak in China. In the new waste water / sewer tracing method (see elsewhere in my document) virus traces have already been found in water samples in Spain from March 2019, in Brazil in November 2019 and in Italy in mid-December 2019, among others. Something similar happened earlier, in the history of the Spanish flu, a third of the inhabitants of the isolated Samoa Islands died without any contact with the outside world. One explanation could be that these viruses do not just appear or disappear, but that they are always dormant among us humans. Triggers can be environmental factors or the extent to which people live close to each other in large cities. The data also supports the indications that the virus can also be spread through human faeces. All these new indications will now focus on the ecology of the virus and what the triggers are and how mutations arise. The good news is that the SARS-CoV-2 virus can disappear as quickly as it reappeared, just like SARS-CoV-1, it just disappeared. This new fact also proves to my opinion once again, that developing a vaccine is completely absurd, nonsensical, wasteful of money and totally useless.

About the course of the disease SARS-CoV-2:

Risk groups: Elderly people aged 70 - 75 + years and older are the group with the most deaths, people who already suffer from and underlying disease such as high blood pressure, vascular heart disease, all kind of cancers, lung diseases, diabetes, neurological disorders and all kinds of other serious or already life-threatening syndromes. Furthermore, people who are overweight or have autoimmune diseases have an increased risk of becoming seriously ill. More generally, people who are not really in a healthy life balance. It is noteworthy that there are more patients with blood group A and fewer with blood group O, so this may also play a role. I note that there will probably also be victims of SARS-CoV-2, who themselves are / were ignorant of the fact that they are or are already sick, a person who has not (yet) been diagnosed with a clinical picture. That is of course difficult to determine and as far as I know there is no record of it, at least I have not found anything. In addition to the fact of

genetic factors, the foregoing may also explain the mortality among people under the age of 70, although these numbers are much less frequent. Remarkably, more men than women die from SARS-CoV-2. The vast majority of people infected with SARS-CoV-2 do not get sick at all. Only a few percent of people become mildly or seriously ill. In summary, 20 - 25% of people can become infected, 10 - 15% of those people belong to the risk group, and 1% of that group can become seriously ill from SARS-CoV-2. The case fatality rate / death rate of that last 1% group of seriously ill people is 0.1 - up to 0.4%.

So it is NOT a deadly SARS-Cov-2 virus.

With the exception of children and young people up to the age of 18, there is almost no chance of becoming infected or getting sick. It is still unclear how the infection progresses here, there are indications that SARS-Cov-2 can infect sick or infected adults possibly children / adolescents, not the other way around.

A new trend since mid-June as follows: After the outbreaks in China / Asia and Europe / Australia and New Sea land, the virus outbreaks there have now largely levelled off. The SARS-CoV-2 is now still roaring around in parts of the USA (North America), South America ,India and Arabic countries.

What is now striking as a new trend is that the fatalities ratio in addition to the elderly is now also more middle-aged and younger people.

In my opinion, the following 6 elements play a major role here:

1. The average age in these countries is lower; there are far more young people than older people;

2. The organization and quality of hospitals, the expertise of doctors / nurses in developing countries may be of a different standard from that in the western countries;

3. The accessibility of millions of people in the population to hospital care in these countries is not, if at all, more difficult, unlike in Western countries with national insurance and anyone with easy access to all forms of care. In the USA and in developing countries, if you cannot pay, you will not come to the hospital, you cannot visit a doctor or you cannot buy medicines;

4. So there are more younger people in these countries with underlying but still (unknown) health problems / underlying diseases;

5. The lifestyle of the (poorer) people is not so healthy, unhealthy eating style and less exercise. There are many overweight people;

6. In these countries, middle-aged people (40-50 years) may be equivalent to the elderly 70+ in Western countries;

Note: elements 3, 4, 5 and 6 are actually applicable in the USA!

Conclusion and my expected outcome: Both in the USA and in most developing countries, the trend towards more SARS-CoV-2 victims at an earlier age will increase in numbers and in proportion to older victims the rest of the year 2020.

Smokers & risk SARS-CoV-2. Another remarkable fact: More men than women die from the SARS-CoV-2 virus, a doctor who was interviewed in the Netherlands stated that men "simply smoke more". In my outlook at the end of March I already wrote that this assumption is nonsense to me. I myself worked as a nurse in a lung cancer department(1976), I am a smoker myself, I still smoke the same amount of tobacco, I was just curious at the time, so I conducted a survey myself to see how many lung cancer patients were smokers. To my surprise, only 20% were smokers and 80% of lung cancer patients were non-smokers (1976, n = 85, 6-month statistic).

Well, last month (May 19) publication in the Lancet: Study of a group at OXFORD University in (GB) and Pasteur Institute / University of Sorbonne (France), very reputable universities, examined the number of SARS-CoV-2 deaths which were smokers. They collected data from more than 20 countries in the world.

In most data (not all data), the outcomes of this study indicates that

1) The smokers among the victims of SARS-CoV-2 are underrepresented

2) One survey indicates that more than 90% of victims are non-smokers

3) No more smokers than non-smokers are victims.

Incidentally, if you google (SARS, Oxford, Sorbonne, nicotine), you will find a lot of contradictory research results, it looks like the smoking and anti-smoking controversy lobby in the world. Nevertheless, the assumption made from the

research I mentioned is that the protein (s) membrane in the cells, which serve as receptors for the SARS-CoV-2 virus, are disrupted by the nicotine. Smoking more or less disrupts the virus from attaching to the cells. The French University of Sorbonne will try to prove the hypothesis with an experiment with nicotine patches.

Serious course.

Lungs: To put it simply (without all medical terms), the contamination with the SARS-CoV-2 is by inhalation directly into the lungs. The virus binds to the lung (blood) cells, the lung cells now contain much more fluid, which can cause a lot of pressure in the lungs due to fluid accumulation. That is the severe shortness of breath, which can even become life-threatening. However, the virus can also spread from the lung cells into the bloodstream.

Heart & circulatory system: Many SARS-CoV-2 patients are seen, who have to do with the lung problems and / or with all kinds of symptoms of blood clots in the bloodstream. A variety of syndromes such as various heart problems, thrombosis, stroke and many more serious syndromes are described. These lung and circulatory disorders often require an acute hospital admission to the Intensive Care Unit and many complaints can lead to death.

Mild course.

There are infected people who do not get sick at all (but can infect other people) and there are infected people who become less (mildly) ill. Mild turnover affects the majority (95% +) of the infected people.

Mildly ill mainly has the form with the symptoms: irritated throat, nose cold, tickly (serious) cough, headache, sometimes slightly stuffy, sometimes (mild) fever. The complaints disappear after a few days or weeks. However, in a part of the group of people who are classified as mildly ill, the mild symptoms are still more severe and longer up to several months, people are in home isolation, but often a normal hospitalization is also required. These people have really severe stuffiness from time to time, feverish, are very tired and lethargic, bedridden, unable to take a short action and can remain unbalanced for weeks to months. Sometimes hospital admission must still take place afterwards. Typical complaints of loss of taste and smell and more also occur in this group.

Medication simply put, there is no specific SARS medicine (yet)

Much attention in the world, which medicines work against this unknown disease of the SARSCoV-2 virus? However, it is unimaginable and in my opinion never before shown how much data about this new disease has become known worldwide in a short time. To speak with Johan Cruyf: every disadvantage has its advantage ... but medicines that work against this disease? There is still a lot of disagreement and discussion about this. There is simply no cure for SARS-CoV-2 yet. And Vaccine?

I will come back to this later, my personal opinion about a possible vaccine: no, don't.

Anti-viral agents: People speak of dexamethasone as an anti-viral drug, it seems to shorten the disease duration somewhat. In The Netherlands most recent experimental dexamethasone & immunity medicine combination results in less mortal SARS-CoV-2. Similarly, the anti-virus drug Remdesivir (Ebola virus drug) is now approved in Europe, but the USA has already bought up the entire world stock: where is the solidarity? It is also not a SARS-CoV-2 medicine.

However, I also read an examination of a number of doctors with the statement:

"What we are saying is that perhaps the best antiviral therapy is not actually antiviral therapy. Perhaps the best therapy is a drug that stabilizes the vascular endothelium. We are building a drastically different concept. "

A possibility of medication, based on their new understanding that the virus affects the circulatory system, are antihypertensive agents such as both statins and ACE inhibitors.

Malaria medicines such as (hydro) chloroquin have been written about nonsense enough, you have to make your own choice. The administration of the BMR vaccine (Tuberculosis) is also mentioned as a relief option.

From a nursing point of view, it seems to me that dehydration plays a major role and should be avoided. Yes and then the eating habits ... all the junk foods (McD, KFC, etc) from the USA all over the world, eating rice all day (3 times a day) and no vegetables in Asian countries, with widespread millions of Obesity people and children as a result ..... As prevention and increasing immunity, healthy eating and exercise (walking, cycling, swimming) is important, as well as consuming the necessary vitamins and especially zinc combinations in fruit and vegetables. But

that should be a lifestyle, start now? Oh well better late than never.....Me, I always tell people: You are what you eat and drink!

About the treatment at the Intensive Care in severe course

In the 1990s, at one of my conventions, I made the following statement, which I was not thanked for back then either:

The nurse diagnosis offers a greater guarantee for the correct estimate of the length of stay and healthcare costs for patients in the hospital in the event of illness than that the medical diagnosis can offer.

My personal opinion: When treating seriously ill SARS-CoV-2 patients in the intensive care unit, doctors decide too quickly to switch to artificial respiration of the patient. I believe this is due to the fact that ICs are run by medical managers and not by nurse managers. As a nurse, we know that artificial respiration is a last resort, and if the SARS-Cov-2 patient regains consciousness and can breathe independently, a (months) long rehabilitation is required afterwards.

Intensive Care, IC, especially DO NOT expand, (In the Netherlands) nonsense

Normally severely ill patients are on ventilation for only a few days or a week. SARS-CoV-2 patients are on ventilation for several weeks! The chance is then even greater that the patient will die afterwards during the long rehabilitation. Nurses know that in case of severe respiratory distress there are also alternatives available. There is also a circle bed, although that is difficult. In addition to applying oxygen, it is also possible to alternate between the abdomen, the side and the supine position. Especially in the prone position, the pressure of the lungs can be reduced and thus improve breathing, this is also not a pleasant position, so alternation should be used. That is more labour intensive, but you can train people shortly before, who can then apply these actions under the guidance of a nurse. I think this nursing approach could save many lives. And in my opinion ...

(The following applicable for The Netherlands, but maybe also in other (Western) countries) The nurses should oppose an Intensive care bed extension, which is a medical earning model of doctors in hospitals who are not salaried by that hospital! In the near future, it would be better to set up a regional emergency facility (s) that specialize in epidemic care and cure. This specialism is hardly discussed in current nursing education, GGD(ambulant) nurses mainly do vaccination programs. For

epidemic care only, you can train teams very quickly and effectively and then have the regular hospitals function as a Back up and not the Front line in the near future. That is more effective than expanding (too) expensive Intensive Cares in favour of the high-income earning doctors!. Last but not least: During the SARS lock down period, doctors were very concerned about the people with deferred care, people who did not dare to make an appointment because of the high SARS occupancy. The head of IC care in NL, another doctor, informed after the peak in the SARS recordings that the "production" is luckily starting up again. Well, this "production" = the number of people who come to the hospital for an appointment / treatment is still a particularly low number. What does that mean? The doctors want production so much, they earn per operation/act, because they are not salaried employees. Of course there will be people who will be treated late, they will now end up in hospital and ICUs with their care needs. But mainly it turns out that many people no longer have an acute demand for treatment. In other words: no treatment is also treatment, or our Dutch care has become so accessible that this ensures that too much is treated and that our care becomes unaffordable!

That is the reason for my urgent recommendation: Bring the nurse managers back and finally let the doctors work as employees and not as entrepreneurs in the hospitals !!