



Pro-life Healthcare Alliance

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PHA Monthly

*Newsletter for the Pro-Life Healthcare Alliance
Second edition*

Welcome to the second edition of PHA Monthly, the e-newsletter for the Pro-life Healthcare Alliance. This newsletter provides another opportunity for the PHA to share pro-life information about current healthcare issues, PHA events, contributions from members and other relevant information.

Please [share](#) your ideas and suggestions with us.

Visit our website at www.prolifehealthcare.org for more information.

HOSPICE AND PALLIATIVE CARE

By Ralph A. Capone, MD, FACP

Hospice historically refers to the medieval practice of hospitality to guests. The modern specialty of Hospice and Palliative Medicine inherits this tradition of caring. Caring is always possible, even when cure is no longer possible. Born from love, caring cherishes persons and provides for their comfort and ease. It would have been anathema to kill one's guests under one's roof. Sadly, things have changed. Today, both hospice care and palliative care can be and sometimes are inappropriately and unethically used to hasten patients' deaths. The June 2013 issue of Ethics and Medics contains an essay written by colleagues and myself which is a summary description of stealth euthanasia.* Stealth euthanasia is any process by which

death is hastened in a clandestine manner.

Hospice

The traditional role of hospice medicine is to provide end-of-life care to people who are terminally ill and have a limited life expectancy. Comfort, not cure, is the goal.

Let's consider current hospice care in the United States. Some hospices and health care professionals-knowingly or not-participate in stealth euthanasia. Practices include standard orders for the use of opioids (morphine) for all patients once enrolled in hospice, even if they are not suffering symptoms which opioids treat, e.g. pain and shortness of breath. At times, inappropriate dosages are used-dosages well beyond those necessary to control symptoms-which cause the patient to die more quickly than would occur naturally. This is either by healthcare professionals' willful intention-i.e. intending the patient's death-or by their (unacceptable) ignorance concerning the proper use of these drugs which results in the patient's death. Another practice that is employed to hasten death is sedation accompanied by withdrawal of food and fluids. The point is that not all hospices are authentically pro-life. One cannot assume that a particular hospice in our secular culture accepts the Christian teaching of the sanctity of all innocent human life and, correlatively, of the intrinsic evil of euthanasia. Some hospices have forgotten their historical rootedness in authentic hospitality.

Just as there are abuses in hospice care, there are abuses in palliative care. This is reason for vigilance in choosing those hospices and palliative care programs that are sensitive to and respect the value of life and the culture of life.

Palliative Care

Palliative care was defined by the Center to Advance Palliative Care in 2011 as "specialized medical care for people with serious illness. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness - whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. Palliative care ... is appropriate at any age and at any stage in serious illness, and can be provided together with curative treatment." Additionally, palliative care is a new medical specialty that works diligently to assess the patient in holistic terms using eight domains: medical, physical, social, psychological, spiritual, cultural, ethical and legal aspects of medical care. It is a team-approach for care to ensure patients' goals are met and their symptoms well-managed and, as defined, is concurrent with disease-specific "curative treatment."

A noteworthy landmark palliative care study by JS Temel (New England Journal of Medicine, August 2010) demonstrated that early palliative care in patients with non-small cell lung cancer who were also receiving standard chemotherapy (compared to patients who got only chemotherapy but did not receive palliative care) led to significant improvement in self-assessed quality of life and less depression. Also, these patients had less aggressive therapy at the end of life yet lived approximately two months longer than those who did not receive palliative care. Authentic palliative care has the potential to improve overall survival and reduce patients' suffering, i.e. what the patients assessed to be a better quality of life.

It is not genuine palliative care if there is a strong agenda of pushing for a quicker death.

Quality of Treatment Judgments vs. Quality of Life Arguments

Sometimes there is a recognition that the disease is no longer curable and, in those cases, following patients' wishes, withdrawal of therapies may occur. If this is done according to the Catholic Church's long-standing teaching, using the principle of ordinary and extraordinary means to preserve life, the patient or surrogate may request the removal of extraordinary means.

A comment about "quality of life" is also in order here. The judgment - explicitly stated or implicitly assumed - that someone may be better off dead is a judgment concerning the quality of life. Christians, however, recognize that life is pure gift and may never be qualified by any observer. No one may discard this gift as being somehow defective. Even the patient himself cannot morally decide to have his life ended because he considers his life not worth living.

However, the Church understands there are times when a particular form of treatment may excessively burden the patient. Here a very clear distinction is made between a quality of life argument and a quality of treatment judgment. In this case, the person who happens to be the patient may legitimately determine the quality of a particular treatment meant to preserve life. For example, the ventilator used in a patient with ALS may, at some point, become extraordinary. That is to say, when a particular treatment has become burdensome or disproportionate (more harmful than beneficial) to that person, he may decide to forgo that specific treatment. This is the case even if it is foreseen that his death will ensue. In this case, the patient-and the patient alone (or surrogate healthcare decision-maker)-is determining that a particular treatment is too burdensome for him or not beneficial for him. Note that this is not someone determining life has little or no quality, but rather that a treatment to sustain life has inadequate quality. As such, the treatment may be stopped. The intention, then, of the person/patient is to stop a burdensome treatment; it is not an intention to die. There is the clear distinction - and it makes a huge difference.

For both hospice and palliative care providers, there is no justification for making quality of life determinations about their patients' lives. This is an encroachment upon a personal experience that for many Christians is also sacred.

In a culture of death, where the sanctity and dignity of life are seen as extrinsic qualities, it is not surprising to find a growing number of health care professionals (and patients too) who speak about and use quality of life arguments as a tool to intend death. It is only a culture of life that enables the recognition of life's intrinsic dignity and holiness, as pure gift from the Creator. Life derives its value from God, not from any government, society, "enlightened" group of people, or healthcare provider. Therefore, the value of each person's life is inherent and each person's life is inviolable. No entity has the right to dispose of any innocent human life in the name of quality or compassion, and certainly not in the name of economics.

I would advise people to investigate the practices of any hospice or palliative care program, before enrolling in it, in order to assess whether it adheres to a "quality of life" or a "sanctity of life" ethic.

Ralph A. Capone, MD, FACP, is a board certified hospice and palliative care physician, a part-time consultant in palliative care at UPMC McKeesport, PA, a teacher of Catholic bioethics at St. Vincent College in Latrobe, a teacher in the physician-assistant program at Seton Hill University in Greensburg, and former hospice medical director for the Jewish

Association on Aging of Pittsburgh. He is also a member of the Pro-life Healthcare Alliance Working Committee.

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http://www.illinoisrighttolife.org/NCBC_EM_June2013%20The%20Rise%20of%20Stealth%20Euthanasia.pdf

POLST: What is it and why does the PHA oppose it?

Continued...

We began to explore this topic last month by defining POLST (Physician's Orders for Life-Sustaining Treatment) as a standard document that, when signed by a designated healthcare professional, dictates whether to withhold or administer certain treatments and/or care. Among other concerns, we warned that POLST (also known by acronyms such as MOST, MOLST, POST, etc.) is tilted toward influencing patients to refuse treatment and presents treatment options as if they are morally neutral, even though certain decisions may lead to euthanasia by omission.

This month, we highlight a new federal bill - the "Personalize Your Care Act" (H.R. 1173). Introduced by Representative Earl Blumenauer (D-Oregon) on March 14, 2013, it is described as a bill to "amend the Social Security Act to provide for coverage of voluntary advance care planning consultation under Medicare and Medicaid, and for other purposes." This bill resurrects Blumenauer's 2009 proposal (dubbed the "death panels" bill by opponents), but with a twist.

H.R. 1173 includes funding for promotion of POLST throughout the country. Section 3(a) would direct the Secretary of Health and Human Services to make grants for the purpose of (1) establishing statewide programs for POLST or (2) expanding or enhancing existing programs for POLST.

Section 1(b)(11)] declares: "A decade of research has demonstrated that physician orders for life-sustaining treatment effectively convey patient preferences and guide medical personnel toward medical treatment aligned with patient wishes." But evidence and common sense refute that claim. Consider:

(1) California Advocates for Nursing Home Reform (CANHR), a nonprofit advocacy group, conducted a survey of long-term-care ombudsmen in California. The resulting report states, "Many times, POLST forms will be accompanied by handouts meant to sway patient decisions. For example, on the POLST form, CPR is an available option. However, accompanying handouts describe how survivors of CPR may have broken ribs and brain damage and that those revived may only survive a short period of time afterwards. The handouts are clearly intended to convince patients or their representatives to forgo CPR."^[i] The bias against life-sustaining treatments in POLST literature does not foster truly informed consent. Informed consent requires that the patient also be told the possible benefits of treatment, such as recovery.^[ii]

(2) Alleged to be designed for use by terminally ill and chronically ill elderly patients who are near the end of their lives, POLST is now being recommended for people who may be expected to live for up to five more years. And New Jersey recently expanded POLST to any person who wishes "to make their preferences concerning life-sustaining treatment or

other interventions known in advance." POLST invites people to make the most consequential decisions of their lives based on future theoretical scenarios which cannot be foreseen with accuracy. Predicting what one will want or need in the future is guesswork. Informed consent requires that each medical decision be made in the context of a patient's present situation and be based on truthful and complete information presented in a way that patients, agents^[iii] and families can understand.

(3) CANHR also reported that 59% of surveyed ombudsmen found that POLST forms were "often" or "sometimes" signed by third parties, even when the nursing home resident had the capacity to make health care decisions.^[iv] Some state POLST forms do not require witnesses or even the patient's signature (e.g., Wisconsin, Oregon). How can we be certain that a POLST form reflects the patient's own treatment choices rather than someone else's choices?

(4) Sec. 1(b)(6) claims that POLST forms "complement advance directives." However, in some states, they override wishes expressed by patients in their advance directives or by their agents. If a POLST form and an advance directive conflict, the latest (usually POLST) often controls, even when the patient or agent did not sign the POLST.

POLST is not about ensuring that the medical treatment preferences of patients are known and honored. That can be accomplished by encouraging people to use an advance directive (medical power of attorney) to appoint someone they trust to make medical decisions for them in the event they become incapable of voicing their wishes.^[v]

POLST is not needed to cause treatment to be provided. A typical POLST form, such as the Colorado MOST (Medical Orders for Scope of Treatment), states, "Any section not completed implies full treatment for that section." Therefore, filling out a POLST form if one wants full treatment is unnecessary.

POLST is a vehicle used to manipulate patients to choose to limit or refuse treatment which they may need in the future. POLST poses a grave risk to the lives of vulnerable patients. That is why the PHA opposes POLST.

^[i] A SPECIAL REPORT, California Advocates For Nursing Home Reform (CANHR), Physician Orders for Life-Sustaining Treatment ("POLST") Problems and Recommendations, 2010.

^[ii] Chan, Paul, et al., "Long-Term Outcomes in Elderly Survivors in in-Hospital Cardiac Arrest," *New England Journal of Medicine*, 3/124/2013: Nearly 60% of elderly survivors who were resuscitated after cardiac arrest in the hospital were alive after one year. The study's lead author told the *New York Times*, "We shouldn't hold a nihilistic attitude toward resuscitating the elderly, given these results."

^[iii] "Agent" means a legal healthcare decision maker appointed via a patient's advance directive.

^[iv] A SPECIAL REPORT, ...

^[v] The PHA recommends the state-specific Protective Medical Decisions Document (PMDD) formulated by the Patients Rights Council. To order, phone 1-800-958-5678.

Case in Point

The Texas Advance Directives Law was amended in 1999 to allow physicians to refuse to provide life-sustaining treatment (including nutrition and hydration) which patients or their authorized decision-makers (agents) have requested. In a dispute, the hospital ethics committee makes the final decision. The usual outcome is that this hospital-appointed

committee agrees with the physician. The patient/family/agent then has only 10 days to try to arrange transfer to another physician and facility willing to provide the desired life-sustaining treatment.

This law is based on "futile care theory," the proposition that physicians and hospitals are entitled to refuse to provide medical treatment which they deem futile. Granted, healthcare providers should not be required to provide objectively useless or even harmful treatment simply because patients demand it. However, futile care decisions are often based on subjective criteria, such as quality of life judgments and cost of care. In other words, it's not the treatment that is considered useless; it's the patient.

The bottom line is that "futile care" laws give legal immunity from prosecution to physicians and hospitals that commit involuntary euthanasia by omission.

Willie

In March 2012, a family called Texas Right to Life pleading for help to save their father Willie's life. Willie went to a Houston hospital complaining of chest pains. The diagnosis was pneumonia, and, shockingly, leukemia. Surgery and chemotherapy were suggested. Before being sedated, Willie looked into his daughter's eyes and said, "Fight for me, baby. I ain't done living."

Armed with Willie's medical power of attorney, his family told doctors to continue treatment. The doctors decided otherwise. The hospital ethics committee met and told the family to move Willie out of their hospital within 10 days or treatment would cease.

Willie's family could pay for his transfer to another facility and he also had ample health insurance. A hospital social worker told them she would try to find another facility. As the 10-day deadline approached, she told them no facility would accept Willie and she could do nothing more. Too late, they realized that the social worker had painted a picture of a patient no hospital wants—one whose quality of life was gone, with no hope of recovery.

Finally, this desperate family turned to Texas Right to Life. The CEO of a hospital with a religious-sounding name was contacted, but refused to take Willie. A team of pro-life people contacted many attorneys to take the case and asked politicians to pull strings to save Willie's life. All were happy to try to help, but neither the law nor time was on their side.

Willie's family watched helplessly as, one by one, each treatment was stopped. He wasn't fed or given water. In a couple of days, Willie was dead.

Zachary

In 2012, 12-year-old Zachary suffered a gunshot wound to the head. Within 48 hours of arriving at Cook's Children's Hospital in Dallas, the conversation from the medical staff focused on the quality of his life if he did recover instead of the potential treatments and surgeries that would foster his healing and recovery. Even though Zach was seriously injured, his brain stem was not harmed and he was breathing on his own. A week after his injury, the hospital ethics committee decided to withdraw treatment. At the beginning of the ten-day countdown, the family discovered a DNR (Do-Not-Resuscitate) order in his medical records. The family brought the unwanted DNR order to the attention of the facility and it was revoked.

After being moved to another facility and receiving necessary treatment and surgeries, Zach recovered his ability to speak, see and walk, and his full cognitive abilities.

(Case descriptions were condensed from cases reported by Texas Right to Life.)

Take Action

In spite of heroic and persistent efforts made by pro-life organizations and individuals, the stark reality is that the healthcare system itself has become an ever-increasing threat to the well-being and lives of the preborn, the young, the old and the disabled and ailing of any age. The PHA is dedicated to renewing reverence for life within healthcare. For some excellent information about current and historical issues regarding abortion, contraception, euthanasia, stealth euthanasia, hospice, advance directives and other pertinent topics, please check out these resources.

[Join the Pro-Life Healthcare Alliance](#)

[Pro-life Healthcare Alliance](#)

[Hospice Patient's Alliance](#)

[Euthanasia Prevention Coalition](#)

[Patient's Rights Council](#)

[Read Stealth Euthanasia: Health Care Tyranny in America by Ron Panzer](#)

Attend one of the upcoming conferences listed below.

Pray for renewal of reverence for life. In particular we have designated Thursday as a special day of prayer for the mission of the PHA.

Announcements

Preventing Stealth Euthanasia Conference
Saturday, November 9, 2013 8am - 5pm
Benedictine University, 5700 College Road, Lisle, IL 60532

You do not want to miss this full-day conference that will focus on the expanding threats to human life for patients facing serious health issues, and offering steps to prevent this creeping stealth euthanasia. Get details and strategies from experienced speakers who have been working in response to this expansion of the culture of death. Become informed so you can effectively address these important life and death decisions.

Topics to be covered include:

- how to protect yourself with (and from) advanced directives,
- the role of and need for patient advocacy,
- why POLST forms are dangerous,
- fighting for infants who are threatened with euthanasia,
- recognizing quality hospice care versus the hijacked variety that hastens death,
- getting fully informed about organ donation

Our exceptional speakers include:

Peter Breen, executive director and legal counsel at Thomas More Society, Chicago

Julie Grimstad, LPN, director of Life is Worth Living and chair of the PHA

Bobby Schindler, Executive Director at Terri Schiavo Life & Hope Network

Mary Kellett, founder and president of Prenatal Partners for Life

Cristen M. Krebs, DNP, ANP-BC, Catholic Hospice Founder / Executive Director

Sponsoring organizations include: Illinois Right to Life Committee, Thomas More Society (Chicago), and Pro-life Healthcare Alliance

Nursing CEU's will be available.

Euthanasia Symposium 2013: Hope

November 8, 7:00 pm - 9:00 pm and November 9, 9:00 am - 5:00 pm

Renaissance Marriott Hotel, Toronto

We face many challenges world-wide. The Symposium speakers represent that reality.

Margaret Dore - Choice is an Illusion USA

Dr. Kevin Fitzpatrick - Euthanasia Prevention Coalition Europe

Amy Hasbrouck - Toujours Vivant-Not Dead Yet Quebec

John Kelly - Second Thoughts USA

Derek Miedema - Ottawa, ON

Dr. David Richmond - Euthanasia Debate New Zealand

Tim Rosales - Californians Against Assisted Suicide

Paul Russell - HOPE Australia

Dr. Peter Saunders - Care Not Killing Alliance UK

Alex Schadenberg - Euthanasia Prevention Coalition

And more.

More details at www.epcc.ca.

NOTE:

The Pro-life Healthcare Alliance wishes to bring conferences to locations in all parts of the United States and Canada, and eventually, the world. We invite you to work with us to make this happen. In 2014, we already have conferences scheduled in Des Moines, Iowa on March 29th and Minneapolis, MN on May 3rd.

DVDs of our first conference, "Imposed Death 2012," held in New Brighton, MN, June 2, 2012, are available from Human Life Alliance. To order, call 651-484-1040.

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1614 93rd Lane NE, Minneapolis, MN 55449
Tel 651.484.1040

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