Pro-life Healthcare Alliance

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PHA Monthly

Newsletter for the Pro-Life Healthcare Alliance
Eighteenth Edition

Welcome to the eighteenth 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.

PRO-LIFE HEALTHCARE ALLIANCE MISSION STATEMENT

Promoting and developing concrete "pro-life healthcare"* alternatives and advocating for those facing the grave consequences of healthcare rationing and unethical practices, especially those at risk of euthanasia and assisted suicide.

*"Pro-life healthcare" means medical care in which the life and safety of each person comes first, where each person receives medical care across their lifespan based on their need for care, regardless of their abilities or perceived "quality of life."

From the Chairman's Desk

I Will Not Serve! I Will Not Be Served!

Dr. Brian Kopp

The sexual revolution embraced a mindset that is best described by Jeremiah's phrase, "I will not serve!"

"Long ago you broke your yoke, you tore off your bonds.
'I will not serve!' you said."
- Jeremiah 2:20

Jeremiah attributes the declaration "I will not serve" to the people of Israel in their rejection of God. More generally, it is attributed to Lucifer in his refusal to serve the Creator-God and his desire to himself be worshiped. The phrase "I will not serve!" appropriately describes the sexual revolution's rejection of God and His moral law and the idolization of youth and unrestrained sexuality. The "I will not serve" mentality has strewn wreckage in its path.

There is a corollary to "I will not serve": "I will not be served!"

In Scripture, when Jesus talks about the Last Judgment, He says:
"For I was hungry and you gave me something to eat, I was thirsty and you gave me something to drink, I was a stranger and you invited me in, I needed clothes and you clothed me, I was sick and you looked after me, I was in prison and you came to visit me...Truly I tell you, whatever you did for one of the least of these brothers and sisters of mine, you did for me." - Matthew 25:35-36, 40

One can almost hear the lament:
"I will not be served because whatsoever you do to the least of His brothers that you do unto Him. I've always done everything for *me*. I've never done anything for Him. I'm not going to start now! I'm not going to humble myself. I will not allow anyone to do unto Him by letting them do unto me.

"I will not suffer. I would rather die. Now and in eternity, I will shake my fist in the face of God, spit in His eye one last time when I refuse my last meal, take my last pill, draw my final breath. My *last act* will be eternal rebellion and thus damnation."

This rejection of suffering short circuits the cycle of grace that comes both in serving "the least of these brothers and sisters of mine" and in being served as "the least of these." By humbling ourselves so that we may be served, those who serve us may attain Eternal Life.

The tip of the spear in the present battle regarding stealth euthanasia* is death by dehydration. In the vast majority of cases of stealth euthanasia, death occurs primarily due to withdrawal of fluids, leading to volume depletion, organ failure, shock, and death. The symptoms of dehydration are almost always masked by narcotic analgesics, sedatives and anti-psychotics. Stealth euthanasia is not just unethical and immoral, but also an obvious violation of the basis on which Jesus said we would be judged.

Today many are not only quietly acquiescing to the stealth euthanasia agenda, but are requesting the legalization of assisted suicide. The same generation that idolized youth and sex is refusing to bear the ignobility of sickness, old age and vulnerability.

Why accept natural death? Because, instead of final rebellion, it is final surrender. Acceptance of death at the time of God's choosing says:
"Please, Lord, let this cup pass me by. But not my will but Your will be done. If that means taking this cup of spoon feeding or tube feeding or IV hydration, Your will be done! If that means letting others care for me and giving up my radical autonomy, so be it! If that means letting others clean my face or behind,this, Lord, seems

too much to bear! But this too I accept. I am not sufficient unto myself. Without You, God, I am nothing.

"Your will be done. I humble myself and permit others to serve You in my person, in my weak and vulnerable and suffering body, in the ignobility of age and sickness. I accept that, where once I did for others, now I must permit others to do for me. Because I am one of "the least" now, and in Your providence You call forth the next generation to love and serve selflessly, I must swallow my pride. I am no longer the strong one, the warrior. I am now the one who needs protection. You call new warriors into the arena to protect me, feed me, clothe me, bathe me.

"I permit others to console Your heart by consoling and caring for me in my need. That alone makes it possible to bear my cross. Because in doing it for me, they do it for You."

Ultimately, the battle against euthanasia and assisted suicide is a battle for eternal souls--our own souls, the souls of those for whom we fight and for whom we care, and the souls of those who care for us.

** "Stealth euthanasia": hastening death by neglect or intention while pretending to provide appropriate end-of-life care.*

New Feature: Unexpected Recoveries

Some patients are prematurely declared dead or too far gone to benefit from medical treatment. Also, many patients are diagnosed to be permanently unconscious when, in fact, such diagnoses are sometimes mistaken. These patients actually may have a condition called locked-in syndrome, which means a person is aware of what is happening around him but is unable to move or communicate. Surprising and remarkable recoveries are frequently called "miracles." But, calling them "miracles" makes it too easy to brush aside the uncomfortable possibility that a substantial number of patients who are diagnosed to be dead or in an irreversible coma or so-called "persistent vegetative state" simply have no one looking for signs that they might be alive or aware. Worse yet, signs of life and/or awareness may be ignored. [Note: Belief that a person is permanently unconscious cannot and does not morally justify deliberately ending the person's life.]

In order to introduce you to people who have recovered after supposedly "hopeless" diagnoses, we will periodically feature the stories of these surprising survivors. Hopefully, these true stories will give you reason to pause before consenting to organ donation or accepting a medical prediction that a loved one will never recover consciousness.

This month, we feature **Kate Allatt**, a 39-year-old mother and wife and avid runner. Kate had a stroke in February 2010 and was placed on life-support at Sheffield Northern General Hospital (UK). She spent 10 days in a coma, but remembers hearing everything going on around her. She listened fearfully as medical staff talked to her family about removing her from life-support. "They thought I was in a vegetative state. I couldn't move a muscle. There was no signal I was in there," Kate said. As she began to recover, all she could do was blink once for "yes" and twice for "no." Her husband Mark, stated, "We had specialists and medical experts telling us she won't come home, she won't speak, won't walk, won't be able to even breathe or eat, and they have all been proved wrong." Amazingly, eight months after her devastating stroke, Kate was back on her feet and able to speak. Her experience led her to start a charity - Fighting Strokes - to help other people who have suffered strokes. She has also written a book, *Running Free*, published by Accent Press. [Sources: http://www.dailymail.co.uk/health/article-1390659/Mother-left-locked-stroke-year-walks-aisle-renew-wedding-vows.html; Steven Ertelt, "Mother in Coma Heard Everything, Was Scared They'd Turn Off Her Life Support," *LifeNews.com*, 10/20/14]

Non-Brain Death Organ Donation

Part One

By Nancy Valko, RN, ALNC

Most people who sign organ donor cards assume that they will be carefully diagnosed as "brain dead" before their organs are donated. That was generally true years ago, but a new non-brain death organ donation procedure was developed in the 1990s even though the language on organ donor cards did not change.

The current non-brain death organ donation policy started with ethics journal articles in the 1990s. At that time, it was called "non-heart beating donation" and promoted as a way to increase the supply of organs for transplant beyond the usual "brain death" organ donations. This was made possible by linking organ donation to withdrawal of treatment decisions from people considered hopelessly ill or dying but who did not meet the criteria for "brain death." This change in policy came in the wake of court decisions upholding the right to refuse treatment for incapacitated patients like Nancy Cruzan, a brain-injured woman said to be in a so-called "vegetative state."

Since Dr. George Isajiw and I presented the following paper in 2004, the term "non-heart beating organ donation" has been changed to "donation after cardiac death" (DCD) and now around 5% of organ donations are from non-brain death organ donors.[i] The numbers are expected to increase with organ donation policies such as the following:

In June 1996, the American Medical Association issued its opinion that non-brain death organ donation was ethical.[ii] Eventually, the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) required all hospitals to develop policies for DCD, effective January 2007, while the United Network for Organ Sharing (UNOS) proposed new bylaw amendments requiring all transplant centers and Organ Procurement Organizations (OPOs) to develop DCD policies by January 1, 2007.[iii]

Moreover, hospitals currently are being asked to report all deaths, imminent deaths and potential organ donor situations to the local organ procurement organization. Years ago, when only brain death criteria could be used, doctors themselves talked to families about organ donation. Now, many hospitals have policies that only trained organ donation representatives talk to families about donation. Such policies are said to increase the number of families consenting to organ donation.

In Part Two, I will discuss other strategies to increase the number of organ donations.

Nancy Valko, RN, ALNC, has been a registered nurse for 45 years and is a spokesperson for the National Association of Prolife Nurses (www.nursesforlife.org). A long-time speaker and writer on medical ethics and other health issues, she has a website at: http://www.wf-f.org/bd-nvalko.html.*She is also now a legal nurse consultant (www.valkogroupalnc.com).*

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[i] "The Challenge of Organ Donation After Cardiac Death," Matt Wood, *Science Life*, 02/20/2014; http://sciencelife.uchospitals.edu/2014/02/20/the-challenge-of-organ-donation-after-cardiac-death

[ii] "Opinion 2.157 - Organ Donation After Cardiac Death," AMA Code of Medical Ethics, issued 06/1996 and updated 06/2005; http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2157.page

[iii] "Donation After Cardiac Death: Analysis and Recommendations from the New York State Task Force on Life &the Law, 03/17/2007;http://www.health.ny.gov/regulations/task_force/donation_after_cardiac_death/docs/donation_after_cardiac_death.pdf

"Non-heart beating organ donation" and the "vegetative state"

By George Isajiw, M.D. and Nancy Valko, RN

Editor's Note: The following paper was presented by Dr. George Isajiw to the participants in theInternational Congress on "Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas," held in Rome March 17-20, 2004.

On May 23, 2003, the newspaper of the Archdiocese of St. Louis, the *St. Louis Review,* published an editorial stating that "the NHBD (non-heart beating organ donation) protocol is cruel and dangerous and does not meet standards of respect for human life" and called for an immediate moratorium on NHBD at all St. Louis hospitals.

Reaction was swift and critical. The *St. Louis Post-Dispatch* cited transplant surgeons and others who defended NHBD as a way to increase organ donations by taking organs from patients who "have little brain activity and are in a vegetative state with no hope of recovery and whosefamilies decide to discontinue life support."[1] Michael Panicola, vice president of ethics for the Catholic SSM Healthcare System, defended NHBD as "an opportunity for people to give the gift of life when they don't meet brain death criteria."

FACTS ABOUT NON-HEART BEATING ORGAN DONATION

For the past several years, a little-known but disturbing revolution has been occurring in organ donation. In the understandable but sometimes alarming zeal to obtain more organs, a new procedure called "non-heart-beating organ donation" has been quietly added to brain death organ donation in more and more hospitals in the United States and in other countries.[2] Here, we are referring only to so-called "controlled" NHBD protocols, although the "uncontrolled" NHBD protocols, which are used for patients who have failed resuscitation efforts, have their own set of ethical problems which overlap with "controlled" NHBD, such as cannulation for preservation of organs before consent can be obtained.

While brain death organ donation means that the person is legally dead but still has a heartbeat when organs are harvested, the potential NHBD patient does not meet the brain death criteria but is termed "hopeless" or "vegetative" soon after suffering a devastating condition such as a severe stroke or trauma, and while still needing a ventilator to breathe. Because of the legal acceptance of the so-called "right to die," families or other surrogates then agree to have the ventilator turned off, a "do not resuscitate" order is written, and, when the patient's breathing and heartbeat stops, the organs are removed.

In NHBD, the ventilator is usually stopped in an operating room while a doctor watches for up to one hour until the heartbeat and breathing stop. After an interval of usually just 2 to 5 minutes, the patient is declared dead and the transplant team takes over to remove the organs. A determination of brain death is considered unnecessary even though one of the inventors of the NHBD protocol, Dr. Michael DeVita, has admitted, "the possibility of [brain function] recovery exists for at least 15 minutes." Nonetheless, Dr. DeVita defends waiting only 2 minutes before harvesting the organs because he believes that the person is unconscious and, as he writes, "the 2-minute time span probably fits with the layperson's conception of how death ought to be determined."[3]

A recent article in the *New England Journal of Medicine* illustrates the disturbing lack of objective medical standards for withdrawal of ventilators.[4] This article, published in September of 2003, admits that no study was done to "validate physicians' predictions of patients future functional status and cognitive function," and the researchers did not ask doctors to "justify their predictions of the likelihood of death or future function."

With such subjective standards being used for withdrawal of ventilators, it should not be surprising that the potential NHBD patient will unexpectedly continue to breathe for longer than the usual one hour time limit required for the organ transplant to be successful. In these cases of failed NHBD, the transplant is then cancelled but, rather than resuming care, the patient is just returned to his or her room to eventually die without any treatment or further life support.

The recent case of Jason Childress illustrates the lethal problems with this non-treatment plan and the lack of objective medical or ethical standards for withdrawing ventilators.[5]

Jason is a young man who was severely brain-injured in a car accident and became the subject of a "right to die" case in which the judge ordered the removal of his ventilator two months after his accident. Against all predictions and because his tube feedings were not also stopped, Jason continued to breathe on his own and is now showing signs of improvement and receiving treatment. Ominously, the doctor's initial recommendation to withdraw the ventilator two days after his accident could have made him a prime candidate for NHBD since he would have possibly been too injured to breathe on his own that soon after his accident. The rush to declare patients "hopeless" or "vegetative" soon after illness or injury can thus deprive at least some patients of the chance of survival or even recovery.[6]

Some NHBD protocols do not even require that the donor be mentally impaired at all. For example, one ethicist wrote about the case of a fully conscious man with ALS who decided to check himself into a hospital, have his ventilator removed and donate his organs under NHBD criteria. The ethicist wrote, "An operating room nurse reported feeling that the procedure was 'Kevorkian-like'."[7]

CONCLUSION

Even more pressure to increase the use of NHBD is apparently coming in the US, even though the public has been kept largely uninformed about this new method of obtaining organs. For example, last November, an advisory committee to the US Health and Human Services department recommended that, in the future, all hospitals should establish policies and procedures to "manage and maximize" NHBD and also be required to "notify organ procurement organizations prior to the withdrawal of life support to a patient, so as to determine that patient's potential for organ donation."[8] Unknown to most of the public, hospitals are now already required to report every death to the local transplant organization even when tissue or organ donation is refused and, if enacted, this new proposal will put further pressure on medical personnel and distraught families.

Ironically, at the same time, new information is coming forward about these so-called "hopeless" patients who are considered potential NHBD candidates. A September 2003 article in the New York Times featured the work of Dr. Joseph T. Giacino and others with people who have had severe brain damage but who are now showing signs of "complex mental activity even after months or years with little sign of consciousness."[9] And, of course, there are many reported cases even in the media of brain-injured people who improve or even recover long after the doctors declared them hopeless.

Yet, even this may not be enough for some ethicists like Dr. Robert Truog, who recently proposed that "individuals who desire to donate their organs and who are either neurologically devastated or imminently dying should be allowed to donate their organs, without first being declared dead."[10] In other words, Dr. Truog wants to eliminate even the controversial NHBD protocol in favor of just taking organs from incapacitated or dying patients while they are obviously still alive.

Linking the so-called "right to die" with organ donation, as NHBD does, has truly opened a terrible Pandora's box. While organ donation can be a gift of life and a worthy goal, we must not allow the deaths of some people to be manipulated to obtain organs for others. The position of Cardinal Justin Rigali, now Archbishop of Philadelphia, who was at that time the Archbishop of St. Louis and who asked for an immediate moratorium and re-evaluation of NHBD, is eminently sensible and should be replicated worldwide.

George Isajiw, M.D. is based in Washington, DC, and is Internal Medicine Consultant to the Linacre Institute of the Catholic Medical Association. He is also past president of the Catholic Medical Association, USA.

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[1] "Archdiocese criticizes some organ retrievals," Deborah L. Shelton, St. Louis Post-Dispatch, 06/10/03.
[2] "It is difficult to determine whether other countries such as Holland and Japan adopt a uniform defensible template in their practice of controlled NHBD and information from the UK is also extremely limited as to the extent and nature of practice" from "Non-heart beating organ donation: old procurement strategy-new ethical problems," M. D. Bell, *Journal of Medical Ethics* 2003; 29:176-181.http://jme.bmjjournals.com/cgi/content/full/29/3/176
[3] "The Death Watch: Certifying Death Using Cardiac Criteria," Michael A. DeVita, MD, University of Pittsburgh Medical Center, Pittsburgh, Pa., *Prog. Transplant* 2001; 11(1):58-66, © 2001 North American Transplant Coordinators Organization
[4] "Withdrawal of Mechanical Ventilation in Anticipation of Death in the Intensive Care Unit," Deborah Cook, M.D., et al. *New England Journal of Medicine*, 09/18/2003;349 (12):1123-1132.http://content.nejm.org/cgi/content/short/349/12/1123
[5] "Jason Childress Still Breathing, Receives Proper Medical Care," Steven Ertelt, Editor, *LifeNews.com*, 09/25/2003. http://www.lifenews.com/bio58.html
[6] "Ethical Implication of Non-Heart Beating Organ Donation," Nancy Valko, RN, *Voices* magazine, Michaelmas 2002; XVII (3). http://www.wf-f.org/02-3-OrganDonation.html

[7]*A Primer for Health Care Ethics,* Kevin O'Rourke, O.P., Georgetown University Press, 2000, p.182
[8] US Department of Health and Human Services Advisory Committee on Organ Transplantation, Recommendations to the Secretary, 11/2002. http://www.organdonor.gov/acotrecsbrief.html
[9] "What if There Is Something Going On in There?" Carl Zimmer, *New York Times,* 09/28/03
[10] "Role of brain death and the dead-donor rule in the ethics of organ transplantation," Robert D. Truog, MD, FCCM and Walter M. Robinson, MD, MPH, *Critical Care Medicine Journal*, 09/2003; 31(9):2391-2396

PHA SPEAKERS' BUREAU

The following members of the Pro-life Healthcare Alliance are available to speak anywhere on the healthcare topics indicated. If you are planning an event, please consider inviting one or more of these excellent, well-informed speakers on crucially important matters of life and death. Call 651-484-1040 or emailreverence4life@prolifehealthcare.org

William (Bill) Beckman, retired Executive Director, Illinois Right to Life:*"Choosing Advanced Directives and Scope of Medical Treatments (including a focus on the Catholic perspective)," "Dangers of Hospice Care (including real life case examples)," "Brain Death and Organ Donation," "The True Agenda of Planned Parenthood," "ObamaCare Threats to Religious Freedom," "Stem Cell Research," "Pro-Life Activism"*

Ralph A. Capone, MD, FACP (University of Pittsburgh School of Medicine) is board-certified in Internal Medicine and Hospice and Palliative Medicine with over 30 years of clinical experience and an abiding interest in American bioethics, its impact on the medical profession and on society:*"Patient Virtue in Healthcare Decision-making"*

Elizabeth Graham, Director, Texas Right to Life since 1998, has experience in public policy on the myriad life issues, patient advocacy and guiding patients and families on life-affirming health care decisions, and helping pregnant women, and has spearheaded the passage of historic prolife legislation in Texas: *"Death Panels in Texas," "Denial of Treatment," "Futilitarianism"*

Julie Grimstad, Executive Director, Life is Worth Living and former Chair of the PHA, has been a pro-life patient advocate for 28 years: *"The Urgent Need for Patient Advocates and Befrienders," "Medical Decision Making/Advance Directives and POLST," "Medical Futility: Quality of Life v. Sanctity of Life," "Brain Death, Organ Donation and Transplantation"*

Mary Kellett, Executive Director, Prenatal Partners for Life: *"A Poor prenatal diagnosis," "Prenatal Testing," "The Gift of a Child with Special Needs," "Prenatal Hospice," "Peter's Story," "Euthanasia in Children with Special Needs," "Pressure to Abort Children with Special Needs," "Pressure to Not Treat Children with Special Needs"*

Cristen Krebs, DNP, ANP-BC, Catholic Hospice Founder / Executive Director, is a graduate of Robert Morris University's Doctor of Nursing Practice Program with twenty years of end-of-life care experience: *"Pro-life Hospice and Palliative Care," "End-of-life Care and Challenges," "Fraud in Hospice," "Misconceptions of Hospice Care/ What to look for when choosing Hospice Care"*

Mark Davis Pickup, Human Life Matters: *"I Am More Than My Disability," "Suffering, Disability, and the Sanctity, Dignity and Equality of All Human Life," "Abortion, Euthanasia, Assisted suicide," "Ethics Pertaining to End of Life Care," "Bioethical Issues," "Grief"*

Alex Schadenberg, International Chair, Euthanasia Prevention Coalition: *"Euthanasia," "Assisted Suicide," "Eugenics," "Eugenic Euthanasia," "Disability and Euthanasia"*

Jo Tolck, Executive Director of Human Life Alliance (an international pro-life organization based in Minneapolis, Minnesota), has been actively involved in the pro-life movement since before Roe v. Wade and was a founder of the North Side Life Care Center: *"'Non-persons': From Abortion to Euthanasia"*

Nancy Valko, RN, Advanced Legal Nurse Consultant, spokesperson for the National Association of Prolife Nurses and past president of Missouri Nurses for Life, has been a nurse for 45 years working in such specialties as critical care, hospice and home health, dialysis, and oncology: *"The Dark Heart of Euthanasia - Selling Death," "Whatever Happened to Common Sense at the End of Life?," "Then and Now - The Descent of Ethics," "Are Pro-life Healthcare Providers Becoming an Endangered Species?," "The War Against Children with Disabilities,"* as well as numerous other titles addressing assisted suicide, bereavement, organ donation, etc.

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.

The Pro-life Healthcare Alliance needs your support. The suggested PHA membership donation is $25 per year. Please renew your membership or join today. Be a part of this vitally important work and help the PHA continue and grow.

Join the Pro-Life Healthcare Alliance

Pro-life Healthcare Alliance

Hospice Patient's Alliance

Euthanasia Prevention Coalition

Patient's Rights Council

Prenatal Partners for Life

Read Stealth Euthanasia: Health Care Tyranny in America by Ron Panzer

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.

STAY CONNECTED

Pro-life Healthcare Alliance

a program of Human Life Alliance
1614 93rd Lane NE, Minneapolis, MN 55449
Tel 651.484.1040