Pro-life Healthcare Alliance

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PHA Monthly

Newsletter for the Pro-Life Healthcare Alliance
Nineteenth Edition

Welcome to the nineteenth 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

By Dr. Brian J. Kopp

The "big news" in the pro-life battle this month is the Canadian Supreme Court's dreadful decision in ***Carter v. Canada***. The Justices unanimously overturned Canada's criminal statute which stated that "every one who (a) counsels a person to commit suicide, or (b) aids or abets a person to commit suicide, whether suicide ensues or not, is guilty of an indictable offence." The Court also overturned its own 1993 decision in ***Rodriguez v. British Columbia*** that the "long-standing blanket prohibition [of assisted suicide] in s. 241

(b), which fulfills the government's objective of protecting the vulnerable, is grounded in the state interest in protecting life and reflects the policy of the state that human life should not be depreciated by allowing life to be taken." The Court in *Rodriguez* also found that this prohibition "has never been adjudged to be unconstitutional or contrary to fundamental human rights."

The Court flip-flopped in *Carter v. Canada*, stating, "Section 241 (b) and s. 14 of the Criminal Code unjustifiably infringe s. 7 of the Charter [i.e., Canadian Charter of Rights and Freedoms] and are of no force or effect to the extent that they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition."

Through its decision in *Carter v. Canada* the Supreme Court has thrust Canada into a rogues' gallery of nations that includes Belgium, the Netherlands, and Switzerland in allowing assisted suicide as well as direct euthanasia. (The *Carter* ruling will permit "physician-assisted death," a term broad enough to encompass direct euthanasia.) Also holding the dubious distinction of having legalized assisted suicide are the American states of Oregon, Washington, and Vermont.

Unfortunately, the assisted suicide battle here in the States is heating up. While legislators in Colorado voted down assisted suicide legislation earlier this month, Compassion & Choices and its allies plan to target 14 or more states for assisted suicide legislation in 2015. They are riding a crest of PR momentum as a result of their shameful exploitation of the Brittany Maynard case last fall.

Frankly, deaths by assisted suicide represent a relatively small number of premature deaths in our current healthcare system. As stated in the October 2013 PHA Newsletter:

> Of the 1.5 million who die annually under hospice care or palliative care, a growing number are dying premature deaths due to "stealth euthanasia," primarily via over-medication, terminal sedation and withdrawal of hydration and nutrition. Furthermore, hospice Medicare fraud is soaring. Most of the large corporate hospice providers have been accused of millions, and in some cases billions, of dollars in insurance fraud, often certifying patients for hospice care who were not actually dying, while profit-driven negligence in patient care has hastened the deaths of many. Because death records never list overmedication, terminal sedation, deliberate dehydration or neglect as the immediate cause of death, it is very difficult to obtain concrete data regarding the number of those dying in such circumstances.
>
> However, having spoken with pro-life leaders in the end of life care field, I think it is safe to say that the numbers are not small and that they are increasing rapidly. A very conservative estimate would be that about one out of five patients under the care of the hospice and palliative care industry are caused to die premature deaths at present. That is 300,000 deaths by stealth euthanasia yearly. Many in the hospice and palliative care field are trying to make terminal sedation the standard of care. Those who are terminally sedated cannot take food and water, and the end of life care industry rarely provides assisted nutrition and hydration. As terminal sedation becomes more prevalent, the number of those dying by euthanasia will increase steadily.

The cultural acceptance of stealth euthanasia over the past several decades has made the legalization of assisted suicide that much easier. The numbers of assisted suicides, though small in comparison, will rise every year with more and more people finding self-killing with a doctor-prescribed lethal dose acceptable, and more and more states legalizing assisted suicide.

So, between assisted suicide (which, undoubtedly, will be suggested to patients whose care is costly and/or who are suffering from depression) and stealth euthanasia (which is done usually without the patient's request or consent because the patient's life is considered not worth living or too costly to sustain or for other reasons of greed), planned death is now and increasingly will become the final solution for many

people.

These changes are truly frightening. It won't have to be a terminal condition that seals our fate. It will only take a stroke, brain injury, mental illness or dementia, old age and incontinence, any "incurable" chronic condition, etc. to qualify us for the final solution. And if we fail to join the battle against this juggernaut, we will only have ourselves to blame when it crashes upon our own friends, our families and ourselves.

Available now!

10 QUICK REASONS FOR OPPOSING THE LEGALIZATION OF ASSISTED SUICIDE

For your copy contact Human Life Alliance at feedback@humanlife.org

Case in Point: Still Knitting at 109

By Julie Grimstad

This is not our usual kind of Case in Point, but it's worth noting that Alfred "Alfie" Date, 109, is Australia's oldest living person and still using his talent to serve others. Alfie taught three generations of his family to knit and continues to knit scarves for friends and beanies for premature babies. He has recently put his talent to work making sweaters for penguins affected by oils spills off Australia's southeastern coast. Oil separates and mats the penguins' feathers, letting cold water seep in and chill them. The sweaters help keep them warm and prevent them from preening their feathers and swallowing oil. Alfie's nurses in his long-term care home asked him if he'd help a few penguins and he got to work. A self-described "sucker," Alfie says, "I can't say no."[1]

One of the reasons Alfie Date's story struck me is that it contrasts so drastically with an essay I read recently which made me cringe: "Why I Hope to Die at 75: An argument that society and families-and you-will be better off if nature takes its course swiftly and promptly." Just the title is scary. The author, Dr. Ezekiel J. Emanuel, is a highly influential man, which is even more troubling. Emanuel is an oncologist, a bioethicist, and a vice provost of the University of Pennsylvania. He is also the author or editor of 10 books, including Reinventing American Health Care.

Emanuel explains his hope to die at 75 by declaring that "living too long" is a loss. "It robs us of our creativity and ability to contribute to work, society, the world."

Tell that to Alfred Date.

[1] Nadine Kalinauskas, "Australia's oldest man knits sweaters for oil spill-affected penguins,"https://ca.news.yahoo.com/blogs/good-news/australias-oldest-man-knits-sweaters-for-oil-203500628.html
[2] Ezekiel J. Emanuel, "Why I Hope to Die at 75,"http://www.theatlantic.com/features/archive/2014/09/why-i-hope-to-die-at-75/379329/

Non-Brain Death Organ Donation

Part Two

By Nancy Valko, RN, ALNC

Although non-brain death organ donation started over 20 years ago, it is mostly unknown to the general public who sign organ donor cards assuming that they will be carefully diagnosed as "brain dead" before their organs are harvested. (See "Non-Brain Death Organ Donation, Part One," *PHA Monthly*, January 23, 2015.)

Originally called non-heart beating organ donation (NHBD), and later DCD (donation after cardiac death), it is now called donation after circulatory death (also DCD) because donor hearts can sometimes be restarted for transplantation. I call it non-brain death organ donation because "brain death" criteria are not used.

In March, 2011, the Organ Procurement and Transplantation Network (OPTN) published proposed policy rules on non-brain death organ donation and opened its website for public comments. Despite many critical comments and an article in the Washington Post titled "Changes in controversial organ donation method stir fears"[1], the OPTN has now finalized some very dismaying standards.[2]

In one of the most disturbing sections, "Consent for DCD", the OPTN states that "Conditions involving a potential DCD donor being medically treated/supported in a **conscious mental state**will require that the OPO (organ procurement organization) confirms that the healthcare team has**assessed the patient's competency and capacity to make withdrawal/support and other medical decisions."** [Emphasis added.] There is no mention of evaluation for depression or other difficulties that may influence the person's decision, which omission obviously could lead to a new form of assisted suicide.

The OPTN policies also state that "Any planned withdrawal of life sustaining medical treatment/support will be carried out in accordance with hospital policy." Even the guidelines suggested in the two Institutes of Medicine reports on non-brain death organ donation, like waiting a minimum 5 minutes (after cessation of the donor's breathing and heartbeat) before harvesting, have been generally jettisoned in favor of locally decided rules. As the OPTN admits, its policies "...set the minimum requirements for DCD recovery but do not address local practices, cultural and resource issues..." Thus, like brain death criteria, the rules surrounding non-brain death donation can potentially vary even from hospital to hospital without the patient or family even being aware. And as 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."[3]

Another major problem is that, even though doctors screen such patients for a rapid inability to continue breathing without a ventilator, at least an estimated 20 per cent of non-brain death donors do not stop breathing and heartbeat fast enough after withdrawal of a ventilator to have usable organs. These patients are then just returned to their rooms to die without further treatment.[4]

How can doctors be so wrong in some cases? Could such patients potentially improve? A 2003 article in the New England Journal of Medicine illustrated a disturbing lack of objective medical standards for withdrawal of ventilators even outside an organ donation decision. This article admitted that no study was done to "validate physician 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."[5]

These are just a few of the criticisms of non-brain death organ donation that have been raised by ethicists, doctors and other concerned people.

Informed Consent

How many people know the Uniform Anatomical Gift Act was revised in 2006 to include "first person" authorization when a person signs an organ donor card or other legal donation document that "not only continues the policy of making lifetime donations irrevocable but also is restated to take away from families the power, right, or authority to consent to, amend, or revoke donations made by donors during their lifetimes."[6]?

With the discussion about problems with non-brain death organ donation absent in mainstream media, what can you do to protect yourself from a potentially unwanted organ donation?

First of all, know the facts. It is necessary to do your own research since fact sheets often provide only minimal information when you sign an organ donor card while you are renewing your driver's license or checking off a box in your advance directive. Therefore, you may not be giving the truly informed consent such a momentous decision requires.

Keep informed about new strategies being proposed such as "presumed consent" which is the assumption that everyone is willing to donate his/her organs unless there is evidence that they would not want to donate. Illinois narrowly avoided a "presumed consent" statute a few years ago.

However, there are alternative ways to donate that people who are uncomfortable with brain death and/or non-brain death donation might consider. One is becoming a living organ donor for a kidney or part of the liver. While there are risks to such a surgery for the donor, living organ donation avoids the ethical concerns about determining death. Another alternative is donating tissues like bone or corneas that can be taken even hours after death is certain. This can be discussed with family or put in writing.

Also, there is hopeful medical research involving adult stem cells to repair organs and building artificial organs that may someday replace the organ donation we have now.

Having a daughter-in-law who currently needs a living donor kidney transplant, I am aware of how much such a "gift of life" can mean, but I believe it should not be at the expense of ethics or informed consent.

About the author: **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).

FOOTNOTES

[1] "Changes in controversial organ donation method stir fears" by Rob Stein. Washington Post, September 19, 2011. Online at: http://www.washingtonpost.com/national/health-science/changes-in-controversial-organ-donation-method-stir-fears/2011/09/15/gIQAlY9agK_story.html
[2] Organ Procurement and Transplantation Network Policies. U.S. Department of Health & Human Services. Current as of 2/1/2015. Online athttp://optn.transplant.hrsa.gov/ContentDocuments/OPTN_Policies.pdf
[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] "Organ Procurement after Cardiocirculatory Death: A Critical Analysis", Mohamed Y. Rady, MD, PhD, Joseph L. Verheijde, PhD, MBA, and Joan McGregor, PhD. Journal of Intensive Care Medicine. September/October 2008, available online at http://jic.sagepub.com/cgi/reprint/23/5/303.pdf
[5] Withdrawal of Mechanical Ventilation in Anticipation of Death in the Intensive Care Unit" by Deborah Cook, M.D., et al. New England Journal of Medicine, Volume 349:1123-1132, September 18, 2003, Number 12. Abstract available online at: http://content.nejm.org/cgi/content/short/349/12/1123
[6] UNIFORM ANATOMICAL GIFT ACT was revised in 2006 and updated in 2009. Note this quote from REVISED UNIFORM ANATOMICAL GIFT ACT (2006), page 30. Online at:http://www.uniformlaws.org/shared/docs/anatomical_gift/uaga_final_aug09.pdf

An Unforgettable Pro-life Nurse: Joyce Terry, RN, BSN (1923-2014)

Reflections by Mary Senander

Few live as fully or make such an impact as this particular prolife nurse. While the first half of Joyce Terry's life was fascinating and full, it was her second half that most inspired and amazed me.

I met Joyce in 1987 at the first White Rose conference hosted by the [then] International Anti-Euthanasia Task Force in Steubenville, Ohio, which assembled prolife thinkers and activists to address euthanasia, assisted suicide, advance directives, disability rights, pain management, etc. At a time when most people are retiring, she was just gearing up. I was struck by her no-nonsense persona-the efficient, almost brusque demeanor of an experienced nurse-but also her considerate, open and enthusiastic approach to learning and building relationships. Through the years, I would be awed and inspired by the ways she reflected-and applied-her commitment to life, faith and family. But she would have been embarrassed by such talk. Above all, she was a humble servant.

Joyce grew up in Minneapolis. She received her RN and BSN from the University of Minnesota, then worked at the university as a head nurse in surgery. Her adventurous spirit led her to move to the west coast to serve as a head nurse, then as an instructor. A year or so later, she and a friend "played and worked" in Honolulu for two years. Upon returning to California, she worked on a research project at UCSF until she found the opportunity to be a ship's nurse on the S.S. Gordon, a former troop ship. She again sailed to Honolulu...then to Okinawa, Yokohama and Hong Kong. Long story short: She married the ship's navigator, adopted two children, went back into nursing education, became involved in Bible Study Fellowship, and later divorced.

At age 50-and this, for me, is when the "story gets really good"-she returned to UCSF to earn her master's in geriatrics. In 1983, she went to England to visit and learn about hospices, and then taught hospice classes for several years.

But it was in the 1990s that this woman, now in her 70s, really started to soar. After the Iron Curtain fell, she went to Russia with the Josh MacDowell ministry to distribute Bibles-which, in turn, opened doors for her to make return trips for teaching missions to Estonia and Ukraine. She considered these seven trips (seven!), or as she called them "jaunts," to be the highlight of her nursing career. I remember when she was scouting for contents-past-date medicines and nursing supplies, toys and nail polish, and more-to fill an entire shipping container for one trip. Even if the meds could no longer be used in the U.S., they were better than what these former Soviet countries could offer their sick and dying.

Her eyes would reflect deep sorrow when she talked about how their elderly and dying were "warehoused" in drab and dreary institutions-an ongoing social and economic oppression of sorts which would require long-term economic, cultural, educational and faith changes. But, oh, how her Irish eyes would sparkle when she recalled how the patients would "come alive" through simple interactions with a volunteer who painted their fingernails or introduced music (rather common activities in American nursing homes, but strange there). Language was no barrier; hers was the language of love...and of Jesus. She delighted in telling me about one old man who pulled himself from his wheelchair and literally danced with joy.

Horrified to discover that basic pain relief and comfort care were neither understood nor practiced, this consummate nurse instructed Estonian and Ukrainian caregivers on practical nursing skills. Trip after trip after trip.

Summarizing this time in her life, Joyce wrote, "What a delight to be where the Lord wants one to be, teaching what was necessary and appreciated, as well as telling about Jesus to those who had been denied freedom to worship for so many years." ("Delight" was one of her favorite words.)

In her 80s, she immersed herself in mentoring troubled young men in the Teen Challenge program, yet another opportunity to share a faith that was born during her own teenage years when a Sunday school teacher introduced her to Jesus. And for as long as I knew her, she never stopped accepting (perhaps engineering!) speaking opportunities at churches, schools and civic groups, to share the message of Life.

Joyce understood spiritual warfare and the need to be grounded. I'll always be grateful for her special care of me after I'd spent several intense days in the midst of an international "right to die" conference-an "enemy camp"-in 1988 in San Francisco. She recognized (before I did!) my need for R&R before transitioning back to "real life." She picked me up at the hotel and then, with a hug and a prayer, dropped me off at a Franciscan priory where she'd arranged for me to stay for 24 hours of sleep, quiet and prayer. Afterwards, she took me to her Concord, CA, home for lunch (no surprise: it was filled with books and videos!) before taking me to the airport. Whenever she came to Minnesota (where I lived) for a family or class reunion, we'd meet, relishing that, despite the ugliness of the battles which brought us together, God had consoled us with a lasting friendship.

Joyce Terry saw Jesus in every person she met: the belligerent young man trying to lift himself from a life of addiction or crime, the student nurse facing difficult choices, the elderly dying and those who are disabled, alone or in pain, the distraught mother facing an unplanned pregnancy, the careworn father struggling to make ends meet for his family, the battered woman, the spiritual seeker. An American patriot, she was a relentless prayer warrior, that our country would experience spiritual and cultural renewal and protect human life from the womb to the tomb.

Joyce passed away peacefully on November 18, 2014, body weary but surrounded by beloved family and friends. Her family shared words she wrote before she died: "Thank you, Lord, for so many great experiences, and for Your Word and Your promises for the days and months to come!"

Amen!

About the author: Mary Senander joined the Right to Life movement in 1970 when the legalization of abortion was being considered at the Minnesota legislature. Within weeks after the Roe vs. Wade decision, she gave her first talk on euthanasia, a topic she'd followed since writing a high school term paper on it. Among the first in the prolife movement to connect abortion to end-of-life issues, she eventually became an internationally recognized writer, speaker and resource. She also co-founded Human Life Alliance of Minnesota and the International Anti-Euthanasia Task Force. In 2001, she joined the corporate world where she continues to apply communication and marketing skills honed by more than 30 years of prolife activism. She currently lives in Arkansas with her husband, Alan.

Editor's Note: Joyce Terry was a generous source of encouragement and a trusted mentor as I developed my patient advocacy "skills" in the 1980s and 1990s. A pioneer in the concept of creating pro-life medical care and an exceptional pro-life nurse and educator internationally, Joyce is a model for those of us who, today, are striving to renew reverence for life within healthcare. Upon receiving the news that Joyce had died, I asked Mary Senander, my former writing partner, to pen a tribute to our mutual friend. The beautiful memories Mary shares by no means tell the whole story of this selfless woman who dedicated her life to the service of God and the most vulnerable of His children. For that, we would need to write a book. - Julie Grimstad

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

Prenatal Partners for Life

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

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.

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

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