Pro-life Healthcare Alliance
A Program of Human Life Alliance

March 21, 2014

PHA Monthly

Newsletter for the Pro-Life Healthcare Alliance
Ninth Edition

Welcome to the ninth edition of PHA Monthly, the e-newsletter for the Pro-life Healthcare Alliance. This newsletter provides an 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.

The Pro-life Healthcare Alliance, founded in June 2012, is striving to:

- Establish a support network of healthcare providers, organizations and individuals who subscribe to the "pro-life healthcare philosophy." (See PHA Mission Statement at www.prolifehealthcare.org.)

- Encourage the growth and availability of pro-life healthcare services for all.
- Respond to persons needing pro-life healthcare or seeking reliable information about medical decision making.
- Educate the public by articulating principles guiding the care, support, and protection of the life and dignity of all human beings, including those who are preborn.

As always, we continually pray for renewal of reverence for life within healthcare. In particular, we have designated Thursday as a special day of prayer for the mission of the Pro-life Healthcare Alliance. St. Paul tells us in Philippians 4 to "not be anxious about anything, but in everything by prayer and petition, with thanksgiving, present your requests to God." We invite you to join us each Thursday by pausing to ask God to guide and bless the PHA and all its members and supporters. Thank you.

The First National Symposium on

EUTHANASIA AND ASSISTED SUICIDE

Friday and Saturday, May 2-3, 2014
Minneapolis, Minnesota
Register Early- Seating Limited

The Euthanasia Prevention Coalition and the Pro-Life Healthcare Alliance are excited to announce this 2-day event hosting a line-up of exceptional speakers covering a wide range of end-of-life topics.

Alex Schadenberg, Executive Director, Euthanasia Prevention Coalition, will speak about *Exposing Vulnerable People to Euthanasia and Assisted Suicide*and *Euthanasia World Overview* as well as leading the Coalition Building Workshop.

Julie Grimstad, LPN, Executive Director of Life is Worth Living and chair of the Pro-life Healthcare Alliance, will speak on *Medical Futility, Brain Death and Other Threats*. She will also be leading the Patient Advocacy Training.

Ryan Verret, Louisiana Right to Life, Center for Medical Ethics, will talk about*Playing Defense and Offense in Medical Ethics: What's Happening in the U.S.and how we took control of the ball in Louisiana!* He will also be leading in the Coalition Building Workshop.

Tim Rosales, Vice President, The Wayne Johnson Agency, a public affairs firm. Tim will be participating as a leader in the Coalition Building Workshop.

Jennifer Marie Hamann, RN, BSN, MHA former Executive Director of California Nurses for Ethical Standards, will share *Stealth Euthanasia- A Personal Experience*

Bobby Schindler, Executive Director of the Terri Schiavo Life and Hope Network, Will speak on *Media Ethics and The Bioethics Movement* and *The Terri Schiavo Case.*

Cristen M. Krebs, DNP, ANP-BC, Catholic Hospice Founder/Executive Director, will speak about *Poking Holes in the Darkness:Pro-life Hospice*.

Nancy Elliott, former New Hampshire State Rep., currently serving on the leadership team for Euthanasia Prevention Coalition,International, will discuss *State Sponsored Suicide: What it really is and how to effectively fight against it.*

Mary Kellett, founder and President of Prenatal Partners for Life, will discuss *Prenatal and Infant Euthanasia.*

Mark Davis Pickup, Pro-Life speaker, will share about *Grief and the Common Good*

Schedule

Friday May 2, 2014

1-5pm Coalition Building Workshop,Alex Schadenberg, Tim Rosales, John Kelley and Ryan Verret
1-5pm Patient Advocacy Training*,Julie Grimstad

7:00-9:00pm

Alex Schadenberg ***Exposing Vulnerable People to Euthanasia and Assisted Suicide***
8:10-9:00pm Bobby Schindler ***Media Ethics and The Bioethics Movement***

Friday-Nursing Continuing Education Units, 2

Saturday May 3, 2014 9-5pm with Registration beginning at 8:30am

Saturday-Nursing Continuing Education Units, 7.8

Ramada Plaza Minneapolis
1330 Industrial Blvd
Minneapolis, MN 55413
612-331-1900

Conference $50.00
Coalition building/leadership seminar $30.00
Patient Advocacy Training $20.00

Special room rates for this event
Room rate $85.00 per night
Mention Human Life Alliance

Register at www.imposeddeath.org or call 651-484-1040

*The Coalition Building Workshop will bring together people from around the nation to learn, strategize and organize against legalization of assisted suicide and other pro-euthanasia legislation. Hear from leaders who have effectively fought legislation in their own states.

*Patient Advocacy-Julie Grimstad has 28 years experience as a volunteer patient advocate. She says, "Being a patient advocate is an awesome privilege and a profound obligation. For some medically vulnerable people, we are their last friends. They need us like a person who is drowning needs a life-preserver."
You will learn:

1. What a volunteer patient advocate is.
2. What a patient advocate does.
3. Why there is an urgent need for an army of pro-life patient advocates

Even if you are not ready to be a patient advocate, you can simply be a friend. Julie will introduce you to the Befriender Program. Learn what you can do to enhance the quality of life of nursing home residents and other people isolated from society.

In the course of examining complex issues such as death with dignity and true mercy, Julie tells heart warming and heart wrenching stories about some of the people she has assisted as a patient advocate.

Come discover how you can safeguard the welfare of a patient in the healthcare system and/or alleviate the suffering of a lonely person whose number one need is a friend.

Scholarship Help Needed

Help us offer scholarships to students and healthcare workers who cannot afford to attend the First National Symposium on Euthanasia and Assisted Suicide.

We want to help people who are eager to learn and cannot afford the registration fees. Could you consider a gift of $50, $100, $75 or more to support our efforts?

Your donation will enable those who cannot afford the conference to attend and share this life-saving information in their own communities.

Please designate donations as "Symposium Scholarship Fund" and mail to Human Life Alliance, 1614 - 93rd Lane NE, Blaine, MN 55449 or call 651-484-1040

NEW HAMPSHIRE ASSISTED SUICIDE BILL IS DEAD

On March 6, 2014, the New Hampshire House of Representatives voted on HB 1325, a bill to enact an Oregon-style assisted suicide law in New Hampshire. Many people wrote letters to the New Hampshire Representatives in opposition to HB 1325, and the legislation was overwhelmingly defeated in a 219 to 66bipartisan vote.

Featured here is the noteworthy letter written by the National Director of Physicians for Compassionate Care, Dr. William L. Toffler. It is followed by his statement "What People Mean When They Say They Want to Die."

Dear Members of the Committee:

I am a doctor in Oregon where assisted suicide is legal. As a professor of Family Medicine and practicing physician in Oregon for over 30 years, I write to urge you to not make Oregon's mistake and vote No on HB 1325.

I understand that there was a question during your recent hearing regarding the appropriateness of suicide prevention with a terminal patient. Terminal patients, like other patients, will sometimes express suicidal desires and ideation. Terminal patients, like other patients, do not necessarily mean it and may even want you to say "no." They may also be clinically depressed, i.e., colloquially, not in their "right minds." With this situation, suicide prevention is not only appropriate, but necessary to provide good medical care and to avoid discrimination based on the patient's quality of life as perceived by the doctor.

In my practice, I have had well over twenty patients ask me about participating in their suicides or giving them information about assisted suicide. In every case I have explored the issues behind their request, and then assured them that I will provide their medical care to the best of my ability. At the same time, I also strive to reflect and convey their inherent worth and my inability to collude with their request to help end their life. I remember one case in particular: the man's response was "Thank you."

To read more about that case and some of my other cases in Oregon, please read my statement to the BBC, since re-titled as "What People Mean When They Say They Want to Die?" http://www.choiceillusion.org/p/what-people-mean_25.html

Please vote No on HB 1325.
Thank you,

William L. Toffler MD
Professor of Family Medicine

What People Mean When They Say They Want to Die

by William Toffler, MD

Originally published as a statement for the BBC

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There has been a profound shift in attitude in my state since the voters of Oregon narrowly embraced assisted suicide 11 years ago. A shift that, I believe, has been detrimental to our patients, degraded the quality of medical care, and compromised the integrity of my profession.

Since assisted suicide has become an option, I have had at least a dozen patients discuss this option with me in my practice. Most of the patients who have broached this issue weren't even terminal.

One of my first encounters with this kind of request came from a patient with a progressive form of multiple sclerosis. He was in a wheelchair yet lived a very active life. In fact, he was a general contractor and quite productive. While I was seeing him, I asked him about how it affected his life. He acknowledged that multiple sclerosis was a major challenge and told me that if he got too much worse, he might want to "just end it." "It sounds like you are telling me this because you might ultimately want assistance with your own assisted suicide-- if things got worse," I said. He nodded affirmatively, and seemed relieved that I seemed to really understand.

I told him that I could readily understand his fear and his frustration and even his belief that assisted suicide might be a good option for him. At the same time, I told him that should he become sicker or weaker, I would work to give him the best care and support available. I told him that no matter how debilitated he might become, that, at least to me, his life was, and would always be, inherently valuable. As such, I would not recommend, nor could I participate in his assisted-suicide. He simply said, "Thank you."

The truth is that we are not islands. How physicians respond to the patient's request has a profound effect, not only on a patient's choices, but also on their view of themselves and their inherent worth.

When a patient says, "I want to die"; it may simply mean, "I feel useless."

When a patient says, "I don't want to be a burden"; it may really be a question, "Am I a burden?"

When a patient says, "I've lived a long life already"; they may really be saying, "I'm tired. I'm afraid I can't keep going."

And, finally, when a patient says, "I might as well be dead"; they may really be saying, "No one cares about me."

Many studies show that assisted suicide requests are almost always for psychological or social reasons. In Oregon there has never been any documented case of assisted suicide used because there was actual untreatable pain. As such, assisted suicide has been totally unnecessary in Oregon.

Sadly, the legislation passed in Oregon does not require that the patient have unbearable suffering, or any suffering for that matter. The actual Oregon experience has been a far cry from the televised images and advertisements that seduced the public to embrace assisted suicide. In statewide television ads in 1994, a woman named Patty Rosen claimed to have killed her daughter with an overdose of barbiturates because of intractable cancer pain. This claim was later challenged and shown to be false. Yet, even if it had been true, it would be an indication of inadequate medical care-- not an indication for assisted suicide.

Astonishingly, there is not even inquiry about the potential gain to family members of the so-called "suicide" of a "loved one." This could be in the form of an inheritance, a life insurance policy, or, perhaps even simple freedom from previous care responsibilities.

Most problematic for me has been the change in attitude within the healthcare system itself. People with serious illnesses are sometimes fearful of the motives of doctors or consultants. Last year, a patient with bladder cancer contacted me. She was concerned that an oncologist might be one of the "death doctors." She questioned his motives--particularly when she obtained a second opinion from another oncologist which was more sanguine about her prognosis and treatment options. Whether one or the other consultant is correct or

not, such fears were never an issue before assisted suicide was legalized.

In Oregon, I regularly receive notices that many important services and drugs for my patients--even some pain medications--won't be paid for by the State health plan. At the same time, assisted suicide is fully covered and sanctioned by the State of Oregon and by our collective tax dollars.

I urge UK leaders to reject the seductive siren of assisted suicide. Oregon has tasted the bitter pill of barbiturate overdoses and many now know that our legislation is hopelessly flawed. I believe Great Britain, the birthplace of Dame Cicely Saunders, and the Hospice movement, and a model to the rest of the world, deserves better.

On May 12, 2006 the Physicians-Assisted Suicide Bill was defeated in the United Kingdom (UK) Parliament House of Lords 148 - 100 vote.

Source: http://www.pccef.org/whoweare/memberviewpoints.htm
Reprinted with permission of the author, William Toffler, MD.

Case in Point

by Brian J. Kopp

My mother-in-law Kay, a non-smoker, was diagnosed with Stage IV lung cancer in February 2009. She was having right shoulder pain. The tumor was an incidental finding on a routine shoulder x-ray. Scans revealed that the cancer had already metastasized to her sacrum. She underwent extensive radiation and chemotherapy, which did shrink the tumor in her lung. At diagnosis, the prognosis was 3 to 6 months, but her oncologist did not tell her this. She was determined to take care of my father-in-law Jim, who had suffered a brain bleed after a fall in 2006 with subsequent development of mild dementia. Throughout the summer and fall, Kay persevered while undergoing treatment and caring for Jim. He passed away peacefully at home that September.

The bone metastases in her sacrum, which spread to her lumbar spine and eventually her ribs, caused continual pain over the next two years. She underwent kyphoplasty and sacroplasty for pathological fractures of a lumbar vertebra and her sacrum. Thankfully, her oncologist was able to control most of her pain with gradually increasing doses of Fentanyl patches and later Vicodyn for break through pain.

One morning in April of 2011, Kay could no longer swallow the large Vicodyn pills. A very independent and strong woman, she did not tell us. At midnight, she called in severe distress. I was on my way to Eucharistic Adoration and our pharmacist has the hour before mine. After I told him about our crisis, he went directly to his shop and delivered liquid Vicodyn for Kay. My wife Sue stayed with her mother pretty much 24/7 from that point forward to make certain her pain was under control and help her in every way possible.

On May 17, 2011, Kay expressed concern about pain in her gall bladder area to her visiting home nurse. Kay's primary care physician (PCP) recommended she be evaluated in the ER. The ER doctor could find no cause for the pain, but she was admitted for observation. It turned out she had a new metastasis in her lower rib. Being in the hospital and under their care, Kay insisted that my wife and I go home and get some rest.

We returned at 1:00 pm the next day to find Kay writhing in agony on the edge of her hospital bed, praying for the Lord to "take me now." We flew to the nurses' station to find out why Kay was in such extreme pain, because under our care she had not experienced anything remotely like this. We were told that Kay had decided to admit herself to hospice care that morning (even though we felt we could care for her with the help of home nursing and her excellent oncologist). Her PCP, serving as her hospice provider, had terminated the Fentanyl patches and Vicodyn and started her on Morphine 5mg IV. He had also ordered oral MS Contin (morphine sulfate-controlled release), which would take 24 hours or more to take effect. We demanded to know why she was in such pain. They replied that she had to request the IV Morphine every two hours and she had not done so. We went back and asked her if she knew she needed to request the Morphine, but she was in such agony she could neither answer nor locate the nurse's call button. We asked the nurses to increase the

dose of Morphine, since she had already been successfully managed for over a year with Fentanyl and Vicodyn, but they said they were concerned about suppressing her respirations if they went over 10mg. We had to fight to get the nursing staff to administer the Morphine every two hours. Usually the dose was a half hour late and the staff openly resented our constant pleas to administer it on time.

The next couple days were pure hell. She started to receive some relief when the MS Contin began to take effect 36 hours later. In hindsight, our pharmacist friend insisted she was also suffering the effects of abrupt Fentanyl and Vicodyn withdrawal. Placed on MS Contin and oral liquid morphine upon discharge May 21st, she progressively became more incoherent, started hallucinating and was unable to communicate.

We were blessed to be put in contact with a pro-life Catholic hospice administrator who helped us navigate this minefield of proper pain relief. She informed us that the oncologist's pain management was 100% correct - the combination of Fentanyl and narcotic analgesics were the drugs of choice for metastatic bone pain. Our pharmacist and this hospice administrator both thought the only explanation for changing her pain control regimen was that Morphine costs pennies per dose versus the high cost of Fentanyl patches, which were not on that hospice's formulary. Furthermore, because of her deteriorating condition, the pro-life hospice administrator felt that, within a day or two, Kay would not be able to swallow the MS Contin and wanted to know how our local hospice team planned to treat her at that point. Our local hospice informed us that they would simply roll Kay twice a day and administer the MS Contin as a suppository.

We told them this was unacceptable, as it could not be done without hurting a woman who had already suffered multiple sacral, lumbar and rib fractures from metastatic tumors. On May 27th, after a contentious battle with the hospice team and their pharmaceutical provider, we were able to change Kay's pain control regimen back to higher dose Fentanyl patches with liquid Morphine for break through pain. Her pain levels improved dramatically. She was once again alert, oriented and able to communicate meaningfully.

By May 27th, she could no longer swallow food and most liquids. Her greatest comfort and only source of hydration and nutrition was the ice shaver and flavored syrups we had purchased to keep her comfortable. She asked for the ice frequently to quiet her growing thirst. We requested an IV to keep her comfortable. The local hospice refused, saying they did not do IVs. I got on the phone with the lead hospice nurse and told her that hospice benefits, under federal law, do not deny IV hydration when it is medically indicated. She replied that, if we would admit Kay to the hospice unit, they would attempt to start an IV. I insisted that the patient and our family did not want her to go to the unit; if possible, it was our desire that she die at home; and, according to federal hospice regulations, it was her right to receive proper IV hydration *at home*. They finally relented, sending out a young RN who admitted she had not started an IV in over two years and informed us she was only permitted to attempt to start the IV three times. She failed all three attempts, apologized, and left.

We were heartbroken. We had done everything in our power to keep Kay's pain under control and prevent the discomfort of dehydration from adding to her suffering. Five days later, on June 1st, we mentioned to Kay's home aide how upset we were that the RN had failed to start the IV. She was shocked that an attempt had not been made by another hospice RN since the order for the IV was still outstanding. The aide must have brought this to the attention of the hospice administrator because she called that afternoon asking if we still wanted an IV. I was incredulous. Of course we did. A nurse showed up at our door within an hour. She started an IV line and the hospice administrator herself hung the IV bag.

The next day, Kay decided she wanted to be admitted to the unit. I believe she was concerned that "the end" was just too much for us to handle at home. On admission, the hospice nurses said she seemed strong and this would probably be a short term visit because Kay would likely stabilize and go back home.

We brought along the ice shaver and flavored syrup and continued to give her tiny amounts of flavored shaved ice for comfort. One RN, rolling her eyes, said, "You've got to trust me. Read this!" and pushed a printout into our hands. Here is an excerpt from that form:

> They are not starving; nature is at work assisting them to die in a more comfortable way.
> Dehydration is nature at work and can bring relief from distressing symptoms such as

- Hiccups

- Abdominal bloating
- Vomiting from increase stomach secretions
- Pressure from the tumor causing pain
- Shortness of breath
- Lung congestion
- Rattling secretions
- Impaired consciousness

On Saturday morning, June 4th, her PCP made rounds. He said Kay's heart was strong and she would still live for days. Despite the impressions of the hospice staff and the doctor, Kay passed away peacefully later that evening. We are convinced they simply were not used to seeing patients come into their hospice unit who were not dehydrated at that point in their terminal illness.

NOTE: In order to protect yourself or your loved one, it is essential you interview a hospice prior to signing up and being admitted. For a list of questions to ask a hospice and for guidance regarding other critical medical decisions, read Human Life Alliance's new magazine "Informed."

"Informed" is available online at http://www.prolifehealthcare.org/Informed_lowRez.pdf.
To request a copy, call the Pro-life Healthcare Alliance at 651-484-1040.

Announcements

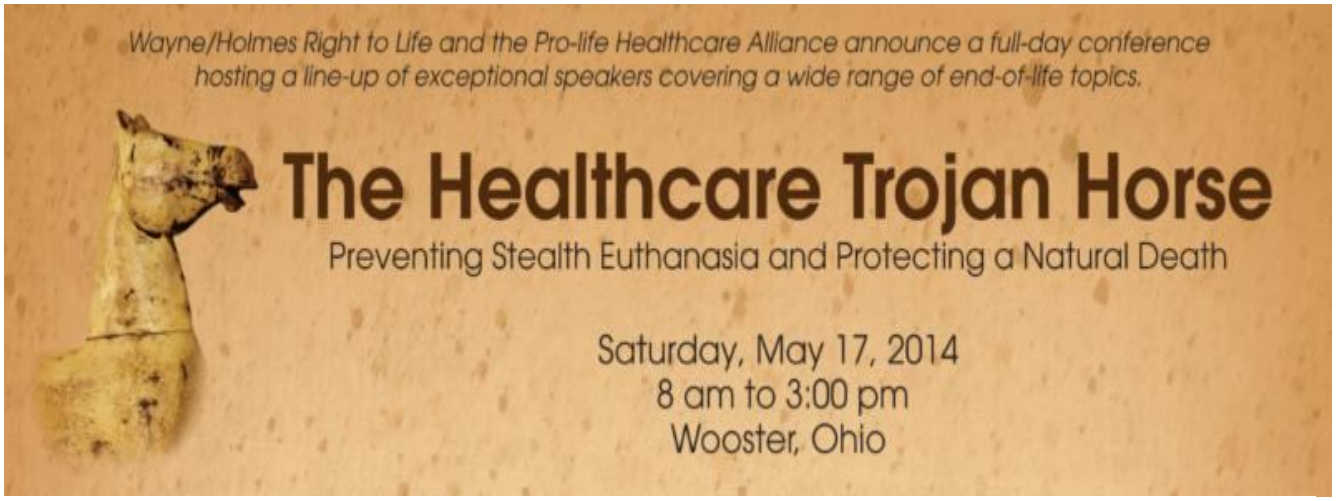
March 29, 2014, Des Moines, IA
Imposed Death: A Conference on Stealth Euthanasia,

New Hope Assembly of God
Student Center
6800 Townsend Ave, Urbandale, IA, 50322
(515) 254-9094

Schedule
8-4:30

Speakers and Topics
Alex Schadenberg, (1) US and Worldwide Overview of Euthanasia Studies (2) Assisted Suicide
Cristen Krebs, (1)Stealth Euthanasia (2) Hospice
Julie Grimstad, (1) Advance Medical Directives and POLST (2)Organ Donation and Patient Advocacy
Mary Kellett, Infant and Prenatal Euthanasia

Registration:$30/individual or $50/couple
Registrations by phone: toll free 1.877.595.9406
email:iowa@iowaRTL.org or through Iowa Right to Life website:www.iowaRTL.org
We can take registrations by credit card payment over the phone or on our "donate" page on the website.
By mail:Iowa Right to Life, 1500 Illinois Street, Des Moines, IA 50314



"The Greeks celebrated as they pulled the Great Horse into the City of Troy."

Saturday, May 17, 2014

Location: Grace Church, 4500 Burbank Road # A , Wooster, Ohio 44691
Title of conference: The Healthcare Trojan Horse
Speakers: Julie Grimstad, Dr. Cristin Krebs, Dr. Loren Kirchner, Ione Whitlock
Time: 9:00 am to 3:00 pm - Registration begins at 8:00 am
Tickets: $30.00, includes continental breakfast and lunch
Pre-registration required
Mail checks to WHRTL, P.O. Box 1231, Wooster, Ohio 44691 or call:
Diana Talmon 330-435-0344 or
Paulette Matter 330-620-0630

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.

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.

Join the Pro-Life Healthcare Alliance

STAY CONNECTED

Pro-life Healthcare Alliance

a program of Human Life Alliance
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