



Pro-life Healthcare Alliance

March 26, 2015

PHA Monthly

*Newsletter for the Pro-Life Healthcare Alliance
Twentieth Edition*

Welcome to the twentieth 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 February 2015 [Linacre Quarterly](#) (official journal of the Catholic Medical Association) features a ground breaking study by Chris Kahlenborn, MD of [The Polycarp Research Institute](#) titled "[Mechanism of action of levonorgestrel emergency contraception](#)". The study contrasts the theoretical basis on which emergency contraception (otherwise known as "Plan B") is claimed to function with the facts and statistics of the most recent research outlining the mechanism by which it causes early abortions. Though *Linacre Quarterly* is a journal of the Catholic Medical Association and Dr. Kahlenborn's concern is primarily regarding Catholic institutions, the Po-life Healthcare Alliance is dedicated to defending each and every human life "from the very first moment they are created, when their own developmental process of human life is initiated, and throughout the rest of their lives until true death" and this study should be a matter of grave concern for all of us in the pro-life movement.

The study's abstract lays out front the serious nature of the debate:

... Proponents of LNG-EC have argued that they have moral certitude that LNG-EC works via a non-abortifacient mechanism of action, and claim that all the major scientific and medical data consistently support this hypothesis. However, newer medical data serve to undermine the consistency of the non-abortifacient hypothesis and instead support the hypothesis that preovulatory administration of LNG-EC has significant potential to work via abortion. The implications of the newer data have important ramifications for medical personnel, patients, and both Catholic and non-Catholic emergency room protocols.

Dr. Chris Kahlenborn was interviewed about his study for the PHA newsletter via phone and email correspondence:

PHA: Dr. Kahlenborn, can you give us a quick overview of the study and its findings?

Dr. K: Our article is a review of the most recent medical data to date, which strongly support the assertion that Plan B is an abortifacient, especially when given prior to ovulation. Two other recent papers also strongly support an abortifacient method of action of LNG-EC (Peck et al, 2013 and Raviele, 2014). Simply put, the evidence supporting an abortifacient effect of LNG-EC is clearer and more compelling than ever before. Certainly any claim of "moral certainty" regarding a non-abortifacient method of action no longer has credibility. Indeed, given the strength of the most recent evidence, the nomenclature of emergency contraception should be changed to emergency contraception/abortion and this should be reflected in Catholic/pro-life and the secular literature as soon as possible.

PHA: Does Plan B ever act as a contraceptive?

Dr. K: Ideally, Plan B should be named emergency abortion/contraception instead of emergency contraception because it has high potential of working as an abortifacient when given prior to ovulation. We noted in our paper that, when given prior to ovulation, Plan B frequently allows ovulation to occur and has no major impact on sperm flow or quality, yet one does not see any evidence of clinical pregnancy. If both sperm and an egg are present and one does not see evidence of clinical pregnancy, then abortion is the most likely mechanism of action. In the minority of cases, when Plan B truly stops ovulation, it likely works via a contraceptive method.

PHA: Your paper goes into great depth regarding the issue of when Plan B is taken, including the fact that taking it on the day of ovulation essentially renders Plan B completely ineffective.

Dr. K: Yes, it appears to be useless or actually may increase a woman's risk of getting pregnant when taken on or after the day of ovulation, according to the data presented by Dr. Noe in her 2010 and 2011 studies (Contraception). Other leading researchers, such as Dr. Trussell and Davidoff, also raise this very real

possibility: "it even raises the counter-intuitive but undocumented possibility that Plan B used after ovulation might actually prevent the loss of at least some of the 40% of fertilized ova that ordinarily fail spontaneously to implant or to survive after implantation." (Journal of the American Medical Association, October, 2006). In practical terms this means that, while Plan B likely often works by abortion if given prior to ovulation, it has either no efficacy or actually could have a pregnancy enhancing effect if given on the day of ovulation or after.

PHA: What is the history behind the Church's position on emergency contraception?

Dr. K: In 1995, then Bishop Myers accepted what is known today as the Peoria Protocol which, in a nutshell, states that it is okay to give Plan B to women who have been raped if it is given prior to ovulation, since it is based upon the assumption that Plan B consistently stops ovulation in this phase - which it clearly does not, as noted by the most recent research and even admitted to by the most notorious Plan B advocates/researchers (e.g., Horacio Croxatto, MD and James Trussel, PhD).

Many Bishops have accepted this protocol while others have remained skeptical. Unfortunately, we now know from several large studies such as that of Dr. Croxatto (Contraception, 2004), that Plan B does not consistently stop ovulation. Therefore, the entire Peoria Protocol is based on a faulty premise.

For years now, liberal theologians have given liberal Bishops the cover they need to permit this faulty protocol. In this age where so many Bishops are afraid to stand up for the Church's harder teachings, it's hard to believe that they will stand up based on the findings of our paper, especially since the press will try to paint courageous Bishops as "endorsing rape." But, with the publication of this paper, there is now something different. Now, it is no longer a question of theology - actually it never was - but a simple matter of the science supporting an abortifacient mechanism of action.

PHA: Does this mean that Catholic hospitals that currently allow Plan B or other emergency contraception are allowing abortions to occur?

Dr. K: The answer to this is almost certainly yes, and I say "almost certainly" because, at this point in time, it is difficult to measure the frequency of abortions given the small size of the embryo when he or she dies in utero.

Obviously, this is a big, big problem....I mean, could the Devil be any happier? Catholic hospitals allowing abortions? If Catholic hospitals continue to allow this, given this overwhelming evidence, are they still Catholic?

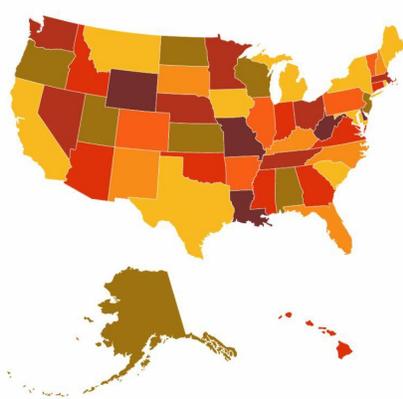
PHA: Thank you, Dr. Kahlenborn

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[10 QUICK REASONS FOR OPPOSING THE LEGALIZATION OF ASSISTED SUICIDE](#)

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

UPDATE ON ASSISTED SUICIDE IN THE UNITED STATES



Minnesota: On March 20, a hearing was announced for Senate File 1880, the Minnesota Compassionate Care Act of 2015. This bill is sponsored by Compassion and Choices (the old Hemlock Society) and designed to legalize assisted suicide in Minnesota.

Montana: Good news! Compassion and Choices had a setback in Montana. House Bill 477 passed the House by a vote of 51-48 on March 17. This bill stipulates that those who are convicted of "physician-assisted suicide" (PAS) would face up to 10 years in prison, thus definitively criminalizing PAS. The bill now goes to the Senate for consideration. Many people have been confused about the status of physician-assisted suicide in Montana since the state Supreme Court in 2009 ruled there is no legal precedent that says it is against public policy. If enacted, HB 477 will end the confusion.

Nevada: On March 16, Senate Bill 336, the Nevada Patient Self-Determination Act, was introduced. SB 336 is modeled after physician-assisted suicide laws in Oregon and Washington. Vermont has a similar law. A more truthful name for SB 336 (and, indeed, every assisted suicide bill or law) is the "Patient Self-Extermination Act." [Editor's note: The choice of a name for this bill is interesting. Patient Self-Determination Act is the name of the federal law enacted in 1990 that requires most health care facilities - including hospitals, nursing homes and clinics - to inform all adult patients of their right to accept or refuse medical treatment, and their right to execute a medical advance directive. This federal law, in effect, forces healthcare providers to promote advance directives under threat of losing reimbursements for care provided to Medicaid/Medicare covered patients. If SB 336 becomes law in Nevada, will healthcare providers be forced to inform patients of their legal right to physician-assisted suicide?]

Oregon: In 1994, Oregon became the first state to legalize assisted suicide, in part by assuring voters that the law would apply only to terminally ill people expected to die within six months. A new bill, HB 3337, now proposes to stretch the definition of "terminal disease" from six months to 12 months. This is an example of the incremental strategy of assisted suicide proponents. They'll promise anything - e.g., "strict safeguards" - in order to gain social and legal acceptance of assisted suicide, and then continually work to expand the reach of such laws.

In 2015, across the United States, in state after state, Compassion and Choices is lobbying for assisted suicide. At last count, more than 25 states plus the District of Columbia were considering legislation that would sanction physician-assisted suicide. In a recent letter to supporters, the president of Compassion and Choices, Barbara Coombs Lee, boasted, "We are on the cusp of delivering monumental social change!" In addition to the states/bills mentioned above, here are some of the bills that have been introduced so far this year (note: not all bill numbers are listed):

Alaska: Voluntary Termination of Life (HB 99), February 9

California: End-of-Life Option Act (SB 128), January 20

Connecticut: Compassionate Aid in Dying for Terminally Ill Adults (SB 668), January 23

Colorado: Colorado Death with Dignity Act (HB 15-135), January 27

Hawaii: Death with Dignity (HB 1255), January 28

Iowa: Iowa Death with Dignity Act (HF 65), January 21

Kansas: Kansas Death with Dignity Act (HB 2150), January 28

Maryland: Death with Dignity Act (SB 676, HB 1479), February 6

Missouri: Missouri Death with Dignity Act (HB 307), January 8

Montana: Montana Death with Dignity Act (SB 202), January 21

New York: New York End-of-Life Options Act (S3685/AO2129), February 13

Oklahoma: Oklahoma Death with Dignity Act (HB 1673/HB 1021), February 2

Rhode Island: Lila Manfield Sapinsley Compassionate Care Act (H 5507), February 12

Utah: Utah Death with Dignity Act (HB 391), February 24

Washington, D.C.: Death with Dignity Act of 2015 (B21-0038), January 14

Wisconsin: SB 128, February 11

Wyoming: Death with Dignity (HB 0119), January 22

The "right to die" quickly becomes the "duty to die." Once the stigma of ending one's own life is gone, pressure will build to stop using medical resources to preserve lives deemed not worth the expense. We must prevent Compassion and Choices from achieving the "monumental social change" it is crowing about. **If you have contacts in states in which bills concerning assisted suicide have been introduced, be sure they are aware of them and offer your help in the fight.**

UNEXPECTED RECOVERY

In order to introduce you to people who have recovered after supposedly "hopeless" diagnoses, we periodically feature the stories of surprising survivals/recoveries. 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.

40-year-old Ruby Graupera-Cassimiro's baby girl had just been delivered by C-section when disaster struck the afternoon of September 23, 2014. Ruby went from talking to unconsciousness while in the recovery room at Boca Raton (FL) Regional Hospital. Doctors and nurses tried for over two hours to revive her. Suddenly, her heart stopped. She had no pulse for 45 minutes while the medical team kept pumping her chest and repeatedly tried shocking her heart back into action. Finally, doctors told her family there was nothing more they could do. All life-saving procedures were stopped. Then the seemingly impossible happened. There was a blip of a heartbeat on the heart monitor, then another and another. Within a few hours, Ruby was tugging at the breathing tube on her face and scribbling notes to her family. Her breathing tube was removed the next day.

The cause of Ruby's near-death experience was an amniotic fluid embolism, which occurs when fluid that surrounds a baby in the uterus enters a mother's bloodstream and heart, creating a vacuum that stops circulation. Amazingly, doctors say she suffered no reduced brain function from the loss of circulation and 45 minutes without a pulse. ["Woman who had no pulse for 45 minutes makes full recovery; doctors call miraculous," *Sun Sentinel*, 11/7/2014]

Editor's note: Saturday, March 21st, was the 10th annual World Down Syndrome Day. This year's theme highlighted the positive contributions that families make for their loved ones and others in the Down syndrome community.

This international day is intended to raise awareness of Down syndrome and that children with Down syndrome, both in the womb and after birth, deserve and need our protection. A 2012 survey of studies found that, among women who had received a positive prenatal diagnosis of Down syndrome, between 89-97% aborted their unborn children.

[<http://www.redstate.com/2014/11/30/cdcs-latest-abortion-report/>]

Mary Kellett, the author of our feature article this month, is the founder of Prenatal Partners For Life, which supports parents of children who have special needs, including children with Down syndrome. In this article, Mary highlights some legal efforts to protect children with special needs and to ensure that their families receive all the support, information and help available, both before and after birth.

MEDICAL DISCRIMINATION AGAINST DISABLED CHILDREN

By Mary Kellett

Many people have a hard time believing that doctors would do things to cause or hasten a child's death, or would knowingly withhold treatments that would help a child. Yet this is what is happening to many children with disabilities whose families are often unaware.



Parental Rights

Currently there is a bill in Missouri called Simon's Law, an effort to offer some protection for children and their families. Simon's Law would forbid health care facilities and others from withholding life-sustaining procedures from a minor patient lacking the written consent of a parent or legal guardian.

The law is named after Simon Crosier who was born with trisomy 18. Simon lived for three months and was loved tremendously by his family. After Simon died, his mother discovered that a DNR (do not resuscitate) order had been placed in her son's medical records without her knowledge. She also found that Simon was to receive nutrition as a comfort measure only.

Most telling was that the hospital had a Futility of Care policy in place when Simon was in their care. This hospital policy allows physicians to withhold or withdraw care they consider futile. Understandably the Crosier family was devastated when they found out about all of this.

The bill, HB 113, sponsored by Rep. Bill Kidd, R-Kansas, would require physicians, health care facilities and nursing homes to disclose in writing any policies that relate to a patient's care, including life-sustaining or non-beneficial treatments.

The issue of parental rights is very dear to my heart. My own son Peter also had trisomy 18 and died under very suspicious circumstances after having his appendix removed at the age of 6 ½. We were told he died from infection and his heart couldn't take it. An independent autopsy revealed Peter bled to death. We also found out the children's hospital where Peter was a patient had an internal Futility of Care policy about which even many of the hospital's own doctors were unaware.

Right to Basic Medical Care and Unbiased Information

Recently, over a dozen disability rights groups filed a second amicus brief in a case defending the rights of people with disabilities to receive basic medical care. This was in response to two cases in 2009 after a thirteen-year-old boy and one adult died. Both had illnesses that were treatable. The hospital physicians advised the families to withdraw antibiotics, nutrition, and hydration, using the argument that, as persons with disabilities, they had low quality of life.

That is an argument I am most familiar with, hearing it hundreds of times during my own son's journey and with the families I support through Prenatal Partners for Life. It is arrogant and unprofessional to claim to know a person's quality of life when you see the person only when sick, at his or her lowest and weakest point. To make decisions about life and death based on seeing someone such a short time and in such a limited way is absurd and shortsighted.

We always carried pictures of Peter when he was well, laughing and smiling with his siblings, with us to the hospital to show the doctors whose own biases might cloud their judgment about Peter's care.

Several states have enacted laws insuring that, when a family receives a diagnosis of Down syndrome, they also receive all the support, information and help available. In Minnesota, a bill that covers Down syndrome, Trisomy 18 and 13 has been introduced. SF 462 and HF 439, called the Prenatal Trisomy Diagnosis Awareness Act, will insure that up to date, evidence based information will be given to families when they

receive the diagnosis.

Families do not need to feel like they are alone in their journey. Through social media there is access to a plethora of support groups for many conditions. These groups provide not only vital support and encouragement but also helpful information about treatment and ideas about helping children reach their full potential. Many times, because of the discriminatory attitude of some medical professionals, this kind of information is not given to parents.

Term "Incompatible With Life" Deceives Parents

Families of children with disabilities are also taking their complaints to the United Nations. They held a special conference on March 11th to launch a campaign that will hopefully end the use of the term "incompatible with life" in describing children diagnosed with life limiting conditions. Many families find the phrase highly offensive and discriminatory and feel it leads to poor care or lack of care for their child.

The Declaration reads, "As medical practitioners and researchers, we declare that the term 'incompatible with life' is not a medical diagnosis and should not be used when describing unborn children who may have a life-limiting condition."

Tracy Harkin is the spokesperson of Every Life Counts, the Irish support group leading this worldwide proposal. They are "calling on medical professionals to stop using this term, because it misinforms parents, and because it pushes families towards abortion, and denies them a chance to spend time with their children, to make memories and to heal."

Families who have children with life limiting conditions are increasingly being denied treatment that could benefit the child because the medical providers consider the treatment futile. The care is called futile not because it may fail to have benefit and extend life, but because, in the medical providers' estimation, the child's life is not worth saving because of his or her low quality of life.

When we were expecting Peter, our son with trisomy 18, we were told there were no survivors beyond two weeks. After he was born and the diagnosis was confirmed we found out there were many children and some adults living with trisomy 18. When I confronted the doctor, his chilling words were that they had to think about resources, that Peter would never be able to contribute to society and we should let him go.

At the time those words were spoken, still recovering from a cesarean section, all I could do was cry. Now looking back, I think at least the doctor was honest. The discrimination that many families face is often about money and the utilitarian view of life that many have adopted.

Unconditional Love

My friends Rick and Karen Santorum have recently written a book called Bella's Gift. In it they write about their daughter Bella who will be seven years old in May and has trisomy 18. It is a beautiful book sharing the joys and struggles of having a child with special needs and the blessing little Bella is to their family and to so many.

On page 73 of the book, Karen describes how the hospice doctor gave them a prescription of morphine for Bella. The Santorum's family pediatrician checked the dosage and explained that it would have been a lethal dose. Karen likens their experience to navigating their way through a battlefield.

No family should have to feel that way, but the sad reality is that a lot of them do. The discriminatory attitude of many medical professionals towards families who are expecting a child or who have a child with special needs is heartbreaking and extremely disturbing. The attitude that these precious children will not contribute to society and therefore are not worth the resources needed to treat them is a sick eugenic mentality that harms us all.

The truth is that kids like Simon, Bella and Peter teach us how to love unconditionally. They stretch us and open our hearts to be more compassionate and caring. Their presence in the world and in our families is a great gift and they deserve the same care any other person would receive. They are truly teachers of our souls and have, in my opinion, the most important role in the world to play - helping all of us be better people.

About the author: Mary Kellett is founder and executive director of Prenatal Partners For Life (PPFL), a group of concerned parents (most of whom have or had a special needs child), medical professionals, legal professionals and clergy whose aim is to support, inform and encourage expectant or new parents. PPFL offers support by connecting parents facing an adverse diagnosis with other parents who have had the same diagnosis. PPFL has many resources, including adoption agencies with clients waiting to adopt and love a special needs child should parents feel they could not care for them. Mary states, "We believe each child is a special gift from God." Mary is also a member of the Pro-life Healthcare Alliance Working Committee and Speakers' Bureau. www.prenatalpartnersforlife.org

WHAT ARE WE DOING?

Julie Grimstad, Executive Director, Life is Worth Living: spoke at St. John the Apostle Church, North Richland Hills, TX, Feb. 13, on Medical Decision Making.

Mark Davis Pickup, HumanLifeMatters.org: spoke in Canada for the Diocese of Hamilton, near Toronto, ON, Feb. 13, and for the Ukrainian Eparchy of Saskatoon, Saskatchewan, March 7, regarding The Implications for the Incurably Ill and Disabled of the Canadian Supreme Court's Terrible and Perilous Decision.

Alex Schadenberg, Executive Director/International Chair, Euthanasia Prevention Coalition: has had numerous speaking engagements - Minnesota, Feb. 11; Montreal, Feb. 22; Ottawa, March 4; Terrace, BC, March 19; Smithers, BC, March 20; Houston, BC, March 21; and Barry's Bay, ON, March 24. Upcoming engagements - Archdiocese of Vancouver, March 27; Kincardine, ON, April 16; Walkerton, ON, April 17; Wingham, ON, April 22; St. Thomas, ON, April 24; Ottawa, ON, April 29; March for Life, Ottawa, ON, May 14-15; Adelaide, Australia, May 22-23; and Dublin, Ireland, June 5-6.

Jo Tolck, Executive Director, Human Life Alliance: spoke in Clearwater, FL, March 3, to the Luncheons4Life group on *The Connection Between Abortion and Euthanasia*.

Nancy Valko, RN, National Association of Pro-life Nurses: spoke at the Massachusetts Citizens for Life Convention, March 21, on Assisted Suicide.

In addition to speaking and other educational endeavors, every month, Human Life Alliance/Pro-life Healthcare Alliance receives many requests from people seeking information, guidance or assistance. This report by Jo Tolck, Executive Director of Human Life Alliance, is just one example:

A couple drove around the area looking for us. They didn't have our address but spoke with Ann Olson (Education Director for Human Life Alliance) when she was tabling at an event. They were looking for help for a friend whose mother is in a nursing home. She is 96 and has a feeding tube. Her nursing home is pushing for hospice and the friend had questions. This woman called the next day questioning if her mother wasn't receiving some care that she would receive if she were in hospice. She thought that was not the case and said her mom sleeps most of the time. I sent her our publications *Imposed Death Euthanasia and Assisted Suicide* and *Informed: A guide for critical medical decisions* with the suggestion she read the article "Interviewing A Hospice Agency: What questions Should I Ask?" The woman was leaning toward keeping her mother where she is. I talked with her about the importance of her own comfort level with the care her mother is receiving and encouraged her to call back with any future questions or concerns.

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



Pro-life Healthcare Alliance

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