



Pro-life Healthcare Alliance

May 22, 2014

PHA Monthly

Newsletter for the Pro-Life Healthcare Alliance
Eleventh Edition

Welcome to the eleventh 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.

WHAT HAVE WE BEEN DOING?

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.

Recent Activities:

The PHA co-sponsored *The First National symposium on Euthanasia and Assisted Suicide* with the Euthanasia Prevention Coalition. The conference was held May 2-3 in Minneapolis, Minnesota. It was a success! Conference attendees filled out feedback forms and from their comments we can tell they were glad they attended. Here are a few of the comments:

"Wow-poignant and thought provoking"

"A nice variety of speakers"

"Well planned"

*"Very informative!
"Excellent-vitally important information"
"Great topics. Thank you for organizing this!"
"I benefited greatly from the leadership workshop"
"I've been asking God what more I could possibly do to defend those that are defenseless.
This would be a classic case of 'be careful what you pray for.' That prayer was answered
today!"*

Julie Grimstad and Cristen Krebs spoke at *The Healthcare Trojan Horse, Preventing Stealth Euthanasia And Protecting a Natural Death* conference, Saturday, May 17, 2014 in Wooster, Ohio. This was another very successful conference with a lot of good feedback.

Julie Grimstad also led an afternoon seminar on Medical Decision Making in Breckenridge, Minnesota on May 4, 2014.

PERSISTENT VEGETATIVE STATE

By Julie Grimstad, Executive Director
Life is Worth Living, Inc.

Human beings are not "vegetables." The dehumanizing term "persistent vegetative state" (PVS), crafted in 1972, became more familiar in the 1980s as "right to die" activists, courts, state legislatures, physicians and bioethicists^[1] began to use the PVS label as justification for withdrawing food and fluids from persistently unresponsive patients. PVS is a diagnosis that kills people.

What is a "Persistent Vegetative State?"

Many people have blind faith in medical labeling. Most probably think that PVS is a reliable diagnosis. However, experts disagree about what it is and methods for diagnostic testing are disputed. PVS is grouped in the International Classification of Diseases with "Symptoms, Signs and Ill-Defined Conditions."

A vegetative state is not a coma. According to the 1994 Multi-Society Task Force (MSTF) on the medical aspects of PVS, a person in a coma is neither awake nor aware; a person in a vegetative state is awake but not aware. The MSTF defined a "persistent vegetative state" as a vegetative state that lasts more than one month.^[2]

The person in PVS has sleep-wake cycles, eye movement, and normal respiratory, circulatory and digestive functions. Individuals in PVS are seldom on any life-sustaining equipment other than a feeding tube. Some can swallow, others cannot. Some have random movement, some do not. Some have been physically injured; others suffer from stroke or dementia. In some cases, the brain itself appears to change; in others it appears unchanged.

In simple terms, the diagnosis of PVS is based on lack of evidence of awareness of self or environment. However, it is not that simple.

Some patients who are misdiagnosed to be in PVS do exhibit evidence of awareness, but the diagnostician misses (or dismisses) the evidence. These patients may be mute and immobile ("locked-in"), but mentally alert and able to communicate by blinking or

through aids such as computers-if someone gives them the opportunity. Other patients retain some measure of awareness even though they do not exhibit any evidence of it. Patients who have recovered from such a state can recall things that were said or done to them while no one knew they were aware.

Kate Adamson was diagnosed as PVS after a brain stem stroke. Actually aware, she underwent surgery with inadequate anesthesia. That pain was nothing compared with the agony of starvation and dehydration. Interviewed by Bill O'Reilly in 2003, Ms. Adamson said, "When the feeding tube was turned off for eight days, I thought I was going insane. I was screaming out in my mind, 'Don't you know I need to eat?'...It was sheer torture."

The *Washington Post*, 9/8/2006, reported a case that astounded neurologists. A sophisticated brain scan upon a woman supposedly in a vegetative state indicated that she was clearly aware. The researchers told her to imagine she was playing tennis. They were shocked to see her brain "light up" exactly as an uninjured person's would. They repeated the test again and again with the same result.

Misdiagnosis of PVS is not uncommon.

- In 2002, a study of mistaken diagnoses of PVS revealed a 15% error rate.[\[3\]](#)
- Data gathered by the MSTF on a group of 434 adult patients who were in PVS as a result of traumatic injury showed that three months after injury, 33% had regained consciousness; by six months, 46% had; and at 12 months, 52% had.[\[4\]](#)
- Out of 40 patients diagnosed as being in PVS, 17 (43%) were later found to be alert, aware, and often able to express a simple wish. The author, London neurologist Dr. Keith Andrews, said, "It is disturbing to think that some patients who were aware had for several years been treated as being vegetative."[\[5\]](#)
- "Another study shows that around 40% of patients were wrongly diagnosed as in a vegetative state, when they in fact registered the awareness levels of minimal consciousness. Comparing past studies on this issue shows that the level of misdiagnosis has not decreased in the last 15 years."[\[6\]](#)

Using functional magnetic resonance imaging (MRI), Dr. Haggai Sharon and Dr. Yotam Pasternak of Tel Aviv University's Functional Brain Center have shown that some patients in PVS emotionally react to photographs of people they know. Their findings offer hope for better care and the development of novel treatments.[\[7\]](#)

What now?

Objections to deliberately ending the lives of patients in PVS often rest on the hope that "they might recover." Let's face it: many people with disabilities will not recover. But killing them is not a cure.

It is common for persistently unresponsive patients who are not dispatched by dehydration to wind up warehoused in nursing homes, deprived of rehabilitation and beneficial medical treatment. Their world is far more complex than most of us can imagine. Those who have severe brain damage may still enjoy touch, scent, taste, and sound; they may also feel pain, loneliness, fear, and despair.

A person's inability to satisfy our longing for response does not justify abandonment or imposed death. Patients labeled PVS are our brothers and sisters, human beings created in the image and likeness of God. We must treat them with respect and compassion.

NOTE: This article is also a brochure in the *Life is Worth Living* series produced and distributed by Pro-Life Wisconsin. Other brochures in this series are: [Get a Grip on the Grammar](#), [Organ Donation](#), [Advance Directives for Health Care, Feeding and Hydration](#) and [The Money Factor](#). To order these brochures, call Pro-Life Wisconsin at (262) 796-1111.

[1] [Bioethicists](#) often determine who should die. The core principle of modern bioethics is "quality of life." The core principle of traditional medical ethics is "sanctity of life."

[2] Mappes, Thomas A., "Persistent Vegetative State, Prospective Thinking and Advance Directives," *Kennedy Institute of Ethics Journal*, 2003: Vol. 13, No. 2: 119-139

[3] Ibid

[4] Ibid

[5] *British Medical Journal*, 7/6/96

[6] Quote from <http://www.news-medical.net/news/2007/06/20/26672.aspx>

[7] <http://www.aftau.org/site/News2?page=NewsArticle&id=19561>, 12/16/2013

CASE IN POINT

SHE DESERVED A CHANCE TO LIVE

By Mike Hodas

Laurie and I were married for 35 years. Shortly after our wedding we moved to San Francisco, CA. Laurie and I had a very close relationship. We shared a love of art and music. Laurie was known for her collection of WWII home front posters and her love for the color purple, quilts, and especially chocolate. Caregivers loved to work with Laurie and, even after going on to do other things (many became nurses), they continued to stay in contact with her.

Laurie was diagnosed with primary progressive multiple sclerosis (MS) in 1988. After her diagnosis she dedicated her life's work to promoting improved access for the disabled. Some of the access projects Laurie was involved with were: founding and chairing the San Francisco Museum's Access Advisors Committee for 24 years; working with the city transit agency (MUNI) to establish ramped taxi for all San Francisco taxi companies; and leading exponent and initiator for curb ramps throughout the city.

Previous to Laurie's last hospitalization she had been admitted to the same hospital twice. The first time was for a urinary tract infection which became toxic. The second time was for a morphine overdose. The overdose happened after her implanted pump was updated to a newer model. The previous dosage going through the older, less

effective pump was not lowered for the new pump.

Her final hospitalization was caused by aspirating her peg-tube feeding. Despite following instructions given by the nutritionists, we probably overfed her. Since she had not been able to eat much by mouth for the last year, her stomach's capacity probably was reduced. However, previous to this incident, Laurie's condition had shown marked improvement due to the increased nutrition. Her energy had increased and even her speech had improved.

When Laurie was admitted to the hospital, it was our expectation that the doctors and nurses would do their utmost to cure or improve her presenting problem. We also expected that the attending doctor would seek additional specialist help if the situation was beyond his expertise.

Dr. Y did neither of these things.

Dr. Y immediately ordered that Laurie to be put in "comfort care" ("the treatment of a patient actively dying"). No effort beyond deep suctioning was made to attempt to improve her condition. He refused her hydration and nutrition either through her peg tube or through her PIC line. On the sixth day, Dr. Y placed her on a morphine drip. He told me it was for pain, even though he knew this would be detrimental to her challenged respiratory system, which was her primary problem. That same day he also ordered her BiPAP (breathing mask) removed without consulting me. The next day, struggling to breathe and gasping for breath, Laurie died.

The question must be raised: why would this hospital and doctor, who are supposed to be dedicated to healing, resort to euthanasia? Based on the hospital report, Dr. Y determined treatment was futile.

Was this "medical futility" determination driven by economics or a profound disrespect for the disabled? I have no evidence for the former, but that does not mean it could not have been a factor. As to the latter, there is some telling evidence. The two times Laurie was previously admitted to this hospital, I had discussed with her hospitalist, Dr. T, what I assumed were efforts to euthanize Laurie. I objected very strongly to this approach. The matter was dropped. Each time, Laurie improved sufficiently to be discharged and went home to continue living a relatively normal life.

This last time Laurie was admitted, she was labeled "End Term MS"-a diagnosis that does not exist. This diagnosis was used to pursue the course they had intended to pursue during her two previous hospitalizations. When Laurie left the emergency room, her condition had been diagnosed as moderate. As soon as Dr. Y took over her treatment, he put her on "comfort care," knowing full well that I was opposed to this kind of treatment given Laurie's condition. To avoid another disagreement, they decided to forbid discussion of Laurie's treatment plan with me. The requirement for no discussion was stated in the hospital report. Throughout this whole time I felt like I had absolutely no understanding or control as to what they were doing. Every day I told the charge nurse that I wanted to talk with Dr. Y., but he never came to the room when I was there except for the time he came to tell me he was putting Laurie on the morphine drip.

I do not know whether Laurie would have improved if she had been treated to the fullest

of the hospital's capabilities. However, any caring person would acknowledge that she deserved medical treatment to help her improve as much as possible and live. Nevertheless, the hospital and doctor decided the best thing for this wonderful woman was to be euthanized because, obviously, her life was not worth saving.

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

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STAY CONNECTED



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