



Pro-life Healthcare Alliance

Oct. 24, 2014

PHA Monthly

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

Welcome to the fifteenth 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."

WHAT ARE WE DOING?

Upcoming Event

Admission is free!!!!!!!!



For questions and registration please call Human Life Alliance at 651-484-1040



LETTER TO CANADA'S SUPREME COURT REGARDING ASSISTED SUICIDE

Canada's Supreme Court is considering the matter of assisted suicide. Will they strike down the nation's laws against it, just like they struck down Canada's law on abortion in 1988? I fear they may, but pray they will not. On October 16, 2014 I wrote an urgent letter to the Canadian Supreme Court Chief Justice Beverley McLachlin pleading with the high court not to strike down Canada's laws pertaining to assisted suicide. Below is the text of that letter. - Mark Davis Pickup

Dear Chief Justice McLachlin:

Canada's Supreme Court is considering the case of Kay Carter and physician assisted suicide. As a Canadian who has been incurably ill and disabled for more than 30 years with degenerative multiple sclerosis (MS), **I implore the Supreme Court not to strike down Canada's laws prohibiting assisted suicide.** The laws are there to protect vulnerable people when they are at their lowest point of life and overwhelmed by their circumstances. Let me illustrate:

I was diagnosed with MS in 1984. At about the 2-3 year point in my downhill slide with MS, my grief was so profound and unimaginable, my sorrow so deep, my heartache so sharp, that my judgment was clouded (although I did not know that at the time). If assisted suicide had been available in the mid-1980s, and if I had not been surrounded by people who held up my value even when I doubted it, I may have taken my life at a low point. I am so glad now that did not happen. I needed to safely grieve and not be helped with a death wish I might have expressed at my lowest point. Back then, I could not see past my darkness. I had no idea that the future would eventually grace my life with five beautiful grandchildren to love and new avenues for joy and new reasons to live despite my chronic, incurable, degenerative disease and serious disability.

You will hear much about unbearable pain and suffering. Such arguments are suitable to the 1970s not the 21st Century. Pain management has become so advanced it can eliminate all physical pain. Ottawa's Dr. John Scott is a world renowned palliative care and pain management specialist. He wrote: "The World Health Organization has demonstrated that access to pain-

relieving drugs, along with a simple education program, can achieve relief in the vast majority of patients. Specialists in various parts of the world estimate that these basic approaches can control 85-98 percent of cases. The remaining cases require more careful attention and the use of multiple drugs and therapies to achieve **complete relief** [emphasis mine]."*

Those words were written back in 1995. How much more has the wonderful science of pain relief progressed in these intervening 19 years?! If someone is suffering great pain in 2014, they do not need suicide, they need a new doctor! For a civilized society, the answer to suffering is never to kill the sufferer, rather to protect and care for them within state-of-the-art palliation which does not, and must not, include suicide or euthanasia.

AUTONOMY VERSUS COMMUNITY

I want to conclude with this thought: Many people hold up personal autonomy and independence as the highest rights. But, if you value community, they are not the highest rights. The idea of independent personal autonomy is diametrically opposed to the concept of interdependent community. One person's actions don't affect just them. They never do. If I choose assisted suicide it will affect my wife, my children and my grandchildren. It will affect my doctor because I will ask her to stop being a healer and become my killer. My suicide will affect my community and, in a small way, it will affect my nation by helping to entrench the notion there is such a thing as a life unworthy to be lived.

No, Madam Chief Justice, no one has a right to assisted suicide and that includes the incurably ill and disabled, like me. It will not just affect me - it will help to put in peril vulnerable people who will come after me. No matter how sick I become I still have a responsibility to the Common Good of society and posterity. I have a right to expect the best palliative care available and those things that foster life with dignity, even at its end.

Believe me,
dear Chief Justice,
Yours sincerely.

Mark Davis Pickup

*John Scott, M.D., *EUTHANASIA AND ASSISTED SUICIDE: The Current Debate*, edited by Ian Gentles, Stoddart Publishing Co., 1995, page 96.

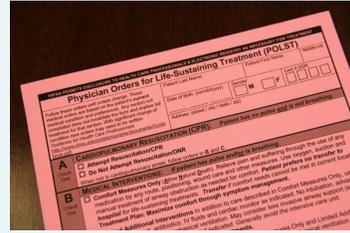
About the author: Mark Davis Pickup is a member of the Pro-life Healthcare Alliance Advisory Committee and Speakers Bureau. As a speaker, he addresses "I Am More Than My Disability," "Suffering, Disability, and the Sanctity, Dignity and Equality of All Human Life," "Abortion, Euthanasia, Assisted suicide," "Ethics Pertaining to End of Life Care," "Bioethical Issues." To learn more about Mr. Davis, visit the Pro-life Healthcare Alliance website at <http://www.prolifehealthcare.org/>

This letter is reprinted with permission. Source: www.humanlifematters.org

POLST: Not as advertised

This month's Case in Point illustrates some of the most serious problems with POLST (Physician Orders for Life-Sustaining Treatment).[i]

POLST is advertised as a way to enhance patient autonomy and ensure a patient's medical treatment wishes are respected and followed. In actuality, POLST limits a patient's choices to the few treatment options listed on the form. A patient is asked to put himself in a category, e.g., Full Treatment, Limited Additional Interventions, or Comfort Measures Only.[ii] In many cases, a patient's medical situation, needs and preferences don't fit exactly into any of these categories. Complicated medical situations call for careful assessment of the patient's condition and treatment options as well as creativity. Medicine, after all, is both a science and an art. The limited cookie-cutter treatment options a POLST form offers do not ensure that a patient has all the information necessary to express his genuine treatment preferences. Furthermore, a POLST may actually tie the hands of a health care provider who is forced to follow the directions in a POLST form rather than his/her own medical judgment.



Additionally, POLST does not improve the quality of medical decision-making. It is impossible to make morally sound, sensible, informed health care decisions based on guesswork about some future medical situation and future treatment options. Health care decisions must be based on current information.

As noted in this month's Case in Point, POLST is advertised as being voluntary. Don't let anyone force you or a loved one to fill out a POLST form. It might not be as easy to revoke as POLST promoters say it is.[iii]

[i] For more information on POLST see *Informed: A guide for critical medical decisions* at www.humanlife.org and "The POLST form: You could be signing your life away," Julie Grimstad, *Celebrate Life*, May-June 2014, <http://www.clmagazine.org/article/index/id/MTM4MDA/>

[ii] The Pennsylvania POLST lists these treatment categories. Other states' POLST forms may have different wording.

[iii] Pennsylvania Orders for Life-Sustaining Treatment (POLST) Frequently Asked Questions: "Can a patient revoke a POLST? Yes. Should a patient revoke a POLST, 'VOID' should be written on the front side of the form. A new form can then be completed, but a new POLST is not required." Source: <http://www.upmc.com/Services/AgingInstitute/partnerships-and-collaborations/Documents/POLST-FAQs.pdf>

Case in Point

By Dr. Brian J. Kopp

Jim is 79 years old and resides in a county nursing home in Pennsylvania. He has needed a wheelchair for over two decades due to advanced MS, with a history of severe decubitus ulcers, recurrent respiratory infections and severe urinary tract infections (UTI). A stalwart pro-lifer and deeply committed Catholic, Jim desires to follow the teachings of his Church regarding end of life care. He accepts his suffering and actively offers it up for the pro-life movement and the salvation of souls. He has always asked for a full code (cardio-pulmonary resuscitation) and everything that may prolong his life because he knows the value of suffering and the desperate need for sacrifice in this fallen world. In the past, he has declined the nursing home's requests to fill out a Living Will,[i] preferring to have a friend, a fellow pro-life activist, serve as his medical decision-maker. Jim appointed this friend to be his legal agent in a Health Care Power of Attorney (HCPA).[ii] This has worked well for coordinating his care in the past.

In December of 2013, without his agent's knowledge or consent, the nursing home required Jim to fill out and sign a POLST form, explaining that their institution and parent company now require this of all their patients. In retrospect, his agent noticed that she had started receiving fewer and fewer calls about Jim's care since the New Year. Many in health care fields have noted that, once a POLST is obtained, the agent named in a HCPA is sidelined when it comes to critical care decisions. [Note: Generally, an agent makes medical decisions for the patient only when the patient is incapable of making them for himself. However, a person may stipulate in his HCPA that his agent be involved in all medical decisions even when the person is competent.]

Jim was hospitalized for UTI and sepsis in late August 2014, his fourth hospitalization this year. When he returned to the county home, the staff encouraged him to change his status to a DNR (do not resuscitate). Jim has struggled with his DNR (do not resuscitate) decision for a while. According to his agent:

Whenever he comes back [to the nursing home], as part of procedure, they ask if he still wants a full code. This time he told me that it would be easy to say no to a full code.

I sensed a change in his attitude, so today I went to visit and talk with him. His question: Is the DNR the best decision in his case when there is a choice of full code to continue serving the Lord in suffering? If the Church says that a DNR order is appropriate in Jim's case, which is more pleasing to God? He began to talk about not wanting to be on the first floor of [the nursing home] because that is where you are when you have a ventilator. He feels that he would be so isolated there and the quality of life he enjoys now, with being able to have a Rosary group and especially take care of Father [his roommate], would be gone. Would he be wrong to say no to the ventilator? He sees this as trying to avoid suffering.

After careful consideration, Jim chose a DNR status. In discussing the options, his agent was made aware that Jim had filled out a POLST in December, not comprehending the implications of the form for his health care decisions. His agent explained the problems with POLST forms and obtained another HCPA form, had it signed and notarized. She and Jim presented the new HCPA to the nursing home staff, requesting it be placed in his chart and the POLST be made null and void. The nursing home refused, stating that it is their facility's policy to have a completed POLST form in the chart for every patient. As a compromise, Jim and his agent requested the POLST form be amended to indicate DNR status but with "Full Treatment." The nursing home staff again refused, stating they did not permit a DNR status in conjunction with the "Full Treatment" option; it could only be used with the "Limited Treatment" POLST option.

Jim's agent contacted me for assistance. I joined her for a follow up meeting with the Director of Nursing and Social Worker. A printed copy of the following letter, with the Federal and State rules and regulations regarding advance directives, were provided to the staff (bold and underlining added for emphasis):

Federal law (2006)] prohibits health facilities from requiring anyone to execute an advance directive, including POLST:

Code of Federal Regulations

Title 42 ' Chapter IV ' Subchapter G ' Part 489 ' Subpart I ' Section 489.102

Requirements for providers.

(a) Hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care (and for Medicaid purposes, providers of personal care services), hospices, and religious nonmedical health care institutions must maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care, or patient care in the case of a patient in a religious nonmedical health care institution, by or through the provider and are required to:

...

(3) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(4) Ensure compliance with requirements of State law (whether statutory or recognized by the courts of the State) regarding advance directives. The provider must inform individuals **that complaints concerning the advance directive requirements may be filed with the State survey and certification agency;**

2012 Pennsylvania Consolidated Statutes, Title 20 - DECEDENTS, ESTATES AND FIDUCIARIES Chapter 54 - Health Care, Section 5428 - Health care instruments optional, § 5428, states: "**A health care provider...may not: (1) Require an individual to execute an advance health care directive or order...as a condition for...receiving health care services...**"

Furthermore, the National POLST Paradigm Task Force (see www.polst.org, "FAQ") states, "Remember, the use of a POLST form is *always voluntary*." [Emphasis in original]

§ 5425 specifically states, "**If a provision of an advance directive conflicts with a provision of another advance health care directive, the provision of the instrument latest in date of execution shall prevail to the extent of the conflict unless the instruments expressly provide otherwise.**"

Obviously, the POLST conflicts with the latest advance directive, Jim's new Health Care Power of Attorney, and is therefore not enforceable.

Section § 5444, in regard to a Living Will, says: "**A revocation is effective upon communication to the attending physician or other health care provider by the principal or a witness to the revocation.**" This also applies to any advance directive, because section § 5459 also permits revocation of a Health Care Power of Attorney. This law obviously applies to all advance directives and POLST is a directive for health care, so it can be revoked/replaced by another advance directive (e.g., a Health Care Power of Attorney).

Based upon this documentation, the staff agreed that, in principle, the facility cannot require a POLST in every patient's file. In Jim's case, they also agreed to fill out his POLST with both DNR status as well as "Full Treatment." They agreed to consult the HCPA agent for all medical decisions, regardless of the POLST. Finally, they agreed that for any patient or responsible party opposed to POLST, some other form of advance directives should be available. As of this writing, unfortunately, Jim's POLST is still in effect.

[i] "Living Will" is a type of health care advance directive defined in Pennsylvania law (Title 20, Chapter 54): "A writing made in accordance with this chapter that expresses a principal's wishes and instructions for health care and health care directions when the principle is determined to be incompetent and has an end-stage medical condition or is permanently unconscious."

[ii] "Health Care Power of Attorney" is defined in Pennsylvania law (Title 2, Chapter 54): "A writing made by a principal designating an individual to make health care decisions for the principal."

Take Action

In spite of heroic and persistent efforts made by pro-life organizations and individuals,

the stark reality is that the healthcare system itself has become an ever-increasing threat to the well-being and lives of the preborn, the young, the old and the disabled and ailing of any age. The PHA is dedicated to renewing reverence for life within healthcare. For some excellent information about current and historical issues regarding abortion, contraception, euthanasia, stealth euthanasia, hospice, advance directives and other pertinent topics, please check out these resources.

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

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

[Pro-life Healthcare Alliance](#)

[Hospice Patient's Alliance](#)

[Euthanasia Prevention Coalition](#)

[Patient's Rights Council](#)

[Read Stealth Euthanasia: Health Care Tyranny in America by Ron Panzer](#)

[Prenatal Partners for Life](#)

Pray for renewal of reverence for life. In particular we have designated Thursday as a special day of prayer for the mission of the PHA.

STAY CONNECTED



Pro-life Healthcare Alliance

a program of [Human Life Alliance](#)
1614 93rd Lane NE, Minneapolis, MN 55449
Tel 651.484.1040