Pro-life Healthcare Alliance
A Committee of Human Life Alliance

Dec. 20, 2013

PHA Monthly

Newsletter for the Pro-Life Healthcare Alliance
Sixth Edition

Welcome to the sixth 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.

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/mission-statement.html).
- 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.

Embracing the Journey:
Providing comfort and support in the final phase of life

By Cristen Krebs, DNP, ANP-BC

Human life is a precious gift. The uncertainty of life compels us to appreciate its fragility.

Just as the onset of labor and date of delivery is a mystery, no one can predict the exact day, hour or moment of death. When a loved one is living the last stages of a terminal illness, family and friends often question when death will occur. Because the process of dying is a personal journey, the time of death is difficult to predict, even for doctors and nurses who specialize in care of the dying. While certain symptoms are usually associated with the natural dying process, these symptoms of approaching death may vary a bit depending on the unique end stage illness a person is experiencing. Not all the symptoms will be present in every case, and most individuals demonstrate a combination of the symptoms in their final days or hours of life. Additionally, some individuals never display any of the common symptoms as death approaches.

The dying process usually begins several weeks before death occurs. As the physical body begins to decline, an individual's emotions and sense of spirituality also begin to change as the mind strives to embrace one's own mortality.

The following list accounts for the most common changes that occur in the last months, weeks and days of life. This article is also intended as a guide for providing comfort and support to patients as they approach death.

Withdrawal from Family and Friends
In the process of accepting their own mortality and approaching death, patients often begin to withdraw from their immediate surroundings and family and friends closest to them. Even activities previously pleasurable to the patient may be abandoned as death nears. This process of separating from their earthly world while contemplating life and past memories is a necessary part of the dying process for many patients. Patients experiencing the final stages of a terminal illness frequently decline visits from family and friends. Visitors can easily exhaust a patient and leave the patient feeling as if they are responsible to entertain them. When visitors are permitted, patients often act reserved and introverted. Additionally, patients who have had a long day of visitors often display increased fatigue and exhaustion the following day. This may result in the patient sleeping much of the day, being unable to awaken easily, or not communicating verbally.

During this time, patients require privacy. It is necessary to respect a patient's wishes for solitude and quietly express love to the patient during this period of withdrawal. Patients nearing the final phase of terminal illness are very sensitive to what is communicated by those around them--both verbally and non-verbally. Calmly sitting nearby, holding hands, or offering silent prayers are ways to remain engaged with a loved one who is withdrawing. Providing safe, peaceful and comforting surroundings allows the patient the time needed to reflect on life closure.

Loss of Appetite and Weight Loss
As the body begins a natural decline, an individual's energy needs also decline. The energy required by the body to process food becomes greater than the energy the body can derive from it. As a result, patients often experience a loss of appetite and routine eating habits change. Patients frequently refuse full meals and large amount of liquids and request smaller quantities of food items that are soft and bland, such as puddings, scrambled eggs, or hot cereals. Favorite foods are also of little interest as the body declines.

We are taught at a young age that food is a fuel that gives the body energy and helps sustain life.

Family and friends want to nourish their loved one with plenty of good food in the hopes that the patient will begin to feel stronger and possibly recover or live longer. While caregivers are often troubled by the patient's loss of appetite, and subsequent weight loss, it is important they understand the patient's refusal of food to be a signal that nourishment must be derived in other ways--through the mind, soul and spirit. Additionally, they should be aware that the body naturally requires less food and drink as it declines. Caregivers can frequently offer sips of liquids and ice chips, or small bites of ice cream, pudding or other soft foods.

Refraining from force feeding and following the patient's food requests will enhance comfort. Forcing a patient to eat or making them feel guilty if they refuse food, strains the patient-caregiver relationship and may lead to patient isolation. Patients who are declining require reassurance that loss of appetite is accepted. This respect and acceptance ultimately enhances patient comfort.

In the last 2-3 days of life, the patient may be unable to swallow, resulting in the inability to take medications by mouth. At this time, caregivers can apply balm or petroleum jelly to the lips to keep them moist, and can use mouth swabs dipped in cool water to keep oral membranes hydrated. These measures further ensure comfort.

Declining Metabolism and Excessive Weakness, Fatigue and Sleep
As the patient's food/fluid intake and metabolism decline, the body begins to display other changes. Body temperature lowers by a degree or more, blood pressure slowly lowers, and the pulse becomes irregular and may slow down or speed up.

As these changes occur, less oxygen is available to the muscles, resulting in increased weakness. It requires more effort to complete everyday tasks that were previously easy to accomplish. Patients often display discouragement or depression as they resolve to ask for assistance with bathing, walking, and eating.

Patients may begin to sleep 12-20 hours each day and may be difficult to awaken. Even simple activities become difficult, such as changing position, holding a cup, or sipping from a straw. As the fatigue and amount of sleep per day intensifies, the patient's awareness of immediate and even familiar surroundings begins to fade.

Caregivers assisting with daily physical tasks must remain sensitive to the patient's feelings.

Allowing the patient to sleep without interruption is essential as the body and mind decline. Keep in mind however that a patient's sense of hearing is believed to remain intact up until the time of death. Therefore, even if the patient appears unresponsive, presume all verbal communications can be heard.

Mental Confusion or Disorientation
During the progression of terminal illness, a patient's level of awareness often changes frequently and unexpectedly. As the body adjusts to a slower metabolism, vital internal organs also slow down, including the brain. When a patient becomes confused, it can be due to decrease of oxygen to the brain resulting in the inability to recognize familiar people or places, or the current time of day or year. Also, patients may hear voices or see visions. This type of disorientation is common.

As mental capacity declines, the patient may no longer speak or answer questions, and their responses may be slow and difficult to comprehend. Responding to or openly conversing with people who can't be seen in the room by others is common. Often these people are ones who have already died. Hallucinations and visions, especially if they are of deceased loved ones, can be comforting to the patient and the caregiver.

Caregivers and visitors are encouraged to always identify themselves and speak softly and calmly to the patient, while not placing expectations on the patient. A reassuring voice and gentle physical presence provides much comfort. Caregivers should never negate what a patient is saying or seeing, or debate with them. This confused state becomes the patient's reality. It is often a pleasant and comforting experience and may be a sign that the patient's mind is at peace with joyful and happy thoughts. Attempting to convince a pleasantly confused patient that a loved one isn't there can make that person agitated or combative.

If the patient begins to express, verbally or non-verbally, upsetting or disturbing experiences, caregivers are encouraged to gently stroke their arm or hold their hand, while speaking calmly in a soft reassuring voice and reminding them of who you are, where they are, and what day it is.

During periods of confusion, a patient's favorite music or prayer may help to provide familiarity and comfort.

Restlessness
It is common for patients to become restless or agitated and make repetitive motions. For example, they may pick at the air, bed sheets or clothing. While these movements and actions may seem pointless and do not make sense to caregivers and visitors, they can be a sign of decreased oxygen to the brain or of other physical stress such as pain, nausea, distended bladder or constipation.

During periods of restlessness, caregivers must remain calm and stationary as they assess the needs of the patient. Caregivers must refrain from the desire to interfere or restrict a patient's restless motions, but instead strive to protect the patient from physical injury. Proper pain and symptom management is crucial to soothe a restless patient.

Restlessness can also be a sign that the patient is experiencing emotional stressors such as anxiety or spiritual distress. Praying with the patient or calling clergy to the bedside to meet one on one with the patient may help to alleviate patient fears and instill a sense of peace and confidence. Caregivers may also need to give the patient permission to 'let go' so that rest may follow.

In some cases, a patient may experience 'terminal delirium' during the last days or hours of life. Terminal delirium is defined by heightened restless activity and intense confusion that is often accompanied by hallucinations and aggressive behavior such as striking out or screaming at caregivers, or attempting to climb out of bed or leave the room. Keeping the patient safe and protecting from injury is the top priority. Utilizing medications prescribed by the patient's physician specifically to treat terminal delirium also assists in alleviating these distressing symptoms. Non-medical interventions include keeping the room safely, but not brightly, lit (bright light can increase restlessness) and maintaining a quiet room by avoiding loud noises and multiple visitors.

Difficulty Swallowing
As the body declines, the reflex that controls swallowing becomes weaker. Patients often experience difficulty swallowing and may even develop fears when taking food or fluids by mouth.

Caregivers are encouraged to offer small amounts (half a teaspoon) of food or fluid and observe the mouth and throat to see if swallowing has taken place. Also, to enhance patient safety, caregivers should feed a patient only after the patient is placed in an upright position, with head elevated, straight and not turned to the side. Caregivers must never orally feed or hydrate a patient who is unable to awaken fully to swallow, is unconscious, can no longer hold their head up, or remain upright, as the risk of aspiration of food/fluid into the lungs is increased.

A patient's food tolerance most often progresses from solid foods to soft foods, and then from liquids (soups and dietary supplements) to ice chips and water/juice spooned or sucked from a straw. The sucking reflex often remains intact until the last days/hours before death.

Difficulty swallowing can hinder the patient's ability to swallow oral medications. When this occurs, alternative medications or modes of delivery are available. For example, some medications can be crushed and capsules opened and mixed with pudding, yogurt or like foods, and many pharmacies can manufacture medications to be given as drops under the tongue, patches for the skin, or topical creams and gels applied directly to the skin.

Elimination
As weakness increases and circulation of blood and oxygen diminish, the muscles that control the bowel and bladder are also affected. These muscles often begin to relax and incontinence (involuntary loss of urine or feces) may occur. The patient may experience embarrassment as a result of incontinence. Caregivers must offer dignified and respectful care.

Additionally, as the patient's oral fluid intake diminishes the amount of urine produced decreases. Urine becomes dark in color, indicating that the kidneys are shutting down. At times, a urinary catheter is necessary to drain the bladder and keep urine away from the patient's skin.

As the kidneys shut down, body fluids often accumulate in areas of the body that are away from the heart, such as the patient's feet and ankles. However, the fluid may also accumulate in the patient's face, hands, or torso. The skin begins to work to eliminate toxins from the body. As a result, the patient may complain of itching over different parts of the body, and may experience increased sweating. Offering the patient warm baths, frequent linen changes, frequent repositioning, or cool cloths for the face, armpits or groin may provide relief from skin irritations.

Keeping the skin clean and dry is essential to comfort. Incontinence and sweat can lead to skin rashes or open sores that lead to further discomfort.

While daily bowel movements are not expected as a patient declines, too many days between bowel eliminations can result in problems and increased discomfort. Therefore, caregivers are encouraged to keep track of each bowel movement. As food intake decreases, smaller less frequent bowel movements can be expected.

Cooling Body Temperature and Skin Color Changes
In the days and hours before death, blood circulation draws back from the arms and legs as vital organs work hard to retain circulation. Mechanisms that control the body's ability to control its temperature will start failing. Hands, feet, fingers, and toes become cool to the touch. Lips and nail beds may also look more pale or bluish. At times, the patient may complain of feeling cold as circulation declines. Warm blankets provide comfort if needed. Also, it is important to avoid drafts that may cause the body's temperature to fall too fast and cause shivering.

The patient's skin may develop a distinctive pattern of blotchy pale purplish/reddish/bluish coloring called mottling. This is one of the later signs of approaching death that results from a reduction in blood circulation. Mottling is often first detected on the soles of the feet, toes and knees, and may slowly work its way up the legs, torso, and arms.

Labored Breathing
Changes in breathing patterns are common as patients decline.

Intermittent use of oxygen is often beneficial if breathing becomes difficult, or irregular due to anxiety. Also, a ceiling or floor fan blown over the patient's body may give the sensation of being

in fresh air, providing comfort and relief. Furthermore, keeping the head of the bed elevated can enhance breathing.

As a patient approaches death, breathing often becomes irregular, shallow and labored. The exhalation (out-breath) is longer than the inhalation (in-breath). For some patients, a distinctive pattern of breathing, known as Cheyne-Stokes respirations, occurs. Cheyne-Stokes respirations consist of loud, deep, and rapid respirations (up to 30-50 per minute) that involve the whole rib cage, followed by a pause in breathing (apnea) for a period of approximately five seconds to as long as a full minute. Following this period of apnea, the loud, deep breathing resumes. The patient is not aware of this altered breathing pattern. The cycle of loud breathing with pauses may continue for a few days, several hours or minutes until death occurs, and can be stressful for caregivers to observe.

Sometimes congestion and excessive secretions create coughing or loud, gurgling sounds during inhalation and exhalation. These sounds are often referred to as the "death rattle." When a patient can no longer swallow, this "rattle" is caused by the accumulation of saliva in the back of the throat. While the noise can be distressing to caregivers, it does not seem bothersome to the patient. Because the pool of secretions is too far down the throat, the use of suctioning devices is not recommended. Suctioning can result in increased oral secretions. It is sometimes beneficial to reposition the patient with their head to the side to allow secretions to naturally drain from the mouth.

Changing the patient's position often alleviates noisy respirations. Elevating the patient's head with pillows, elevating the head of the bed, or gently rotating the patient's head or body slightly to the side may lessen audible respirations. Keeping the patient's mouth and lips moist with mouth swabs, a wet cloth or lip balm also lessens noisy breathing. Additionally, oxygen and a room vaporizer add moisture that quiets breathing.

Unexpected Alertness and Increased Energy
As previously discussed, a few days before death a patient may stop interacting with loved ones completely. Surprisingly, however, in the last days or hours, a patient may experience an unexpected period of clarity, lucidity and energy.

During this surge of energy, which can last less than an hour or up to 24 hours, the patient may wake up, become alert, and eat, talk or spend quality time with loved ones. This is a very special time for final spiritual practices and mental preparations which can be shared with loved ones.

As quickly as it occurs, the period of attentiveness grows faint, and the patient again returns to an unresponsive state. The caregivers should treasure this fleeting period of alertness, because, once it passes, the patient is usually moving closer toward death.

Saying Good-bye
It is often difficult to determine when the time has come to call family and friends to the bedside to say a final goodbye. When it becomes evident that death is near, family members and close friends should be notified and given the option to visit the patient one last time. This also allows family and friends the opportunity to support one another.

Signs of Imminent Death
In the days or hours prior to death, patient symptoms often become more intense. These symptoms include:

Little or no bladder or bowel activity

Occasional grimaces, groans, or scowls

Eyes may tear or become glazed

Glassy fixed stare with large pupils

Unresponsive to voice or pain

Unable to swallow

Unconsciousness or drifting in and out of consciousness

Faint or irregular pulse and heart beat

Falling body temperature

Mottling of the skin of the knees, feet, and hands (once the mottling starts, death often occurs within 24 hours)

Very rapid or very slow breathing through mouth (often with rattle) with pauses of 20-50 seconds between breaths

Clinical Death
Clinical death is hallmarked by the following:

No breathing (chest does not move)

No heart beat (no pulse)

Pupils large, do not change

Sometimes release of bowel or bladder

Conclusion
Caring for a loved one facing a terminal illness is a very difficult task, both physically and emotionally. Family members, friends, and other caregivers play a vital role in providing comfort and support to someone entering the final phase of life. Although dying is a natural part of life, many family and friends do not have experience caring for someone who has weeks or days to live. As caregivers attempt to meet the ever changing physical and emotional needs of their dying loved one, fear and feelings of uncertainty are common. Understanding and recognizing the symptoms of dying prepares caregivers for the changes their loved one will be experiencing. The information provided in this article is intended to teach and guide caregivers, while enhancing caregiver confidence.

Being well informed of these signs and symptoms also assists patients and their loved ones to reach acceptance of the impending death. Enhanced acceptance empowers family, friends and other caregivers to surround a loved one with comfort and peace, enabling their loved one to experience a natural death in God's time--a beautiful gift and privilege.

About the author: Cristen M. Krebs, DNP, ANP-BC, is the Founder/Executive Director of Catholic Hospice of Pittsburgh and a member of the Pro-life Healthcare Alliance Advisory Committee.

Dr. Krebs began her career in oncology nursing and has twenty plus years' experience in end of life care. During this time, her passion for helping those at end of life began. After several years

in the field of hospice nursing, disheartened that hospices in the Pittsburgh region were becoming more business oriented than patient focused, Dr. Krebs became increasingly concerned that direct patient care was being compromised. In 1997, believing that these patients deserved better, Dr. Krebs began the first faith-based, nonprofit hospice program serving Pittsburgh and surrounding counties. This program, *Good Samaritan Hospice*, began in the Fall of 1998 and grew under her tenure through April 2007. Dr. Krebs' vision was also the driving force for building The *Good Samaritan House*, the first free-standing hospice residence in southwestern Pennsylvania. This beautiful home served those who could not safely remain in their own homes during their final weeks of life. Under Dr. Krebs' direction, a second inpatient hospice unit was designed, as well as *Camp Good SAM- A Pediatric Bereavement Camp.*

Believing that the founding Christian mission of hospice required a louder voice, in May 2007, she incorporated *Catholic Hospice*, the only *pro-life,* non-profit hospice in Pittsburgh. Catholic Hospice embraces the Vatican's Declaration on Euthanasia, encouraging all faiths to uphold the teachings of the Church when caring for those experiencing terminal illness.

Dr. Krebs received the 2003 *Carlow College/Pittsburgh Women of Spirit Award* as well as the 2008 *Penny Smith Award* for courage and determination to rebuild a faith-based hospice and empower predominantly female employees who work alongside her in sharing the mission of caring for the dying.

With fraudulent hospice practices against Medicare and other insurance carriers on the rise in the United States, Dr. Krebs spearheads education, for both health care professionals and health care consumers, regarding Medicare Hospice Law and Hospice Patient Rights and Entitlements.

Dr. Krebs resides with her family in the north hills of Pittsburgh, where she enjoys spending time with her five children.

Case in Point-2013

A Minnesota woman, now in her late 50s, was diagnosed with Multiple Sclerosis at age 28. Previously a very active runner and body builder, she has an extremely positive outlook in spite of her disability. She was recently admitted to a hospital suffering from pneumonia. A physician attempted to drain fluid from her lung which caused her lung to collapse. She doesn't have the muscle strength to cough. After a week, she still was not responding to antibiotics, so the physician suggested to her husband that he might want to let her die. Her husband said no. He was shocked (and still is) that the doctor would suggest such a thing. The woman began recovering the next day and is now home.

PHA comment: Unfortunately, medical advice for patients who are chronically ill or disabled is frequently based on an unjust and prejudicial "quality of life" standard instead of the objective "sanctity of life" standard. The latter standard holds sacred the life of every human being regardless of physical or mental condition, age, or "usefulness." It is the profound obligation of physicians to regard every patient as worthy of their best efforts to protect and preserve the patient's life and never to extinguish hope, for there is no greater medicine than hope.

Merry Christmas!

By Ralph and Andrea Capone

Saint Gianna Sodality for the Sanctity of All Human Life is a parish organization (Our Lady of

Grace, Diocese of Greensburg, PA) that we started in January 2011. In a few short years the Holy Spirit has blessed us by enabling us to spread the gospel of life in and around our local area. The Sodality is uniquely dedicated to safeguarding the dignity and sanctity of human life from its very beginning to its natural end. Human life, both at the beginning and end of our days, is endangered in a culture darkened by sin. Selfishness, materialism, greed, injustice, and violence threaten many, including our pre-born, disabled and elderly. We identify with those among us who are threatened with extinction. We cry out in the wilderness of this feral and hypocritical culture that speaks of "social justice" but metes out no justice to those whose voices are weak or lost. The Sodality's mission is a reaction to the cumulative assaults upon and degradation of life.To quote from our mission statement: "The Sodality believes that genuine respect for life is achieved through prayer, education and self-sacrificial love modeled on our Lord and Savior, Jesus Christ and His saints, e.g., Saint Gianna Beretta Molla, who emptied herself and followed Him. Thus, we dedicate ourselves to prayer, constant learning and charitable works in order to advance the transcendent dignity of human life..."

One of our charitable works, made possible by the bountiful and unsolicited generosity of many, is our billboard for life campaign. Since our inception, in collaboration with Pro-Life Across America (www.prolifeacrossamerica.org), we have sponsored four pro-life billboards focusing on preventing abortions. This most recent billboard is located on a main thoroughfare, Pittsburgh Street in Greensburg, PA. It is a propitious location because it is on the way to the local hospital.

Christ summarized the old law in creating the new law. It is simply this: love God with your entire being and love your neighbor as yourself. These are clear directives though hardly simple to follow unless we cooperate with His grace. We must identify in love with those whose basic right to life is under assault. The Sodality seeks to pray, to educate and to lovingly agitate in order to shed the detritus of death in this un-lightened culture.

Soon we are to welcome Christ into the world to enlighten and save it:
Et lux in tenebris lucet et tenebrae eam non conprehenderunt
(John 1;4,5). In Him there is great hope and joy! Merry Christmas!

Ralph A. Capone, MD, FACP (University of Pittsburgh School of Medicine), a member of the Pro-life Healthcare Alliance Working Committee, is board-certified in Hospice and Palliative Medicine and Internal Medicine. He serves as medical director of the palliative care consultation service, UPMC McKeesport Hospital. Dr. Capone and his wife Andrea are co-founders of the Saint Gianna Sodality for the Sanctity of Human Life, Our Lady of Grace Parish, Greensburg, Pennsylvania. Both he and his wife are members of the Equestrian Order of the Holy Sepulchre of Jerusalem and Dr. Capone is a 4th degree member of the Knights of Columbus. Currently, Dr. Capone is on the Adjunct Faculty, Theology Department, St. Vincent College, where he teaches Catholic Bioethics, and Adjunct Instructor, Seton Hill College, Physician Assistant Program.

ALISON DAVIS, REST IN PEACE

On December 3, 2013, Alison Davis, National Coordinator of No Less Human-UK, passed away at home. We mourn the death of a brave and gentle woman who was involved in campaigns against the legalization of euthanasia and assisted suicide in the UK for more than 26 years. Disabled by spina bifida, hydrocephalus, emphysema, osteoporosis, arthritis and kypho-scoliosis, she suffered greatly for many years. She had "a settled wish" to die that lasted over ten years and seriously attempted suicide several times. Alison stated,*"If 'assisted dying' had been legal, I wouldn't be here now. I would have missed the best years of my life. What I wish most for those who despair of life is that they could have the sort of support and the reasons for hope which turned my life around, bringing me from the brink of death to an appreciation and enjoyment of life."*

Read more about Alison's inspiring journey from death to life:

http://www.humanlife.org/eid.php

http://www.patientsrightscouncil.org/site/wp-content/uploads/2012/07/Update_2012_3.pdf, pp.4-5.

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

Euthanasia Prevention Conference, May 3, 2014, Minneapolis, MN

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

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