



Pro-life Healthcare Alliance

May 12, 2016

PHA Monthly

*Newsletter for the Pro-Life Healthcare Alliance
Thirty-first Edition*

Welcome to the thirty-first 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 Jim Hentges



On June 6, 2016, the Pro-life Healthcare Alliance will celebrate its fourth anniversary. The PHA has accomplished much and undergone many changes in four short years.

I could fill several pages with a list of the PHA's successful endeavors: educational conferences the PHA has held in various states; the publications, fact sheets and other educational materials we've helped Human Life Alliance produce; the assistance we have given to numerous people who have contacted us needing answers to their questions, someone to listen to them, medical advice or legal help to save a life; the steady growth of the PHA Referral Network of medical and legal professionals and patient advocates; the production of 31 editions of the *PHA Monthly*; etc.

And now, the PHA has an exciting announcement. Our website was relaunched just a few days ago! This major accomplishment is largely due to the expertise and hard work of two men: Anthony Walz, Web/Social Media Administrator, and Bill Beckman, retired executive director of Illinois Right to Life and member of the PHA Advisory Committee.

I invite you to explore our attractive new website at www.prolifehealthcare.org. It has a fresh look, new features, and easier access to information and articles. Now, we can put more energy into expanding the information we share with you, including facts about threats patients may face in the healthcare system, advance directives, medical decision-making, hospice, personal stories, and much more.

To those of you who remember our long-ago promise of a new website, I say, "It has finally arrived! Thank you for your patience." To those who have supported, worked with, and encouraged the PHA since its beginning, I say with heartfelt gratitude, "Many thanks and HAPPY ANNIVERSARY!"

WHEN GOING TO DIE BECOMES SUPPOSED TO DIE

By Jennifer Warner



Physician-assisted suicide (PAS) is often touted as essential for patient autonomy. However, apart from the immorality of helping to end a life, not enough attention is given to how PAS might also be misused by people with selfish aims.

In 2014, shortly before the End of Life Option Act (which decriminalized PAS) began wending its way through the California legislature, I learned a bitter lesson: *a law that is meant to protect the rights of the infirm can be used as a*

vehicle for violating those very rights.

In July 2014, my grandmother--who raised me as her own child--went under probate conservatorship. Previously, I was caring for her and had medical power of attorney, but I did not have access to the money needed to pay for her expensive in-home custodial care. So, I agreed to allow a licensed professional fiduciary to become her court-appointed conservator, subject to the California Probate Code. Pursuant to this code, I was promised that the conservator would make decisions in accordance with my grandmother's wishes. It was also understood that the conservator would share medical consent with her, which meant that he could not force any medical treatment on her, unless it was an emergency. Also, he was to be supervised by the court.

A soon-to-be centenarian in the last stages of congestive heart failure, Grandma's simple wish was to live out the remainder of her life in her own home, surrounded by family. But the conservator had a different agenda.

Soon after taking power, the conservator put Grandma on hospice care and signed a do-not-resuscitate order on her behalf. He began isolating her from family members and withdrew permission for us to communicate with her medical professionals, including hospice staff. Then--completely out of the blue--he informed us that Grandma's health had suddenly declined, and she was in need of mandated bed rest and an end-of-life cocktail that included liquid morphine. The clincher: he said the hospice predicted that she would be dead within the month.

No One Asked Grandma

It does not seem out of the ordinary for a very old woman receiving hospice care to have a sudden decline in health. The problem was that we, her family, did not observe any sign of decline. She was still walking around the house, had a robust appetite, and was talkative and upbeat. We were planning her 100th birthday bash, and she was counting down the days until she would blow out her candles.

We saw no need for a powerful narcotic, as Grandma was not complaining of pain. In fact, she had always avoided strong medications. She even put up a fuss about taking Tylenol. Everyone--including

her conservator--knew this. Yet I watched in horror as the morphine was brought into her home, and her caregivers were instructed to put it under her tongue if they thought she needed it. No one asked Grandma if she wanted morphine, so I took it upon myself to do so. She emphatically answered that she had no interest in taking morphine *under any circumstances*.

In spite of her wishes, the conservator increased his efforts to give it to her, and told me numerous times that he or the caregivers could administer the morphine, but not the family. Therefore, I filed paperwork with the court to stop them. I also petitioned the court to have the restrictions on my visits overturned and for clarification regarding how the end-of-life medications would be handled, including who could administer them. The conservator stated before the judge that he had the power to administer morphine himself.

Then came the chilling revelation that no hospice staff had actually told the conservator that my grandmother was on the brink of death. I could draw only one conclusion: the conservator was trying to shorten Grandma's life by giving her drugs she did not want or need.

Why would he do such a thing? I will never know for sure, but it may have been because I had agreed to make him sole trustee of my grandmother's large estate, upon her death. Relying on the benevolence of a court-appointed who portrayed himself to be a compassionate father figure and devoted churchgoer, I had unwittingly given him the financial incentive and the power to snuff out my grandmother's life.

Worse still, with all of the power he wielded as her conservator, he was in a position to continue pushing his agenda, even after he realized I was onto him. For over two months he continued to look for any excuse possible to push morphine on my grandmother. I pleaded with Adult Protective Services, local law enforcement, and eventually the probate court to investigate his actions and to protect my grandmother, but my pleas went unheeded.

She never received a drop of morphine--only because she had family members who stood between her and the conservator. The threat was finally removed when the hospice personnel decided to withdraw from her case and took their drugs with them. Grandma went on to live another whole year without hospice care and without needing any drugs. And she celebrated her 100th birthday in style.

Too Much Power, Too Little Accountability

Having experienced this nightmare, I am terribly concerned about the unintended consequences of California's End of Life Option Act, which is slated to go into effect on June 9. Like conservatorship, legalized PAS is meant to be a last resort for people who see no way out of a crisis. Its premise is that those charged with assisting the desperate person are compassionate helpers with noble intentions.

As my grandmother's case demonstrates, conservatorship in the wrong hands can be harmful to a vulnerable person. Likewise, the End of Life Option Act gives one human being the power to end the life of another human being who is vulnerable due to illness.

This act leaves the door wide open for abuse because it gives one attending physician a huge amount of power with almost no accountability. The attending physician is responsible for determining that

the patient is terminally ill (that is, in the doctor's estimation, the patient has six months or less to live) as well as explaining the End of Life Option and its alternatives to the patient. Furthermore, this physician, whether or not he is qualified to do so, is supposed to determine that the patient is competent to give medical consent, is not displaying signs of a mental disorder that could impair judgment, and is not being unduly influenced to choose PAS. So, the patient will likely be relying upon this one doctor for all of the information needed to make an informed choice, and the same doctor must decide whether the choice is a valid one.

This same attending physician prescribes the lethal drug. Also, while not required to do so, this physician is allowed to prepare the drug, deliver the drug (see California Health and Safety Code, Section 443.5(b)(1)), and act as the only witness to the ingestion of the fatal drug--presumably self-administered by the patient.

From start to finish, it is possible for the attending physician to carry out PAS with almost no interference, even from the patient's loved ones. The law specifically states that the attending physician has to have a discussion with the patient "outside of the presence of any other persons" (Section 443.5(a)(4)) and that a patient's request cannot be denied because he or she "declines or is unable to notify next of kin" (Section 443.5 (a)(5)(C)). Translation: even if the patient showed every intention of including family members in medical decisions, the doctor can simply claim that the patient communicated in private that he or she wanted this one decision to be kept a secret.

The only outside documentation of the patient's request for suicide comes from the consulting physician and the two written requests that are supposed to be signed by the patient. However, a closer reading of the law reveals that these also pass through the attending physician. The attending physician makes the referral to this "independent" consulting physician, so it would not be difficult to find another doctor who shares his agenda, especially since, according to the California Medical Association's analysis of the End of Life Option Act's legal requirements, "The law does not define 'independent.'" Furthermore, the consulting physician does not submit his or her documentation directly to the California Department of Public Health (CDPH), but to the attending physician. The same is true of the written requests signed by the patient. The patient's first request must be submitted by the attending physician to the CDPH within 30 days of writing the prescription. The patient could be dead by then.

As if these facts are not bad enough, the attending physician does not have an affirmative obligation to determine whether the lethal drugs are used, when they are used, whether anyone witnessed their use, or what happened to any remaining drugs. Once the drug is prescribed, there is no one providing direct supervision over what happens next, including ensuring that the patient still actually wants to take the lethal dose. So, in addition to having immunity from all liability, as long as he or she acts in "good faith compliance" with the law (Section 443.14(b)), the attending physician can always fall back on plausible deniability (i.e., claim innocence by denying knowledge of or involvement in certain events).

Opening the Door to Invisible Crime

The End of Life Option Act makes it possible for a person to be ushered into death without the person's loved ones knowing what happened. The attending physician does not need to inform anyone of the

request for suicide, and the act could be committed when the doctor is alone with the patient. The doctor will presumably tell everyone that the patient died of natural causes, and the death certificate will confirm it because actions taken under the act "shall not, for any purposes, constitute suicide, assisted suicide, homicide, or elder abuse under the law" (Section 443.18).

Assuming adherence to the law, the patient's medical record will indicate PAS, but would a family think to ask for these records? The documents submitted to the CDPH are confidential and cannot be discoverable (Section 443.19(a)), so it is improbable that family members will be able to access this information. Indeed, this law makes it difficult to detect suicide, let alone confirm that it was voluntary. Besides, who will investigate the matter if there is suspicion that it was not? The act is silent on this point.

I shudder to think what might have happened if the End of Life Option Act had been available to my grandmother's conservator. It is plausible that she would have been a candidate, since she was considered "terminal" and retained her ability to consent to her own medical treatment. The conservator could have "shopped" for one additional doctor who was willing to overlook my grandmother's wishes. Her attending physician likely would have been on board, since he ignored her wishes regarding the morphine. With the "aid in dying" prescription in hand, the conservator could have had it delivered directly to himself and given it to my grandmother while alone with her. This all could have been accomplished under the cover of confidentiality, since, as conservator, it was his legal prerogative to exclude the family from medical decisions.

Instead of having received an email telling me that my grandmother had suddenly declined and was going to need end-of-life medications, it is likely that the conservator would have told me that my grandmother had passed away in her sleep--from natural causes, of course.

Jennifer Warner is a mental health professional and elder advocate. She lives in the San Francisco Bay area. For more information, see the video A Centenarian's Conservatorship Story at https://youtu.be/X7QU85_vEF4.

References:

California Health and Safety Code, Division 1, Part 1.85: End of Life Option Act(Section 443),https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520162AB15.

California Medical Association Legal Counsel, *Document #3459: The California End of Life Option Act*, (CMA On-Call Online Health Law Library, January 2016), <http://www.cmanet.org/resource-library/detail/?item=the-california-end-of-life-option-act>.

ASSISTED SUICIDE UPDATE

New York: A victory in court! On May 3, 2016, the NY Appellate Division, in *Myers v. Schneiderman*, found **no constitutional right to assisted suicide**, affirming the NY Supreme Court's previous decision (10/16/2015) to dismiss the appellants' case. Appellants were seeking a court order prohibiting prosecution of physician-assisted suicide under New York penal laws, as well as a court declaration that New York penal laws against physician-assisted suicide are unconstitutional violations of due process and equal protection provisions.

A , filed by Not Dead Yet (NDY) and 10 other national and state disability organizations, articulated many important concerns of persons opposed to assisted suicide. In their "Statement of Issues Presented," NDY, et al, wrote:

Were this Court to reverse the Supreme Court's decision, it would soon face a number of related issues in future cases, including the following:

- Why should a constitutional right be limited to people who have a disabling condition that is labeled "terminal"? Why not any disabling condition? Why not a firm decision to commit suicide by any competent person?
- Why should the constitutional right be limited to providing only lethal medications? Why not lethal injections?
- If such a constitutional right exists, why should a person's right be limited to "aid" only from doctors? What about family members, friends, or advocates?

The Appellate Court, in its 36-page decision, cited the unanimous recommendation of the New York State Task Force on Life and Law (1994) that "New York laws prohibiting assisted suicide and euthanasia should not be changed." The Court noted:

The Task Force based its view on the risks that could be presented to the elderly, poor, socially disadvantaged, and those without access to good medical care; and the role of treatable symptoms such as pain and depression in creating a desire for lethal medications. It also noted that most doctors lack a sufficiently close relationship to their patients to appropriately evaluate a request for help in ending life, and expressed the concern that it could open the door to euthanasia of those incapable of giving consent.

Indeed, cases like *Myers v. Schneiderman*, are designed by those promoting the legalization of assisted suicide precisely to open the door to expansion of the "right to die," more accurately called the "right to kill." This victory in New York is a significant setback to their deadly agenda.

Oregon and Washington: The Secretariat of Pro-Life Activities of the United States Conference of Catholic Bishops updated its fact sheet on the Oregon and Washington situations. Released February 4, 2016, it is available here: <http://www.usccb.org/issues-and-action/human-life-and-dignity/assisted-suicide/to-live-each-day/upload/Oregon-and-Washing-euthanasia-2013.pdf>

United States: Assisted suicide is legal in California, Oregon, Vermont, and Washington. In Montana,

assisted suicide may still be prosecuted, but the Montana Supreme Court created a defense for a physician who is charged with the crime of assisting a suicide. Their victory in California last year bolstered the optimism of Compassion and Choices and others working to legalize assisted suicide throughout the U.S. Nevertheless, despite persistent efforts in many states, the assisted suicide lobby has been thoroughly disappointed, thus far, in 2016.

Canada: State-sanctioned killing, barring a miracle, will be legal in Canada next month. In February 2015, Canada's Supreme Court unanimously struck down the nation's laws against assisted suicide and euthanasia, giving Parliament and the provincial legislatures a year to enact legislation "consistent with the constitutional parameters set out" by the Court. The time limit was later extended until June 6, 2016. There is no legislation in place yet, but a reading of the Supreme Court's decision leads to the conclusion that assisted suicide and euthanasia will be permitted with or without legislation that defines the rules for medical killing.

Federal liberals have proffered a bill, but frenzied debate continues with some significant dissension in the ranks. Liberal MP Robert Falcon Ouellette, a 38-year-old Cree, says he plans to vote against his party's proposed bill. He thinks the federal government should take more time to make its decision, especially in light of Attawapiskat. Attawapiskat, a Cree community in Ontario's James Bay region, recently declared a state of emergency after a rash of attempted suicides. Ouellette stated, "I think there are communities that have this issue and if you allow, all of a sudden, this to occur...it might be very difficult." He added, "If grandma, grandfather decides they had enough in life...if they weren't able to carry on, why should I carry on? If they weren't strong enough, why should I be strong enough?"[http://aptn.ca/news/2016/04/20/indigenous-liberal-mp-ouellette-voting-against-governments-assisted-dying-bill /](http://aptn.ca/news/2016/04/20/indigenous-liberal-mp-ouellette-voting-against-governments-assisted-dying-bill/)

Yes, suicide is contagious. More time will not change this fact. Legalizing assisted suicide and euthanasia is simply and always a bad idea.

Mr. Ouellette, a 38-year-old Cree, delivered a speech to Parliament on May 2 that was both hard hitting and personal. He declared, "This debate strikes at the very heart of the meaning of life, it strikes at the heart of bureaucracy, and it strikes at the heart of how we care for the most vulnerable in our society." And, backing his concerns with real-life examples, he stated, "We make laws often for the average person, but the impact is felt most by those who are on the margins of society." Read more of Mr. Ouellette's crucially important speech at:<http://www.nationalrighttolifenews.org/news/2016/05/robert-falcon-ouellette-suicide-assisted-suicide-speech-in-parliament/#.Vy1XCSghzJ>. Then, pass it on.



LIFE IS ALWAYS WORTH LIVING

By Adam Crouch

I was deeply saddened to hear that Brittany Maynard decided to accept the laws in Oregon, USA (where euthanasia is legal) and ended her life in November 2014, after a battle with brain cancer.

I am a victim of brain cancer myself. I was diagnosed with a brain tumor* in 2011. I am concerned about and reject attitudes of government officials who believe euthanasia is a reasonable option and solution for people such as Brittany and me, who are faced with life-threatening illnesses such as brain cancer.

Avoiding pitfalls and maintaining perspective

When we get sick, often there is too much stress and too much happening to make wise and logical decisions.

Throughout two and a half years of treatment, I suffered emotionally. I felt sadness, fatigue, disappointment, anxiety, and fear. I was upset about putting on weight and losing my hair, and I could not stop thinking about the many frustrations I was experiencing. During this time, I was tempted to give up, especially when my tumor grew back after radiation therapy.

In this experience, my Christian faith helped me. In our spiritual lives, when we are sick, we experience desolation. It seems that God has abandoned us. The golden rule, when we are experiencing this desolation of sickness, is to not change course, but to continue on our journey, and be faithful to our previous decisions and commitments. We have to bravely move dead slow ahead, like a wounded ship moving out of troubled waters.

Although we are sick, we still have our role to play in society and our lives have value. We are still precious and loved by our families and friends, who also suffer with us during our sickness.

Blessings received and lessons learned

After two major operations, chemotherapy, and radiation treatment, I am back on my feet and making a good recovery. I am grateful to and inspired by the people who looked after me at my hospital. We have great oncologists and surgeons whom we can trust. Treatments and advancements are improving every day.

I do not have life all together. I am sensitive to the painful disappointments and rejections that we all experience in life. The experience of my tumor has been humbling and frustrating; however, it has also made me a more grateful and mature person. I realize that not everyone survives cancer. None of us knows what lies ahead. But life is always worth living, and some of my greatest blessings and healing of relationships came as a result of my sickness. Having brain cancer made me realize just how special I am to other people. I realized people do actually care.

I have continued my theological studies at the Missionaries of God's Love seminary, where I was discerning a call to the priesthood even before I became ill with the tumor. I am still having scans to monitor tumor activity in my brain, but less often. I was ordained a deacon last October at St. Dominic's Parish in Camberwell (near Melbourne) and hope to be ordained a Catholic priest in October of this year. Before joining the seminary, I enjoyed carpentry and participating in sports, and still enjoy participating in these activities today.

I grew up in a privileged family with many opportunities. My parents have invested a lot in education, health care, and all the other resources needed to raise children. I hope this is not all put to waste. I hope I can become a good and respected person in the community in which I live and encourage others to keep going. *Life is always worth living.*

Adam Crouch is from Melbourne, Australia.

Additional reading

The International Brain Tumour Alliance provides information about support and advocacy for brain tumour patients, as well as brain tumour research: www.theibta.org.

Dana Palmer was diagnosed as having a terminal glioblastoma (brain cancer) in 2005. Here's Dana's story, as told by her in February 2016: <http://m.gazette.com/guest-column-against-colorados-proposed-assisted-suicide-bill/article/1569190>

JUNE 15TH IS WORLD ELDER ABUSE AWARENESS DAY

Every June 15, World Elder Abuse Awareness Day serves as a call-to-action for individuals, organizations, and communities to bring attention to the issue of elder abuse, neglect, and exploitation.

The Centers for Disease Control and Prevention (CDC), one of the major operating components of the U.S. Department of Health and Human Services, views elder abuse as a significant public health problem. Each year, hundreds of thousands of adults over the age of 60 are abused, neglected, or financially exploited. Elder abuse, including neglect and exploitation, is experienced by 1 out of every 10 people ages 60 and older who live at home. This statistic is likely an underestimate because many victims are unable or afraid to tell the police, family, or friends about the violence. The following six types of maltreatment occur among persons over the age of 60:



- Physical abuse
- Sexual abuse
- Emotional abuse

- Neglect
- Abandonment
- Financial abuse

<http://www.cdc.gov/features/elderabuse/>

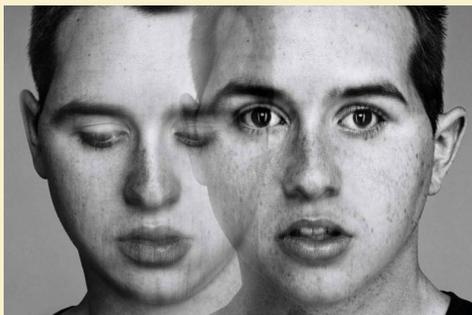
According to the most recent study of elder abuse in the *New England Journal of Medicine* (issue of Nov. 12, 2015), factors increasing the likelihood of elder abuse are: Victim is

- female (the abusers are more often male)
- Elderly, but not at the top range of age (the "young old," between 65 and 75)
- Living with a spouse or adult children
- Living with a larger number of household members other than spouse
- Lower income
- Isolation and lack of social support (key word here is "support" -- family members who resent your demands on them are the opposite of support)
- Functional impairment and poor physical health.

If you are a victim of elder abuse, or if you suspect someone you know is, call the National Center on Elder Abuse's Elder Care Locator at 1-800-667-1116. For more information, visit their website at <http://www.ncea.aoa.gov/>

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 accepting a medical prediction that a loved one will never recover consciousness or have a "meaningful life."



19-year-old Dylan Rizzo played hockey and high-jumped at his high school in Lynnfield, Massachusetts, and he had a great sense of humor. On December 28, 2010, a car accident changed his life forever. First responders doubted he would live long enough to reach the hospital. At Massachusetts General Hospital, he was rushed into surgery where neurosurgeons worked to stop multiple brain hemorrhages. From there, he was transferred to the neuro intensive-care unit. He was in a deep coma and on a ventilator, with his head wrapped in bandages.

On day 8, a neuropsychologist, Joseph Giacino, administered a bedside test called the Coma Recovery Scale. Dylan scored one out of 23. Giacino noted that "the probability of recovery of functional, vocational, and social independence is low." The best-case scenario, in his estimation, was that Dylan

would be severely disabled, but even that outcome was highly unlikely.

The family met with Dylan's medical team and listened to the doctors' dire predictions. In spite of their dismal prognosis, the family decided to do everything they could for Dylan. On day 17, Dylan opened his eyes. He had progressed from a coma to what some refer to as a "vegetative state"--awake, but unresponsive and supposedly unaware. However, according to Giacino, a researcher in this area of neuroscience, "Thirty to 40 percent of people who are believed to be unconscious actually retain some conscious awareness."

From the beginning, when they visited him in the ICU, Dylan's family played an iPod filled with his favorite music or watched hockey games on the TV.

There was always a Rizzo family member at his bedside. Some 70 family members helped maintain a round-the-clock vigil. His mother, Tracy, quit her job to be with him. On day 27, something remarkable happened. When Tracy tried to wipe his forehead, Dylan raised his hand. When he did it again, she gave him the cloth and said, "Dylan, wipe it yourself." He wiped his mouth and nose.

During Dylan's fifth week in the hospital, his doctors saw signs that he was becoming aware of his surroundings. Six weeks after the accident, a brain scan (MRI) suggested that some of Dylan's damaged "wiring" was repairing itself.

There were many ups and downs, but, at the end of February (day 60), Dylan was transferred to Spaulding Rehabilitation Hospital. Slowly but steadily, he improved until, on day 208, Dylan was ready to leave Spaulding. A family video shows Dylan sitting in his wheelchair, waving and smiling at all the well-wishers at his farewell party. Dylan recalls it as the first event he was aware of since his accident. "Coming out of it, it was like I was asleep, and I was just back alive," he said. "The last day at Spaulding, that's when I felt alive."

Dylan would spend two months at another rehab center in New Hampshire, working to regain motor skills and the ability to speak, before returning home to Lynnfield in September 2011. On day 1,541, his mother said, "His personality didn't change at all. He's still the same person. Just neater. He was a slob before the accident." Now 23, Dylan is "functionally independent. He volunteers as an assistant track coach at his old high school, occasionally helps his father on construction projects, and hopes to resume his studies at a local community college."

This article is adapted from "How One Brain Came Back from Unconsciousness" <http://nymag.com/scienceofus/2015/06/dylan-rizzo-coma.html>] by Stephen S. Hall, originally published in New York Magazine (June 8, 2015).

ANNOUNCEMENT

Leaders' Conference on Assisted Suicide, sponsored by Euthanasia Prevention Coalition (EPC) - USA, Monday, May 23, 2016, 9:30 AM to 4:00 PM, 440 - 1st St. NW, Washington, DC.

Alex Schadenberg, Executive Director, EPC, states, "If you are a leader who wants to stop assisted suicide, then you need to attend this conference." For more information/to register: <http://epcusa.eventzilla.net/web/event?eventid=2138861177>

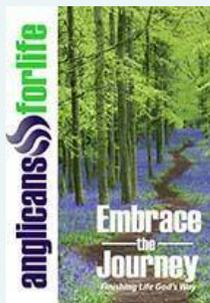
RESOURCES



Get Your Copy Today!

First high school unit study just released
Euthanasia: An Introduction [CLICK HERE](#)

Euthanasia: An Introduction is part of American Life League's CULTURE OF LIFE STUDIES PROGRAM. For more information: <http://cultureoflifestudies.com/fighteuthanasia/>



Embrace the Journey: Finishing Life God's Way, an eight-week series addressing aging and dying which is user-friendly and easy for your church to implement, developed and published by Anglicans for Life, www.AnglicansforLife.org. To order: email Info@AnglicansforLife.org or call 412-749-0455.

Euthanasia Prevention Coalition

Belgium's Advice to Canada is a new online video series on assisted death. As Canadians debate the controversial Bill C-14 in light of the June 6 Supreme Court imposed legislation deadline, the Euthanasia

Prevention Coalition (EPC) is releasing four short videos entitled: "Belgium's Advice to Canada" from selected clips from our upcoming documentary film, [Vulnerable - The Euthanasia Deception](#). In January 2016, a film crew went to Belgium, where euthanasia has been legal since 2002. Victims and advocates offer a stern warning to Canada and any country considering enacting laws that allow assisted death. Contact EPC for more information on the online video series and the upcoming documentary film, [Vulnerable - The Euthanasia Deception](#) at info@epcc.ca or call: 1-877-439-3348 or 519-851-1434.

RECOMMENDED READING

"The True Face of Assisted Suicide" by Richard M. Doerflinger

<http://www.nationalrighttolifenews.org/news/2016/05/the-true-face-of-assisted-suicide/#.Vyz7NoQrLIU>

"Dumb and Dumber - Part One: Opioids" by Ron Panzer, Hospice Patients

Alliance: <http://hospicepatients.org/dumb-and-dumber-part-one.html>

"The Rise of Stealth Euthanasia-Imposed Death Disguised as Pain Relief" by Ralph A. Capone, MD, FACP; Kenneth R. Stevens Jr., MD, FACR; Julie Grimstad; and Ron Panzer,

LPN: <http://www.hospicepatients.org/capone-stevens-grimstad-panzer-ncbc-em-june2013-the-rise-of-stealth-euthanasia.pdf>

"Against Colorado's Proposed Assisted Suicide Bill" by Dana Palmer, a long-term survivor with Glioblastoma-terminal brain cancer (same cancer as Brittany Maynard

had): <http://m.gazette.com/guestcolumn-against-colorados-proposed-assisted-suicide-bill/article/1569190>

A "friend of the court" legal brief to the U.S. Supreme Court on behalf of the Little Sisters of the Poor, in defense of their conscience rights: www.scotusblog.com/wp-content/uploads/2016/01/Families-of-Residents-Brief.pdf

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 unborn, 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](http://www.prolifehealthcare.org/pha-membership-request-fillable-form.pdf) <http://www.prolifehealthcare.org/pha-membership-request-fillable-form.pdf>

[Pro-life Healthcare Alliance](http://www.prolifehealthcare.org/) <http://www.prolifehealthcare.org/>

[Hospice Patient's Alliance](http://www.hospicepatients.org/) <http://www.hospicepatients.org/>

[Euthanasia Prevention Coalition](http://alexschadenberg.blogspot.com/) <http://alexschadenberg.blogspot.com/>

[Patient's Rights Council](http://www.patientsrightscouncil.org/site/) <http://www.patientsrightscouncil.org/site/>

[Prenatal Partners for Life](http://www.prenatalpartnersforlife.org/) <http://www.prenatalpartnersforlife.org/>

[American Life League](http://www.all.org/) <http://www.all.org/>

[Read Stealth Euthanasia: Health Care Tyranny in America by Ron Panzer](http://www.hospicepatients.org/this-thing-called-hospice.html)
<http://www.hospicepatients.org/this-thing-called-hospice.html>

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

a program of [Human Life Alliance](http://www.humanlife.org)

<http://www.humanlife.org>

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