Pro-life Healthcare Alliance
A Program of Human Life Alliance

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PHA Monthly

Newsletter for the Pro-Life Healthcare Alliance
Thirty-fifth Edition

Welcome to the thirty-fifth 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

The great and good physician Albert Schweitzer, who received the 1952 Nobel Peace Prize for his philosophy of "Reverence for Life," wrote, "At times our own light goes out and is rekindled by a spark from another person. Each of us has cause to think with deep gratitude of those who have lighted the flame within us."

We acknowledge and give thanks for all who have supported us and worked beside us to renew reverence for life within healthcare.

May God bless you and yours this Thanksgiving Day, and always.

Update on Assisted Suicide and Euthanasia

Colorado: On November 8, voters overwhelmingly approved a ballot measure, Proposition 106, to legalize assisted suicide, becoming the fifth state to allow doctors to prescribe lethal doses of pills for suicidal patients to kill themselves. **Suicide is not seen as socially desirable, so why is assisted suicide seen as compassionate for seriously ill and disabled people? This is discrimination, pure and simple.**

Washington, DC: On November 15, DC City Council members voted 11-2 to legalize assisted suicide in spite of strong opposition from black residents, disability rights advocates, medical professionals, and others concerned that the bill would target not just the terminally ill, but also the elderly, poor, chronically ill, disabled, and minorities. The bill, B-21-28, was sent to Mayor Muriel Bowser who had already said she will not veto the legislation. But that does not mean it will become law. Bills passed by the DC City Council must also be approved by the U.S. Congress. This legislation is so expansive that it will go beyond assisted suicide, legalizing active euthanasia by permitting third parties to administer the lethal drugs. http://www.lifenews.com/2016/11/16/washington-d-c-passes-bill-to-legalize-assisted-suicide-targeting-elderly-black-people/

Note: Compassion & Choices is rejoicing over its victories and licking its chops for more. In a recent email to supporters, C&C's political director, Charmaine Manansala, wrote: "The 2017 legislative season is right around the corner, with many states reconvening in January, and we hope to have a full Senate vote scheduled for New Jersey's Aid in Dying for the Terminally Ill Act soon. And we expect to see similar legislation in nearly half the states in 2017, with more state victories possible over the next three years." WE MUST BE VIGILANT AND RELENTLESS IN OUR EFFORTS TO ENSURE THAT NO MORE STATES LEGALIZE ASSISTED SUICIDE.

Quebec, Canada: Quebec's end-of-life care commission's first annual report, based on the reported euthanasia deaths from Dec. 10, 2015 to June 30, 2016, is alarming. 262 people were legally euthanized during the first seven months the law was in effect. That is three times the number expected, according to Health Minister Gaétan Barrette. http://montrealgazette.com/news/quebec/more-seeking-medical-aid-to-die-than-expected-barrette

South Australia: A bill to legalize euthanasia has been defeated. Speaker Michael Atkinson used his vote to defeat the Death with Dignity Bill at the Third Reading stage after the vote was tied 23-23 in the House of Assembly. http://www.thetablet.co.uk/news/6418/0/speaker-defeats-assisted-dying-bill-over-world-s-worst-legislative-practice

Correction: In the "From the Editor's Desk" column in last month's newsletter, when I listed the reported reasons people in Washington State sought physician-assisted suicide, I wrote: "Neither actual pain nor fear of pain was reported as a concern of these participants!" I should have written: "Neither actual pain nor fear of pain was reported as a concern **or as the main concern of the vast majority** of these participants." [Correction highlighted.] - Julie Grimstad

"I overheard the doctor giving my husband a sales pitch for assisted suicide."

The following Letter to the Editor appeared in the Hawaii Free Press, 2/15/2011.

http://hawaiifreepress.com/ArticlesDailyNews/tabid/65/ID/3647/February-2011-Letters-to-the-Editor.aspx

Dear Editor,

Hello from Oregon.

When my husband was seriously ill several years ago, I collapsed in a half-exhausted heap in a chair once I got him into the doctor's office, relieved that we were going to get badly needed help (or so I thought).

To my surprise and horror, during the exam I overheard the doctor giving my husband a sales pitch for assisted suicide. "Think of what it will spare your wife, we need to think of her," he said, as the clincher.

Now, if the doctor had wanted to say, "I don't see any way I can help you, knowing what I know, and having the skills I have," that would have been one thing. If he'd wanted to opine that certain treatments aren't worth it as far as he could see, that would have been one thing. But he was tempting my husband to commit suicide. And that is something different.

I was indignant that the doctor was not only trying to decide what was best for David, but also what was supposedly best for me (without consulting me, no less).

We got a different doctor, and David lived another five years or so. But after that nightmare in the first doctor's office, and encounters with a 'death with dignity' inclined nurse, I was afraid to leave my husband alone again with doctors and nurses, for fear they'd morph from care providers to enemies, with no one around to stop them.

It's not a good thing, wondering who you can trust in a hospital or clinic. I hope you are spared this in Hawaii.

Sincerely,

Kathryn Judson, Oregon

QUESTIONS AND ANSWERS REGARDING ASSISTED NUTRITION AND HYDRATION

By Chris Kahlenborn, MD

The specific question of whether to place a stomach tube in a patient who has had a stroke or has advanced dementia is one of the most difficult dilemmas for patients and/or family members who often have questions regarding the ethics of either giving or withholding assisted nutrition and hydration (ANH). As a board-certified internist with 28 years of medical experience, Dr. Chris Kahlenborn answers some basic questions regarding the issues involved in the decision of whether to provide assisted nutrition and hydration (ANH) to the patient(s) in need. Dr. Kahlenborn is a Catholic physician who clearly articulates the Catholic Church's teaching regarding ANH. His practical medical advice respects the sanctity of human life and applies regardless of one's faith tradition.

Q1: **What do you mean by assisted nutrition and hydration (ANH)?**
ANH is the delivery of nutrition and/or hydration to a person via an assisted means of delivery such as via a person's veins, often called TPN (total peripheral nutrition) or via a tube that goes into a person's stomach, called a PEG tube (percutaneous endoscopic gastrostomy tube).

Q2: **What does the Catholic Church teach in regard to ANH?**
The teachings of the Catholic Church support the use of ANH except in those rare cases when death is imminent or when ANH may do more harm than good. For example, the United States Conference of Catholic Bishops (USCCB) cited Pope John Paul II's address (March 20, 2004) regarding people in the so-called "vegetative state," noting: "1) Patients who are in a 'vegetative state' are still living human beings with inherent dignity, deserving the same basic care as other patients; 2) nutrition and hydration, even when provided with artificial assistance, are generally part of that normal care owed to patients in this state, along with other basic necessities such as the provision of warmth and cleanliness."

Q3: **Can assisted nutrition harm a patient?**
It is possible, albeit rare, that ANH can harm a patient. For example, a patient with severe congestive heart failure may not be able to tolerate fluids for a period of time, or a patient who has cancer in the abdomen may not be able to tolerate a PEG tube. However, I have found that in more than 99% of cases assisted nutrition and hydration is beneficial, and I have rarely seen a case in which giving fluids or assisted nutrition harms the patient.

Q4: **Most hospitals have palliative care teams and/or hospice nurses/physicians. What role do they play on the issue of ANH?**
I have found that, in general, hospice and palliative care personnel try to dissuade patients from assisted nutrition and hydration. In my opinion, the reasons for this vary. Unfortunately, financial pressure often plays a significant role. Patients who forego ANH are frequently transferred to hospice centers and die within days from dehydration, thereby allowing hospitals to reduce their lengths of stay. In addition, insurance companies save money when a patient foregoes ANH since they do not have to pay the many expenses involved in treating these fragile patients. Today, insurance companies are actively putting pressure on hospitals to increase their number of palliative care consults, which is quite revealing.

Q5: **Can you give a common example of when this conflict may arise?**
I personally have seen this issue most often in patients who are not able to swallow for the first few weeks after they have had a stroke and sometimes for longer periods. Often a family member will note that the patient has a living will. If the patient cannot communicate well at this point in time, the decision may be made that food and water are considered "extraordinary." The tragedy is that many of these patients could recover if they were to receive short-term parenteral nutrition (i.e., intravenous food and water) for a few days or weeks.

Q6: **Some doctors claim that ANH does not prolong life. Is this true?**
Many doctors cite studies in the medical literature that support the claim that ANH does little to decrease a patient's mortality or increase quality of life. The medical literature has become highly politicized over the past two decades. My impression as a physician and a researcher is that some studies which are favorable to ANH are likely excluded from publication due to editorial bias. In addition, studies, where one measures mortality by comparing patients with dementia who receive ANH to those who do not receive ANH, may suffer from selection

bias, since the patients who require ANH are often far sicker than those who do not require ANH and are, by definition, at higher risk of mortality. A recent article in the August 2016 *Linacre Quarterly* entitled "Is tube feeding futile in advanced dementia?" by Dr. Matthew Lynch addresses these issues nicely.

Q7: **Is it painful to die from dehydration and nutrition?**
Some practitioners have the arrogance to state rather definitively that dying from dehydration is not painful. But, how can anyone know what a patient in this state is experiencing unless they themselves have experienced it? Anyone who has been moderately to severely dehydrated has noted the phenomenon of stinging eyes, dry skin, burning urine, and pain with swallowing. It would follow that the patient who is no longer given water would experience similar symptoms.

Q8: **Patients often have living wills that state that they do not want feeding tubes if death is imminent. Does this apply to the stroke and dementia patients who are developing dehydration?**
No. In general, this does not apply and it is very confusing for patients. Death only becomes imminent in most stroke and dementia patients if ANH are withheld. If ANH are given, death is usually not imminent.

Q9: **Is it good to have a living will?**
Many people, often under the guidance of their lawyer, have living wills which specify what type of medical treatment they wish to have or forego should they have a terminal illness. There are several problems with this. First, the living will is a rather rigid document, often prepared years prior to the occurrence of the patient's first medical illness, after which circumstances and opinions have often changed. Second, many physicians interpret a living will as a "do not resuscitate (DNR)" order, so that, if you are admitted for a non-terminal illness, you could be categorized as a DNR patient, when that may not be your wish. Third, patients with living wills, in general, will get less aggressive hospital treatment. My advice is to speak with a trusted friend or family member and make them your power of attorney for healthcare decision maker instead of obtaining a living will.

Q10: **Can Catholic physicians, physician's assistants, nurses and pharmacists do anything to promote the teachings of the Church?**
In my personal experience, the best one can do is to offer the patient and their family the teachings of the Church and try to get a more traditional Catholic priest or deacon to consult with the family. Often these families are misguided but well-intentioned. If the case becomes too problematic for the physician, he or she may have to recuse himself or herself from the case. I have had to do this on rare occasions, but have also noted that many families and patients will work with the physician if the physician offers them compassionate care and gives them time to consider their options (e.g., giving a few weeks of TPN after a stroke while they think about the decision to use a PEG if needed for the long term).

Q11: **Would it help if there were a more specific statement from the Church regarding ANH?**
I think it would help if a more specific statement were made by the Church, especially since this is such a confusing area for the public and for most Catholics, including physicians. I suggest the following statement, which several theologians/scholars* have reviewed and believe is consistent with Church teaching**:

"The Church rejects either the act or omission which, of itself or by intention, causes death in order to

eliminate suffering; therefore, any omission of nutrition and hydration, by itself or with the intention to cause or hasten a patient's death, must be rejected. Therefore, we must hold for a presumption in favor of providing nutrition and hydration for every patient-especially the dementia or stroke patient who receives hospice, comfort or palliative care. If a patient is not able to sustain himself (herself) by oral intake of food and water, then assisted nutrition and/or hydration (e.g., intravenous fluids, total peripheral nutrition {TPN} and/or a PEG tube) should be offered and should not be withheld or considered burdensome except for rare exceptions in which they could acutely worsen a person's medical outcome (e.g., giving intravenous fluids to a patient who is experiencing an acute episode of congestive heart failure). These measures are ordinary treatments and therefore cannot be based on a person's "quality of life." **Patients who suffer from dementia or stroke should not die due to dehydration and/or malnutrition.** The symptoms of dehydration should be treated with oral or assisted fluids and not via pain medications or sedatives such as morphine or lorazepam."

Q12: **Are there dangers to placing a stomach tube or giving TPN?**
The placement of a stomach tube is a relatively low-risk procedure that takes about 30 minutes to perform and is done under sedation. In addition, a stomach tube can be easily removed if a patient is able to eat again. The administration of TPN is also quite routine and can be done via a special IV placed in the patient's forearm, termed a PICC line, which is also a very low-risk procedure.

Q13: **Should cancer patients generally get ANH?**
Most oncologists believe that, if you have cancer, it is not a good idea to place a feeding tube as it "may feed the cancer." However, there is little support for this statement in the medical literature. There may be certain times when ANH can be very useful in the patient with cancer, such as for those with mechanical obstructions (e.g., patients with esophageal cancer) or those with prolonged nausea from chemotherapy.

Q14: **Can the medical literature be trusted in regard to ANH?**
In my 28 years of practicing medicine, I have noted that the medical media (including most medical journals), most medical associations, and the lectures given at large annual conferences have increasingly leaned toward positions that are aligned with the culture of death. Researchers are under great pressure to publish findings that support this death culture and may have their grant money (i.e., usually given by the National Institute of Health or National Cancer Institute) "dry up" if they do not conform. In light of this, I am personally very skeptical of the findings noted in today's medical journal articles in relation to ANH. Sadly, the older medical literature, that is, studies from more than 20 years ago, although dated, are often more candid about their findings and seem to be less influenced by political correctness.

Q15: **What can a patient/family do if they think they are being pressured by a hospital or physician to forego ANH?**
Sometimes the best first step is to try to get some ANH, such as TPN, started while the decision regarding a PEG tube is being considered. If you are still pressured by your doctor, do not be shy about stating that you are being discriminated against due to your religious beliefs and to speak with an administrator citing this specific claim (i.e., religious discrimination). If ANH is still being denied, you may have to resort to the threat of legal action and consider the transfer of your loved one to another hospital.

**William E. May, theologian (deceased); Fr. James Buckley, theologian; Professor Dianne N. Irving, Bioethicist; Professor Robert P, George, Princeton University, Professor of Jurisprudence*

***The assistance of my friend and colleague Mr. Mark Chuff in the preparation of this statement is greatly appreciated.*

NEW FEATURE

A PHA member recently suggested that we highlight one of our partner organizations each month. I thought it was an excellent idea, so we begin this new feature by introducing you to California Nurses for Ethical Standards (CNES).-Julie Grimstad, Editor

CALIFORNIA NURSES FOR ETHICAL STANDARDS

By Zonya Townsend, RN BSN, CNES President

California Nurses for Ethical Standards (CNES) is a 501(c)(3) nonprofit educational organization founded to promote respect for the dignity and sanctity of all human life.

Significantly, the purposes and practices of medicine have fundamentally changed over the decades. Healthcare ethics and laws had previously been indisputably life affirming and in concert with one another. Today, however, practices that intentionally end human life are legal. This dramatic shift has created a great disconnect between our ethical duty as nurses and what has been legalized in healthcare.

In this challenging environment, CNES is a stalwart supporter of the traditional pillars of medical ethics: respect for autonomy of the patient (facilitate informed consent), beneficence (promote what is best for the patient), non-maleficence (do no harm), and justice. These principles guide our activism and educational involvement on issues such as physician-assisted suicide and SB 277, California's mandatory vaccination bill (which removes parents' right to informed consent and raises ethical concerns regarding the relationship between the abortion industry and vaccine manufacturers).

The benefits of membership

CNES provides a forum for nurses to share practical information on ethical issues, offers useful tools for nurses to employ when confronted with these issues, and develops continuing education materials for nurses. Our quarterly newsletter informs membership of legal developments and trends in medical/nursing ethics and offers articles of interest that demonstrate how ethical issues impact the lives of nurses.

We work to advance our organization's presence by seeking to expand our professional membership, which gives pro-life nurses, allied health professionals, and others who share our Judeo-Christian values a vehicle for having their voices heard in the medical communities and the public square. As an organization, we seek parity in healthcare ethics and practice by realignment of universally accepted, time-honored ethics with life-affirming laws.

As our membership grows, we seek to re-establish local chapters throughout the counties of California. As CNES grows and expands, so will our influence in the nursing and medical communities.

Educational initiatives

CNES offers continuing education units for registered nurses through our many courses. To support that mission, we have written educational materials that can be downloaded and printed from our website. We also offer mentoring opportunities for nursing students, allowing for school credit with the instructor's approval.

CNES' recently retired founder, Germaine Wensley, RN BSN, designed and published brochures, tens of thousands of which have been marketed throughout the United States. This work proved instrumental in helping CNES become known on a national level.

CNES has cosponsored three symposiums at Biola University and a five-day course on medical ethics with Fr. Juan Velez MD, board certified in Internal Medicine, and sponsored by the International Institute of Theological and Tribunal Studies.

Our speakers' bureau goes into high schools, giving presentations on sexual health. We look forward to expanding this educational outreach.

A pro-life presence

CNES facilitates placement of registered nurses as volunteers or staff in crisis pregnancy clinics whenever possible, through our website and electronic communication. We monitor and encourage action on legislation affecting the right to life, other ethical issues, and conscience rights in the nursing and medical professions. We also support and participate in annual pro-life marches and events held in San Francisco, Los Angeles, San Diego, and Washington, DC.

The present and future of California Nurses for Ethical Standards encompasses both the protection of patients' life interest and the conscience rights of health care providers.

Please visit our website (ethicalnurses.org), join our CNES Facebook forum, and "Like Us" on our Facebook page for timely articles. You may also contact us through our website or email us atinfo@ethicalnurses.org or zonya@ethicalnurses.org. CNES depends on the good will of our supporters, and donations are tax-deductible.

A PATIENT ADVOCATE'S STORY: SAVING A LIFE FROM FOUR STATES AWAY

By Allison Wiggins

I was a guardian to a homeless man in Corpus Christi in 1998. This man, Stanley Nowak, was inhis late 80s, but very lucid, not an alcoholic or schizophrenic. Stanley would sit outside the Cathedral where I attended daily noon Mass. Due to his appearance, he wouldn't come in for Mass even though I invited him. We became friends and I sort of took over his meager finances, which were in a state of disarray. The Social Security Administration had been underpaying him for years, so I arranged a meeting and brought his income out of arrears to a livable amount of money. Stanley was a wonderful person, although feisty. He would not let us move him into an apartment.

In the summer of 1998, he wanted to travel by bus to meet some military friends in Dubuque, Iowa for a few weeks. I was nervous for him to travel alone, but he was determined, well outfitted and well financed, so I saw him off at the bus station and told him to let me know when he arrived with a pre-addressed postcard I gave him. A week went by. I didn't get the card, but didn't worry too much. I had put a note with my phone number in his wallet, taped to his Medicare card, saying that I was his guardian and Dr. Wiggins and I would be responsible for him in a medical crisis.

A few more days went by. My phone rang. The anonymous caller identified herself as a social worker at a Dubuque Catholic Hospital. She had found a note to call Dr. Wiggins in Stanley's wallet. I told her she had the right number. She said, "I can't stay on the phone, but the person you are guardian to is in our hospital. They are euthanizing him. He had a stroke five days ago. They have put him in a room away from other patients, have labeled him DNR [do not resuscitate] and NPO [nothing by mouth] and put him on high doses of Lasix. That's all I can tell you. I can't say anymore. I can't stand to watch it so I had to call you." She told me the name of the hospital, the floor number and room where Stanley was.

Fast and forceful action

I straightaway called the floor nurses station and asked if Stanley Nowak was a patient. They said yes. I informed them that I wanted all his medical records immediately faxed to me in Corpus Christi. I was nearly blind with rage at a Catholic hospital doing such a horrible thing.

Within minutes, all the records came and it was as the social worker had said. I paged the doctor on the record and, in no uncertain terms, told him I wanted a feeding tube and IV fluids put in immediately. If he refused, I promised to be on the next plane to meet with an attorney in Dubuque and my first stop would be the archbishop's office. I threatened him with every possible action that could be taken.

My next call was to the hospital's CEO, who was a nun. I told her everything. She said, "Let me investigate this. I will call you right back." She called back in 10 minutes and said, "It is exactly as you described. I am horrified." The tubes were put in my friend while I consulted with an Iowa attorney from the Catholic directory. The attorney said he would arrange a chancery meeting or a press conference in front of the hospital, if need be.

I arranged with two doctor friends for a bed in a stroke center in Corpus Christi to facilitate Stanley's recovery. Once the tubes were in and he started to revive, I told the physician who ordered his death that I wanted my friend returned to Texas on an air ambulance the next morning. The physician said the hospital in Dubuque would not be willing to do that due to the extremely high cost. He was aggressively in favor of letting my friend die, calling him "a vegetable."

At this point, my husband took charge of dealing with this cruel physician. My husband said, "You don't know my wife, but it would be in the hospital's best interest to do as she asks. She will be unrelenting." Still, I was not sure they would do it.

"Just watch me."

I called the CEO back and told her I had spoken to a pilot for the air ambulance service and he would need $10,000 from the hospital to transport Stanley to me the next morning. She said they would call a board meeting immediately. I told my husband what was happening and he said, "Allison, homeless people don't ride in Lear Jet air ambulances just because you want them to. It won't happen. Only millionaires have this at their fingertips." I responded, "Just watch me."

This had all happened within 12 hours of that first call from the concerned social worker telling me they were killing my friend. In another hour, the pilot called to say the $10,000 from the hospital was in his account and he would pick up Stanley in the next few minutes and fly him to Texas. By this time Stanley was lucid and talking. Within hours, I was at the Corpus Christi airport with an ambulance to transport him. I followed in my car to the stroke center.

I was terrified Stanley wouldn't recognize me at all. They put him in bed and then I came in. He knew me right away, grabbed my hand and pulled me next to him. He would not let go. He was crying and said, "They tried to kill me." Over and over he said that. I knew then he would be okay. He was afraid for me to leave him that evening, fearful that the Corpus Christi stroke center would try to hurt him also.

In a week, Stanley was walking and eating and going through a stroke rehab program. I cannot tell you what pleasure it gave me to forward progress reports to the doctor who ordered his death in Iowa.

Everything in this story occurred over a 24 hour period. I did not have the luxury of a meltdown. I had to get to work to save a life from four states away.

My friend died some months later, but he was able to receive last rites and make a last confession, as well as have a Catholic Mass and burial.

In a stunning turn of events, the Dubuque hospital filed Medicare claims on my friend for "stroke rehab." Fraud, on top of trying to kill a patient! Medicare sent me copies of the bills they received and I told them the truth. Medicare began a fraud investigation against the Catholic Hospital System of Dubuque. I had to give sworn statements. It was very upsetting. A bloodbath followed. The hospital was investigated and fined. The doctor who ordered Stanley's death was censured for life on his record for "failing to nourish and hydrate a patient he admitted." It is on his permanent professional record wherever he goes.

We must be willing to go to great lengths to save a life.

When we call ourselves "patient advocates," we must be willing to go to great lengths to save a life. To be politically savvy. To be threatening and aggressive when needed. And to be fearless. We must be willing to take on any CEO in our path, a diocese if necessary, and even the archbishop himself.

But, I would not have been able to save Stanley's life had I not gotten a call from a very brave hospital social worker with a conscience. If not for that call, my friend would have been euthanized and buried without me every knowing what happened to him.

Allison Wiggins was raised in Norman, Oklahoma. In 1993, she moved to Austin, Texas to pursue a degree in psychology. She is a speaker and lecturer on family counseling issues, volunteerism, and many other topics. From 1986 to 1989, Allison was a volunteer counselor and fundraiser for Hospice Austin. From 1990 to 1994, she had a private practice in Marriage and Family counseling in Austin. She retired in 1994 and moved to Corpus Christi where she worked as a full time volunteer for Catholic Charities. In 1999, Allison moved to San Antonio to be a full time grandmother and parish volunteer. She attends Our Lady of the Atonement Catholic Church.
Allison is married to Robert Wiggins, M.D. They have one daughter, Elizabeth, and a granddaughter, Lily.

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.

Texas Right to Life https://www.texasrighttolife.com/

Pro-life Healthcare Alliance http://www.prolifehealthcare.org/

Hospice Patient's Alliance http://www.hospicepatients.org/

Euthanasia Prevention Coalition http://alexschadenberg.blogspot.com/

Patient's Rights Council http://www.patientsrightscouncil.org/site/

Prenatal Partners for Life http://www.prenatalpartnersforlife.org/

Pro Life Wisconsin https://www.prolifewi.org/

American Life League http://www.all.org/

Read Stealth Euthanasia: Health Care Tyranny in America by Ron Panzer
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

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