May 30, 2017

PHA Monthly

Newsletter for the Pro-Life Healthcare Alliance
Forty-first Edition

Welcome to the forty-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 EDITOR'S DESK:

By Julie Grimstad

A very beautiful newsletter from the Sisters of Life was waiting for me when my husband and I returned from a recent vacation. The Spring 2017 issue of IMPRINT is all about true compassion. Every story is inspiring and uplifting--just what I needed to get back in the spirit of work after a few weeks of play.

The article that most captivated me was the interview with Dr. Michael J. Brescia, Executive Medical Director and co-founder of Calvary Hospital, a Catholic palliative care facility and hospice in the Bronx. Dr. Brescia explains, "We're different; we're mission driven. Gospel driven. We come across a symptom that is unacceptable, and we treat the symptom until there is relief. Our doctrine is succor, compassion, love, gentleness."

"At Calvary we treat 6,000 patients a year," he states, "and no one, after they have been here for 24 hours, asks for assisted suicide." Want to know why? Then I recommend reading Dr. Brescia's interview. But don't stop there. Read every impressive story. In my estimation, this is the best ever issue of IMPRINT. It is available at:
http://www.sistersoflife.org/wp-content/uploads/2017/04/SV-Imprint-Spring-2017.pdf

A Reality Check on Assisted Suicide in Oregon

By Richard Doerflinger, M.A.

Executive Summary

The group "Compassion & Choices" (C&C) promotes Oregon's state law allowing physician-assisted suicide as a model for the nation, claiming: "Almost two decades of rigorously observed and documented experience in Oregon shows us the law has worked as intended, with none of the problems opponents had predicted." The evidence shows otherwise:

- All reporting of cases is by the physician who prescribed the lethal drug overdose, with no allowance for independent scrutiny; even death certificates are falsified to prevent such scrutiny.
- The vast majority of patients receive no psychological or psychiatric evaluation. The law allows assisted suicide for patients with depression or other mental disturbance, if the doctor feels that their condition has not led to "impaired judgment."
- There is seldom a health professional present, and never an assessment of competency, psychological conditions or freedom from coercion, when the drugs are taken.
- Conditions qualifying a patient for the lethal prescription have grown to include cases of chronic illnesses, benign tumors, and sometimes no reported illness at all.
- Predictions that a patient will die within six months have proven highly unreliable, and like other actions by the physician need only be done "in good faith," allowing actions that in other medical contexts would show negligence.
- Assurances of a quick and "painless" death have also proved unreliable.
- The law does not clearly require that the patient self-administer the lethal dose; in practice others may take an active role, and even health professionals who directly kill patients are not prosecuted.
- The pressures on patients include a state policy of reimbursing for assisted suicide but not for treatments that may sustain life.
- Despite a reporting system designed to conceal rather than detect problems, news of individual abuses has leaked out that may be only the tip of the iceberg.

Introduction

Compassion & Choices (formerly the Hemlock Society), the nation's most prominent advocate for legalizing assisted suicide for seriously ill patients, claims that experience in Oregon demonstrates that such "medical aid in dying" is a safe and well-regulated procedure. According to its fact sheet:

"Medical aid in dying is a safe and trusted medical practice because the eligibility requirements ensure that only mentally capable, terminally ill adults with a prognosis of six months or less who want the choice of a peaceful death are able to request and obtain aid-in-dying medication.... Almost two decades of rigorously observed and documented experience in Oregon shows us the law has worked as intended, with none of the problems opponents had predicted."[1]

In fact, even the official data collected by Oregon's health department indicate otherwise, and independent sources confirm that the "safeguards" hailed by C&C do not prevent abuse.

"Rigorously observed and documented"?

Reporting to the state is done solely by the physician prescribing the lethal drugs, who has every incentive to report that all is well. The Oregon Health Division has admitted that a doctor's account "could have been a cock-and-bull story," adding that "we cannot detect or accurately comment on issues that may be under reported."[2]

At the time when the patient actually ingests the drugs and dies, this physician is not present in 90% of known cases; in 80% of known cases, *no* health care provider is present to observe.[3]

Physicians' reports are destroyed after the state does its annual statistical review.[4]
Death certificates are falsified to report the underlying illness as the cause of death. [5] Yet the Oregon Health Department acknowledges that its reports include "the number of people for whom DWDA [Death with Dignity Act] prescriptions were written (DWDA recipients) and the *resulting deaths from the ingestion of the medications* (DWDA deaths)."[6] Death certificates are falsified to avoid autopsy or other scrutiny.

Physicians and others are exempt from liability if they act "in good faith" - the lowest legal standard, allowing actions that are negligent.[7]

Only "mentally capable" patients without depression or other mental disturbance?

Whether to request a psychological or psychiatric evaluation is optional for the physician. Over 96% of patients are given the lethal drugs without such evaluation.[8]

The law provides for such evaluation only when the patient "may be suffering from a psychiatric

or psychological disorder or depression *causing impaired judgment*." This allows giving the lethal drugs even to patients with clinical depression if the doctor decides the depression is a "normal" reaction to serious illness, and hence does not involve impaired judgment.[9]

Competency at the time the drugs are taken?

Proponents claim that obtaining the prescription for lethal drugs or the drugs themselves does not necessarily indicate a desire to die, that some patients are simply reassured that if their condition were to become unbearable they would have that option. This means that assessing competency and freedom from mental disturbance is most important at the time the drugs are actually taken, which could occur many months later. The Oregon law provides for no assessment or scrutiny at that decisive time.[10]

Only for "terminally ill adults with a prognosis of six months or less"?

Diagnoses that qualify patients for the drugs increasingly include less predictable conditions like chronic respiratory or cardiac disease, diabetes, etc. Even "benign and uncertain" tumors qualify.[11]

Since 1998 there have been three Oregon patients with no known illness at all.[12]
Nineteen patients who died from the drugs in 2016 (as well as seven in 2015 and 11 in 2014) had been diagnosed as having less than six months to live in previous years.[13]
Of the 90 patients who received prescriptions in 2016 but did not take the drugs, only 36 died that year of other causes.[14]

A sure and "peaceful" death?

In 2016, the drugs are known to have taken as long as nine hours to cause death (with this figure unknown in 81% of cases).[15] In 2009, at least one patient died 104 hours after ingesting the drugs.[16]

At least 30 patients in Oregon (three in 2016) have regurgitated some or all of the drugs. In all, six regained consciousness after taking them and died later. Five died from their underlying illness, and one patient in 2012 apparently died six days later from the effects of the drugs. No patient who has gone through this experience once seems ever to have tried again.[17]

The patient's own "choice"?

Just as there is no assessment of competency at the time the drugs are actually ingested, there is no scrutiny to determine whether this is voluntary or coerced. Even the law's provision for criminal penalties for coercing a patient or exerting undue influence apply only to the "request for medication," not the later administration of the drugs.[18]

No provision of the Oregon law clearly requires that only the patient can administer the drugs; it does speak of the patient "ingesting" (swallowing or absorbing) the drugs. The Oregon attorney general's office has said the state may have to allow other persons to administer them to patients with disabilities, to comply with laws such as the Americans with Disabilities Act.[19]

Seventy percent of the patients taking the drugs in 2016 (and 71% in 2015) had no or only governmental health insurance. Oregon's state health plan provides full funding for "aid in dying," while capping coverage for potentially life-supporting therapies, raising the specter of financial pressure toward assisted suicide.[20]

Troubling cases

The Oregon law creates a closed system in which all reporting is by those most directly involved, rendering scrutiny by others almost impossible. Yet troubling cases in Oregon have become publicly known that may only be the tip of the iceberg:

- An elderly woman with dementia who received the lethal drugs, because her grown daughter (described by one physician as "somewhat coercive" in her demand for the drugs) kept shopping until she found a doctor willing to overlook the woman's mental state and prescribe them.[21]

- A man who suffered from clinical depression for decades before becoming physically ill, who nevertheless qualified for the lethal drugs -- and was allowed to retain them even after guns were removed from his home due to his suicidal tendencies.[22]

- A psychologist who never saw the patient but did his psychological assessment using a written questionnaire, with answers filled in at home by family members who laughed as they read the questions together.[23]

- Nurses giving lethal drugs to patients they said had requested assisted suicide, and a physician injecting an unconscious patient with a paralyzing drug to cause death, leading to no prosecutions although all the law's procedures were ignored.[24]

Conclusion

In short, despite a thoroughly inadequate reporting system designed to cover up rather than reveal problems, Oregon shows exactly the problems that critics predicted: No meaningful protection against coercion, influence by others on patients with depression and dementia, an expansion beyond imminently dying patients, and a road toward active euthanasia.

C&C's claim is false.

Richard M. Doerflinger, M.A. is an associate scholar with the Charlotte Lozier Institute and a Public Policy Fellow at the University of Notre Dame's Center for Ethics and Culture.

This article is reprinted with permission. It was originally published April 13, 2017, at Charlotte Lozier Institute: www.lozierinstitute.org.

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[1] Compassion and Choices, "Medical Aid in Dying Fact Sheet" (December 2016).
[2] Or. Rev. Stat. 127.855 §3.09 and 127.865 §3.11; Oregon Health Division Center for Disease Prevention and Epidemiology, "A Year of Dignified Death," in CD Summary (March 16, 1999) at 2, available
at http://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/CDSummaryNewsletter/Documents/1999/ohd4806.pdf.
[3] Oregon Public Health Division, "Oregon Death with Dignity Act: Data Summary 2016" (henceforth "Oregon 2016") at 10; available
at http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year19.pdf.
[4] British House of Lords, Assisted Dying for the Terminally Ill Bill, Volume II: Evidence (2005) at 262 (Testimony of Dr. K. Hedberg of Oregon Department of Human Services, December 9, 2004), available at http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/86ii.pdf.
[5] Dr. K. Hedberg, "Oregon Department of Human Services Reporting," in Task Force to Improve the Care of Terminally-Ill Oregonians, The Oregon Death with Dignity Act: A Guidebook for Health Care Professionals (2008), Chapter 14; available
at http://www.ohsu.edu/xd/education/continuing-education/center-for-ethics/ethics-outreach/upload/Oregon-Death-with-Dignity-Act-Guidebook.pdf.
[6] For example, see Oregon 2016, op. cit., at 4.
[7] Or. Rev. Stat. 885 §4.01; H. Hendin and K. Foley, "Physician-Assisted Suicide in Oregon: A Medical Perspective" (henceforth "Hendin and Foley"), 106 Michigan Law Review 1613-39 (2008) at 1626-7, available
at http://repository.law.umich.edu/cgi/viewcontent.cgi?article=1374&context=mlr.
[8] Or. Rev. Stat. 127. 585 §3.03; Oregon 2016, op. cit., at 9.
[9] Or. Rev. Stat. 127.825 §3.03; Hendin and Foley, op. cit., at 1621-3, 1631.
[10] See J. Gross, "Landscape Evolves for Assisted Suicide," The New York Times (Nov. 10, 2008), at http://www.nytimes.com/2008/11/11/health/11age.html, quoting Dr. Timothy Quill ("Most patients will be reassured by the possibility of an escape, and will never need to activate that escape").
[11] Oregon 2016, op. cit., at 9 and 11 n. 2.
[12] Oregon Public Health Division, "Oregon Death with Dignity Act: 2015 Data Summary" (henceforth "Oregon 2015"), at 6; available at
http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf.
[13] Oregon 2016, op. cit., at 5; Oregon 2015, at 4; Oregon Public Health Division, "Oregon's Death with Dignity Act-2014," at 2, available

at http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf.
[14] Oregon 2016, op. cit., at 5.
[15] Id. at 11.
[16] Oregon Public Health Division, "2009 Summary of Oregon's Death with Dignity Act" at 5; available at
http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year12.pdf
[17] Oregon 2016, op. cit., at 10 and 11 n. 7; see annual reports for 2005, 2010, 2011 and 2012 at Oregon Health Authority, "Death with Dignity Act Annual Reports," http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx .
[18] Or. Rev. Stat. 127.890 §4.02.
[19] Or. Rev. Stat. 127.875 §3.13; M. Dore, "'Death with Dignity': A Recipe for Elder Abuse and Homicide (Albeit Not by Name)," 11.2 Marquette Elder's Advisor 387-401 (Spring 2010) at 391-3, available
at http://scholarship.law.marquette.edu/cgi/viewcontent.cgi?article=1027&context=elders; Letter of Oregon deputy attorney general David Schuman to state legislator Neil Bryant, March 15, 1999.
[20] Oregon 2016, op. cit., at 9; Oregon 2015, op. cit., at 5; D. Springer, "Oregon Offers Terminal Patients Doctor-Assisted Suicide Instead of Medical Care," Fox News, July 28, 2008,
at http://www.foxnews.com/story/2008/07/28/oregon-offers-terminal-patients-doctor-assisted-suicide-instead-medical-care.html.
[21] Hendin and Foley, op. cit., at 1624-5.
[22] After obtaining the drugs from a doctor claiming he had less than six months to live, the patient received encouragement and care from others and died peacefully of natural causes more than a year later, after reconciling with his grown daughter. Hendin and Foley, op. cit., at 1631-3; Physicians for Compassionate Care Education Foundation, "Five Oregonians to Remember" (henceforth "PCCEF"), at http://www.pccef.org/articles/art60.htm.
[23] Hendin and Foley, op. cit., at 1622-3.

HOMES OF LIFE ACROSS AMERICA

A New Pathway of Care for the Elderly, Sick, and Terminally Ill

By Ed and Nan Weber

In 1992, we founded the Holy Family Ministry Center "for the Renewal and Restoration of the Family and Catholic Family Life through the Spiritual and Corporal Works of Mercy." An acute awareness of the growing disintegration of the family in American society became a passionate call and work in our lives. It was in this ministry that we realized that the growing lack of respect for human life at its beginning was spilling over to those at the end of life.

The value of **each member of the family**, as a vital person created by God with a mission, bringing unique gifts, talents, experience, and wisdom to that group, has been lost in today's language, which is more focused on "I" and "me" than on "you" and "us". Ed always told our children, "Ask first 'How can I serve you?'"

In 1999, we came to realize that it wasn't enough to work solely to preserve the lives of God's children at the beginning of life. God inspired us to reach out to serve the elderly, sick, and terminally ill. And, in due time, Loreto on the Plains Personal Care Home became the fruit from that first seed of an idea. Loreto is located in Hartley, Texas and is a "Respect Life Care Home for the Sick and Terminally Ill where the sacredness of every human life is respected and protected." However, we know that this idea is not just for little Hartley, Texas, population 400. All across America there is a need for homes like Loreto on the Plains.

Homes of Life Across America is simply about this attitude: "How can I serve you? How can I make you more comfortable?" Phrases like these are heard in homes where the elderly are revered and caring for the sick and terminally ill is seen as our opportunity to give back. At the same time, from those we serve we gain wisdom, encouragement, stories of earlier times, lessons in faith, and a relationship with God that will last a lifetime.

We envision these Homes of Life being modeled after Loreto on the Plains, as undocumented homes where up to three unrelated persons live with a family to be cared for and loved. These homes will be a new pathway for care for those in harm's way due to the current culture of death that has permeated society and medicine, a culture which views certain people as less valuable simply because they need care and are no longer "productive."

Homes of Life are simply homes in which loving people desire the privilege of serving those in

need of tender care and attention. Each such home will be like a family. We know from experience that a loving, welcoming, and (to borrow a word from today's world) inclusive environment improves our resident patients' lives and adds months and even years to their lives.

It is unnatural to be in an institution, but very natural to be at home.

Homemade meals and sharing around the table at mealtime is a focus for us, as we are family. Other activities give life and happiness to our residents, such as birthday parties, playing games together at home, going to basketball games at the local school and, when we are able, taking everyone to a favorite restaurant. Each resident has their own room and has privacy and quiet when desired, especially at nap time or bed time.

You see, Homes of Life are exactly that--homes of life!

We are happy to talk by phone with anyone interested in joining the Homes of Life Across America movement. Get your questions together and call 806-361-5097 or email nanweber@xit.net. Our team will get back to you with the answers. Visits to Loreto on the Plains PCH can be arranged as well. Visitors participate in and experience the routine and the life in the Care Home. The Loreto Team is here to help you. If it would help for us to visit with a group of people who are interested in opening their homes or creating a home, we can arrange that. Please call your friends and organize a group meeting in your home or a neighborhood center, or hold a workshop or conference. We also recommend our website www.homesoflife.net, where you can take a peek at us and what we do. We believe the Homes of Life Across America movement is an urgent matter of health and life for the elderly, sick, and terminally ill children of God. Contact us today.

CASE IN POINT: What if...?

By Alexandra Snyder
Executive Director
Life Legal Defense Foundation

Robert, a friend of my parents, was diagnosed with "terminal" brain cancer early last year. Doctors told him he only had four months to live. He struggled with depression after the diagnosis and planned to request a prescription for so-called "aid in dying" drugs. He wanted to control the time and manner of his death.

This grieved me. **Robert bought the lie that choking down a lethal dose of barbiturates somehow leads to a "dignified" death**. This is just one of many lies in the End of Life Option Act, California's physician-assisted suicide law.

Note that Compassion and Choices, the George Soros funded group that drafted the Act, only considers **one option at the end of life: suicide**.

Life Legal filed our lawsuit challenging the assisted suicide law in June of last year, just a few months after Robert was diagnosed. The End of Life Option Act allows doctors to prescribe lethal drugs to patients deemed "terminally ill." For purposes of the Act, a patient is "terminal" if he or she is expected to die within six months.

Last month, my parents visited their friend to see him one last time. He had already outlived his "terminal" diagnosis and they expected to find him near death. Instead, he surprised them with the good news that at his last exam, doctors were unable to find any tumors. He had a new lease on life!

What if Robert had taken the life-ending drugs on a difficult day when he believed his death was imminent?

This story was excerpted from "When 'Terminal' Is Not the End...," April 23, 2017, and is reprinted with the permission of Life Legal Defense Foundation, https://lifelegaldefensefoundation.org/

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.

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/

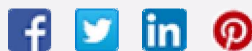
Texas Right to Life https://www.texasrighttolife.com/

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



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