PHA Monthly

Official Newsletter for the Pro-Life Healthcare Alliance
47th Edition
Feb. 8, 2018

Welcome to the forty-seventh 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.

-life healthcare" means medical care in which the life and safety of each person comes first, e each person receives medical care across their lifespan based on their need for care, dless of their abilities or perceived "quality of life."

FROM THE EDITOR'S DESK

By Julie Grimstad

In this edition of the PHA Monthly, we address a crucially important issue--palliative care (PC). PC is a medical specialty that focuses on helping patients manage their pain and other unpleasant symptoms associated with serious medical conditions. However, the culture of death has deeply infiltrated the practice of palliative care. The Pro-life Healthcare Alliance is extremely concerned that the federal government and state governments are promoting universal access to PC, which more and more frequently is being misused to deny life-sustaining and life-saving treatment and even to directly cause death in order to eliminate "unwanted" people and reduce healthcare costs.

A bill that was introduced to create a 20-member Palliative Care Council in Wisconsin was withdrawn last month when the Wisconsin Hospital Association (WHA) objected to language proposed by several organizations seeking to protect patients' lives. Here is the language (underlined) that the WHA did not like:

146.695 Palliative care. (1) In this section:
(b) "Palliative care" has the meaning given in s. 50.90(3) provided it does not intentionally hasten, assist in or cause hastened death.
(c) "Intentionally" has the meaning given in s. 939.23.

1. (**6**) Nothing in the section may be construed to create a cause of action or create a standard of care, obligation, or duty that provides a basis for a cause of action unless it intentionally hastens, assists in or causes hastened death.
"Intentionally" is defined in s. 939.23 as follows:
"Intentionally" means that the actor either has a purpose to do the thing or cause the result specified, or is aware that his or her conduct is practically certain to cause that result.

Alarm bells should go off when a state hospital association opposes language clarifying that palliative care "does not intentionally hasten, assist in or cause hastened death." This is tantamount to the WHA admitting it does not oppose the intentional hastening of deaths by PC providers.

The Wisconsin bill is dead, for now, but it will be back. Twenty-one states already have created Palliative Care Councils. These state councils complement the federal effort underway to make palliative care universally available.

Please read and share the "Palliative Care" article below. It was prepared for use as talking points for citizens who are fighting PC-promoting legislation, but I hope it will also be used to alert people to the very real threat that palliative care may pose to them or someone they love.

It is important to note that there are some pro-life palliative care specialists. The problem lies in identifying doctors who can be trusted to care for patients and not to kill them. If you are a pro-life PC physician, please contact the Pro-life Healthcare Alliance and let us know who you are. Patients are looking for you.

Imposed Death: Euthanasia and Assisted Suicide

HLA's new 16-page Magazine...

...unveils the tactics and goals of the "right to die" movement; explains the life-threatening attitudes and policies often encountered in various health care settings today; and highlights the experiences and opinions of those most intimately affected by health care policies and laws which endorse imposed death in its various guises. This publication will be an effective educational and life-saving tool only if it reaches people. YOU are a vitally important partner in this work. Please help distribute Imposed Death. To order copies, call 651-484-1040 or email **feedback@humanlife.org**. or click https://resources.humanlife.org/imposed-death/

PALLIATIVE CARE

Prepared by Julie Grimstad, Patient Advocate
Pro-life Healthcare Alliance
January 29, 2018

Opposition to legislation (like Wisconsin Assembly Bill 633) which would establish a Palliative Care Advisory Council to promote palliative care (PC) is **not** opposition to good pain management and medical treatment. Relieving pain and other bothersome symptoms of disease are ordinarily good things to do. However, PC medicine in practice often is not as advertised.

The 'Tools' of Palliative Care Medicine Can Be and Are Used to Hasten Death

Dr. Ralph A. Capone, who is board-certified in Hospice and Palliative Care Medicine and Internal Medicine, writes,

> According to the new bioethics, when applied to certain people, "do no harm" implies further life is harmful and, therefore, killing them is beneficent. In hospice and palliative care settings, the administration of intentionally larger doses of analgesia, beyond that necessary to diminish pain, is sometimes done to intentionally end patients' lives. **This is not a secret within the medical profession.** [Emphasis in the original.] [1]

Human Life Alliance and its committee, the Pro-life Healthcare Alliance, as well as other organizations (e.g., Hospice Patients Alliance, Terri Schiavo Life and Hope Network, Life Legal Defense Foundation), cite numerous tragic cases of people who have sought our help when a loved one was being overdosed with analgesics and sedatives and denied basic care or when a loved one's death was hastened in a PC setting without the family realizing what was happening at the time. Consequently, we are hard-pressed to know which hospice and palliative care programs can be trusted to care for and not kill the patients entrusted to them. We, who are involved in protecting patient's lives every day, are very concerned that PC medicine has become an agent of death in many cases.

involved in protecting patient's lives every day, are very concerned that PC medicine has become an agent of death in many cases.

Dr. Farr A. Curlin, a Palliative Medicine Specialist at Duke University, validates our concerns:

> Many patients and their families don't trust HPM and are resistant to it. I encounter such individuals in the hospital and in the community, among people of all walks of life and social strata but particularly among ethnic minorities and members of religious communities. These individuals tell stories about loved ones who declined slowly over time, fighting the good fight with the support and companionship of their family members and friends. When HPM professionals became involved in their care, their loved ones were put on powerful drugs, became unconscious and unresponsive, and were soon dead. These stories are clearly shared within communities and powerfully shape people's perceptions of HPM, which many see as a sophisticated and seductive way of getting people to die. In fear that HPM will usurp the role of the patient and that of the community in dying well, these people choose to go without the palliation that could help the patient participate in dying well. [2]

Dr. Curlin warns, "When the goal of HPM shifts from helping patients who are dying to helping patients die, practices that render patients unconscious or hasten their death no longer seem to be last-resort options." [Emphasis added.] [3]

"Stealth Euthanasia" in Hospice and Palliative Care Settings

Some PC providers intentionally kill patients under false pretenses. "Stealth euthanasia" is a term used to describe the intentional hastening of a patient's death while pretending to provide appropriate treatment. (The deliberate ending of a patient's life can be covered up easily by claiming a pure intention to ease pain and suffering.) Usually we hear of such a case from a family member who contacts us after the patient has died in a hospice and palliative care setting. For example, after describing her father's cruel and untimely death, Heidi Wise wrote,

> I have done a lot of research and have come to understand that "stealth euthanasia" is a widespread problem and a deeply troubling trend. For example, an indictment was recently handed down for sixteen people who were overdosing patients at a hospice in Texas. In some cases the overdoses led to death. [4] ... In just one month, three of my friends told me that they have had similar horrifying experiences. Even people I don't know have reached out to me on Facebook to tell me about their loved ones who they believe were killed by health care providers. Just like me, they are traumatized and extremely distressed." [5]

A Cost-Containment Strategy

Any cost savings are most likely due to reducing or stopping curative and life-sustaining treatment and even withdrawing basic care such as the provision of nutrition and hydration. Palliative care is not focused on treatment for medical conditions. **PC (pain and symptom relief), of itself, does not reduce costs.**

PC is exploited to limit treatment and/or cause death as a cost-containment strategy.

Dr. Timothy E. Quill, President of the American Academy of Hospice and Palliative Medicine (AAHPM), in 2012, stated,

> There is growing consensus that one of the biggest challenges of healthcare reform is the costs attributable to the sickest patients-especially the costs attributable to treatments of no or marginal benefit. This is why our demonstrated ability to improve quality of life, assist with difficult decision making, and decrease the overall costs of patient care make palliative care an obvious inclusion in the healthcare reform bill." [6]

Dr. Quill may have a very different view of what constitutes treatment "of no or marginal benefit" than a patient, family or treating physician has. Our experience has been that many PC providers deem "allowing" patients to die to be compassionate and cost-efficient.

Also, PC specialists do not focus on treating patients' underlying medical conditions, but only on treating symptoms which cause distress, yet Dr. Quill notes that they "assist with difficult decision making." How can they discuss treatment options with patients when they are not the ones who provide treatment for patients' diseases and other life-threatening conditions?

Many Palliative Care Leaders Are Comfortable With Killing

Dr. Quill (cited above) is not only a leader in the palliative care movement, he is also a board member of the Death with Dignity National Center which promotes the legalization of assisted suicide throughout the United States. In 1991, he wrote in the New England Journal of Medicine about providing a lethal dose of drugs to his patient, Diane. In 1997, Dr. Quill was the respondent in the U.S. Supreme Court case Vacco v. Quill challenging the ban on assisted suicide in New York. He argued that there is no difference between refusing lifesaving medical treatment and assisted suicide. In 2017, Dr. Quill again sought to overturn New York's law against assisted suicide as a plaintiff in Myers v. Schneiderman. It is important to note that Dr. Quill is very much in the mainstream of the mindset of Hospice and Palliative Medicine. In 2013, he was celebrated by his peers as one of several "Hospice and Palliative Medicine Visionaries."

The National Hospice and Palliative Care Organization (NHPCO) is the largest organization representing Hospice and Palliative Care programs and professionals in the United States. "The NHPCOis the actual legal and corporate successor to the Euthanasia Society of America. [7] The Euthanasia Society of America was successively known as the Society for the Right to Die, Choice in Dying, Partnership for Caring, and Last Acts Partnership before finally being absorbed into the NHPCO. This explains the contradiction between the publicly stated hospice mission and the reality in too many clinical settings. It appears that the NHPCO is intent on quietly subverting that life-affirming mission." [8]

Dr. Quill and Dr. Ira R. Byock, another prominent hospice and palliative care physician, have suggested that terminal sedation (a.k.a. palliative sedation)-making and keeping a patient unconscious until death occurs-

and voluntarily stopping eating and drinking (VSED) can "substantially increase patients' choices at this inherently challenging time." [9]

When leaders in Hospice and Palliative Medicine are comfortable with killing, is palliative care safe for patients?

A Foot in the Door for Legalization of Assisted Suicide

The *2016 International Association for Hospice and Palliative Care Position Statement on Euthanasia and Physician-Assisted Suicide* declares,

> The IAHPC believes that no country or state should consider the legalization of euthanasia or PAS [physician-assisted suicide] until it ensures universal access to palliative care services and to appropriate medications, including opioids for pain and dyspnea. [10]

The IAHPC does not oppose euthanasia and PAS. Note the word "until." We hear this type of rhetoric repeatedly along with the **unproven** claim that palliative care reduces requests for assisted suicide and, therefore, once there is universal access to palliative care, it will be "safe" to legalize PAS. Safe, legal suicide? Nonsense!

These are just some of the reasons for opposition to legislation promoting PC. For more information: Pro-life Healthcare Alliance, 651-484-1040, www.prolifehealthcare.org.

[1]Ralph A. Capone, MD, FACP, "Hospice and Palliative Care Medicine: Is It Losing Its Soul?" Imposed Death: Euthanasia and Assisted Suicide, p.10, https://resources.humanlife.org/pdf/Imposed_Death.pdf
[2]Farr A. Curlin, MD, Hospice and Palliative Medicine's Attempt at an Art of Dying, ch. 4 in *Dying in the Twenty-First Century*, p. 48, edited by Lydia Dugdale, MD, MIT Press 2015.
[3]Ibid. p.58.
[4] https://www.dallasnews.com/news/frisco/2017/02/28/frisco-man-15-others-indictedmedicare-hospice-scheme-used-human-life-vulnerable-stage
[5]Heidi Wise, "I Witnessed Involuntary Euthanasia in Hospice,"https://www.prolifehealthcare.org/wp-content/uploads/2017/12/12-06-2017-newsletter.pdf
[6]http://digitaleditions.walsworthprintgroup.com/article/Meet+AAHPM+President+Timothy+E.+Quill,+MD+FACP+FAAHPM/1010399/105036/article.html
[7] Hospice Patients Alliance, "From Euthanasia Society of America to National Hospice & Palliative Care Organization (1938-Present)," http://www.hospicepatients.org/euthanasia-soc-of-america-to-natl-hosp-and-palliative-care-org.pdf.
[8] Ralph A. Capone, MD, Kenneth R. Stevens, MD, et al, "The Rise of Stealth Euthanasia," *Ethics & Medics*, 06/2013, Vol. 38, No. 6, https://www.prolifehealthcare.org/rise-stealth-euthanasia/
[9]Timothy E. Quill and Ira R. Byock, "Responding to Intractable Terminal Suffering: The Role of Terminal Sedation and Voluntary Refusal of Food and Fluids," *Annals of Internal Medicine* 132.5 (March 7, 2000): 408-414.
[10] http://online.liebertpub.com/doi/full/10.1089/jpm.2016.0290?src=recsys&

PALLIATIVE CARE READING LIST

Capone, Ralph A, MD, Kenneth R. Stevens, MD, et al, "The Rise of Stealth Euthanasia," *Ethics & Medics*,

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Curlin, Farr A, MD Hospice and Palliative Medicine's Attempt at an Art of Dying, ch 4 in *Dying in the Twenty-First Century*, edited by Lydia Dugdale, MD, MIT Press 2015.

Dietz I, Borasio, GD, Med DP, et al, "Errors in palliative care: kinds, causes, and consequences: a pilot survey of Experiences and attitudes of palliative care professionals," *Journal of Palliative Medicine*, 2013; 16:74-81.

Rousseau, Paul, MD, "The Ethical Validity and Clinical Experience of Palliative Sedation," Mayo Clin Proc. 2000; 75:1064-1069, http://www.mayoclinicproceedings.org/article/S0025-6196(11)64426-1/pdf

"The Progression of Death Rhetoric in the U.S.A. 1938-2017" (see, in particular, year 2004), *Imposed Death: Euthanasia and Assisted Suicide*, edited by Julie Grimstad, Human Life Alliance,https://resources.humanlife.org/pdf/Imposed_Death.pdf

How the Culture of Death Was Brought to American Medicine (see, in particular, years 2000 to 2004), http://lifetree.org/timeline/EOLchronology.pdf

CASE IN POINT

MILD STROKE LED TO MOTHER'S FORCED STARVATION

By Kate Kelly

I watched an old woman die of hunger and thirst. She had Alzheimer's, this old woman, and was child-like, trusting, vulnerable, with a child's delight at treats of chocolate and ice cream, and a child's fear and frustration when tired or ill. I watched her die for six days and nights.

I watched her suffer, and I listened to the medical practitioners, to a son who legally decided her fate, and to an eldest daughter who advised him and told me that the old woman, my mother, was "comfortable," except when she was "in distress," at which times the nurses medicated her to make her "comfortable" again.

I watched the old woman develop ulcerations inside her mouth as she became more and more dehydrated; the caregivers assured me these were not painful.

I listened to her breathing become more and more labored as her lungs became congested from the morphine administered every three to four hours, and later every hour.

That is what morphine does, you see. It relieves pain, but its cumulative effect is that eventually it shuts down the respiratory system.

No one explained why the old woman was given morphine in the first place, since she was conscious and trying to speak. It is normal that a mild stroke causes temporary inability to swallow, slurred speech, and a severe headache, but all of these are often reversed when the stroke victim is treated and the treatment includes nourishment and water.

The explanation for not giving nourishment and water-a feeding tube and IV (intravenous)-is that these were "extraordinary measures" for keeping someone alive.
I watched the old woman day and night for six days. The first night, after the first shot of morphine, her mouth hung open and her tongue started to roll and flutter. At the same time, her jaw trembled continuously.

This went on all night and into the early hours of the morning. Her mouth never closed again, except to clamp tightly on wet cloths placed on her lips. Her eyes were partially closed, but they moved back and forth, back and forth, becoming small slits after seven or eight hours, not closing fully until that long first night was over.

She opened her eyes only once after that, when the nurse was late with the morphine on the third, or maybe the fourth, day.

The old woman started to moan.

Not moaning, said the nurses and the old woman's eldest daughter. Just air escaping from the lungs. Not moaning at all.

The old woman's eyes started to open, and the air escaping from the lungs sounded exactly like a moan of agony as the old woman's face twisted in horrible contortions. I screamed, "Her eyes are opening! Oh, God. Oh, God!"

Even as the morphine, quickly injected by a disconcerted nurse, caused the old woman's eyes to close and her face to relax, I doubted its efficacy. I thought back to the night before, when I, in tears at the old woman's slow dying, had been confronted by a delegation of four of the nursing staff, each of them in turn trying to convince me that the old woman was not suffering in any way at all. The morphine, they said, takes away all pain.

But, I answered them, she can feel: she's squeezing my hand, and if I try to take my hand out of hers, she squeezes tighter, and when I hold a little piece of gauze to her lips, she tries to suck the water out of it. She's thirsty! This is a horror; this is cruelty!

No, they said. She's not thirsty. It's just reflex. But, I tell them, I watched her clamp her lips on the gauze so tightly that I had to pull to get it out of her mouth.

She reacts when you touch her feet, her legs, and her hair. If she can feel that she can feel thirst, I plead with them.

It's not the same, they tell me. She's not in pain.

I look at her. But what if you're wrong? I say. What if you're wrong?

They stand there, saying nothing. Then one looks at the old woman and says, we'd better turn her now. She and another care worker go about the business of re-positioning the old woman, to keep her "comfortable" and the other two leave.

The days and nights went in and out of focus. I sat in a chair at the side of the old woman's bed, one hand grasped tightly by her hand. I slept an hour or two, here and there, waking always with a start.

"I'm here," I murmured, so the old woman would know I was keeping the promise I made to her on the first night, after her son and eldest daughter left to get some food, drink, and rest. I promised her then, "I will not leave here until you do.

The old woman was fading by the fourth day. Her eldest daughter had been visiting for an hour or so each day, usually mid-morning. This daughter, a former hospital worker, lightly stroked her mother's face and hair and timed the length of her mother's "breath apnea," the length of time her mother stopped breathing.

She announced the number of seconds, and then counted the number of breaths between each stopped breath. Seven breaths, she said, 11 breaths.

Sometimes she described the progress of her mother's death. She's probably down to about 60 pounds now, she pronounced.

Sometimes-I'm not sure when I noticed it first-the nurses asked us to leave while they attended to the old woman. Other times they didn't. Once, perhaps on the fourth day, I told them I didn't have to leave. I had watched them turn her, I had seen her tiny naked body as they gently washed her. I didn't even flinch anymore when they injected the syringe of morphine.

We have to give her a suppository, they said.

A suppository? Why?

For anxiety, they said.

Anxiety. So that she would appear to die with dignity. The morphine was no longer enough. This courageous old woman, who could face, who had faced, unimaginable hardships with nothing but her faith and her dignity, she could teach you about dignity, I thought to myself.

On the fifth day the eldest daughter visited twice. On her second visit, several staff members entered the room with her. They were all talking loudly, about nothing in particular, except for one care worker, fond of the old woman, who walked over to the bed and called the old woman's name loudly enough to interrupt the others' light conversation. She examined the old woman's hands, lifted the sheet covering her and looked at her legs and feet. She called the old woman's name again, and the care worker's face showed alarm.

How long has it been? she asked. She's not even mottling! (Mottling is the term given to describe the blackening of the feet and hands as the body, dehydrating, tries to preserve the vital organs by stopping the flow of blood to the limbs).

You know, continued the care worker, I don't think it's her time. It's been, what, five days? If she had been ready to go, she'd have gone in 24 hours.

The room went quiet. The care worker and I looked at each other. You're right, I said. The eldest daughter and one of the nurses began to tell her she was wrong, and a nurse hustled her out of the room.

By the sixth night I was not sure I could go on. I slept for an hour or so every four or five hours. I still sat in the chair by her bed, but now I slept with my head on bed, near her stomach.

The old woman's breathing was labored, her will to live defying the system and the foolish young doctor who, on that first night, gave her 24 hours to live, as though he were God Himself.

My heart was breaking for her. I could do nothing to save her, could do nothing but suffer with her. I cried much of the time, but softly, so she would not know. I didn't want to add to her agony.

I had been there six days. She could no longer hold my hand, so I slipped my hand gently under hers. I felt an anguish so profound that I began to wonder if I could survive it.

The old woman's breathing was suddenly no longer labored. Her breath eased from her, and her face-oh, her face had become the color of pearls.

In a split second, the frown that had creased the line between her brows was smoothed away. Her head rested gently to one side. Two care workers entered the room. I saw them in my peripheral vision, but I kept my gaze on the old woman.

We're just going to turn her, one of the workers said.

No, I said, my mother is dying.

One of them left to get a nurse, and then the old woman-my dear mother, my little, child-like, beautiful mother-died.

I put my arms round her, kissed her poor, closed eyes and her now relaxed mouth, and held her limp, tiny body, no more struggling for breath.

I watched an old woman die of hunger and thirst. I watched her die for six days and nights. I watched her suffer, and struggle, and hold onto life.

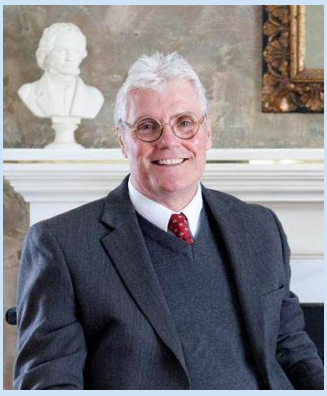
She had not often found life easy, but she had always found it worthwhile. She was 94 years old. She had been born and had lived all her life in Canada. She had worked hard all her life, married, raised three children, voted, paid taxes, saved enough money to buy her own home, obeyed the laws, donated to charity, done volunteer work, paid her bills, and given much love and brought much joy to many, many people in her 94 years.

In return, in the spring of 2009, her son and her eldest daughter, with the permission and assistance of the law, because this old woman had had a mild stroke, refused her food and water. She could not swallow, so she would have needed the food and water administered artificially.

And the youngest daughter could do nothing except watch her mother die slowly, and write this, in the hope that my mother's death, like her life, will have made a difference.

Reprinted with permission of the author from the website for STOP HOSPITAL EUTHANASIA, a volunteer organization led by people who have had a loved one euthanized against that person's expressed desire or without any request for euthanasia from that person. Our primary goal is to prevent patients in an inpatient hospital situation from being euthanized against their will. https://www.stophospitaleuthanasia.org/mild-stroke-mothers-forced-starvation.html

AN ELOQUENT SPEAKER WITH A POWERFUL MESSAGE



MARK DAVIS PICKUP is available to address issues pertaining to disability and life from a Christian perspective. He can be reached for bookings by email at HumanLifeMatters@shaw.ca .

Mark has been chronically ill and disabled with multiple sclerosis for over 33 years. He has spoken across North America warning against accepting euthanasia and assisted suicide. He has addressed politicians in Canada and the United States, churches and denominational leaders, universities, high schools and community groups, hospital medical staffs, local, state and provincial pro-life conventions as well as keynote speaker to U.S. National Right to Life Prayer Breakfasts (2001, 2005, and 2010). He also addresses a Christian perspective on suffering. Mark is extensively published. He has appeared on innumerable radio and television programs warning against a cultural drift toward euthanasia acceptance. He has received numerous awards for his work including the Monsignor Bill Irwin Award for Ethical Excellence, and a Governor General's Medal for community service.[1]

What do people say about Mark?

I thoroughly enjoyed working with Mark and know him as a truly gifted orator. He is a powerful, eloquent speaker whose passionate and deeply insightful testimony as a disabled man, exposes the problems of legalized euthanasia (mercy killing, assisted suicide) and the implications that it can have on the most vulnerable people. --**Ann Olson, Education Director, Human Life Alliance, Minneapolis, Minnesota**

"I recommend Mr. Pickup as a resource to those committed to resisting euthanasia. He is a champion of disability inclusion and is utterly committed to the value, dignity and equality of all human life." -- **Bobby Schindler, brother of Terri Schiavo and Executive Director, Terri Schiavo Life & Hope Foundation.**

"Mark's experience as a disabled man, his rigorous intellect, and his love of all people are in evident abundance as he mounts an eloquent and powerful critique against the culture of death. Mark's is a voice we all need to hear - and heed." -- **Wesley J. Smith, author and international Life Issues speaker.**

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[1] The Governor General is Queen Elizabeth II's official representative to Canada.

RECOMMENDED READING

"Nurses, 'Living Wills' and Healthcare Economic$," Nancy Valko, RN, 1/26/2018: https://nancyvalko.com/2018/01/26/nurses-living-wills-and-healthcare-economic/

"'No One is Coming:' Investigation Reveals Hospices Abandon Patients at Death's Door," Jonel Aleccia and Melissa Bailey, TIME, 10/25/2017: http://time.com/4995043/no-one-is-coming-investigation-reveals-hospices-abandon-patients-at-deaths-door/

"Q&A: How to Prevent, Detect, and Treat Dehydration in Aging Adults," Leslie Kernisan, MD MPH: https://betterhealthwhileaging.net/qa-how-to-prevent-diagnose-treat-dehydration-aging-adults/

"Pulling the Plug on Hope," Focus on the Family, 12/14/2017: https://www.focusonthefamily.com/socialissues/citizen-magazine/pulling-the-plug-on-hope

RESOURCES

The following resources are provided by the Hospice Patients Alliance (www.hospicepatients.org) as a follow-up to William Beckman's article "Risks of Guardianship Abuse," PHA Monthly, December 2017:

National Association to Stop Guardian Abuse
www.stopguardianabuse.org
The National Association to Stop Guardian Abuse is an organization formed by victims and for victims of unlawful and abusive guardianships and conservatorships. They have been working for a long time to bring long overdue reform the system. Many articles are listed along with information about individual's rights.

Americans Against Abusive Probate Guardianship
www.aaapg.net/category/hotline-to-report-guardianship-abuse
Much information about guardianship abuse is provided along with lists of articles, court cases, stories of abuse, efforts to reform the system and much more.

Guardian Abuse Cases
www.guardianabusecases.com
Guardian Abuse cases.com has been created to inform the public about the illegal and unethical activities of private professional guardians. Private guardians use techniques, which cause family members to feel isolated and alone after receiving harsh treatment from a private guardian. We will feature cases where private guardians have submitted false documents to courts, bragged about bribing judges in family courts, committed fraud, kidnapped seniors from their homes, turned relatives against each other, double billed, and in some cases committed direct theft of funds from senior bank accounts. A forum to share information is provided along with links to many articles about Guardianship abuse.

View the Human Life Alliance Video:
Informed: Life is Worth Living
https://www.youtube.com/watch?v=Zrk2YUaPAwE

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.

[Hospice Patient's Alliance]
[Euthanasia Prevention Coalition]
[Patient's Rights Council]
[Prenatal Partners for Life]

[Pro Life Wisconsin]
[American Life League]
[Texas Right to Life]
[Read Stealth Euthanasia: Health Care Tyranny in America by Ron Panzer]

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