PHA Monthly

Official Newsletter for the Pro-Life Healthcare Alliance
48th Edition
April 3, 2018

Welcome to the forty-eigth 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

A Quick Fix Is Not Good End-of-Life Healthcare

By Julie Grimstad

Organizations and individuals who promote societal and legal approval of killing--allegedly for the "good" of people who are seriously ill or suffering--are misguided. Killing a person does nothing to upgrade his or her well being. Rather, killing in the name of compassion downgrades the perceived worth of the person and reduces compassion to a quick fix.

Healthcare is not a quick fix.

Healthcare promotes optimal health and development throughout the human lifespan, cures illness, heals, cares, comforts and alleviates suffering.

Even when a cure is not possible, ethical and compassionate healthcare providers do all they can to minimize the patient's suffering, short of deliberately killing the patient. This requires that experts in pain and symptom management take the time necessary to find the most effective ways to relieve the patient's suffering. It also requires patience as caregivers attend to the patient's comfort and other needs. Furthermore, good healthcare in general and good end-of-life care in particular can be costly in terms of resources used and money spent.

Deliberately ending a patient's life is a quick and cheap fix. It is not healthcare.

Find Real Care and Avoid Death Traps Disguised as "Comfort Care"

Killing patients to end their suffering is as low as we can go. Instead, let's aim for as high as we can get by striving to provide the best healthcare possible to every patient.

In this edition of the *PHA Monthly,* we introduce you to Generous Home Care Management, LLC, an agency in Texas which provides modern hospice and home health care that safeguards patient's rights and lives. Jose Aquilar, RN, President and Administrator of Generous Home Care, asserts that they embrace the PHA's "pro-life healthcare" philosophy.

Before signing on with any hospice or other healthcare agency, check it out carefully. As a guide, we recommend "Interviewing A Hospice Agency: What Questions Should I Ask?" on page 12 of *Informed: A guide for critical medical decisions,* a publication of Human Life Alliance. It may be previewed at https://resources.humanlife.org/pdf/informed.pdf and ordered by calling 651-484-1040. Your life or the life of a loved one may depend on your due diligence.

[1] "POLST: What is POLST and Why Does the PHA Oppose

it?" https://www.prolifehealthcare.org/polst-what-is-it-and-why-does-the-pha-oppose-it/
[2] North Texas Respecting Choices Advance Care Planning Fact Sheet "Tube Feeding: What you should know,"
http://www.northtexasrespectingchoices.com/

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/

Generous Home Care Management, LLC

Currently servicing Regions 8 and 11 in Texas. Effective 4/30/18, servicing all Texas regions.

1. PHILOSOPHY, MISSION, AND VISION

Our Philosophy of shared beliefs is the foundation of Generous Home Care Management, LLC. We believe in morals and acceptance of God. We believe healthcare must be transparent, safe, and responsible. We believe in our country, the United States of America, and its people. We believe that protecting life is the most important issue on earth. We believe obsession with money ends lives, directly and indirectly. We believe in safeguarding the integrity of healthcare professionals. We believe patients have rights and we implement those rights. We believe in connecting hands that need employment with hands that need support. We believe in the pro-life movement and agree with the "pro-life healthcare" philosophy of the Hospice Patients Alliance and the Pro-life Healthcare Alliance. We believe our calling is to protect human life by working together. We believe this calling is given by our Heavenly Father.

Our mission is to restore the broken relationship between healthcare professionals and the community. We strive to protect patients from health care financial predators. We earn our reputation one patient and one home at a time.

We envision creating a transparent service that works for those facing illness. We envision protecting patients from political and health care systems that seek to minimize costs and maximize profits no matter the toll on human lives. We foresee a day when the United States of America will

protecting patients from political and health care systems that seek to minimize costs and maximize profits no matter the toll on human lives. We foresee a day when the United States of America will have a healthcare system that provides real care and support to patients and communities.

2. SERVICES IN HOSPICE AND HOME HEALTH CARE

Hospice is a program of care and support for people who are terminally ill. The hospice team is composed of physicians and nurses, social workers and chaplains, therapists and volunteers who join in the effort to provide holistic care that helps a person with a terminal illness live a comfortable and dignified life. This professional group attends to the biological, psychological, sociological and spiritual needs of the person at the end of life and his or her family members. This end-of-life care includes adequate pain management, relief from uncomfortable symptoms, assistance coping with existential issues and addressing social concerns. A physician must certify that the patient is terminally ill with a six-month or less life expectancy if the disease takes its normal course. The patient and or family must be aware of the prognosis and elect palliative comfort care rather than active curative interventions.

Home Health Care focuses on the patient's recovery. Knowledge is crucial to protect one's health. Therefore it is our responsibility to educate the patient and/or the patient's caregiver(s) about the patient's health and matters that can cause him or her harm. Details matter. The more patients and caregivers know, the more tools they will have to protect themselves and others.

Our Philosophy is the primary reason that you will find yourself comfortable with our services. We are about service that is transparent and free of fraud. We seek to safeguard our patients' well being and lives by serving them responsibly. We believe in a health care system that allows the voice of the patient to be heard. We strongly believe words such as "compassion" and "high quality service" cannot be used by an organization until such words are earned by the service it provides to patients and their families.

Nursing Services: We provide a wide range of skilled nursing procedures and interventions to meet the health care needs of our patients. We work side by side with physicians to provide optimum care, including evaluation, direct service, patient education, and consultation service.

Medical Social Worker: The social worker coordinates with the physician and nursing agency to help patients obtain community resources that assist with housing, medications, food, and security; and assists with advance directives for health care and other legal documents.

Physical Therapy/Occupational Therapy: Therapists evaluate and treat patients who have muscular and joint deficiencies from surgical procedures, stroke, falls, or generalized weakness. They provide evaluation, direct service, exercise instruction, and/or consultation service.

Speech Therapy: The therapist provides evaluation, direct service, language instruction, and/or

consultation service. They provide assistance with speech difficulty related to recent trauma or lesion.

Nutritional Counseling: A registered nurse (RN) or dietitian provides direct services. Home Health Aide: Aides provide services related to personal care and specific tasks assigned and directed under the supervision of an RN. They also provide services related to extension of therapy to patients under the supervision of a registered therapist.

3. GENEROUS VIEWS ON DNR, HYDRATION, AND NUTRITION

A. Do Not Resuscitate (DNR) order: The patient has the right to choose either a DNR order or full code. Patients have the right to call 911 and use hospital systems. Education on advance directives for health care is common practice for our clinicians. We make certain that no patient/family is placed under pressure regarding these serious life decisions. We believe education about the Patient Bill of Rights is essential in order to keep patients safe.

B. We provide intravenous (IV) hydration in home settings if indicated by the patient's plan of care. (Note: the Generous team and family/patient/caregiver work together in these circumstances.)

C. Generous provides assistance with tube feedings if indicated. We support patients with a terminal diagnosis. We do not hasten the end of life. We do not perform euthanasia. We do not agree with any organization (such as Compassion & Choices, formerly known as the Hemlock Society) that promotes euthanasia and/or assisted suicide. We oppose laws, such as Oregon's "Death with Dignity Act," which permit doctors to provide patients with drugs to kill themselves.

4. GENEROUS HOME CARE MANAGEMENT, LLC: PIONEERS OF MODERN HOSPICE AND HOME HEALTH CARE

Generous is pioneering how service works--efficiently, safely, and transparently. Generous brings together clinicians who agree with our Philosophy, since we have found our Philosophy to be the most important piece of this new movement. We have already seen results in improved quality of care. Quality service is our focus and is measured by performance. For example, nurses are not overloaded with work, so we have very little nurse turnover. This improves quality because it results in consistency of care and improved communication with patients and families and between team members. We have found that including the patient and family in all aspects of their care, listening to their suggestions for improving our services, and asking them to rate our performance, keeps our organization on the right path. We welcome both positive and negative comments as a way to assess our service and improve our performance. This helps us continually shape how we make our service work for many people.

5. HEALTH CARE PREDATORS

The health care system, in general, is no longer safe, particularly for patients who are "devalued"--mentally or physically disabled, chronically ill, incurable, elderly, or poor. Healthcare has become an industry controlled by aggressive business and financial decisions made for merging health care groups. As a result, physicians, nurses, and other health care providers are pressured to serve business interests even when these conflict with patients' interests. They are often misled about what is ethical and moral. Those health care providers who disagree with practices that endanger patients' lives are unable to speak up.

Some healthcare providers are motivated by financial compensation rather than patient welfare. Generous coined the term "health care predators" to describe providers who act in this way.

6. TIPS FOR PROTECTING PATIENTS FROM HEALTH CARE PREDATORS

- It is essential to understand the Patient Bill of Rights, which spells out a patient's rights such as the right to accurate information, the right to emergency services, the right to complain, the right to respect, etc.
- Read the organization philosophy and do not be afraid to ask uncomfortable questions.
- If in a hospital setting, ask for a list of options, pay attention to attitudes and to any high-pressure push for a decision on your behalf.
- With the exception of the person (agent) you appointed in your Durable Power of Attorney for Healthcare, absolutely do not allow others to decide for you in matters of health care.
- If you have been given a terminal diagnosis, research the disease and obtain full records.
- Do not lose hope no matter how others view your circumstances. Health care predators often play on a patient's loss of hope to the patient's disadvantage.
- Understand that hospice is a service which is only to assist patients facing terminal illness.
- If the philosophy of a hospice or home health care agency doesn't sound right, that's because it's not right.
- Avoid agencies that use the term "empowering physicians." Empowering is a word commonly used among health care predators.

Contact information:
Jose Aguilar, RN, President and Administrator
Generous Home Care Management, LLC
8600 Wurzbach Road, Ste. 802
San Antonio, TX 78240
Phone: (210) 239-5056
Fax: (210) 267-9011
Website: www.ghcmtx.com
Email: generoushomecare@ghcmtx.com

CASE IN POINT

Lyndee Pellettiere-Swapp's Astonishing Recovery

A 45-year-old Arizona woman, Lyndee Pellettiere-Swapp, was in a coma for 12 days after her son found her unconscious at her home. The medical team, believing there was nothing more they could do for her, suggested to her family that Lyndee be removed from life support in order to carry out her wish to be an organ donor.

The family, one by one, spoke to Lyndee and said farewell to her. She heard the doctors and her family and realized that she was in great danger. "It was very agitating," she said later. "I couldn't move, I couldn't talk, I couldn't respond."

Lyndee heard her husband whisper in her ear, "You are a fighter... You have to fight." Medics were outside her room waiting to receive her organs, but, when her life support was removed, to everyone's astonishment, instead of dying she came out of the coma.

On Facebook, Lyndee advised, "Just because you're not conscious doesn't mean you can't hear, so you should talk to your loved ones if somebody's in that situation."

Yes, and tell them to fight!

Source: http://mb.ntd.tv/2017/01/23/coma-planning-pull-plug-can-hear-miracle-can-save/

HAWAII'S ASSISTED SUICIDE BILL AND MY TESTIMONY AGAINST IT

By Nancy Valko, RN

While groups like Compassion and Choices and a mostly sympathetic mainstream media continue to tout allegedly strong "safeguards" in assisted suicide laws that allegedly prevent abuse, these "safeguards" already have been mostly eliminated in countries like Canada and Holland--and are now beginning to fall here in the US and other countries.

A case in point is Hawaii, whose legislature rejected assisted suicide just last year. Hawaii has a new bill this year, HB 2739. Called the "Our Care, Our Choices Act," this bill was recently fast-tracked in the legislature with testimony scheduled for February 27, 2018.

HB 2739 (before amendments) would allow **advanced practice registered nurses** as well as doctors to be the "attending provider" for assisted suicide. Despite the ubiquitous problems with assisted suicide, which I have written about previously [1], the Hawaii legislators claimed "robust safeguards" such as "**if appropriate**," the doctor can refer the terminally ill patient for "counseling" to be

performed by "**a state-licensed psychiatrist or psychologist**" but just for the purpose of "determining that the patient is capable of making medical decisions and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment." [Emphasis added.] This is not the same as the usual psychiatric/psychological evaluation required for other suicidal people.

After "an emotional 5-hour hearing" [2] on February 27th, a joint House panel voted in favor of an amended version of HB 2739 that will head to a vote of the full House in the near future. The amended bill includes the welcome removal of advanced practiced registered nurses as "attending providers" but added social workers to the psychiatrists or psychologists designated as the counselors to determine the patient's "capability" and allows "counseling" by telehealth instead of in person. Finally, the new bill would also lengthen the time between oral requests for assisted suicide from 15 to 20 days.

As usual, Compassion and Choices continues to describe HB 2739 deceptively:
"Medical aid in dying is an end-of-life medical practice in which a terminally ill, mentally capable individual who has a prognosis of six months or less to live requests, obtains and-if his or her suffering becomes unbearable-self-ingests medication to die peacefully in their sleep." [3]

We all need to know that we are being lied to about assisted suicide and fight against such laws!

My Testimony on Hawaii's HB 2739
February 26, 2018

Please Do Not Approve HB 2739, From a Mother and a Nurse

As the mother of a suicide victim who used an assisted suicide technique and as a registered nurse who has cared for suicidal people both personally and professionally for over 40 years, I implore you not to approve the dangerous HB 2739, the "Our Care, Our Choice Act." This bill puts both desperate people and our health care system in danger. I want to address both issues.

My Daughter Marie Killed Herself Using an Assisted Suicide Technique

In 2009, I lost a beautiful, physically well, 30-year-old daughter, Marie, to suicide after a 16-year battle with substance abuse and other issues. Her suicide was like an atom bomb dropped on our family, friends and even her therapists.

Despite all of our efforts to save her, my Marie told me that she learned how to kill herself from visiting suicide/assisted suicide websites and reading Derek Humphry's book Final Exit. The medical examiner called Marie's suicide technique "textbook final exit," but her death was neither dignified nor peaceful. Marie was a victim of the physician-assisted suicide movement, seduced by the rhetoric of a painless exit from what she believed was a hopeless life of suffering.

Suicide Contagion

Adding to our family's pain, at least two people close to Marie became suicidal not long after her suicide. Luckily, these two young people received help and were saved, but suicide contagion, better known as "copycat suicide," is a well-documented phenomenon. [4] After Oregon's physician-assisted suicide law took effect in 1997, the rate of suicide increased. [5] In 2015, the state's health department said "The rate of suicide among Oregonians has been increasing since 2000" and as of 2012 was "42% higher than the national average"; suicide had become "the second leading cause of death among Oregonians aged 15 to 34 years." [6] These figures are in addition to deaths under the Oregon assisted suicide law, which legally are not counted as suicides.

My Marie was one of the almost 37,000 reported US suicides in 2009. According to the Centers for Disease Control and Prevention, suicide is the 10th leading cause of death among Americans with more than 44,000 people dying by suicide in 2015, more than 1.4 million people reported making a suicide attempt in the past year and almost 10 million adults reported thinking about suicide in the past year. [7]

Our urgent health care crisis is the staggering and increasing number of suicides, not the lack of enough medically assisted suicides.

My Story

Several years after Oregon's law was passed, I was threatened with termination from my job as an intensive care unit nurse after I refused to participate in a deliberate overdose of morphine which neither the patient nor his family had requested. He was an older patient who had experienced a crisis after a routine surgery.

The patient had improved but did not wake up within 24 hours after sedatives used with a ventilator were stopped. It was assumed that severe brain damage had occurred and doctors recommended removing the ventilator and letting the patient die. However, when the ventilator was removed, the patient unexpectedly continued to breathe even without oxygen support. A morphine drip was started and rapidly increased, yet the patient continued to breathe.

When I refused to participate in this, I found no support in my hospital's "chain of command." I could not pass off this patient to another nurse so I basically stopped the morphine drip myself, technically following the order to "titrate morphine for comfort, no limit." The patient eventually died after I left. Ironically, a later autopsy requested by the family showed **no lethal condition or brain injury** as suspected. The physician who authorized the morphine demanded that I be fired.

The Effect of Medically Assisted Suicide on Our Health Care System

I've known other doctors, nurses and therapists who have put their jobs on the line to protect their

patients. Unfortunately, we are fast becoming pariahs in the face of medically assisted suicide legalization.

For thousands of years, doctors (and nurses) have embraced the Hippocratic standard that "I will give no deadly medicine to anyone, nor suggest any such counsel." Should the bright line doctors and nurses themselves drew to separate killing from caring now be erased by legislation?

As a nurse, I am willing to do anything for my patients--except kill them. Working with the terminally ill, I have been struck by how rarely these people say something like, "I want to end my life." The few who do express such thoughts are visibly relieved when their concerns and fears are addressed and dealt with instead of finding support for the suicide option. I have yet to see such a patient go on to commit suicide.

In 2015, the Canadian Supreme Court approved MAID (medical aid in dying, a.k.a. medically assisted suicide) and lethal injection suicides began in Quebec, one of Canada's largest provinces. Now, MAID is practiced throughout Canada and "only 5 of more than 2,000 Canadian patients who used medical aid in dying self-ingested the lethal medication." [8]

A December 2017 Canadian medical journal (*Le Specialiste*) contains a fascinating but disturbing English language article, "First Results from a Unique Study," on pages 36-40. The study, done in Laval, Canada, showed that, prior to the law, 48% of doctors said they would participate, 30% with conditions, and only 28% said they would never participate. Afterwards, 77% of the physicians getting MAID requests refused to actively participate, using the conscientious objection clause, even though the study claimed the majority (72%) were in favor of MAID with only 13% of the doctors being neutral or ambivalent. The most common reason given for refusal was "too much of an emotional burden to bear."

Do assisted suicide supporters really expect us doctors and nurses to be able to assist the suicide of one patient, then go on to care for a similar patient who wants to live, without this having an effect on our ethics or our empathy? Do they realize that this can reduce the second patient's will-to-live request to a mere personal whim-perhaps, ultimately, one that society will see as selfish and too costly? How does this serve optimal health care, let alone the integrity of doctors and nurses who have to face the fact that we helped other human beings kill themselves?

Conclusion

Medically assisted suicide is a dangerous and slippery proposition. As noted, the vast majority of MAID deaths in Canada have been accomplished by lethal injections, not self-ingestion of the lethal prescription. Other countries have gone farther to include chronic psychiatric conditions, birth defects and even just old age.

We must not discriminate on the basis of health and choice when it comes to desperate people

seeking suicide. We must treat all of our citizens with equal concern.

Note: *This article was adapted from the original, available at* https://nancyvalko.com/2018/03/01/they-are-lying-to-us/ *. Nancy Valko's testimony has been condensed*.

About the author: I have been a registered nurse since 1969 and currently I am a spokesperson for the National Association of Prolife Nurses (www.nursesforlife.org). I have also been a past President of Missouri Nurses for Life and past co-chair of the St. Louis Archdiocesan Respect Life Committee. In 2015, I was honored to receive the People of Life award from the US Catholic Conference of Bishops. After working in critical care, hospice, home health, oncology, dialysis and other specialties for 45 years, I am currently working as a legal nurse consultant (www.valkogroupalnc.com) and volunteer.

[1] https://nancyvalko.com/2017/12/27/six-things-you-need-to-know-about-physician-assisted-suicide/
[2] http://www.civilbeat.org/2018/02/medical-aid-in-dying-bill-generates-an-emotional-5-hour-hearing/
[3] https://www.compassionandchoices.org/hawaii-house-health-human-services-and-judiciary-committees-approve-medical-aid-in-dying-bill/
[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3384446/
[5]http://www.oregon.gov/oha/ph/DiseasesConditions/InjuryFatalityData/Documents/NVDRS/%20Suicide%20in%20Oregon%202015%20report.pdf
[6] https://digital.osl.state.or.us/islandora/object/osl%3A94197/datastream/OBJ/view
[7] https://www.cdc.gov/violenceprevention/suicide/consequences.html
[8] https://www.canada.ca/content/dam/hc-sc/documents/services/publications/health-system-services/medical-assistance-dying-interim-report-sep-2017/medical-assistance-dying-interim-report-sep-2017-eng.pdf

Recommended Reading

"What happens when a patient says, 'Doc, help me die'," by E. Wes Ely, M.D., https://www.cnn.com/2018/03/20/opinions/caregiving-what-its-like-to-be-me-wes-ely-opinion/index.html

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.

- **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.

Pro-life Healthcare Alliance

a program of Human Life Alliance
1614 93rd Lane NE, Minneapolis, MN 55449
Tel 651.484.1040