



IMPOSED DEATH

euthanasia and assisted suicide

WHAT'S THE BIG DEAL?

EUTHANASIA literally translated from Greek means “good death.” Some who promote euthanasia call it “mercy killing.” Death by euthanasia is neither good nor merciful. Therefore, in this publication, the more accurate term “imposed death” is frequently substituted for “euthanasia” and “assisted suicide” (see Definitions, p. 3).

You may ask: Why should I be concerned? Why do I need to read this publication? Because the whole human race has a stake in the answer to the question, “Should imposed death be permitted and regulated by law?” History teaches us that a society which fails to respect and protect everyone’s life is not a safe place for anyone.

We need not reach back farther than the last century for a horrific example. In October 1939, Adolph Hitler issued a directive allowing physicians to grant a “mercy death” to “patients considered incurable.” This program quickly expanded to include children and adults with disabilities and was the forerunner to the much greater holocaust to come. By the time Germany lay in ruins at the end of World War II, physicians and nurses, willingly participating in the euthanasia program of the Third Reich, had

dispatched 250,000 to 300,000 incurable patients and disabled persons by sedation, starvation, gas inhalation, and lethal injection. What motivated these medical professionals, ostensibly dedicated to helping their fellow human beings, to carry out these murders? The answer is simple: a flawed philosophy that some people are less worthy of life than others and that there would be more resources available to care for the healthy if the unhealthy were eliminated.

Allowing certain people to be killed because their lives are viewed as “not worth living” or “burdensome” has profound repercussions for all of us. Devaluing one human life devalues all human life. (See the true stories in our “Case in Point” features.)

This supplement examines imposed death from various angles, highlighting the experiences and opinions of those most intimately affected by it. In order to make informed decisions, you need the unvarnished truth about this vitally important topic.

Advocates of euthanasia and assisted suicide use terms like “choice in dying” and “self-determination.” They promote the social and legal acceptance of the “right to die” — that is, the “right” for individuals to choose how, when, where and why to die, and to receive assistance in dying from others. Although the expression “right to die” is seductive, giving governments the right to authorize our “right to die” begins the progression from voluntary imposed death to

involuntary imposed death. Who will decide for those who cannot make their own choices? At what point does a “right” become an expectation, even a duty?

Instead of pursuing a “right to die,” let us strive to create an environment, a culture of life, in which no person feels compelled to seek the “quick fix” of death and every person’s life is respected by society and protected by law.

ACKNOWLEDGMENTS

Human Life Alliance assembled a talented team of writers, researchers and experts who contributed to developing this publication. We are grateful to these women and men for their dedication to this project, as well as for their perseverance in defending the unalienable right to life of all human beings, especially those who are most vulnerable, the voiceless. Foremost, we want to thank our multitude of friends whose faithful support enables Human Life Alliance to continue its life-saving educational projects.

Severely Aslikowski
Board President

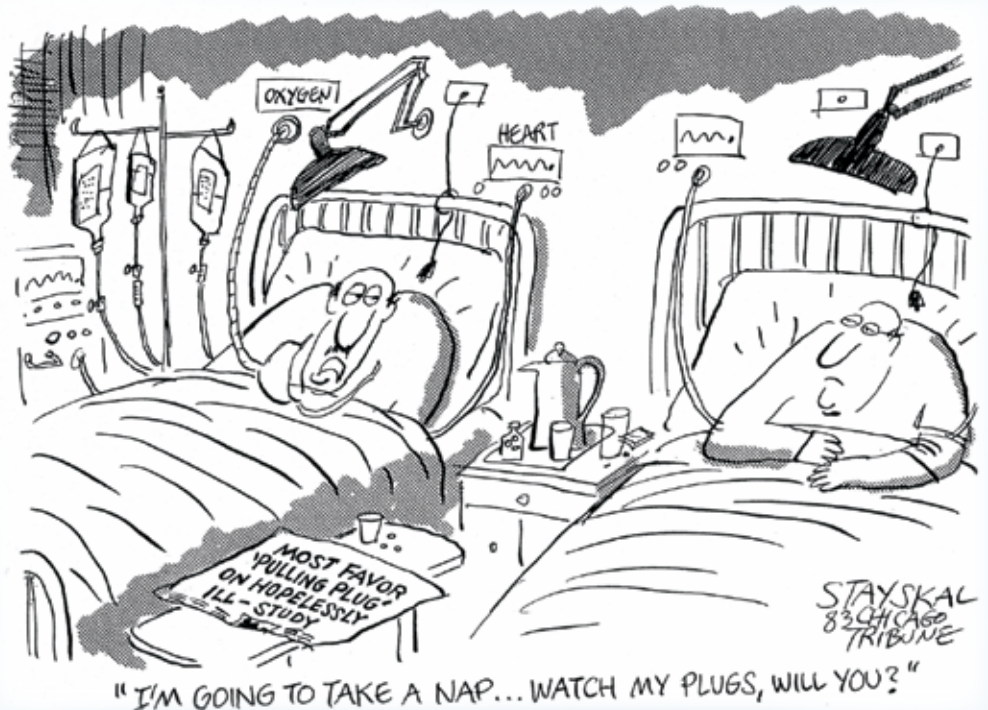
Julie A. Grimstad
Contributing Editor and Advisor

Inside:

- 3** **The Dark Heart of Euthanasia**
by Nancy Valko A startling look into what our society is beginning to believe.
- 5** **Are You Sure You'd Never Want to be Hooked Up to a Machine?**
by Marlene Reid It might just save your life.
- 6** **Thirsty? Too Bad.**
Withholding food and water is the new “mercy killing.”
- 7** **“Persistent Vegetative State”**
How reliable is a PVS diagnosis?
- 8** **What You Should Know About Hospice Care**
by Tracy Bernsten Tread carefully when you select a hospice.
- 9** **Not Dead Yet**
Alison Davis tells her story, having outlived doctors’ predictions by over 20 years.
- 10** **Organ Donor: Did You Know...?**
The rules for organ donation have changed.
- 11** **At the Bottom of the Slippery Slope**
by Wesley J. Smith Organ harvesting after lethal injection is no longer just a gruesome idea.
- 12** **Living Wills: Vital or Deadly?**
A Living Will may be a license to kill. There’s a better option.

Additional Features

- 4** **“Futile Care”**
- 9** **What in the World is Going On?**
- 10** **The World’s Great Loss**
- 12** **POLST: End-of-Life Planning Gone Overboard**



NEED MORE COPIES?

Contact Human Life Alliance (HLA), a non-profit, educational organization dedicated to protecting human life from fertilization to natural death. Human Life Alliance has distributed publications in more than 55 different countries on all seven continents, reaching more than 175.9 million people.



humanlifealliance

1614 93rd Lane NE | Minneapolis, Minnesota 55449 USA
www.humanlife.org | 651-484-1040

THE DARK HEART OF EUTHANASIA

"Eleanor" (not her real name) was larger than life even when she became ill with cancer in her 50s. Spirited and feisty with a wicked sense of humor, Eleanor regaled us doctors and nurses with her tales about her event-filled life. But as her cancer treatments failed to cure her, Eleanor's mood darkened and she told us of her plans to commit suicide either with a doctor like Jack Kevorkian* or by her own hand. She was insistent that she die before she became mentally diminished or physically dependent on others.

We worked with Eleanor by treatment and especially by addressing her fears and the ramifications of a suicide decision. We were elated when Eleanor changed not only her mind but also her attitude. Once she decided against suicide, she embraced life fully and with gusto. She eventually died comfortably and naturally.

However, when Eleanor initially changed her mind about suicide, her friends tracked me down on the oncology unit where I worked to complain that we doctors and nurses were unjustly "interfering with her right to die." Instead of being happy or relieved for Eleanor, these friends were outraged that we took the usual measures we would take with anyone to prevent a suicide.

At first I thought this incident was an aberration, but over the years since Eleanor, I've seen this disturbing enthusiasm for "choosing" death go mainstream, especially with the help of the media. What was initially sold to the public by the euthanasia movement as a "living will" to choose to forgo extraordinary means when death was inevitable (a choice that was already available ethically) has now evolved into a demand for medically assisted death. This has led to a change in attitudes not only among the public but also in law and medicine.

Exploiting the natural fear of suffering (see *Pain Control*, p.11) most people have led to a growing acceptance of the premise that it is noble to choose death instead of becoming a burden on family members or a drain on society. But many — if not most — people are unaware that the "right to die" issue has gone far beyond just the stereotype of the terminally ill person in unbearable pain.

Suicide kits and billboards

For example, a 91-year-old California woman started a business selling "suicide kits" by mail for \$60 each. When a 29-year-old depressed but physically healthy Oregon man recently killed himself using this kit, the elderly woman defended herself by claiming that she was providing a valuable service while noting that

her business is growing rapidly. Just as appalling was the response to this young man's suicide from Faye Girsh, president of the pro-assisted-suicide Hemlock Society of San Diego, who said "If I were his mother, I'd be very upset, but I don't think I'd be very upset because somebody provided a peaceful means to end his life."¹

This callous disregard of even actual or potential suicide victims and their families is unfortunately not isolated.

In another example, the Final Exit Network (FEN) erected a billboard in San Francisco that simply says "My life, My death, My choice," and gives the web site for the group. FEN said that the billboard was intended to "provoke discussion about the 'right to die'" even as suicide-

Many — if not most — people are unaware that the "right to die" issue has gone far beyond just the stereotype of the terminally ill person in unbearable pain.

prevention experts pointed out that the billboard could lead other suicidal people to take their lives.² Nevertheless, FEN has continued its billboard campaign for assisted suicide to places like Boston, stating that it believes that, like civil rights, the right to die will become the "ultimate right of the 21st century."³

It should also be noted that members of the Final Exit Network have been present (their terminology) at approximately 300 deaths of people they claim were suffering from "intractable and irreversible disease." Although it received scant media attention, eight of their members are now facing charges related to assisted suicide, including cases in Georgia and Arizona.

Outrage or apathy?

Now, following the template of abortion, the "right to die" is being mostly protected from bad publicity or even serious discussion beyond sound bites. There is a constant drumbeat of newspaper editorials, TV medical and crime dramas, award-winning movies like "You Don't Know Jack" (about Dr. Kevorkian), etc., that are sympathetic to the "right to die" movement. Opposing arguments are routinely dismissed as cruel ignorance or extreme religious ideology. This has had a profound impact on society.

Polls are showing increasing support for assisted suicide.⁴ One more state has joined Oregon in legalizing assisted suicide with similar laws being proposed in many other states. Relatives or friends who claim that out of compassion they helped a loved one die now often escape criminal charges or prison time even in states with laws against assisted suicide. Books like *Imperfect Endings* tout the acceptance of even a non-terminally ill

relative's decision to die as a wonderful act of love and respect.⁵ Oregon, the first state to legalize assisted suicide in the 1990s, now finds itself with a suicide rate 35% above the national average.⁶

Conscience rights for doctors, nurses and pharmacists are especially at risk because without medical participation, the euthanasia movement falls apart. Thus, euthanasia activists like Barbara Coombs Lee, one of the architects of Oregon's assisted suicide law, claims that strong conscience-right protections encourage "workers to exercise their idiosyncratic convictions at the expense of patient care."⁷ Do we really want only health care providers who are comfortable with ending life?

At its dark heart, the euthanasia movement is primarily about a selfish insistence on avoiding suffering no matter what the consequences to others or to society. It is accomplishing its goal by trying to intimidate everyone — health care professionals, grieving relatives, the unsuspecting public — into accepting their lethal agenda.

Will we respond with apathy or outrage?

By Nancy Valko, RN



Mrs. Valko is a contributing editor for *Voices* (publication of *Women for Faith and Family*). A registered nurse since 1969, she currently works in intensive care, has served on several medical and nursing ethics committees, and given speeches on medical ethics issues around the country.

Source: *Voices*, 6/12/2011, www.wf.f.org/11-2-Valko.html
Reprinted with permission of the author.

*Jack Kevorkian, dubbed "Dr. Death" because of his ghoulish obsession with death, died June 3, 2011 at the age of 83. An unemployed pathologist, he lived in Michigan where he gained notoriety for using his home-made death machines to kill suicidal people. He admitted to having assisted the deaths of at least 130 people, most of whom were disabled or depressed, but not dying. History may well remember him as a grisly serial killer.

Definitions

Euthanasia means an act or omission which intentionally ends the life of an incurably ill, disabled or elderly person so that suffering and other difficulties may be eliminated. An act such as a lethal injection, smothering or shooting. An omission such as withholding or withdrawal of medical treatment and/or care (including food and water) that is life-preserving, beneficial (i.e., comforts or cures) and not unduly burdensome to the patient.

Involuntary Euthanasia is euthanasia without the person's consent. This is gross patient abuse.

Voluntary Euthanasia is euthanasia with the person's consent and is a form of suicide — self-killing. For instance, the voluntary stopping of eating and drinking by a person who is not in the throes of the dying process is suicide. And, if a physician prescribes drugs to keep the person highly sedated while

he/she starves and dehydrates to death, this is a form of assisted suicide.

Assisted Suicide is self-killing with the assistance of another — e.g., a physician, friend or relative, or an organization that promotes assisted suicide. The means — drugs, gun, plastic bag, how-to instructions, counseling, etc. — may be provided by someone else, but the last act is done by the person being killed.

Imposed Death is the more accurate term for ending the lives of human beings in order to end their suffering or to relieve others of the duty to care for them.

Note: It is not imposed death (euthanasia, suicide or assisted suicide) when a person refuses a potentially beneficial treatment because he/she deeply fears it or perceives it to be overly burdensome. That is a patient's right. There is a world of difference between "allow her to die" and "kill her off."

¹Allyn, Richard, "Local senior's 'suicide kit' business ignites controversy" KFMB TV Channel 8, San Diego, California, March 26, 2011, cbs8.com | ²Miezkowski, Katherine, "Suicide-Prevention Experts Decry Ad", The Bay Citizen, June 22, 2010, baycitizen.org | ³"Billboard Advertises 'Right To Die'", TheBostonChannel.com, March 21, 2011, thebostonchannel.com | ⁴"Large Majorities Support Doctor Assisted Suicide for Terminally Ill Patients in Great Pain", Harris Interactive, January 25, 2011, harrisinteractive.com | ⁵Span, Paula, "A Mother's Decision to Die", New York Times, March 1, 2010, newoldage.blogs.nytimes.com | ⁶"Report: Oregon has higher suicide rate than national average", Gazette Times, September 9, 2010, gazettetimes.com | ⁷Lee, Barbara Coombs, "New HHS 'Conscience' Rule Jeopardizes End-of-Life Pain Care", Huffington Post blog, huffingtonpost.com

The Euthanasia Society of America (ESA) was founded to promote legalization of euthanasia, both voluntary and involuntary.

1938

ESA established the Euthanasia Educational Council (EEC) which introduced the Living Will, a tool to gain acceptance of euthanasia.

1967

ESA changed its name to the Society for the Right to Die (SRD).

1975

EEC changed its name to Concern for Dying (CFD) and split from SRD.

1979

The Hemlock Society (HS), formed to promote death-on-demand, was named after the poison used in ancient Greece for executions and state-approved suicides.

1980

SRD and CFD—having merged in 1990—became Choice in Dying.

1991

THE PROGRESSION OF DEATH RHETORIC

1993-1994

Compassion in Dying (CID), an HS spin-off, was created to provide information and assistance to sick people who want to die and to promote “aid-in-dying” laws.

The Death with Dignity National Center (DDNC) was established in Washington D.C. to work to replicate the new voter-approved Oregon “physician-assisted suicide” (PAS) law in other states.

Together, CID and DDNC have relentlessly led campaign after campaign attempting to legalize physician-assisted suicide throughout the U.S.

1997

Last Acts, a coalition of more than 100 prominent organizations, funded by the Robert Wood Johnson Foundation, was established purportedly to improve the quality of end-of-life care. (“Improving care” is often code for hastening death.)

1999

Choice in Dying became Partnership for Caring (PFC). PFC managed the Last Acts program.

These groups all use nice sounding words like rights, compassion, dignity and choice, but every one of them sprang from the Euthanasia Society of America and the Hemlock Society—deadly names for deadly organizations. They know they won’t win if accurate language is used to describe themselves and their agenda. So, they constantly devise new, syrupy names for euthanasia and assisted suicide – honey to help the hemlock go down.

2003

HS started End of Life Choices, a political action committee, in Denver.

2004

Final Exit Network (FEN) was started by disgruntled former HS and End of Life Choices members, including HS founder Derek Humphry. FEN counsels people on ending their lives with helium and plastic bags. “Exit guides” attend suicides.

PFC merged with Last Acts to form Last Acts Partnership, which folded soon thereafter. Some Last Acts Partnership leaders moved on to positions of influence in the realm of hospice and palliative care.

2005

Compassion in Dying and End of Life Choices joined to form Compassion & Choices (C&C). C&C describes itself as “working to improve care and expand choice at the end of life,” but its actual efforts have been directed at only one “choice”—suicide. Since 1997, CID/C&C have facilitated most of the physician-assisted suicides in Oregon as well as numerous deaths elsewhere. C&C, along with DDNC, has led campaigns to legalize PAS throughout the U.S.

“Futile Care”

“Futile care” used to mean that the patient would not benefit from treatment and, therefore, treatment was useless and should be stopped—a sound medical decision. In recent years, a new theory of “futile care” has taken hold. It is the proposition that a physician is entitled to refuse to provide treatment based on his/her opinion that the quality of a patient’s life is too low or the cost is too high to warrant continued treatment. In other words, the treatment is deemed “futile” not because it doesn’t work, but precisely because it does.

Futilitarians turn the physician’s sacred duty to “do no harm” on its head. They consider caring for a seriously ill patient harmful and “allowing” him to die (even against his will) compassionate and cost-efficient!

On the one hand, doctors routinely go along with patients’ decisions to refuse life-sustaining treatment. On the other hand, when patients want life-sustaining treatment, hospital “futile care” policies and some state laws permit physicians and hospital ethics committees to decide that their lives are not worth extending. Consider Texas. In 1999, the state legislature enacted a “medical futility” law which requires that the patient’s family be given a mere 48 hours’ notice before

the hospital committee meets to decide the patient’s fate. If the committee decides that continued treatment is “medically futile”, the family has 10 days to find another facility that will accept the patient. Failing that, treatment—including food and fluids—will be stopped. This controversial law has caused untold suffering for many patients and their families.

It was inevitable that the acceptance of the “right to die” when and how you choose would lead to the “duty to die” when and how someone else chooses for you. It was,

The treatment is deemed “futile” not because it doesn’t work, but precisely because it does.

after all, the euthanasia movement’s original plan to gain social, medical and legal acceptance of both voluntary and involuntary euthanasia. If we hope to protect our loved ones and ourselves from being thrown under the wheels of the euthanasia bandwagon when we become sick or disabled or old, we must reverse its direction. The time has come to kill “futile care” policies and laws and restore our right to self-preservation.

Are you sure you'd **NEVER** want to be “hooked up to a machine?”

Your life or the life of a loved one may depend on having correct information about the ventilator, commonly called a “respirator.”

Respiration is a bodily function, not a machine's function. It can only occur when the body's respiratory and circulatory systems are intact and functioning. A ventilator is an aid to breathing. The ventilator machine supports the ventilation part of breathing—moving air into and out of the lungs. It does not and cannot cause the other part of breathing—respiration. Thus, the machine should always be referred to by its accurate name, “ventilator.”

Many people with disabilities use ventilators every day of their lives to assist their breathing. For them, a ventilator is a necessity of life which allows them not only to continue living, but to breathe easier and enjoy life to its fullest. The ventilator is also commonly and effectively used to save lives.

I had not given much thought to the indispensable role that a ventilator plays in the healing process until three real life incidents brought the truth home to me.

My 41-year-old nephew was suffering from shocked lung syndrome after being injured in an automobile accident. This is a condition in which the elasticity of the lungs is greatly curtailed,

causing intense pain and severe shortness of breath. To give his body a chance to heal without fighting for breath, the doctors induced a comatose state and put him on a ventilator. He was on the ventilator for more than three weeks. His life was hanging by a thread or, more literally, a machine. When he was finally taken off the ventilator, his body took over, eventually completing the healing process. Today he is back working at his heavy-duty construction job—thanks to the ventilator and endless prayers.

In the second incident, a dear friend sustained a head injury. Because his traumatized body started to shut down following surgery to close the wound, he too was put into a medically induced coma and hooked up to a ventilator. He was in critical condition. After five days, he was taken off the ventilator and his natural breathing functions took over. This friend, who at 80 didn't believe in retirement, went back working fulltime, none the worse for the wear.

Imagine the outcome had he signed a Living Will that stated he would never want to be put on a “respirator.” If you have made a statement to this effect, either orally or in writing, I advise you to promptly and emphatically rescind it.

In the third incident, a friend had a cardiac

arrest. He was taken to the hospital by ambulance and subsequently pronounced “brain dead.” The attending physicians wanted to disconnect life support, but his wife wouldn't hear of it until all of their children could get home to say their goodbyes. After 72 hours, the sorrowing children had bid their father farewell. When life support was disconnected, their father sat up in bed and started talking to the family! He went home shortly thereafter and the family was able to enjoy his company for four more years before he was called home to his Maker. WHAT IF his wife had given consent to stop life support before his body's own healing powers had a chance to take their course with the aid of the ventilator?

I am now an enthusiastic believer in the healing benefit of the ventilator. We must all do our part to dispel the mistaken assumption that use of a ventilator is an extraordinary or heroic measure used only to temporarily prolong life. Its role in protecting and preserving lives must be made more widely known. Providing accurate information about medical technology's benefits gives people the ability to make truly informed treatment decisions.

*By Marlene Reid
President Emeritus
Human Life Alliance*

Ventilator Relieves Lung Cancer Pain

If you automatically refuse a ventilator (for instance, in your health care advance directive), you may be refusing the best medical help available to relieve your suffering.

Research done by Dr. Stefano Nava, chief of respiratory critical care at Istituto Scientifico di Pavia in Italy, showed that a ventilator—a machine that uses pressure to push oxygen into the lungs—can help lung cancer patients avoid sedation at the end of life. Lung cancer patients near the end of life often suffer from pain and difficulty breathing. Many patients did not want anything to do with a ventilator, which requires a face mask, but those who tried the treatment needed much less morphine and found that it reduced discomfort in their final hours. Dr. Neil Schachter, medical director of the respiratory care department at Mount Sinai Medical Center in New York City, said, “By doing it this way, you're not sedating them, making them go to sleep. They can presumably have a better interaction with their family in these last moments.”

Source: Dotinga, Randy, “Ventilator Relieves Lung Cancer Pain in Final Hours”, HealthDay News (health.usnews.com), 5/20/2008.





thirsty? too bad.

**"Imagine going one day without a glass of water!
Death by dehydration takes 10 to 14 days.
It is an extremely agonizing death."**

CASE IN POINT

In 2009, the Office of National Statistics in England revealed that, according to death certificates, 816 hospital patients died suffering from dehydration. In early 2011, the Health Service Ombudsman cited cases of patients who had become so thirsty that they could no longer cry for help. As a result of this neglect by nursing staff, doctors are writing prescriptions for drinking water for elderly patients in order to remind nurses to make certain that patients get enough fluids.

Health Secretary Andrew Lansley ordered the Care Quality Commission (CQC) to "look into the treatment of older patients and stamp out poor care fast." The CQC found that three of the twelve National Health Service hospitals visited in a 3 month period in the first half of 2011 were failing to meet the most basic standards of care required by law. Inspectors found routine examples of meals being left by the beds of sleeping patients and then being taken away untouched. The CQC also cited three hospitals for less serious concerns. According to the report, patients frequently complained they were spoken to in a "condescending and dismissive" manner.

Michelle Mitchell, of Age UK, said, "Every patient should be properly fed and treated with dignity as part of basic care in hospitals, and it is extremely worrying that a quarter of the first twelve hospitals to be spot checked were non-compliant in both areas."

Source: Borland, Sophie, "Elderly patients dying of thirst: Doctors forced to prescribe drinking water to keep the old alive, reveals devastating report on hospital care," MailOnline (www.dailymail.co.uk), 5/27/2011.

Widespread legal and medical endorsement of death by dehydration and starvation has led to confusion. Is it right or wrong to withhold or withdraw food and water from seriously ill, physically or mentally disabled, or persistently unresponsive (so-called "vegetative") patients?

It is important to distinguish between appropriate medical decisions and discriminatory decisions based on value judgments:

- When a person's body is shutting down during the natural dying process, or when a person is unable to receive food and fluids without harm, it is appropriate to stop providing food

and water. This is a medical judgment. In such a case, the patient dies naturally from his/her disease or injury.

- When a person is not dying (or not dying quickly enough), food and fluids, whether provided by mouth or tube, are sometimes withdrawn in order to cause death simply because the person is viewed as having an unacceptably low quality of life and/or imposing burdens on others. This is a value judgment. In such a case, the person is deliberately killed by dehydration and starvation.

Consider the cases of two elderly women. In 1984, 92-year-old Mary Hier had lived in a state hospital for over fifty years. Demented, but happy, she thought she was the Queen of England. Mary was not terminally ill, but had needed a feeding tube for many years. When her gastrostomy (stomach) tube became dislodged, a court denied permission to replace it, declaring that it would be "a major medical procedure" with "relatively high risk" due to her age. Just as Mary's case was being reported, the same newspaper carried another story about a 94-year-old woman who was doing well after "minor surgery to correct a nutritional problem." The surgery, performed under local anesthesia on an outpatient basis, was the insertion of a gastrostomy tube. The woman was Rose Kennedy, matriarch of a rich and politically powerful family. Mary Hier's life would have been prematurely ended without last minute intervention by a physician and an attorney who exposed the inequity. Her tube was replaced. Both women lived for a number of years longer.

In too many instances, whether inserting a feeding tube is considered a "major" or "minor" medical procedure depends upon whether the person is viewed by others as expendable or valuable, burdensome or beloved. Advocates of euthanasia assert that providing food and fluids

to patients is medical treatment that may be withheld or withdrawn. On the contrary, food and water are basic human needs and therefore basic human rights.

Feeding tubes are used for various reasons. Tube-feeding is often simpler, less costly and safer than spoon-feeding a patient who is a slow eater or chokes on food. It may be necessary for comfort, to ensure adequate nutrition and hydration, or to sustain life when a person is unable to swallow.

Real food and water are delivered through a feeding tube, though they are often inaccurately referred to as "artificial nutrition and hydration." It is the feeding tube that is artificial, much as a baby bottle is an artificial means of delivering real nourishment to an infant who is not breastfed.

Dr. William Burke, a St. Louis neurologist, describes what happens to patients as they die an unnatural death from dehydration:

*They will go into seizures. Their skin cracks, their tongue cracks, their lips crack. They may have nosebleeds because of the drying out of the mucus membranes, and heaving and vomiting might ensue because of the drying out of the stomach lining. They feel the pangs of hunger and thirst. Imagine going one day without a glass of water! Death by dehydration takes 10 to 14 days. It is an extremely agonizing death.**

Food and fluids do not become "treatment" simply because they are taken by tube anymore than penicillin and Pepto-Bismol become "food" when taken by mouth. Those who claim otherwise do so to advance their own agenda. In 1984, at a World Federation of Right to Die Societies conference, bioethicist Dr. Helga Kuhse explained the strategy of euthanasia advocates:

If we can get people to accept the removal of all treatment and care, especially the removal of food and fluids, they will see what a painful way this is to die, and then, in the patient's best interest, they will accept the lethal injection.

Deliberately causing a human being's death by dehydration and starvation is inhuman. It is beneath the dignity of both patient and medical care provider. Nonetheless, in every state it is now legal to impose death by taking away life-sustaining food and water. These laws are unjust and discriminatory. They imply that some people are "better off dead" and society is better off without them. They open the door to medical murder by lethal injection.

"Always to care, never to kill" has been the constant motto of honorable medical professionals. No law can make killing patients, regardless of their perceived "quality of life," medically or morally right.

** Smith, Wesley J. "Dehydration Nation." The Human Life Review. Fall 2003. Vol. XXIX. No. 4. pp. 69-79.*

COMMON SENSE



If a time comes when it is impossible to heal or cure, we do not deliberately hasten death. We do what we can to meet the physical, emotional, social and spiritual needs of those who are seriously ill. We lovingly care for them until they die naturally.

Patients who want potentially effective treatment should not be denied it even when there is faint hope of curing or extending life.

Extraordinary or experimental treatments can be tried with the option of stopping them if they don't produce the hoped for results.

A balanced view rejects imposed death, while it accepts the ethically sound decision to stop medical interventions that are ineffective, harmful, extremely burdensome to the patient or overly zealous. It's just common sense.

“PERSISTENT VEGETATIVE STATE”

Human beings, even if seriously impaired in their higher brain functions, are not “vegetables.”

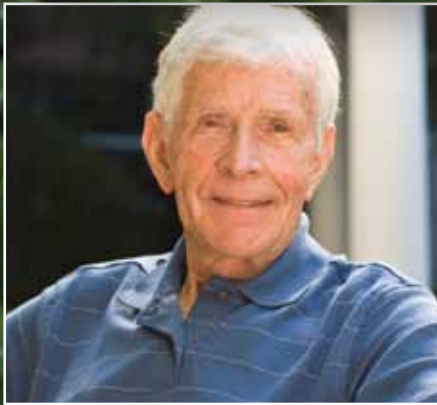


Exhibit A: Person



Exhibit B: Vegetable

Any questions?

The dehumanizing label “persistent vegetative state” (PVS) was crafted in 1972 just as the euthanasia movement began to take on steam. It became more familiar in the 1980s as “right to die” activists, courts, state legislatures, physicians and bioethicists¹ began to use PVS diagnoses as justification for withdrawing food and fluids from severely brain damaged patients.

There is disagreement about what PVS is and methods for diagnostic testing are disputed. Some experts are even questioning whether PVS is a valid diagnosis.

In the past decade, Dr. Joseph Giacino, director of rehabilitation neuropsychology at Spaulding Rehabilitation Hospital, and Nicholas Schiff, a neurologist at Weill Cornell Medical Center, have conducted experiments that prove this bleak diagnosis is often wrong. They have discovered apparently “vegetative” people whose minds can still imagine, recognize and respond. The first “vegetative” patient Schiff saw was the victim of a stroke who had no sign of consciousness. Three years later, he ran into her at a rehabilitation center and was shocked to find her capable of talking to him.²

PVS is grouped in the International Classification of Diseases with “Symptoms, Signs and Ill-Defined Conditions.” A vegetative state is not a coma. According to the 1994 Multi-Society Task Force on the medical aspects of PVS (MSTF), a person in a coma is neither awake nor aware; a person in a vegetative state is awake but not aware. The MSTF defined a “persistent vegetative state” as a vegetative state that lasts more than one month.³

The person in PVS has sleep-wake cycles, eye movement, and normal respiratory, circulatory and digestive functions. Individuals in PVS are seldom on any life sustaining equipment other than a feeding tube. Some can swallow, others cannot. Some have random movement, some do not. Some have been physically injured; others have had a stroke or have dementia. In some cases, the brain itself appears to change; in others it appears unchanged.

In simple terms, the diagnosis of PVS is based on lack of evidence of awareness of self and environment.

Misdiagnosis is Not Uncommon

The Washington Post, 9/8/2006, reported a case that astounded neurologists. A sophisticated brain scan upon a woman supposedly in a vegetative state indicated that she was clearly aware. The researchers told her to imagine she was playing tennis. They were shocked to see her brain “light up” exactly as an uninjured person’s would. They repeated the test again and again with the same result.

Data gathered by the MSTF on a group of 434 adult patients who were in PVS as a result of traumatic injury showed that, three months after injury, 33% had regained consciousness; by six months, 46% had; and at 12 months, 52% had.⁴ London neurologist Dr. Keith Andrews reported that, out of 40 patients diagnosed as being in PVS, 17 (43%) were later found to be alert, aware, and often able to express a simple wish. Dr. Andrews, said, “It is disturbing to think that some patients who were aware had for several years been treated as being vegetative.”⁵

Some patients who are misdiagnosed to be in PVS do exhibit evidence of awareness, but the diagnostician misses (or dismisses) the evidence. They may be mute and immobile (“locked-in”), but mentally alert and able to communicate by blinking or through aids such as computers—if someone gives them the opportunity. Other patients retain some measure of awareness even though they do not exhibit any evidence of it. Patients who have recovered from such a state can recall things that were said or done to them while no one knew they were aware.

It is now common for persistently unresponsive or minimally conscious patients who are not dispatched by dehydration to wind up warehoused in nursing homes, deprived of rehabilitation and beneficial medical treatment. The unconscious world is far more complex than most of us can imagine. Those who have severe brain damage may still enjoy touch, scent, taste, and sound; they may also feel loneliness, fear, and despair.

Their inability to satisfy our longing for response does not justify abandonment or imposed death.

¹Bioethicists are concerned with the ethical questions that arise in the interplay between life sciences, biotechnology, medicine, politics, law, philosophy and theology. | ²McGowan, Kat, “Rediscovering Consciousness in People Diagnosed as ‘Vegetative’”, Discover magazine, 3/9/2011. | ³Mappes, Thomas A., “Persistent Vegetative State, Prospective Thinking and Advance Directives,” Kennedy Institute of Ethics Journal, 2003: Vol. 13, No. 2: 119-139 | ⁴Ibid | ⁵British Medical Journal, 7/6/1996

Bias Against Disabled Enshrined in Law

In March 2005, Terri Schindler Schiavo, a woman who had suffered brain damage when she mysteriously collapsed and stopped breathing fifteen years earlier, was dehydrated to death in a Florida hospice. Her parents, Bob and Mary Schindler, and her brother and sister tried desperately to save her life and take her home.

Michael Schiavo, her husband and court-appointed guardian, sought and received judicial approval to remove Terri’s feeding tube. Removing the tube did not merely “allow” Terri’s death—the entire point was to cause her death.

Contrary to various news reports, Terri was not on a ventilator, not terminally ill, and not “brain dead.” Even the diagnosis of “persistent vegetative state” was refuted

by a number of medical experts. She was a profoundly disabled human being totally dependent on others for her care—care her parents wanted to give her.

Why was death imposed on Terri? Simply because the judge, like many able-bodied people, had a bias against the value of life of profoundly disabled people. This bias has been enshrined in official policy throughout the United States by numerous court decisions which have unjustly condemned innocent human beings to death by dehydration.

Information

Terri Schiavo Life and Hope Network
www.terrisfight.org

CASE IN POINT

A psychologist at Putney’s Royal Hospital for Neuro-disability told John Cornwell, a writer for the Times (London), this amusing story: “Young man with motorbike head injury in a coma. His mum, a keen evangelical, comes every day with friends to sing “Onward, Christian Soldiers” by his bedside. She’s hoping to stimulate his brain into action. It works: he comes round, but he can’t speak. So they fit him up with one of those Stephen Hawking type laptops, and the first words he speaks are: ‘For God’s sake, Mum, shut it!’” Cornwell commented, “That’s about as funny as it gets on a brain injury ward, but there’s a serious take home message. Even minimally aware patients can retain emotions, personality, a capacity to suffer—and, as the young biker showed, attitude.”

Source: The Sunday Times, 12/9/07

WHAT YOU SHOULD KNOW ABOUT HOSPICE CARE

“Hospice care is there to make it possible for people who are dying to live fully until they die.” – Dame Cecily Saunders

The purpose of hospice, as intended by its founder, Dame Cecily Saunders, is to provide comfort and supportive care for a person in the final phase of a terminal illness. Hospice forsakes all curative treatment for terminally ill patients, focusing on pain and symptom control. Employing a multidisciplinary team approach, it strives to meet the physical, social, psychological and spiritual needs of patients, their families and friends.

From Charity to Big Business

Hospice, in the 1970's, operated as a charitable service rendered primarily by volunteers. In the 1980's Medicare and Medicaid programs found it cost-effective to include hospice benefits. Since then the number of hospice programs in the United States has increased dramatically.¹ Unfortunately, as government and insurance (most HMOs provide hospice benefits) dollars rolled in, both fraud and cost-containment measures followed.

Euthanasia Advocates Like Hospice

Many of those who are involved in setting hospice and palliative care policies today have histories as key players in the movement to legalize euthanasia. (“Palliative” describes care that comforts and relieves pain.) In 2000, Choice in Dying (see The Progressin of Death Rhetoric, p.4)—a long time promoter of euthanasia—merged with Partnership for Caring (PFC), an organization founded by Dr. Ira Byock, past president of the American Academy of Hospice and Palliative Medicine.² Dr. J. Donald Schumacher, a past vice chair for the now defunct PFC, is currently the president and CEO of the National Hospice and Palliative Care Organization (NHPCO), the largest organization of its kind.³ PFC was largely responsible for advancing the controversial practices of withholding food and water and terminal sedation, two principal avenues for death control and cost control.

Palliative Care Redefined

“Terminal sedation” (TS), sometimes called “palliative sedation,” means that a patient is given sedating drugs to render and keep him/her unconscious until death occurs. TS may be used because the patient is so near death that further treatment is useless and it is difficult to relieve the patient's suffering with less extreme measures. However, this should rarely be necessary. Many experienced palliative care nurses and doctors concur with the World Health Organization that pain can virtually always be controlled and, even in the most difficult situations, it is possible

to adequately control a patient's unpleasant symptoms without inducing a permanent comatose state. The real danger of TS is that, combined with the withdrawal of all food and water, it is used to deliberately end the lives of patients who are otherwise not dying or not dying quickly enough to suit themselves or someone else. Dying from dehydration while under sedation can take up to two weeks. For this reason, TS is sometimes called “slow euthanasia.” TS is legal in every state, has been approved as ethical by the American Medical Association⁴ and is becoming routine in many hospices and palliative care programs. Traditionally, hospice care was limited to patients who had been diagnosed with an incurable terminal disease. The requirement that two physicians must certify a patient has less than six months to live is still in effect today.⁵ However, an increasingly acceptable practice is the admission of non-terminally ill patients. Persons with disabilities, dementia and brain damage are being placed in hospice in order to “help” them die.

Choosing a Good Hospice Program

Hospice patients receive care in their private homes, in hospital or nursing home units or in inpatient centers. Certified hospices are required to provide a basic level of care, but the quality and quantity of care vary significantly from hospice to hospice. If hospice care is deemed appropriate and necessary, it will take time and effort to choose a good hospice. References from the patient's primary physician, other trustworthy health care providers, friends and/or relatives who have had recent experience with the hospice being considered are invaluable. The hospice's policies must be read thoroughly. It is unreasonable for a hospice to require a Do Not Resuscitate Order or an agreement stating that no tubes are to be put in the patient. Forced agreements should not be signed.⁶ While under hospice care the patient will need advocates to:

- check for unnecessary morphine dosages
- know the medications the patient is receiving and why
- make sure that medication and treatment for chronic conditions, other than the terminal illness, are continued for as long as the patient tolerates them
- make sure that temporary curable conditions, pneumonia for example, are properly treated
- insist that nutrition and hydration are continued, artificially-provided if necessary, until the patient

is no longer able to assimilate them

- prevent the unwarranted use of terminal sedation.

Be Vigilant

The movement to incorporate euthanasia and assisted suicide into hospice is led by the few—unrepresentative of the many. There is no implication herein that hospice nurses and caregivers are consciously involved in deliberately hastening patients' deaths. They deserve the utmost respect for their dedication to caring for the dying. However, to counteract and impede the encroachment of imposed death, the cooperation of hospice caregivers, patients, legal representatives, family members and friends is needed. They must be constantly on the lookout for policies and orders intended to cause or hasten death and be willing to oppose them. As imposed death becomes more and more acceptable, those who have had good experiences caring for the dying need to tell their stories to raise awareness of what is at risk when the duties to preserve life and to care for one another are deliberately abandoned.

By Tracy Berntsen
Human Life Alliance

LIFE-AFFIRMING HOSPICE CARE

Hospice Patients Alliance (HPA) is a patient advocacy organization acting to preserve the original life-affirming hospice mission and to promote quality end-of-life services. HPA provides the most complete information on hospice, the standards of care and end-of-life care at www.hospicepatients.org and is making Ron Panzer's new book, *Stealth Euthanasia: Health Care Tyranny in America*, available online at no cost to the

public: www.hospicepatients.org/this-thing-called-hospice.html.

HPA is also working with Cristen Krebs, RN, founder/director of the Catholic Hospice of Pittsburgh, to form a pro-life hospice organization, Hospice Life Association of America, to create new pro-life hospices around the country. Contact: Cristen Krebs, RN at 724-933-6222 or Ron Panzer at 616-866-9127.

¹Dyer MD, Kristi A. “Hospice, Palliative and End of Life Care Statistics.” at dying.about.com. Accessed 12/14/2008. | ²Dying Well. Dr. Byock's Biographical Information, at www.dyingwell.org/byock.htm. Accessed 12/15/2008. | ³Center for the Advancement of Palliative Care. Biography of J. Donald Schumacher, Psy D. at www.capc.org/schmacher-bio/view?searchterm=Schumacher. Accessed 12/15/2008. | ⁴O'Reilly, Kevin B. “AMA Meeting: AMA OKs Palliative Sedation for Terminally Ill,” at www.ama-assn.org/amednews/2008/07/07/prsi0707.htm. Accessed 12/15/2008. | ⁵Chevlen, Eric M. and Wesley J. Smith. Power Over Pain. 2002. | ⁶Barra, Paul A. “Assisted Suicide on the Rise: States Poised to Pass Laws,” National Catholic Register, 1/29 – 2/3/2007.

WHAT IN THE WORLD IS GOING ON?

Euthanasia and assisted suicide are legal in a few jurisdictions in the world, but most countries have rejected their legalization.

Most recently, legislation to legalize euthanasia and/or assisted suicide has been rejected in France, Israel, England, Scotland, Australia, Canada, Bulgaria, etc. In the U.S., where there have been well over 100 legislative proposals to legalize physician-assisted suicide (PAS) since 1994, California, Hawaii, New Hampshire, Vermont, Connecticut, and more have recently rejected it.

In the United States, assisted suicide was legalized by voter initiatives in Oregon in 1994 and Washington state in 2008. A 2009 Montana Supreme Court ruling did not legalize PAS, but it did create a potential defense, based on consent of the patient, for physicians who are prosecuted for assisted suicide. In 2011, a bill to prohibit PAS and a bill to create regulations for PAS were both introduced in the MT legislature. Neither bill had enough votes for passage.

In May 1995, Australia's northern territory became the first jurisdiction in the world to legalize euthanasia. The law went into effect in June 1996 but was overturned by the Australian government in March 1997.

The Netherlands officially legalized euthanasia and assisted suicide in April 2002. Previous to that, the Dutch Courts approved the practice of euthanasia and assisted suicide. Some people suggest that there are no problems with the Dutch euthanasia law, but in fact there is significant abuse and the slippery slope has been very steep.

In the beginning, the Dutch euthanasia law applied only to people who were terminally ill and suffering uncontrolled pain. Now the law applies to people with physical and mental pain, people with chronic conditions, infants with disabilities (Groningen Protocol), people with dementia or Alzheimer's, and the current push is to allow euthanasia for people who are 70 years old and "tired of living." The most recent Dutch government study found that every year there are approximately 550 intentionally caused deaths without request or consent and approximately 20%

of euthanasia deaths are not reported.¹

In Belgium, euthanasia was legalized in 2003. Recent studies have revealed significant abuses of euthanasia and signs that it is "out-of-control." Independent studies, published in May 2010, looked at the practice of euthanasia in the Flanders region. They revealed that 32% of the euthanasia deaths in that region were done without request or consent² and that 45% of all euthanasia deaths done by nurses in Belgium are without request or consent.³ Another highly disturbing study published in October 2010 found that nearly half of the euthanasia deaths in the Flanders region are not reported and that "controversial" euthanasia deaths are usually not reported. Under-reporting explains why the "official" Belgium government report suggests that few if any problems exist.⁴

When looking at the studies concerning euthanasia in the Netherlands and Belgium, one must conclude that choice and autonomy (self-determination) are only the sales slogans for gaining societal acceptance of euthanasia; that in fact euthanasia has become a way to eliminate human lives deemed, by others, to be not worth living.

Much research proves a direct connection between depression and requests for euthanasia or assisted suicide. Published in 2005, a study by a Dutch doctor who supports euthanasia found that people who had cancer were 4.1 times more likely to request euthanasia if they were depressed or experiencing feelings of hopelessness.⁵ A similar study in the state of Oregon, published in 2008, found that 26% of the people who requested euthanasia were depressed or experiencing feelings of hopelessness. The Oregon PAS law has a "supposed" safeguard that requires physicians to refer for psychological assessment anyone who requests assisted suicide and has signs of depression.⁶ Nevertheless, of 124 people who died by assisted suicide in Oregon (2009 and 2010), only one was sent for a psychiatric or psychological assessment.⁷ Yes, depressed people in Oregon are dying by assisted suicide.

Then there is the growing scourge of elder

abuse in our culture. Legalizing euthanasia or assisted suicide creates new paths of abuse. Elder abuse is rarely reported because it is most often perpetrated by a person upon whom the victim is dependent. In the same way, a vulnerable person who is experiencing abuse can be steered to suicide when the law allows doctors to prescribe death.

The euthanasia lobby promotes death on demand based on choice and autonomy. This is an illusion. The legalization of euthanasia and assisted suicide does not give you the "right to die." It gives another person the right to intentionally and directly cause your death.

By Alex Schadenberg

¹www.nejm.org/doi/full/10.1056/NEJMsa071143 |

²www.cmaj.ca/content/early/2010/05/17/cmaj.091876.full.pdf+html | ³www.cmaj.ca/content/182/9/905.full | ⁴www.ncbi.nlm.nih.gov/pmc/articles/PMC2950259/pdf/bmj.c5174.pdf | ⁵jco.ascopubs.org/content/23/27/6607.full.pdf+html | ⁶www.bmj.com/content/337/bmj.a1682.full?ijkey=bc7d37e92efbfea7ce03a2d59bfd0c8b4623fa04&eaf | ⁷public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx



Alex Schadenberg is the Executive Director and International Chair of the Euthanasia Prevention Coalition. He is a published author and has spoken throughout North America, Australia, and Europe on issues related to euthanasia and assisted suicide.

Information

www.patientsrightscouncil.org

www.euthanasiaprevention.on.ca

alexschadenberg.blogspot.com

Toll free: 1-877-439-3348

Email: euthanasiaprevention@on.aibn.com



Not Dead Yet: Support to Live, Not to Die

Editor's Note: Now age 56, Alison Davis has outlived her doctors' prognosis of terminal illness by more than 20 years.

I have spina bifida, hydrocephalus, emphysema, osteoporosis, arthritis and kypho-scoliosis. I use a wheelchair full time. Due to the osteoporosis, my spine is slowly collapsing, trapping nerves in the process. This causes extreme spinal pain which even large doses of morphine cannot fully control. When the pain is at its worst I cannot think, speak or move. It can go on for hours. The prognosis is that it will continue to get worse.

Twenty-three years ago, due to several factors, I decided I wanted to die—a settled wish that lasted over ten years. I seriously attempted suicide several times and was saved only because friends found me in time and got me taken to the hospital, where I was resuscitated against my will. Then I was extremely angry that my life had been saved. Now I'm eternally grateful. I still have the same severe pain I had then. What has changed is my outlook on life. If "assisted

dying" had been legal, I wouldn't be here now. I would have missed the best years of my life.

What I wish most for those who despair of life is that they could have the sort of support and the reasons for hope which turned my life around, bringing me from the brink of death to an appreciation and enjoyment of life.

Sometimes it's said that those who request death are just exercising their "right to choose." The problem is that often they feel they really "have no choice" because support mechanisms are not in place. And, of course, they are not just "choosing" for themselves. To say that death is in the best interests of some suffering people is to make value judgments about all who are disabled or terminally ill and suggests that death is a legitimate way of dealing with suffering. We can do better for suffering people than killing them. Legalizing medical killing would weigh against the further development of social and palliative care services to help us to live.

Once it is established that it is acceptable to cause death as a way of "preventing suffering," no sick or disabled person will be safe. It is instructive that when a non-disabled person expresses a wish to die, every effort is made to save his or her life. We have government strategies against suicide and "suicide prevention teams" to try to save the lives of those who want to die. Yet, when sick or disabled people express the same wish, possibly for much the same reason as those who are not physically affected, they are often assumed to be "right to want to die" and "better off dead." What we really need is the same presumption in favor of life as is routinely given to the non-disabled, and the same help and support to live with dignity until we die naturally. Further reading: www.spuc.org.uk/about/no-less-human/alison.

By Alison Davis

National Coordinator of No Less Human, UK
www.spuc.org.uk/about/no-less-human

Organ Donor: Did You Know...?

"Would you like to be an organ donor—yes or no?" When you applied for your driver's license or made out your advance directive for health care, did you answer that question?

The impulse to "give the gift of life" is noble, but it is unwise to make this vitally important decision on impulse alone. You need accurate and complete information in order to give **informed consent**, the ethical cornerstone of medical decision making.

The Anatomical Gift Act (AGA) has been revised in 43 states since 2006. The revisions allow people who have never agreed to be organ donors to be considered "prospective" donors if they have not explicitly refused, for instance, in an advance directive. The scenario below may not currently be the way organ procurement works in every case, but everything described is now legal and on track to work its way into the system. How might this affect you?

If you are declared "dead" (using "brain death" criteria) or "near death" (still alive), the hospital **MUST** notify the organ procurement organization (OPO). The OPO team will examine you and conduct tests to assess the suitability of your vital organs (heart, lungs, liver, kidneys, pancreas and intestines) for transplantation. Also, you can be subjected to measures designed to ensure that your organs remain healthy — potentially harmful measures that have no benefit for you. For instance, fluids may be increased to preserve your organs. This could increase swelling of the brain if you have a head injury. Such things can be done to you without your family's

knowledge or permission. Only afterward will they be asked to donate your organs. If you said "yes" to organ donation and are 18 or older, your family may not even be asked. Remember, everything described herein is already legal in your state if it has adopted the revised AGA.

"Brain dead" patients may not be corpses, but living persons. The hearts of "brain dead" people are beating; their lungs, aided by ventilators, continue to carry out respiration; their digestive systems continue to digest food and excrete waste. They have a normal color and temperature. They appear to be very much alive. Is this appearance real?

The main problem with organ donation from "brain dead" people is that if such donors are alive — there is good reason to believe they are — removing unpaired vital organs (heart, liver) or both paired vital organs (both lungs or both kidneys) kills the patient.*

Numerous reports about people who have recovered consciousness after firm diagnoses of "brain death" are evidence that a declaration of "brain death" does not mean the person is certainly dead. Ponder Zack Dunlap's case. In November of 2007, this 21-year-old Oklahoman flipped over on his 4-wheeler and sustained catastrophic brain injuries. Thirty-six hours later, doctors declared him "brain dead." Preparations to harvest his organs were halted when Zack's cousin, a nurse, scraped his foot with a pocket knife and Zack jerked his foot away. Zack recalls hearing the doctor pronounce him dead and being "mad inside" but unable to move. He is now not only talking, but walking.

Some organ donors are not even "brain dead" before their organs are removed. The high demand for healthy organs has led to new rules permitting "donation after cardiac death" (DCD). This donor category includes people who are not "brain dead" — mainly patients on ventilators termed "hopeless" or "vegetative" by doctors. DCD rules, however, do not require that donors be mentally impaired. Merely exercising one's legal "right to die" may suffice.

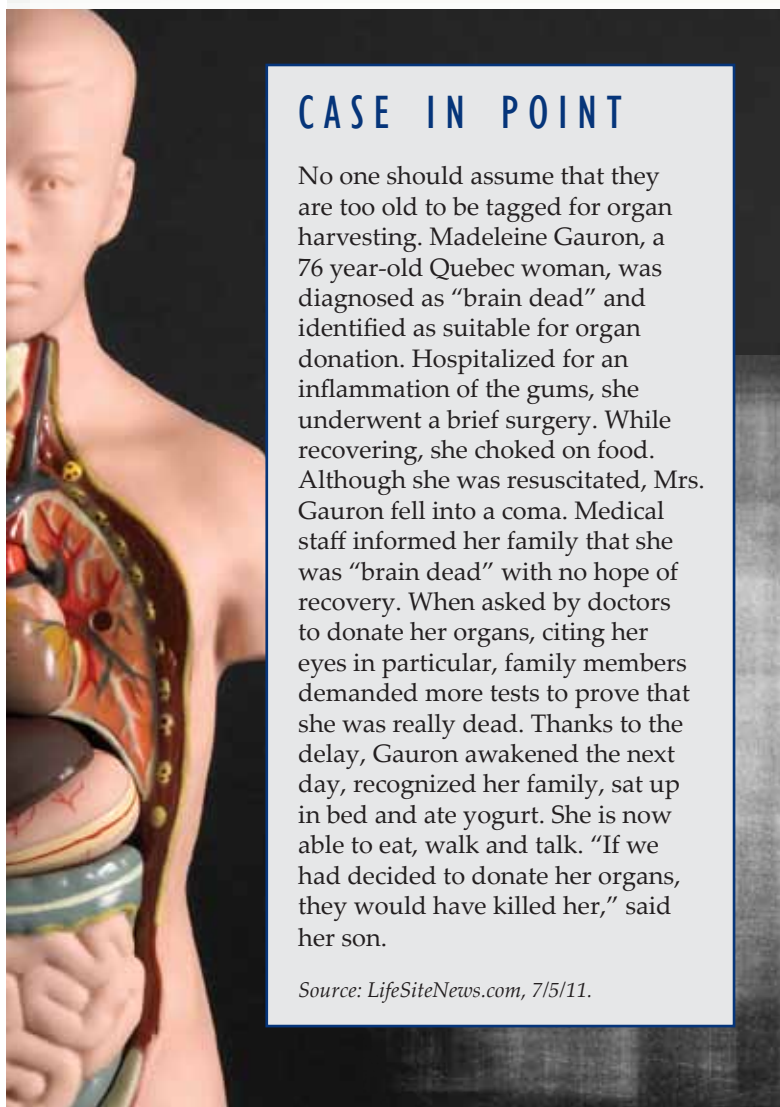
Families or patients agree to a "do not resuscitate order" and to shutting off the ventilator. Doctors hover over the patient, checking for the moment of no discernable pulse or breathing in order to declare "cardiac death." Within 75 seconds to 5 minutes, organ harvesting begins.

Conclusion: Both "brain death" and "cardiac death" are hastily declared because removal of vital organs must be done before they deteriorate due to loss of blood circulation. One thing is certain. The rush to declare patients "dead" in order to take their organs will deprive at least some of the chance to survive or recover.

"Would you like to be an organ donor—yes or no?"

*Potts M, Byrne PA, and Nilges RG (ed), *Beyond Brain Death: the Case against Brain Based Criteria for Human Death*, Boston, MA: Kluwer Academic Publishers, 2000.

Recommended reading: *Wanted Dead or Alive: ORGAN DONORS* (brochure), Paul A. Byrne, M.D., produced and distributed by Pro-Life Wisconsin, phone 1-877-463-7945, www.prolifewisconsin.org.



CASE IN POINT

No one should assume that they are too old to be tagged for organ harvesting. Madeleine Gauron, a 76 year-old Quebec woman, was diagnosed as "brain dead" and identified as suitable for organ donation. Hospitalized for an inflammation of the gums, she underwent a brief surgery. While recovering, she choked on food. Although she was resuscitated, Mrs. Gauron fell into a coma. Medical staff informed her family that she was "brain dead" with no hope of recovery. When asked by doctors to donate her organs, citing her eyes in particular, family members demanded more tests to prove that she was really dead. Thanks to the delay, Gauron awakened the next day, recognized her family, sat up in bed and ate yogurt. She is now able to eat, walk and talk. "If we had decided to donate her organs, they would have killed her," said her son.

Source: LifeSiteNews.com, 7/5/11.

THE WORLD'S GREAT LOSS

"We have to think about resources and you know he will never be able to contribute to society." This was the response from the doctor when Mary Kellet asked him why she was given false information about her two day old son Peter. The false information was that there were no survivors over two weeks old with his condition, trisomy 18. Mary and her husband were advised to stop all treatment, wrap Peter in a blanket, and let him die. Tragically, about a third of infants who die in pediatric hospitals do

looked brighter for people with disabilities.

Imposed death by withdrawal of life-sustaining treatment or abortion would probably not be what the child would choose. Life itself is precious and every person has something good to contribute. Only when we embrace every human being with respect will we see the influence, promise and potential they have. Until then, denying life to babies who are disabled or seriously ill is not only their great loss, it is the world's great loss.

Peter Kellet inspired



MANY PARENTS DON'T KNOW THEY HAVE THE OPTION OF CONTINUING THEIR PREGNANCY BECAUSE THEY ARE NOT GIVEN THAT CHOICE.

so after life support is withdrawn.*

Peter is now six years old. He is a great joy and gift to his family.

Pressure to have genetic testing and amniocentesis can be intense, even though there are risks of bleeding, infection and/or miscarriage. Abortion is seen by many as the solution for a child who may not be healthy. Many parents don't know they have the option of continuing their pregnancy because they are not given that choice. There is a false sense of compassion that leads many to think abortion is the answer. The truth is, considering the advances in treatment and care now available, the future has never

Prenatal Partners for Life, a worldwide nonprofit support group for families experiencing an adverse prenatal diagnosis. His mother Mary, the group's director, notes, "In the hundreds of families Prenatal Partners for Life has supported, I have never heard a mother say she has had too much time with her child."

*American Medical News, 1/19/2009 www.ama-assn.org/amednews/2009/01/19/prsa0119.htm

Information

www.prenatalpartnersforlife.org
Email: mary@prenatalpartnersforlife.org

At the Bottom of the Slippery Slope

Where euthanasia meets organ harvesting.

In 1992, my friend Frances committed suicide on her 76th birthday. Frances was not terminally ill. She had been diagnosed with treatable leukemia and needed a hip replacement. Mostly, though, she was depressed by family issues and profoundly disappointed at where her life had taken her.

Something seemed very off to me about Frances's suicide. So I asked the executor of her estate to send me the "suicide file" kept by the quintessentially organized Frances and was horrified to learn from it that she had been an avid reader of the (now defunct) *Hemlock Quarterly*, published by the aptly named Hemlock Society (which has since merged into the assisted-suicide advocacy group, Compassion & Choices). The HQ taught readers about the best drugs with which to overdose and gave precise instructions on how to ensure death with a plastic bag—the exact method used by Frances to end her life.

I was furious. Frances's friends had known she was periodically suicidal and had intervened to help her through the darkness. The Hemlock Society had pushed Frances in the other direction, giving her moral permission to kill herself and then teaching her how to do it. This prompted the first of the many articles I have written over the years against assisted-suicide advocacy. It appeared in the June 28, 1993 *Newsweek* and warned about the cliff towards which assisted suicide advocacy was steering our society:

We don't get to the Brave New World in one giant leap. Rather, the descent to depravity is reached by small steps. First, suicide is promoted as a virtue. Vulnerable people like Frances become early casualties. Then follows mercy killing of the terminally ill. From there, it's a hop, skip, and a jump to killing people who don't have a good "quality" of life, perhaps with the prospect of organ harvesting thrown in as a plum to society.

The other shoe—"organ harvesting"—has now dropped. Euthanasia was legalized in Belgium in 2002. It took six years for the first known coupling of euthanasia and organ harvesting, the case of a woman in a "locked in" state—fully paralyzed but also fully cognizant. After doctors agreed to her request to be lethally injected, she asked that her

organs be harvested after she died. Doctors agreed. They described their procedure in a 2008 issue of the journal *Transplant International*:

This case of two separate requests, first euthanasia and second, organ donation after death, demonstrates that organ harvesting after euthanasia may be considered and accepted from ethical, legal, and practical viewpoints in countries where euthanasia is legally accepted. This possibility may increase the number of transplantable organs and may also provide some comfort to the donor and her family, considering that the termination of the patient's life may be seen as helping other human beings in need of organ transplantation.

The idea of coupling euthanasia with organ harvesting and medical experimentation was promoted years ago by the late Jack Kevorkian,

"coupling organ harvesting with mercy killing creates a strong emotional inducement to suicide"

but it is now becoming mainstream. Last year, the Oxford bioethicist Julian Savulescu coauthored a paper in *Bioethics* arguing that some could be euthanized, "at least partly to ensure that their organs could be donated." Belgian doctors, in particular, are openly discussing the nexus between euthanasia and organ harvesting. A June 10, 2011 press release from Pabst Science Publishers cited four lung transplants in Leuven from donors who died by euthanasia.

What's more, Belgian doctors and bioethicists now travel around Europe promoting the conjoining of the two procedures at medical seminars. Their PowerPoint presentation touts the "high quality" of organs obtained from patients after euthanasia of people with degenerative neuro/muscular disabilities.

Coupling organ donation with euthanasia turns a new and dangerous corner by giving the larger society an explicit stake in the deaths of people with seriously disabling or terminal conditions. Moreover, since such patients are often the most expensive for whom to care, and given the acute medical resource shortages we face, one need

not be a prophet to see the potential such advocacy has for creating a perfect utilitarian storm.

Some might ask, if these patients want euthanasia, why not get some good out of their deaths? After all, they are going to die anyway.

But coupling organ harvesting with mercy killing creates a strong emotional inducement to suicide, particularly for people who are culturally devalued and depressed and, indeed, who might worry that they are a burden on loved ones and society. People in such an anguished mental state could easily come to believe (or be persuaded) that asking for euthanasia and organ donation would give a meaning to their deaths that their lives could never have.

And it won't stop there. Once society accepts euthanasia/organ harvesting, we will soon see agitation to pay seriously disabled or dying people for their organs, a policy that Kevorkian once advocated. Utilitarian boosters of such a course will argue that paying people will save society money on long-term care and allow disabled persons the satisfaction of benefiting society, while leaving a nice bundle for family, friends, or a charitable cause.

People with serious disabilities should be alarmed. The message that is being broadcast with increasing brazenness out of Belgium is that their deaths are worth more than their lives.

By Wesley J. Smith

Source: *The Weekly Standard*, weeklystandard.com 7/4/2011 Reprinted with permission of the author.

Lawyer and award winning author, Wesley J. Smith is a Senior Fellow at the Discovery Institute's Center on Human Exceptionalism. He is also a legal consultant to the Patients Rights Council and a special consultant for the Center for Bioethics and Culture. In May 2004, because of his work in bioethics, Smith was named one of the nation's premier expert thinkers in bioengineering by the National Journal. In 2008, the Human Life Foundation named him a Great Defender of Life for his work against assisted suicide and euthanasia.

CASE IN POINT

"I'm not ready to die...I've got things I'd still like to do." This was 64-year-old Barbara Wagner's reaction to a crushing letter from the Oregon Health Plan informing her that it would not cover a prescription to slow the growth of lung cancer. "It was horrible," she said. The unsigned letter stated that the plan would not pay for Tarceva, an expensive chemotherapy drug, but instead would cover comfort care, including assisted suicide. William Toffler, M.D., National Director of Physicians for Compassionate Care Education Foundation, was disturbed: "People deserve relief of their suffering, not giving them an overdose." He also noted that the state has a financial incentive to offer death instead of life—drugs for assisted suicide cost less than \$100.

Sources: Harding, Susan and KATU Web Staff, "Letter noting assisted suicide raises questions", ABC News Internet Ventures, www.katu.com, 7/31/08

What About Pain Control?

What you don't know can hurt you. This is especially true of ignorance about the great strides that have been made in the treatment of pain—both physical and emotional.

Fear of unbearable pain is the reason that many people feel drawn to favor physician-assisted suicide and euthanasia. The antidote to this fear is accurate information*, not a cold-hearted offer to end a person's life.

The good news: Most pain is manageable with medications, various therapies, surgery, psychosocial care, or countless other options. The World Health Organization assures us that even the most severe cancer pain can be eliminated or significantly relieved.

The bad news: Some physicians don't have the knowledge, time or compassion to treat pain effectively, even though they may be competent in other fields of medicine.

Patients and their families need to insist that their physicians make every effort to control pain. If your physician cannot or does not do so, find a new doctor—an expert in pain management—immediately.

Pain is invisible. Others can't see it. But it is very real and distressing. Don't try to "tough it out." Pain can lead to loss of sleep, depression, inability to work, impaired relationships, and a generally poor quality of life. So, don't wait if you hurt. The earlier pain treatment is started, the more effective it will be. Find a physician or health care facility that focuses on the diagnosis and management of pain. Relief may be just a phone call away.

*Recommended reading: *Power over Pain: How to Get the Pain Control You Need*, by Eric M. Chevalen, M.D. and Wesley J. Smith, provides practical guidance for patients and their families. To order: Patients Rights Council, 1-800-958-5678.

LIVING WILLS:

Vital or Deadly?



Advance directives for health care are legal documents by which individuals express their wishes in case they are ever unable to make health care decisions for themselves. There are two types: the Living Will and the Durable Power of Attorney for Health Care (DPAHC). Some advance directives are a combination of the two.

The laws governing Living Will and DPAHC documents permit the withholding or withdrawal of ordinary treatment and care, including food and fluids, even when the omission will be the direct cause of death. Thus, these documents can be used to license euthanasia. The wrong kind of advance directive in the wrong hands can be a deadly combination.

Federal regulations require every health facility and program that receives Medicare and Medicaid funds to inform patients about advance directives. Many hospitals and nursing homes give patients a Living Will or DPAHC to sign at the time of admission, a time when most people are under stress and distracted by other paperwork and questions. This is not an ideal circumstance for considering a legal document with life and death consequences. It is wise to arrive with your own carefully prepared directive in hand.

When considering an advance directive, you will need to understand the significant differences between the two types.

A Living Will is downright dangerous. It gives an attending physician, very likely a stranger, the power to make life and death decisions for you. A doctor may do a poor job of deciphering your wishes, particularly if he/she does not share your moral values. Furthermore, real end-of-life decisions often involve complicated medical and ethical questions that can't be answered in a Living Will.

Keeping an open mind to the future is essential. It is impossible to give or withhold consent to treatment based on guesswork about a future illness or injury, and without knowledge of potential future treatment options. Nevertheless, the directions you give in a Living Will, by law, must be followed. Therefore, you may tie the hands of a physician whose skills could restore you to health or save your life. The directions in a Living Will are either so vague as to be useless or so specific as to be hazardous.

A Durable Power of Attorney for Health Care document is a better option. In a DPAHC you specifically name a trusted family member or friend ("agent") to make decisions for you if you are unable, either temporarily or permanently, to do so for yourself. Your "agent" will endeavor to make decisions in accord with your personal values and wishes. Your "agent" will base medical decisions on knowledge of your actual condition and treatment options, not guesswork.

It is important to discuss your wishes with your "agent" on a continuing basis. Preferences tend to change over time. Particularly as health declines, patients often accept medical interventions they previously thought they would never want. Many people are not comfortable talking about aging, illness, injury and death. However, as difficult as it may be to discuss these issues ahead of time, during a medical crisis it may be even more difficult or even impossible.

As with any legal document, the wording of a DPAHC is critically important. Also, it must comply with the laws in your state. That is why Human Life Alliance recommends the Protective Medical Decisions Document (PMDD)* formulated by the Patients Rights Council. The PMDD gives your "agent" the authority to act on your behalf and take legal action, if necessary, to ensure that your rights are protected. The PMDD clearly states that your "agent" does not have the authority

Filling out a PMDD takes only a few minutes - a few minutes that may mean the difference between life and death.

to approve the direct and intentional ending of your life. This limitation not only protects you, but it also protects your "agent" from being subjected to pressure to authorize such actions.

A Durable Power of Attorney for Health Care is absolutely essential for anyone who is 18 years or older. To be certain that a person you trust will be making medical decisions for you if you become incapacitated by an injury or illness, you must have specifically named that person in a legal document.

Filling out a PMDD takes only a few minutes - a few minutes that may mean the difference between life and death.

Information

*To obtain a PMDD packet specific to your state, contact: Patients Rights Council, P.O. Box 760, Steubenville, OH 43952. Phone: 740-282-3810. Toll Free: 800-958-5678.

The Patients Rights Council addresses euthanasia, assisted suicide, advance directives, disability rights, pain control and more at www.patientsrightscouncil.org.

Recommended reading: *Life, Life Support and Death: Principles, Guidelines, Policies and Procedures for Making Decisions to Protect and Preserve Life*, 2nd Ed. 2005, American Life League, 540-659-4171.

POLST: END-OF-LIFE PLANNING GONE OVERBOARD

"I hear often from people who believe they or their aged/ill/disabled loved ones are being pressured into refusing treatment—usually not by being brow beaten or yelled at—but from a constant drip, drip, drip of conversation after conversation after conversation, which only end when the patient agrees to what the doctor or ethics committee wants." -Wesley J. Smith, bioethicist¹

In 1990, Congress enacted a law that requires all health care facilities/programs that receive federal funds to tell adult patients about their right to make an advance directive for health care. (For more information on advance directives, see

Information

LifeTree, Inc. | www.lifetree.org

Living Wills: Vital or Deadly above this article.)

Since 2009, physicians have been required to discuss end-of-life planning with all Medicare patients at their initial "Welcome to Medicare" physical exam.

Prompting people to forgo medical treatment is the main reason for end-of-life planning. The most insidious end-of-life planning is POLST—Physician Orders for Life-Sustaining Treatment.² POLST is a preprinted physician's order sheet with boxes to be checked next to options such as DNR (do not resuscitate), no antibiotics, no tube-feeding, comfort care only, etc.

Imagine that you are in a hospital or nursing home. Your medical condition has taken a turn

for the worse. You're sick and depressed. This is not the ideal circumstance for you to make life or death decisions. Yet, a kindly nurse sits by your bed conversing with you about your "reasonable" treatment options and wishes. You answer her questions while she makes check marks on a brightly colored sheet of paper. You have just filled out a POLST form, perhaps unknowingly. It will go into your medical chart. A physician will stop by later to sign it, making it official doctor's orders. Presto! Your carefully worded and witnessed advance directive has just been superseded by a form you might not even have signed.

Isn't POLST going a little overboard?

¹Smith, Wesley J. "Obamacare: Column Illustrates the Potential for 'Never Ending Conversation' End of Life Counseling Pressure," Second Hand Smoke, 2010. ²POLST was developed in the 1990s by the Ethics group at the Oregon Health & Sciences University with grants from George Soros' Project on Death in America, the Greenwall Foundation and Cummings Foundation, frequent sponsors of right-to-die projects.