



Pro-life Healthcare Alliance

June 24, 2016

PHA Monthly

*Newsletter for the Pro-Life Healthcare Alliance
Thirty-second Edition*

Welcome to the thirty-second 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."

See "Principals and Definitions of the Pro-life Healthcare Philosophy" at <http://www.prolifehealthcare.org/committees/principles-definitions/>



FROM THE EDITOR'S DESK

By Julie Grimstad

Every single human being has the God-given right to life, and a good government recognizes every human being's valid claim to this right by enacting and enforcing laws that protect human lives without exception. The legalization of euthanasia and assisted suicide not only assaults human life, it targets those most in need of protection.

Joseph Conrad, in his novel *Lord Jim*, wrote, "He who wants to persuade should put his trust not in the right argument, but in the right word."

Proponents of euthanasia and assisted suicide are masters of this strategy. They entice by claiming to offer compassion and choices. Instead of "assisted suicide" and "euthanasia," they prefer the euphemism "assisted dying" and insist that everyone use that term. Let's not.

Let's insist on truth in labeling. Killing by any other name is still killing.

Nice-sounding names like "End of Life Option Act" and "Death With Dignity Act" are varnish on garbage.

There is no dignity in killing vulnerable persons, nor any shining mercy.

True mercy is compassion in action. Our challenge is to provide care and comfort to those who are suffering, lonely or despairing. Only by our personal presence and love will we be able to convince them that their lives are worth living.

ASSISTED SUICIDE AND EUTHANASIA UPDATE

California: The End of Life Option Act legalizing assisted suicide went into effect on June 9. This is a terrible law, but it does contain extremely important protection for people of faith and conscience. Brad Dacus, Esq., the founder and president of Pacific Justice Institute, explains: "In an effort to make this deadly law seem more palatable, politicians included provisions that allow doctors and other health care providers to refuse to be part of ending someone's life. These are important provisions--and they must be vigorously enforced." If you are a health care provider in California, don't let anyone coerce you into violating your conscience.

On June 8, the Life Legal Defense Foundation filed a lawsuit challenging California's assisted suicide law. Watch for more details in future editions of *PHA Monthly*.

Canada: On June 17, after several months of debate, the Senate passed Bill C-14 by a vote of 44 to 28. The House of Commons had previously approved the bill. This controversial legislation lays the ground rules for killing Canadians by euthanasia and assisted suicide. It was crafted by Prime Minister Justin Trudeau's government in response to the Canadian Supreme Court striking down the country's ban on assisted suicide in February 2015.

Senator Betty Unger, in a last minute heartfelt speech to her colleagues, declared: "I propose to you that if this legislation was for a clear moral good there would be no need for debate. It would be resoundingly supported not only in these halls, but in the halls of our nation. Yet we do not hear such a sound, fellow Senators. We hear the sound of division, of anger, of disagreement, and of fear. I do not know which is more alarming: The fact that we are on the wrong road, or the fact that we do not recognize it and that so many are cheering." Her entire speech is available at: <http://bettyunger.ca/bill-c-14-i-cannot-support-this-legislation/>

United Kingdom: On June 21, the British Medical Association (BMA) rejected a proposal to take a neutral stance on assisted suicide and euthanasia by a 2 to 1 majority. Read more here: <http://pjsaunders.blogspot.co.uk/2016/06/bma-rejects-attempt-to-push-it-neutral.html>

Note: It is impossible for physicians to be disinterested or on-the-fence about lethally injecting their patients or writing prescriptions for suicide. A position of neutrality is actually a position in favor of killing patients. The BMA's rejection of neutrality maintains the group's stance against assisted suicide and euthanasia.

Announcement: The Patients Rights Action Fund, a national organization opposed to assisted suicide, has launched a new web page where concerned people are invited to "share any personal story that may help others see the untold implications of assisted suicide." Visit this online resource at <http://patientsrightsaction.org/stories>.

CASE IN POINT: A TRISOMY 18 STORY

Katie and Ryan Paul Buck, residents of Des Moines, Iowa, are the parents of two sons, two-year-old Daniel and six-month-old Alexander. Alexander has a chromosomal abnormality, trisomy-18 (t-18), where an extra 18th chromosome exists in a person's genetic makeup, causing severe birth defects. The physician who delivered the news of this diagnosis to Katie and Ryan presented them with the worst case scenario and told them that 90% of babies with t-18 don't make it past the first month.



Defying the doctor's bleak expectations, Alexander is now half way through his first year and his smile melts hearts.

Ryan and Katie have produced a beautiful and hope-filled video, [The Birth of Alexander Buck: A Trisomy 18 Story](https://vimeo.com/170472316), which can be viewed at <https://vimeo.com/170472316>.

Julie Grimstad recently interviewed Katie Buck for *PHA Monthly*.

JG: Did you know before Alexander was born that he had trisomy 18?

KB: No. Trisomy 18 can be either a random occurrence or, in some cases, hereditary. Alex's extra chromosome was not inherited, so we did not expect this. We did not have any prenatal testing done because it is discriminatory against disabled people. We would not have an abortion, no matter what condition our baby might have. None of Alex's t-18 related birth defects showed up on ultrasound. But, in week 33 of my pregnancy, intrauterine growth restriction (IUGR) was detected. IUGR means that the baby is smaller than he should be because he is not growing at a normal rate inside the womb. This condition can have various causes. We assumed Alex would be fine, just tiny.

JG: When did you find out that Alex had t-18?

KB: Labor was induced at 37 weeks because, if he had remained in the womb, he may have died due to IUGR. We would later learn that t-18 babies often are stillborn due to the quality of cord blood flow declining. However, we didn't know Alex had t-18 until three days after he was born. Due to some physical features, a sample of his blood was sent away for FISH testing. It came back positive for t-18.

JG: What happened next?

KB: In our video, you hear the recording of the physician as he delivers the news that Alex's FISH test was positive. It was bad, really bad. He told us all the things that could be wrong with Alex, including significant heart defects, and discouraged us from further testing or surgery to correct a heart defect. Since "90 % don't make it past one month," he asked, "Why put him through it?" We asked about an echo-cardiogram, a simple heart ultrasound that would not hurt him. The doctor said, "I just wouldn't." We got a better doctor the next day and he ordered the echo-cardiogram.

The cardiologist told us not to rush Alex out of the neonatal intensive care unit (NICU) until we were completely comfortable going home. He was very supportive and visited Alex in the NICU every day. We only stayed two weeks. Because there is discrimination against babies with birth defects, we had to ask to keep him in the NICU in order to set up his feeding tube and get him stable. There

were a couple of doctors who pushed hard for us to take him home without even treating his jaundice.

JG: When did you bring Alex home?

KB: At two weeks old. We agreed to hospice care, having been led to believe that, without hospice, we couldn't get home nursing service for quite a while because there was a long waiting list. This was false information.

JG: Can you explain what you mean by "false information?"

KB: We admitted Alex to the hospital with a cold at four weeks old because his blood oxygen level was low. When they saw that we were going to choose aggressive care, hospice reassessed Alex and determined he wasn't imminently dying. We were switched to regular home nursing. It was then that we discovered the waiting list was for full-time nursing care, not part-time care. We were only getting part time hours through hospice anyway. When we switched, the only real difference was the type of care, not the length.

JG: How many times has Alex been hospitalized?

KB: Other than that one time for illness, he has only been hospitalized for tests and for surgery. He had tests for obstructive apnea, a breathing disorder common to babies with t-18, who often have poor tone of their airways. He did catch a cold again, but handled it well and did not need hospitalization. His airway has matured some as he's grown. At three months old, Alex had surgery to place his gastrostomy tube, a feeding tube that goes directly into the stomach and stays in place, making it easier to feed him. At the same time, an intestinal malformation was corrected. He would have needed surgery for his heart defect, but the hole in his heart has almost completely closed on its own and is now quite small. Alex's cardiologist was so happy when he told us Alex would not need surgery after all!

JG: How is Alex doing now?

KB: He's thriving! At birth, Alex weighed only 4 pounds, 5 ounces. At six months, he weighs over 15 pounds and is at 6% on the regular growth chart for babies his age. Nothing in his immediate future is life-threatening, but he is medically fragile.

There are three types of trisomy 18. Mosaic t-18 is when only a percentage of the cells are affected. It is difficult to determine. Full t-18, which Alex tested positive for, is when every single cell in the body is affected. However, because of how well Alex is doing, the geneticist told us to assume he is mosaic. We are pursuing more testing. Many children test as full initially and then mosaicism is later detected. Mosaicism is generally associated with better prognosis, but that is not always the case. The third type of t-18 is called partial and occurs when there is only a piece of the extra chromosome. This type is the only kind that can be inherited. One parent is a carrier, but shows no physical abnormality himself or herself. Mosaic and full are totally random occurrences during a baby's development in the womb.

JG: What are some of the challenges you are still facing with Alex?

KB: Sometimes t-18 children walk and talk. Sometimes they don't. We work with a speech therapist and physical and occupational therapists to help Alex reach his maximum potential. The speech therapist is very encouraged that he may talk because he coos and makes other sounds. He is very

social and smiles a lot. The therapist helping develop Alex's muscle movement has years of experience working with kids with developmental issues. She believes he is going to walk. Either way, all t-18 children enjoy various activities and are happy children with good quality of life regardless of abilities.

JG: Has your extended family been supportive?

KB: Yes, very supportive. The best thing anyone has said to me was when my mom told me, "We're going to help him be the best Alex he can be."

JG: You called Human Life Alliance when Alex was in the NICU, which is when I first heard about Alex. Was that call helpful?

KB: Definitely. We were encouraged with advice and prayer. Joe Langfeld, the deputy director at HLA, referred me to Mary Kellett, the executive director of Prenatal Partners For Life (<http://www.prenatalpartnersforlife.org/>). Mary assured me that we would really enjoy Alex. She taught me to be cautious about what medical professionals tell us, and, in the spirit of Matthew 10:16, to be as "shrewd as serpents and innocent as doves."

JG: Do you have any information or advice to give other parents of babies diagnosed with t-18?

KB: We were told that the extra chromosome would kill Alex. But an extra chromosome has never killed anyone. How well babies with t-18 fare depends on the defects they are born with and the care they receive. Each baby writes their own story.

If your child has a prenatal t-18 diagnosis, be very wary of tactics doctors use to ensure t-18 babies don't survive. They may not monitor the baby for IUGR so a decline in cord blood flow will go undetected, resulting in stillbirth instead of early delivery. Or, they may induce labor very early, before the baby can survive outside the womb.

The experience we had with the doctor and the hospital was not unique. T-18 kids are typically treated this way. It is a common misconception that babies with t-18 don't survive very long and have a poor quality of life. The pattern of destruction of these children's lives and their parents' hopes is so common it could be scripted. Have hope, and find support groups. There is one on Facebook called "Trisomy Families" (<https://www.facebook.com/groups/trisomyfamilies/>) that is popular with long term survivors. The moms in that support group know so much about t-18 that they deserve medical degrees.

Have hope. Regardless of a medical staff's attitude, your baby has value. Your baby matters.

JG: Thank you, Katie. Do you have anything more you'd like people to know?

KB: When we first brought Alex home, the feeling of dread was palpable. The doctor who told us he had t-18 gave Alex only two weeks to live. We knew he could die at any time. But Alex has really blessed us and has taught us so much. He has taught us to live in the moment. None of us is guaranteed tomorrow.

Live for today. Hope for tomorrow.



JUST TO SEE HIM SMILE

By Margaret Pole

We generally accept the fact that meaningful ventures such as pursuing a vocation, sustaining a marriage, raising a family, getting an education, starting a business, entering a profession, and so forth will entail a great deal of time, effort, money, sacrifice, or suffering. We must view caring for our elderly, disabled, and chronically ill family members in the same way. Yes, providing loving, quality care for them can be challenging, and of course, caring for them in a home setting isn't always possible or appropriate. But if you can manage it, I cannot recommend it strongly enough. God's grace and many resources are available to help you through it. No matter how you provide for them, give them the priceless gift of your presence as much as possible. You'll never regret the time and attention you lavish on your elderly parents or other loved ones. Love demands no less.

I hope, by sharing my experiences as my father's caregiver for the last three years of his life, others will find encouragement and helpful ideas about how to advocate and care for their loved ones in similar situations.

In March 2013, I moved in with my beloved elderly parents, then ages 89 and 85, as their caregiver. It was obvious they were no longer capable of living safely on their own. Within a few weeks of my arrival, family members, neighbors, and friends began to comment on my parents' improved health and spirits. Mom and Dad were very appreciative, and I enjoyed caring for them.

In December 2014, Dad fell and fractured his left shoulder bone in multiple places. He received excellent care at the hospital, and despite his mild dementia, his mental state and spirits held up amazingly well throughout his week-long stay. Heart attack and stroke were ruled out as causes. Dad understood what had happened and where he was. Frequent attention from the medical staff lessened his loneliness and gave him a sense of security. He was still able to walk but required

assistance to stand because he couldn't use his left arm and hand. Dad opted to forego the standard surgery for an injured humerus, which, according to the orthopedist, can sometimes heal without surgery.

Just before his discharge, the hospital informed me that Dad needed physical therapy and specialized care in a rehabilitation facility until he improved enough to go home. I very reluctantly agreed to send him to the closest nursing home for rehab on a temporary basis, since, at that time, we weren't adequately prepared to care for him at home. When Dad cheerfully asked if he was going home, it broke my heart to have to tell him no. If I could go back in time, I would insist that the hospital and his own doctor work with me to set up care for him at home prior to his discharge. I was more than willing to do this, but the hospital gave me the impression that we had no option other than sending him to a facility.

Debilitating rehabilitation

I'll never forget the day Dad was transported to the nursing home. He was deposited unceremoniously and left all alone in an empty room. When I arrived, I did my best to make him feel comfortable. I unpacked and arranged his personal items, explaining that this situation was only temporary. But he looked disoriented and depressed, and was largely (and untypically) uncommunicative.

I usually visited Dad daily for a few hours and sometimes for several hours in the evenings. After he was put into bed, I rarely saw any nurses or nurse's aides check on him. Dad didn't understand how to use his call button or the phone, so, if no one checked on him, he couldn't ask for help.

After just a couple of days at this facility, Dad was completely slouched over in his wheelchair, his head almost perpendicular to his chest. When I asked him what was wrong, he said, "My neck hurts." My father, who was 6'2" tall and weighed about 220 pounds, was sitting in a small, short-back wheelchair. He had suffered from chronic back pain for decades and was used to relaxing in a large recliner at home. Dad simply couldn't support his back for an extended period of time. I asked the nursing home doctor to put him in a tall-back wheelchair. When I described the problem, she nonchalantly replied, "Well, their [the patients'] heads hang down when they're falling asleep." I made it clear that he was in pain--not falling asleep. She reluctantly agreed to provide the tall-back chair. Then I promptly transferred his case back to his own primary care doctor.



I discovered Dad was being left in the wheelchair for 10 to 12 consecutive hours daily, which was very uncomfortable, even in a tall-back chair. Therefore, I requested that the staff put him in bed for a nap after lunch. He was accustomed to a long afternoon nap at home, and his therapy and other activities usually took place in the morning. I had to argue with the head physical therapist, who claimed that sitting that long in the wheelchair was "good for his core."

I also realized Dad was now retaining food inside his cheeks after meals. A staff member described this behavior as "pouching" and said it was a symptom of dementia. Dad already had gradually worsening swallowing problems, so it was crucial that his food be divided into small bites.

Prior to his accident, he could do that himself, but now he needed assistance. Nonetheless, the therapists decided he should try to feed himself as much as possible.

When I arrived while meals were in progress in the dining room, I observed that he couldn't eat on his own and was often left unattended. When the dining room had to be cleared, he was fed as quickly as possible, which didn't give him enough time to finish his meal. So, I usually tried to visit him at dinner time in order to feed him in his room at a leisurely pace. Fortunately, the nursing home complied with my request that staff assist him with eating when I wasn't able to be there.

After a couple of weeks, it became painfully evident that Dad was rapidly declining physically, emotionally, and cognitively. I rarely saw him smile anymore. He seemed increasingly depressed, withdrawn, pale, and weak. His usually hearty appetite was decreasing. He was only being given physical therapy 15 or 20 minutes per day, and I saw no evidence of any rehabilitation occurring. I made an appointment with his primary care physician to ask her to issue a discharge order as soon as possible and order physical therapy at home for him, through a reputable home health agency. I silently vowed to get him out of that place one way or the other. Meanwhile, my resourceful brother began looking for a used hospital bed, wheelchair, and hoist lift. We knew we would need the lift, because Dad was no longer walking.

Around the same time, a conscientious nurse's aide showed me that Dad had developed a pressure ulcer. The head nurse claimed it was only "an abrasion." When that nurse wasn't on duty, my niece and I took cell phone photos and texted them to her husband, an experienced internist. He identified it as a stage-two pressure ulcer requiring immediate treatment and informed Dad's physician. She promptly ordered the facility to send him to the nearby hospital's wound management clinic. The head nurse was clearly nervous as she showed me they were now properly bandaging and treating the wound. It was healed by the time we went to the clinic. The clinic confirmed my suspicion that the ulcer was caused by sitting too long.

After a month at the nursing home, Dad was once again put in a short-back wheelchair. I asked his primary care doctor to order his return to a tall-back wheelchair, which she did. However, the physical therapists refused to comply with her order. One told me they would soon need to

discharge Dad because he was making no progress. I responded cheerfully, "Tomorrow we have an appointment with his doctor, and I'll ask her to order his discharge." Once she did so, the therapists suddenly reversed their decision, because Dad had supposedly started walking during a recent therapy session. When I asked how much longer he had to stay, their answer was vague. At the rate Dad was declining, I feared for his life if he remained there much longer.

The great escape

I immediately hired a private-duty certified nurse's aide to stay with Dad a few hours each morning, to observe his care and therapy and report back to me. During the five days she was on duty, she reported he did indeed walk during his physical therapy session, but only once. I believe her presence had the desired effect, because by her fourth day on duty, the therapists announced they would discharge Dad in just a couple of days. We didn't have the necessary medical equipment yet and needed to notify the home health agency, so his doctor ordered the nursing home to keep him there a few more days while we made these arrangements and got the equipment delivered.

My sister and I brought Dad home on January 22, 2015, after six weeks in the nursing home. Besides his usual slumping over in the wheelchair, he was alarmingly weak, pale, and uncommunicative. We're not sure he even recognized us (his family members) or knew he was home again.

I don't blame the nursing home entirely for Dad's decline. I don't think he would have fared well in any setting away from his own home. I've since learned from Julie Grimstad, of the Pro-life Healthcare Alliance, that patients with dementia usually do better mentally and physically at home than in long-term care facilities, precisely because they often become disoriented when institutionalized and this can have the devastating effects that Dad experienced. Yet his mental condition didn't seem to have been taken into account when the hospital made its discharge plan.

The road to recovery

Once he was home, Dad was no longer "pouching" his food because he could eat at his own pace. After a couple of days, he began bouncing back physically, emotionally, and cognitively. His caregivers (who had also seen him at the nursing home) were amazed by his rapid improvement. At the same time, however, we noticed he had severe pain in his right leg. An ultrasound revealed it was full of blood clots. His doctor prescribed appropriate medication, which quickly relieved the pain.

Dad was soon able to partially feed himself and brush his teeth again, and he began to make progress with standing and walking with a walker (with assistance), thanks to caring physical therapists from the home health agency, who spent four hours with him per week. They also trained his caregivers and me to assist him with various exercises. Eventually his injured left arm showed unexpected signs of nerve reconnection and recovery, despite the radial nerve palsy resulting from the injury, and he regained some of the bowel control he had lost while at the

nursing home.

A caregiver came for a few hours each morning, and another came for an hour most evenings to get Dad into bed. We eventually bought a sit-to-stand lift (ideal for a patient who can bear weight on his feet), which was much easier to use than the hooyer lift and allowed me to get him into bed by myself a couple of nights per week. I learned a tremendous amount from our four excellent caregivers, who helped us keep Dad healthy, clean, well groomed, and in good spirits, despite persistent back pain and lingering pain in his left arm and hand.

Dad never fully recovered from the significant cognitive decline he suffered while at the nursing home, but he improved markedly over a period of several months at home. What I yearned for most was to see him feel safe, comfortable, and happy in his own home again, reunited with his beloved wife of 63 years and his family. I wanted to see him smiling again, and my hopes were fulfilled. We enjoyed many sweet moments and many happy family gatherings with Dad over the following year.



A sad discovery

Dad continued to regain strength until the fall of 2015, when he began developing obvious respiratory problems and weakness in the left side of his chest. An x-ray revealed fluid in his right lung. A CT scan was scheduled, but before it could be done, Dad became extremely short of breath and we went to the emergency room with him.

He was hospitalized three times from December 2015 to January 2016. Even before his doctors had diagnosed the reason for the fluid in his lung, they urged me to assign him do-not-resuscitate status, but I refused. By refusing the DNR, I also wanted to make it clear that Dad was not expendable and that we expected full treatment and quality care for him, which he did receive.

During his third hospitalization, he underwent a surgical procedure that helps prevent fluid from re-accumulating in the lung, and a biopsy revealed he had end-stage lung cancer. He was expected to live for two months at most, so I made arrangements for hospice care at home. The surgery proved to be invaluable for helping him breathe comfortably for the remainder of his life.

As had happened in the nursing home, the hospice agency pressured me to fill out a POLST form* for Dad, but I again refused, reminding two hospice liaisons that signing it is voluntary. Later, a kinder and gentler hospice nurse explained that the hospice program is based on an agreement that "heroic measures" will not be used. By then, it made sense to let nature take its course, but since Dad had proven incredibly resilient in the past, I didn't want a POLST form in his medical records in case he improved and needed other medical care later on. Thankfully, instead of the POLST form, she accepted my handwritten statement indicating that if Dad had no pulse and was not breathing, he was not to be resuscitated.

Overall, we had a very positive experience with the home hospice program. The nurse who managed Dad's case gave me general guidelines on pain medication dosage, and she left it up to me to determine how much pain Dad had and administer his medication. This was challenging because he couldn't always communicate clearly. In hindsight, I should have requested an evaluation from the hospice doctor. It was obvious, however, that his pain was steadily increasing, and after about a month, we "graduated" to Fentanyl patches, which brought Dad significant relief. I now wish we had started using them about a week earlier. Other services provided by hospice were very helpful as well.

Ending well

Soon after we started Dad's hospice care, I requested that the hospice agency provide an oxygen concentrator to have on hand in case his oxygen level suddenly plummeted. This happened about a week before he died, when he suddenly became totally unresponsive. His oxygen level returned to normal once we hooked him up to the machine, but he was still unresponsive. We figured that the end was rapidly approaching, but after five hours, while my brother and niece were visiting with him, he was suddenly responsive again. We were elated beyond words to see him look at us and smile, grasp our hands, and return my niece's kiss after she kissed him!

We were given the priceless blessing of Dad being his cheerful self again for the next three days. Even his appetite improved, despite it being increasingly difficult for him to eat even soft foods. Thanks to the machine, his oxygen level remained stable, and we treasured every moment we had left with him. He was then in the active dying phase for about three days, as family members kept a round-the-clock vigil by his bedside, praying, holding his hand, moistening his mouth and lips, and doing our best to keep him comfortable. He was called home by his Creator on March 14 of this year, a week before his ninety-second birthday. He seemed to be very much at peace when he passed away.

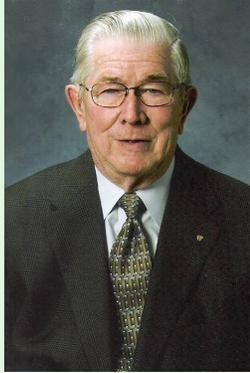
I'm enormously grateful we were able to care for him mostly at home, and I would do it all over again--just to see him smile.

Margaret Pole is a freelance writer and editor. As she promised her father, she now cares for her mother at home.

*Physician Orders for Life-Sustaining Treatment form; see "POLST: What is it and why does the PHA oppose it?" at Prolifehealthcare.org to learn about the dangers of signing this form.

THE APNEA TEST

USED TO DETERMINE "BRAIN DEATH," IT CAN CAUSE DEATH



By Paul A. Byrne, M.D.

The Uniform Determination of Death Act (UDDA) states that a person who has sustained "irreversible cessation of all functions of the entire brain, including the brain stem," is dead. While these words are found in most state statutes, the declaration of "brain death" is determined when the patient (1) cannot demonstrate consciousness; (2) does not have reflex response of cough, gag, eye and ear, which are all brain stem reflexes and 3) is unable to take in a breath when removed from the life supporting ventilator for 10 minutes.

Yes, the ventilator is removed for 10 minutes during what is called the apnea test (not a test for sleep apnea, but a test to see if the patient will breathe on their own). The cruel apnea test, which suffocates the patient, is essential to the clinical declaration of "brain death." Taking away a ventilator needed for life support is harmful to the patient and potentially lethal. 10 minutes without a breath greatly increases carbon dioxide and acids in the blood and tissues of the patient. This is associated with acidosis, which causes the brain to swell and can cause blood pressure to go down, the heart to stop and death of the patient.

The apnea test proves only one thing: the patient needs the ventilator to breathe. It does not prove that the patient is dead. In fact, a ventilator can be effective only in a living person.

The language of the UDDA seems strong, but it is very weak because the declaration is made "in accordance with accepted medical standards." The words "standards," "criteria," and "guidelines" are used interchangeably. In the first 10 years after the UDDA was promulgated, 30 disparate sets of criteria for determining "brain death" were published. A 2012 report on a survey of neurologists in the USA concluded that there was no consensus or consistent rationale as to which set of criteria was to be used.[i] A patient can be declared dead by one set of criteria, while, if another set were used, the same patient would be determined to be alive.

Further study indicated that the criteria are not evidence based.[ii] At that point, the American Academy of Neurology recommended another set of guidelines and the new AAN guidelines were subsequently recommended for general use without further investigation. The AAN guidelines include the apnea test.

Can anyone agree to an apnea test for a loved one with the knowledge that the apnea test will only harm and possibly kill their loved one?

No one should get an apnea test. Doctors and nurses protect and preserve life. To cause harm and/or to kill is contrary to good medicine.

Dr. Paul A. Byrne, a neonatologist and Clinical Professor of Pediatrics at the University of Toledo, is president of the Life Guardian Foundation. For more information, visit <http://www.lifeguardianfoundation.org>

[i]Ari R. Joffe, Natalie R. Anton, Jonathon P. Duff and Allan deCaen, "A survey of American neurologists about brain death: understanding the conceptual basis and diagnostic tests for brain death," *Annals of Intensive Care*, 02/17/2014, 2:4, DOI: 10.1186/2110-5820-2-4

[ii]Joseph L. Verheijde, Mohammed Y. Rady, "The lack of scientific evidence in clinical practice guideline in brain death determination: Implications for organ donation and transplantation," *Indian Journal of Critical Care Medicine*, 9/04/2014, IP: 129.176.151.11

"Protect Yourself"- Get your copy of Human Life Alliance's fact sheet about organ donation!

https://www.humanlife.org/wp-content/uploads/2016/04/OrganDonation_Factsheet_HLA_Mar16_F-sm-2.pdf

ANNOUNCEMENT

LIFE and DEATH MATTERS, a conference retreat at which "brain death," organ transplantation, and other end of life issues will be addressed, is scheduled for July 15, 16 and 17, 2016 in Bloomington, Indiana at Mother of the Redeemer Retreat Center. Speakers will be Paul A. Byrne, MD, Bishop Fabian Bruskewitz, Christine M. Zainer, MD, and Father Elias Mills. **All are welcome.** For more information, contact Mother of the Redeemer Retreat Center: phone 812-825-4642 ext. 200, or email marianoasis@bluemarble.net.

RESOURCES

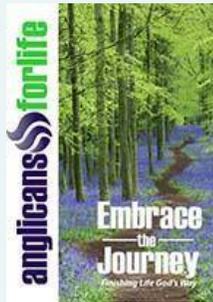


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Embrace the Journey: Finishing Life God's Way, an eight-week series addressing aging and dying which is user-friendly and easy for your church to implement, developed and published by Anglicans for Life, www.AnglicansforLife.org. To order: email Info@AnglicansforLife.org or call 412-749-0455.

Euthanasia Prevention Coalition

Belgium's Advice to Canada is a new online video series on assisted death. As Canadians debate the controversial Bill C-14 in light of the June 6 Supreme Court imposed legislation deadline, the Euthanasia Prevention Coalition (EPC) is releasing four short videos entitled: "Belgium's Advice to Canada" from selected clips from our upcoming documentary film, Vulnerable - The Euthanasia Deception. In January 2016, a film crew went to Belgium, where euthanasia has been legal since 2002. Victims and advocates offer a stern warning to Canada and any country considering enacting laws that allow assisted death. Contact EPC for more information on the online video series and the upcoming documentary film, Vulnerable - The Euthanasia Deception at info@epcc.ca or call: 1-877-439-3348 or 519-851-1434.

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 unborn, 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.

[Join the Pro-Life Healthcare Alliance](http://www.prolifehealthcare.org/pha-membership-request-fillable-form.pdf)

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[Pro-life Healthcare Alliance](http://www.prolifehealthcare.org/) <http://www.prolifehealthcare.org/>

[Hospice Patient's Alliance](http://www.hospicepatients.org/) <http://www.hospicepatients.org/>

[Euthanasia Prevention Coalition](http://alexschadenberg.blogspot.com/) <http://alexschadenberg.blogspot.com/>

[American Life League](http://www.all.org/) <http://www.all.org/>

[Patient's Rights Council](http://www.patientsrightscouncil.org/site/) <http://www.patientsrightscouncil.org/site/>

[Prenatal Partners for Life](http://www.prenatalpartnersforlife.org/) <http://www.prenatalpartnersforlife.org/>

[Read Stealth Euthanasia: Health Care Tyranny in America by Ron Panzer](http://www.hospicepatients.org/this-thing-called-hospice.html)

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The Pro-life Healthcare Alliance needs your support. The suggested PHA membership donation is \$25 per year. Please renew your membership or join today. Be a part of this vitally important work and help the PHA continue and grow.

Pray for renewal of reverence for life. In particular we have designated Thursday as a special day of prayer for the mission of the PHA.

STAY CONNECTED



Pro-life Healthcare Alliance

a program of [Human Life Alliance](#)
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